

**MEDICAL HOME PROVISIONS
IN HEALTH CARE REFORM LEGISLATION
(As of September 17, 2009)**

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SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM. (H.R. 3200 as introduced)

(a) **IN GENERAL.**—For plan years beginning with Y1, the Secretary may utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option. The payment mechanisms and policies under this section may include **patient-centered medical home and other care management payments**, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization based payments, partial capitation, and direct contracting with providers.

(b) **REQUIREMENTS FOR INNOVATIVE PAYMENTS.**—The Secretary shall design and implement the payment mechanisms and policies under this section in a manner that—

(1) seeks to—

(A) improve health outcomes;

(B) reduce health disparities (including racial, ethnic, and other disparities);

(C) provide efficient and affordable care;

(D) address geographic variation in the provision of health services; or

(E) prevent or manage chronic illness; and

(2) promotes care that is integrated, patient-centered, quality, and efficient.

(c) **ENCOURAGING THE USE OF HIGH VALUE SERVICES.**—To the extent allowed by the benefit standards applied to all Exchange-participating health benefits plans, the public health insurance option may modify cost sharing and payment rates to encourage the use of services that promote health and value.

(d) **NON-UNIFORMITY PERMITTED.**—Nothing in this subtitle shall prevent the Secretary from varying payments based on different payment structure models (such as accountable care organizations and medical homes) under the public health insurance option for different geographic areas.

SEC. 1302. MEDICAL HOME PILOT PROGRAM. [Medicare] (H.R. 3200 as introduced)

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 1301, the following new section:

'MEDICAL HOME PILOT PROGRAM

'Sec. 1866E. (a) ESTABLISHMENT AND MEDICAL HOME MODELS.—

'(1) ESTABLISHMENT OF PILOT PROGRAM.—The Secretary shall establish a medical home pilot program (in this section referred to as the 'pilot program') for the purpose of evaluating the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services (as defined under subsection (b)(1)) to high need beneficiaries (as defined in subsection (d)(1)(C)) and to targeted high need beneficiaries (as defined in subsection (c)(1)(C)).

'(2) SCOPE.—Subject to subsection (g), the pilot program shall include urban, rural, and underserved areas.

'(3) MODELS OF MEDICAL HOMES IN THE PILOT PROGRAM.—The pilot program shall evaluate each of the following medical home models:

'(A) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—Independent patient-centered medical home model under subsection (c).

'(B) COMMUNITY-BASED MEDICAL HOME MODEL.—Community-based medical home model under subsection (d).

'(4) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS—

'(A) Nothing in this section shall be construed as preventing a nurse practitioner from leading a patient centered medical home so long as—

'(i) all the requirements of this section are met; and

'(ii) the nurse practitioner is acting consistently with State law.

'(B) Nothing in this section shall be construed as preventing a physician assistant from participating in a patient centered medical home so long as—

'(i) all the requirements of this section are met; and

'(ii) the physician assistant is acting consistently with State law.

'(b) DEFINITIONS.—For purposes of this section:

'(1) PATIENT-CENTERED MEDICAL HOME SERVICES.—The term 'patient-centered medical home services' means services that—

'(A) provide beneficiaries with direct and ongoing access to a primary care or principal care by a physician or nurse practitioner who accepts responsibility for providing first contact, continuous and comprehensive care to such beneficiary;

'(B) coordinate the care provided to a beneficiary by a team of individuals at the practice level across office, institutional and home settings led by a primary care or principal care physician or nurse practitioner, as needed and appropriate;

'(C) provide for all the patient's health care needs or take responsibility for appropriately arranging care with other qualified providers for all stages of life;

'(D) provide continuous access to care and communication with participating beneficiaries;

'(E) provide support for patient self-management, proactive and regular patient monitoring, support for family caregivers, use patient-centered processes, and coordination with community resources;

'(F) integrate readily accessible, clinically useful information on participating patients that enables the practice to treat such patients comprehensively and systematically; and

'(G) implement evidence-based guidelines and apply such guidelines to the identified needs of beneficiaries over time and with the intensity needed by such beneficiaries.

'(2) PRIMARY CARE.—The term 'primary care' means health care that is provided by a physician or nurse practitioner who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine.

