

110TH CONGRESS
1ST SESSION

S. 2376

To establish a demonstration project to provide for patient-centered medical homes to improve the effectiveness and efficiency in providing medical assistance under the Medicaid program and child health assistance under the State Children's Health Insurance Program.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 16, 2007

Mr. DURBIN (for himself and Mr. BURR) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To establish a demonstration project to provide for patient-centered medical homes to improve the effectiveness and efficiency in providing medical assistance under the Medicaid program and child health assistance under the State Children's Health Insurance 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 "Medical Homes Act
5 of 2007".

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

1 (1) Medical homes provide patient-centered
2 care, leading to better health outcomes and greater
3 patient satisfaction. A growing body of research sup-
4 ports the need to involve patients and their families
5 in their own health care decisions, to better inform
6 them of their treatment options, and to improve
7 their access to information.

8 (2) Medical homes help patients better manage
9 chronic diseases and maintain basic preventive care,
10 resulting in better health outcomes than those who
11 lack medical homes. An investigation of the Chronic
12 Care Model discovered that the medical home re-
13 duced the risk of cardiovascular disease in diabetes
14 patients, helped congestive heart failure patients be-
15 come more knowledgeable and stay on recommended
16 therapy, and increased the likelihood that asthma
17 and diabetes patients would receive appropriate ther-
18 apy.

19 (3) Medical homes also reduce disparities in ac-
20 cess to care. A survey conducted by the Common-
21 wealth Fund found that 74 percent of adults with a
22 medical home have reliable access to the care they
23 need, compared with only 52 percent of adults with
24 a regular provider that is not a medical home and

1 38 percent of adults without any regular source of
2 care or provider.

3 (4) Medical homes reduce racial and ethnic dif-
4 ferences in access to medical care. Three-fourths of
5 Caucasians, African Americans, and Hispanics with
6 medical homes report getting care when they need it
7 in a medical home.

8 (5) Medical homes reduce duplicative health
9 services and inappropriate emergency room use. In
10 1998, North Carolina launched the Community Care
11 of North Carolina (CCNC) program, which employs
12 the medical home concept. Today CCNC includes 14
13 networks, that include all Federally qualified health
14 centers in the State, covering 740,000 recipients
15 across the entire State. An analysis conducted by
16 Mercer Human Resources Consulting Group found
17 that CCNC resulted in \$244,000,000 in savings to
18 the Medicaid program in 2004, with similar results
19 in 2005 and 2006.

20 (6) Health information technology is a crucial
21 foundation for medical homes. While many doctor's
22 offices use electronic health records for billing or
23 other administrative functions, few practices utilize
24 health information technology systematically to
25 measure and improve the quality of care they pro-

1 vide. For example, electronic health records can gen-
 2 erate reports to ensure that all patients with chronic
 3 conditions receive recommended tests and are on
 4 target to meet their treatment goals. Computerized
 5 ordering systems, particularly with decision-support
 6 tools, can prevent medical and medication errors,
 7 while e-mail and interactive Internet websites can fa-
 8 cilitate communication between patients and pro-
 9 viders and patient education.

10 **SEC. 3. MEDICAID AND SCHIP DEMONSTRATION PROJECT**
 11 **TO SUPPORT PATIENT-CENTERED PRIMARY**
 12 **CARE.**

13 (a) DEFINITIONS.—In this section:

14 (1) CARE MANAGEMENT MODEL.—The term
 15 “care management model” means a model that—

16 (A) uses health information technology and
 17 other innovations such as the chronic care
 18 model, to improve the management and coordi-
 19 nation of care provided to patients;

20 (B) is centered on the relationship between
 21 a patient and their personal primary care pro-
 22 vider;

23 (C) seeks guidance from—

24 (i) a steering committee; and

1 (ii) a medical management committee;

2 and

3 (D) has established, where practicable, ef-
4 fective referral relationships between the pri-
5 mary care provider and the major medical spe-
6 cialties and ancillary services in the region.

7 (2) HEALTH CENTER.—The term “health cen-
8 ter” has the meaning given that term in section
9 330(a) of the Public Health Service Act (42 U.S.C.
10 254b(a)).

11 (3) MEDICAID.—The term “Medicaid” means
12 the program for medical assistance established under
13 title XIX of the Social Security Act (42 U.S.C. 1396
14 et seq.).

15 (4) MEDICAL MANAGEMENT COMMITTEE.—The
16 term “medical management committee” means a
17 group of local practitioners that—

18 (A) reviews evidence-based practice guide-
19 lines;

20 (B) selects targeted diseases and care
21 processes that address health conditions of the
22 community (as identified in the National or
23 State health assessment or as outlined in
24 “Healthy People 2010”, or any subsequent

1 similar report (as determined by the Sec-
2 retary));

3 (C) defines programs to target diseases
4 and care processes;

5 (D) establishes standards and measures
6 for patient-centered medical homes, taking into
7 account nationally-developed standards and
8 measures; and

9 (E) makes the determination described in
10 subparagraph (A)(iii) of paragraph (5), taking
11 into account the considerations under subpara-
12 graph (B) of such paragraph.

13 (5) PATIENT-CENTERED MEDICAL HOME.—

14 (A) IN GENERAL.—The term “patient-cen-
15 tered medical home” means a physician-directed
16 practice or a health center that—

17 (i) incorporates the attributes of the
18 care management model described in para-
19 graph (1);

20 (ii) voluntarily participates in an inde-
21 pendent evaluation process whereby pri-
22 mary care providers submit information to
23 the medical management committee of the
24 relevant network;

1 (iii) the medical management com-
2 mittee determines has the capability to
3 achieve improvements in the management
4 and coordination of care for targeted bene-
5 ficiaries (as defined by Statewide quality
6 improvement standards and outcomes);
7 and

8 (iv) meets the requirements imposed
9 on a covered entity for purposes of apply-
10 ing part C of title XI of the Public Health
11 Service Act (42 U.S.C. 300b–1 et seq.)
12 and all regulatory provisions promulgated
13 thereunder, including regulations (relating
14 to privacy) adopted pursuant to the au-
15 thority of the Secretary under section
16 264(c) of the Health Insurance Portability
17 and Accountability Act of 1996 (42 U.S.C.
18 1320d–2 note).

19 (B) CONSIDERATIONS.—In making the de-
20 termination under subparagraph (A)(iii), the
21 medical management committee shall consider
22 the following:

23 (i) ACCESS AND COMMUNICATION
24 WITH PATIENTS.—Whether the practice or
25 health center applies both standards for

1 access to care for and standards for com-
2 munication with targeted beneficiaries who
3 receive care through the practice or health
4 center.

5 (ii) MANAGING PATIENT INFORMA-
6 TION AND USING INFORMATION MANAGE-
7 MENT TO SUPPORT PATIENT CARE.—

8 Whether the practice or health center has
9 readily accessible, clinically useful informa-
10 tion on such beneficiaries that enables the
11 practice or health center to comprehen-
12 sively and systematically treat such bene-
13 ficiaries.

14 (iii) MANAGING AND COORDINATING
15 CARE ACCORDING TO INDIVIDUAL
16 NEEDS.—Whether the practice or health
17 center—

18 (I) maintains continuous rela-
19 tionships with such beneficiaries by
20 implementing evidence-based guide-
21 lines and applying such guidelines to
22 the identified needs of individual bene-
23 ficiaries over time and with the inten-
24 sity needed by such beneficiaries;

1 (II) assists in the early identifica-
2 tion of health care needs;

3 (III) provides ongoing primary
4 care; and

5 (IV) coordinates with a broad
6 range of other specialty, ancillary, and
7 related services.

8 (iv) PROVIDING ONGOING ASSISTANCE
9 AND ENCOURAGEMENT IN PATIENT SELF-
10 MANAGEMENT.—Whether the practice or
11 health center—

12 (I) collaborates with targeted
13 beneficiaries who receive care through
14 the practice or health center to pursue
15 their goals for optimal achievable
16 health;

17 (II) assesses patient-specific bar-
18 riers; and

19 (III) conducts activities to sup-
20 port patient self-management.

21 (v) RESOURCES TO MANAGE CARE.—
22 Whether the practice or health center has
23 in place the resources and processes nec-
24 essary to achieve improvements in the
25 management and coordination of care for

1 targeted beneficiaries who receive care
2 through the practice or health center.

3 (vi) MONITORING PERFORMANCE.—

4 Whether the practice or health center—

5 (I) monitors its clinical process
6 and performance (including process
7 and outcome measures) in meeting
8 the applicable standards under para-
9 graph (4)(D); and

10 (II) provides information in a
11 form and manner specified by the
12 steering committee and medical man-
13 agement committee with respect to
14 such process and performance.

15 (6) PERSONAL PRIMARY CARE PROVIDER.—The
16 term “personal primary care provider” means—

17 (A) a physician, nurse practitioner, or
18 other qualified health care provider (as deter-
19 mined by the Secretary), who—

20 (i) practices in a patient-centered
21 medical home; and

22 (ii) has been trained to provide first
23 contact, continuous, and comprehensive
24 care for the whole person, not limited to a
25 specific disease condition or organ system,

1 including care for all types of health condi-
2 tions (such as acute care, chronic care, and
3 preventive services); or

4 (B) a health center that—

5 (i) is a patient-centered medical home;

6 and

7 (ii) has providers on staff that have
8 received the training described in subpara-
9 graph (A)(ii).