'(3) PRINCIPAL CARE.—The term 'principal care' means integrated, accessible health care that is provided by a physician who is a medical subspecialist that addresses the majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management.

'(c) INDEPENDENT PATIENT-CENTERED MEDICAL HOME MODEL.—

'(1) IN GENERAL.—

'(A) PAYMENT AUTHORITY.—Under the independent patient-centered medical home model under this subsection, the Secretary shall make payments for medical home services furnished by an independent patient-centered medical home (as defined in subparagraph (B)) pursuant to paragraph (3)(B) for a targeted high need beneficiaries (as defined in subparagraph (C)).

'(B) INDEPENDENT PATIENT-CENTERED MEDICAL HOME DEFINED.—In this section, the term 'independent patient-centered medical home' means a physician-directed or nurse-practitioner-directed practice that is qualified under paragraph (2) as—

'(i) providing beneficiaries with patient-centered medical home services; and

'(ii) meets such other requirements as the Secretary may specify.

'(C) TARGETED HIGH NEED BENEFICIARY DEFINED.—For purposes of this subsection, the term 'targeted high need beneficiary' means a high need beneficiary who, based on a risk score as specified by the Secretary, is generally within the upper 50th percentile of Medicare beneficiaries.

'(D) BENEFICIARY ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that beneficiaries have agreed to participate in the pilot program.

'(E) IMPLEMENTATION.—The pilot program under this subsection shall begin no later than 6 months after the date of the enactment of this section.

'(2) STANDARD SETTING AND QUALIFICATION PROCESS FOR PATIENT-CENTERED MEDICAL HOMES.—The Secretary shall review alternative models for standard setting and qualification, and shall establish a process—

'(A) to establish standards to enable medical practices to qualify as patient-centered medical homes; and

'(B) to initially provide for the review and certification of medical practices as meeting such standards.

'(3) PAYMENT.—

'(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished by independent patient-centered medical homes. Under such methodology, the Secretary shall adjust payments to medical homes based on beneficiary risk scores to ensure that higher payments are made for higher risk beneficiaries.

'(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall pay independent patient-centered medical homes a monthly fee for each targeted high need beneficiary who consents to receive medical home services through such medical home.

'(C) PROSPECTIVE PAYMENT.—The fee under subparagraph (B) shall be paid on a prospective basis.

'(D) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

'(i) The clinical work and practice expenses involved in providing the medical home services provided by the independent patient-centered medical home (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

'(ii) Allow for differential payments based on capabilities of the independent patient-centered medical home.

'(iii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph in a manner that ensures that higher payments are made for higher risk beneficiaries.

'(4) ENCOURAGING PARTICIPATION OF VARIETY OF PRACTICES.—The pilot program under this subsection shall be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians, as well as physicians in larger practices, particularly in underserved and rural areas, as well as federally qualified community health centers, and rural health centers.

'(5) NO DUPLICATION IN PILOT PARTICIPATION.—A physician in a group practice that participates in the accountable care organization pilot program under section 1866D shall not be eligible to participate in the pilot program under this subsection, unless the pilot program under this section has been implemented on a permanent basis under subsection (e)(3).

'(d) COMMUNITY-BASED MEDICAL HOME MODEL.—

'(1) IN GENERAL.—

'(A) AUTHORITY FOR PAYMENTS.—Under the community-based medical home model under this subsection (in this section referred to as the 'CBMH model'), the Secretary shall make

payments for the furnishing of medical home services by a community-based medical home (as defined in subparagraph (B)) pursuant to paragraph (5)(B) for high need beneficiaries.

‘(B) COMMUNITY-BASED MEDICAL HOME DEFINED.—In this section, the term ‘community-based medical home’ means a nonprofit community-based or State-based organization that is certified under paragraph (2) as meeting the following requirements:

‘(i) The organization provides beneficiaries with medical home services.

‘(ii) The organization provides medical home services under the supervision of and in close collaboration with the primary care or principal care physician or nurse practitioner designated by the beneficiary as his or her community-based medical home provider.

‘(iii) The organization employs community health workers, including nurses or other non-physician practitioners, lay health workers, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician or nurse practitioner in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area.

‘(iv) The organization meets such other requirements as the Secretary may specify.

‘(C) HIGH NEED BENEFICIARY.—In this section, the term ‘high need beneficiary’ means an individual who requires regular medical monitoring, advising, or treatment.

‘(2) QUALIFICATION PROCESS FOR COMMUNITY-BASED MEDICAL HOMES.—The Secretary shall establish a process—

‘(A) for the initial qualification of community-based or State-based organizations as community-based medical homes; and

‘(B) to provide for the review and qualification of such community-based and State-based organizations pursuant to criteria established by the Secretary.

‘(3) DURATION.—The pilot program for community-based medical homes under this subsection shall start no later than 2 years after the date of the enactment of this section. Each demonstration site under the pilot program shall operate for a period of up to 5 years after the initial implementation phase, without regard to the receipt of a initial implementation funding under subsection (i).

‘(4) PREFERENCE.—In selecting sites for the CBMH model, the Secretary may give preference to—

‘(A) applications from geographic areas that propose to coordinate health care services for chronically ill beneficiaries across a variety of health care settings, such as primary care physician practices with fewer than 10 physicians, specialty physicians, nurse practitioner practices, Federally qualified health centers, rural health clinics, and other settings;

‘(B) applications that include other payors that furnish medical home services for chronically ill patients covered by such payors; and

‘(C) applications from States that propose to use the medical home model to coordinate health care services for individuals enrolled under this title, individuals enrolled under title XIX, and full-benefit dual eligible individuals (as defined in section 1935(c)(6)) with chronic diseases across a variety of health care settings.

'(5) PAYMENTS.—

'(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished under the CBMH model.

'(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall make two separate monthly payments for each high need beneficiary who consents to receive medical home services through such medical home, as follows:

'(i) PAYMENT TO COMMUNITY-BASED ORGANIZATION.—One monthly payment to a community-based or State-based organization.

'(ii) PAYMENT TO PRIMARY OR PRINCIPAL CARE PRACTICE.—One monthly payment to the primary or principal care practice for such beneficiary.

'(C) PROSPECTIVE PAYMENT.—The payments under subparagraph (B) shall be paid on a prospective basis.

'(D) AMOUNT OF PAYMENT.—In determining the amount of such payment, the Secretary shall consider the following:

'(i) The clinical work and practice expenses involved in providing the medical home services provided by the community-based medical home (such as providing increased access, care coordination, care plan setting, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

'(ii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph.

'(6) INITIAL IMPLEMENTATION FUNDING.—The Secretary may make available initial implementation funding to a community based or State-based organization or a State that is participating in the pilot program under this subsection. Such organization shall provide the Secretary with a detailed implementation plan that includes how such funds will be used.

'(e) EXPANSION OF PROGRAM.—

'(1) EVALUATION OF COST AND QUALITY.—The Secretary shall evaluate the pilot program to determine—

'(A) the extent to which medical homes result in—

'(i) improvement in the quality and coordination of health care services, particularly with regard to the care of complex patients;

'(ii) improvement in reducing health disparities;

'(iii) reductions in preventable hospitalizations;

'(iv) prevention of readmissions;

'(v) reductions in emergency room visits;

'(vi) improvement in health outcomes, including patient functional status where applicable;

'(vii) improvement in patient satisfaction;

'(viii) improved efficiency of care such as reducing duplicative diagnostic tests and laboratory tests; and

'(ix) reductions in health care expenditures; and

'(B) the feasibility and advisability of reimbursing medical homes for medical home services under this title on a permanent basis.

'(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (1).

'(3) EXPANSION OF PROGRAM.—

'(A) IN GENERAL.—Subject to the results of the evaluation under paragraph (1) and subparagraph (B), the Secretary may issue regulations to implement, on a permanent basis, one or more models, if, and to the extent that such model or models, are beneficial to the program under this title, including that such implementation will improve quality of care, as determined by the Secretary.

'(B) CERTIFICATION REQUIREMENT.—The Secretary may not issue such regulations unless the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the expansion of the components of the pilot program described in subparagraph (A) would result in estimated spending under this title that would be no more than the level of spending that the Secretary estimates would otherwise be spent under this title in the absence of such expansion.

'(f) ADMINISTRATIVE PROVISIONS.—

'(1) NO DUPLICATION IN PAYMENTS.—During any month, the Secretary may not make payments under this section under more than one model or through more than one medical home under any model for the furnishing of medical home services to an individual.

'(2) NO EFFECT ON PAYMENT FOR EVALUATION AND MANAGEMENT SERVICES.—Payments made under this section are in addition to, and have no effect on the amount of, payment for evaluation and management services made under this title.

'(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to this section.

'(g) FUNDING.—

'(1) OPERATIONAL COSTS.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in addition to funds otherwise available, there shall be transferred from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services Program Management Account \$6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

'(2) PATIENT-CENTERED MEDICAL HOME SERVICES.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841—

'(A) \$200,000,000 for each of fiscal years 2010 through 2014 for payments for medical home services under subsection (c)(3); and

'(B) \$125,000,000 for each of fiscal years 2012 through 2016, for payments under subsection (d)(5).

Amounts available under this paragraph for a fiscal year shall be available until expended.

'(3) INITIAL IMPLEMENTATION.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, \$2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(6). Amounts available under this paragraph for a fiscal year shall be available until expended.

'(h) TREATMENT OF TRHCA MEDICARE MEDICAL HOME DEMONSTRATION FUNDING.—

'(1) In addition to funds otherwise available for payment of medical home services under subsection (c)(3), there shall also be available the amount provided in subsection (g) of section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b-1 note).

'(2) Notwithstanding section 1302(c) of the America's Affordable Health Choices Act of 2009, in addition to funds provided in paragraph (1) and subsection (g)(2)(A), the funding for medical home services that would otherwise have been available if such section 204 medical home demonstration had been implemented (without regard to subsection (g) of such section) shall be available to the independent patient-centered medical home model described in subsection (c).'

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the date of the enactment of this Act.

(c) CONFORMING REPEAL.—Section 204 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395b-1 note), as amended by section 133(a)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), is repealed.

SEC. 1722. MEDICAL HOME PILOT PROGRAM. [Medicaid] (H.R. 3200 as introduced)

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish under this section a medical home pilot program under which a State may apply to the Secretary for approval of a medical home pilot project described in subsection (b) (in this section referred to as a 'pilot project') for the application of the medical home concept under title XIX of the Social Security Act. The pilot program shall operate for a period of up to 5 years.

(b) PILOT PROJECT DESCRIBED.—

(1) IN GENERAL.—A pilot project is a project that applies one or more of the medical home models described in section 1866E(a)(3) of the Social Security Act (as inserted by section 1302(a)) or such other model as the Secretary may approve, to high need beneficiaries (including medically fragile children and high-risk pregnant women) who are eligible for medical assistance under title XIX of the Social Security Act. The Secretary shall provide for appropriate coordination of the pilot program under this section with the medical home pilot program under section 1866E of such Act.

(2) LIMITATION.—A pilot project shall be for a duration of not more than 5 years.

(c) ADDITIONAL INCENTIVES.—In the case of a pilot project, the Secretary may—

(1) waive the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) and section 1902(a)(10)(B) of such Act (relating to comparability); and

(2) increase to up to 90 percent (for the first 2 years of the pilot program) or 75 percent (for the next 3 years) the matching percentage for administrative expenditures (such as those for community care workers).

(d) MEDICALLY FRAGILE CHILDREN.—In the case of a model involving medically fragile children, the model shall ensure that the patient-centered medical home services received by each child, in addition to fulfilling the requirements under 1866E(b)(1) of the Social Security Act, provide for continuous involvement and education of the parent or caregiver and for assistance to the child in obtaining necessary transitional care if a child's enrollment ceases for any reason.

(e) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary, using the criteria described in section 1866E(g)(1) of the Social Security Act (as inserted by section 1123), shall conduct an evaluation of the pilot program under this section.

(2) REPORT.—Not later than 60 days after the date of completion of the evaluation under paragraph (1), the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under such paragraph.

(f) FUNDING.—The additional Federal financial participation resulting from the implementation of the pilot program under this section may not exceed in the aggregate \$1,235,000,000 over the 5-year period of the program.

SEC. 212. GRANTS TO ESTABLISH COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME. (As passed by HELP Committee)

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall establish a program to provide grants to eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as “health teams”) to support primary care practices, including obstetrics and gynecology practices, within the hospital service areas served by the eligible entities. Grants shall be used to—

- (1) establish health teams to provide support services to primary care providers; and
- (2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian Tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) submit a plan for achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care management resources into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) ensure that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, nutritionists, dietitians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants; and

(5) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS FOR HEALTH TEAMS.—A health team established pursuant to a grant under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) payment that recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers and existing State and community based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication reconciliation;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services to those who request such services; (G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides onsite visits from the care coordinator, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assuring that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(8) serve as a liaison to community prevention and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology that meets the requirements of certified EHR technology (as defined in section 3000 of the Public Health Service Act (42 U.S.C. 300jj)) to facilitate coordination among members of the applicable care team and affiliated primary care practices; and

(10) where applicable, report to the Secretary information on quality measures used under section 399JJ of the Public Health Service Act.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDERS.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) REPORTING TO SECRETARY.—An entity that receives a grant under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) DEFINITION OF PRIMARY CARE.—In this section, the term “primary care” means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

MEDICAID STATE PLAN OPTION PROMOTING HEALTH HOMES AND INTEGRATED CARE (As proposed by Finance Committee)

Current Law

The Tax Relief and Health Care Act of 2006 (TRCHA, P.L. 109-432) mandated CMS to establish a Medicare medical home demonstration project. However, there is currently no such provision under the Medicaid program.

Chairman's Mark

The Chairman's Mark would create a new Medicaid state plan option under which Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition, could designate a provider as their health home. Qualifying providers would have to meet certain standards established by the Secretary, including demonstrating that they have the systems and infrastructure in place to provide comprehensive and timely high-quality care either in-house or by contracting with a team of health professionals. The designated provider or a team of health professionals would offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services. Teams of providers could be free-standing, virtual, or based at a hospital, community health center, clinic, physician's office, or physician group practice. Designated providers would be required to report to the state on all applicable quality measures in the state Medicaid program. The state would develop a mechanism to pay the health home for services rendered. The state plan amendment would include a plan for tracking avoidable hospital readmissions and plan for producing savings resulting from improved chronic care coordination and management. The Mark will provide an enhanced match of 90 percent FMAP for two years for states that take up this option. In addition, small planning grants may be available to help states intending to take up this option. FMAP rules would apply.

The Mark would require the Secretary to survey states and report to Congress on the nature, extent, and use of this option, particularly as it pertains to hospital admission rates, chronic disease management, and coordination of care for the chronically ill. The state option would be available beginning on January 1, 2011. After two years there would be an independent evaluation of the impact of this option on reducing hospital admissions.

CMS INNOVATION CENTER

Current Law

The Social Security Amendments of 1967, as amended, provide the Secretary of HHS with broad authority to develop research and demonstration projects to test new approaches to paying providers, delivering health care services, or providing benefits to Medicare beneficiaries. Specifically, demonstrations designed to test changes in provider payment are required to increase the efficiency and economy of health care services without adversely affecting quality. Currently CMS is conducting approximately 30 Medicare demonstrations. Some of the key themes addressed in these demonstrations include coordinated care, pay for performance, HIT, and quality improvement. Although demonstrations may be initiated by both the agency and Congress, the number of congressionally mandated demonstrations has increased in recent years.

Section 646 of the MMA mandates that CMS conduct a five-year demonstration program to test ways to improve health outcomes while increasing efficiency. This demonstration, called the Medicare Health Care Quality demonstration, aims to improve patient safety, enhance quality, and reduce variation in medical practice that often in higher costs. One of the major goals of this demonstration is to see if Medicare can improve outcomes while simultaneously achieving cost savings. Improvements in care coordination are one strategy that CMS anticipates providers will attempt as they strive to improve quality but reduce costs. Two demonstration projects under this demonstration are scheduled to begin in 2009 with two others to begin soon thereafter.

Chairman's Mark

The Chairman's Mark would require the Secretary to create an Innovation Center within the Centers for Medicaid and Medicare Services (CMS). The Innovation Center will be a new office established within CMS that is authorized to test, evaluate, and expand different payment structures and methodologies which aim to foster patient-centered care, improve quality, and slow the rate of Medicare cost growth. The Mark would also make permanent the authority granted to the Secretary under Section 646 of the MMA (section 1866C of the Social Security Act).

The Center would be required to conduct an evaluation of each model tested, including an analysis of the extent to which the model results in: (1) coordination of health care services across treatment settings; (2) reduction of preventable hospitalizations; (3) prevention of hospital readmissions; (4) reduction of emergency room visits; (5) improvement in quality and health outcomes; (6) improvement in the efficiency of care; (7) reduction in the cost of health care services covered under this title; and (8) achievement of beneficiary and family-caregiver satisfaction.

In order to facilitate the timely design, implementation, and evaluation of payment models by the Center, the Mark exempts the Center from budget-neutrality requirements for an initial testing period. The Center would be given the authority to terminate or modify the design of models at any time during a testing period.

To support its work, including the Center's evaluation component, the Center would be required to consult regularly with outside experts and stakeholders, including the Medicare Payment Advisory Commission (MedPAC), health professionals with demonstrated expertise in chronic care management of older adults, and representatives of patients and caregivers.

The Secretary would be given the authority to expand the duration or the scope of any project undertaken by the Center if the Secretary determines that doing so would improve the quality of patient care and reduce the rate of growth of Medicare fee-for-service expenditures. The

expected reduction in future Medicare expenditures must be certified by the CMS Office of the Actuary before an expansion could occur.

The Center would be required to test and evaluate patient-centered delivery and payment models. The Center would review models that have shown evidence of success in the Medicare population. The Center would consider models that target beneficiaries who are dually-eligible for both Medicare and Medicaid, and beneficiaries with multiple chronic conditions and at least one of the following: (1) an inability to perform 2 or more activities of daily living; and (2) a cognitive impairment, including dementia.

In addition, the Center would be required to consider for testing, at a minimum, models that achieve at least one of the following criteria:

1. Promote broad payment and practice reform in primary care, including patient-centered medical home models for high-need beneficiaries, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment;

2. Contract directly with groups of providers and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payments;

3. Support care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization through a health IT-enabled network that includes a chronic disease registry, home tele-health technology, and care oversight by the beneficiary's treating physician;

4. Vary payment to physicians ordering advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders;

5. Utilize medication therapy management services;

6. Establish community-based health teams to support small-practice medical homes by assisting the principal primary care practitioner in chronic care management activities;

7. Fund physician, nurse practitioner, or physician assistant-led home-based primary care programs with demonstrated experience in serving high-cost beneficiaries with multiple chronic illnesses and functional disabilities;

8. Establish a program to assist beneficiaries in making informed health care choices by paying providers for using patient decision-support tools that improve beneficiary and caregiver understanding of their medical treatment options;

9. Allow states to test and evaluate fully integrating care for dually eligible members, including the management and oversight of all Medicare and Medicaid funds for this population;

10. Allow states to test and evaluate systems of all-payer payment reform for medical care of residents in each participating State, including individuals dually eligible for Medicare and Medicaid;

11. Align nationally-recognized, evidence-based guidelines of cancer care with Medicare payment incentives in the areas of treatment planning and follow-up care planning for Medicare beneficiaries with cancer, including the identification of gaps in current quality measures;

12. Improve post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospital, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge;

13. Fund home health providers who offer chronic care management services to Medicare beneficiaries in cooperation with interdisciplinary teams.

In selecting models for testing, the Secretary shall also consider the extent to which models meet the following criteria:

1. Foster care coordination for high-cost, chronically ill Medicare beneficiaries who are at highest risk for hospitalization or readmission;
2. Place the patient, including family members and other informal caregivers, at the center of the care team;
3. Include, but are not limited to, in-person contact with beneficiaries;
4. Utilize technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time;
5. Maintain a close relationship between care coordinators and primary care practitioners;
6. Rely on a team-based approach to interventions such as comprehensive care assessments, care planning, and self-management coaching.

To be approved for expansion, models would be required to demonstrate that they meet patient-centered criteria as determined by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

Within 18 months of enactment, the Center would be required to post on the CMS website a report on the Center's initial consideration of the models listed above, as well as a detailed plan for the continuing work of the Center.

The Chairman's Mark would appropriate \$10 billion from the Part A and Part B Trust Funds to the Center over 10 years. The costs of otherwise uncovered benefits delivered under this authority would be counted against the Center's overall funding level. In addition, the Center would be required to directly allocate a portion of such funding for the Center's evaluation activities.