10 (7) PRIMARY CARE CASE MANAGEMENT SERV-
11 ICES; PRIMARY CARE CASE MANAGER.—The terms
12 “primary care case management services” and “pri-
13 mary care case manager” have the meaning given
14 those terms in section 1905(t) of the Social Security
15 Act (42 U.S.C. 1396d(t)).

16 (8) PROJECT.—The term “project” means the
17 demonstration project established under this section.

18 (9) SCHIP.—The term “SCHIP” means the
19 State Children’s Health Insurance Program estab-
20 lished under title XXI of the Social Security Act (42
21 U.S.C. 1396aa et seq.).

22 (10) SECRETARY.—The term “Secretary”
23 means the Secretary of Health and Human Services.

24 (11) STEERING COMMITTEE.—The term “steer-
25 ing committee” means a local management group

1 comprised of collaborating local health care practi-
2 tioners or a local not-for-profit network of health
3 care practitioners—

4 (A) that implements State-level initiatives;

5 (B) that develops local improvement initia-
6 tives;

7 (C) whose mission is to—

8 (i) investigate questions related to
9 community-based practice; and

10 (ii) improve the quality of primary
11 care; and

12 (D) whose membership—

13 (i) represents the health care delivery
14 system of the community it serves; and

15 (ii) includes physicians (with an em-
16 phasis on primary care physicians) and 1
17 representative from each part of the col-
18 laborative or network (such as a represent-
19 ative from a health center, a representative
20 from the health department, a representa-
21 tive from social services, and a representa-
22 tive from each public and private hospital
23 in the collaborative or the network).

24 (12) TARGETED BENEFICIARY.—

1 (A) IN GENERAL.—The term “targeted
2 beneficiary” means an individual who is eligible
3 for benefits under a State plan under Medicaid
4 or a State child health plan under SCHIP.

5 (B) PARTICIPATION IN PATIENT-CEN-
6 TERED MEDICAL HOME.—Individuals who are
7 eligible for benefits under Medicaid or SCHIP
8 in a State selected to participate in the project
9 shall receive care through a patient-centered
10 medical home when available.

11 (C) ENSURING CHOICE.—In the case of
12 such an individual who receives care through a
13 patient-centered medical home, the individual
14 shall receive guidance from their personal pri-
15 mary care provider on appropriate referrals to
16 other health care professionals in the context of
17 shared decisionmaking.

18 (b) ESTABLISHMENT.—The Secretary shall establish
19 a demonstration project under Medicaid and SCHIP for
20 the implementation of a patient-centered medical home
21 program that meets the requirements of subsection (d) to
22 improve the effectiveness and efficiency in providing med-
23 ical assistance under Medicaid and child health assistance
24 under SCHIP to an estimated 500,000 to 1,000,000 tar-
25 geted beneficiaries.

1 (c) PROJECT DESIGN.—

2 (1) DURATION.—The project shall be conducted
3 for a 3-year period, beginning not later than October
4 1, 2009.

5 (2) SITES.—

6 (A) IN GENERAL.—The project shall be
7 conducted in 8 States—

8 (i) four of which already provide med-
9 ical assistance under Medicaid for primary
10 care case management services as of the
11 date of enactment of this Act; and

12 (ii) four of which do not provide such
13 medical assistance.

14 (B) APPLICATION.—A State seeking to
15 participate in the project shall submit an appli-
16 cation to the Secretary at such time, in such
17 manner, and containing such information as the
18 Secretary may require.

19 (C) SELECTION.—In selecting States to
20 participate in the project, the Secretary shall
21 ensure that urban, rural, and underserved areas
22 are served by the project.

23 (3) GRANTS AND PAYMENTS.—

24 (A) DEVELOPMENT GRANTS.—

1 (i) FIRST YEAR DEVELOPMENT
2 GRANTS.—The Secretary shall award de-
3 velopment grants to States participating in
4 the project during the first year the project
5 is conducted. Grants awarded under this
6 clause shall be used by a participating
7 State to—

8 (I) assist with the development of
9 steering committees, medical manage-
10 ment committees, and local networks
11 of health care providers; and

12 (II) facilitate coordination with
13 local communities to be better pre-
14 pared and positioned to understand
15 and meet the needs of the commu-
16 nities served by patient-centered med-
17 ical homes.

18 (ii) SECOND YEAR FUNDING.—The
19 Secretary shall award additional grant
20 funds to States that received a develop-
21 ment grant under clause (i) during the sec-
22 ond year the project is conducted if the
23 Secretary determines such funds are nec-
24 essary to ensure continued participation in
25 the project by the State. Grant funds

1 awarded under this clause shall be used by
2 a participating State to assist in making
3 the payments described in paragraph (B).
4 To the extent a State uses such grant
5 funds for such purpose, no matching pay-
6 ment may be made to the State for the
7 payments made with such funds under sec-
8 tion 1903(a) or 2105(a) of the Social Se-
9 curity Act (42 U.S.C. 1396b(a);
10 1397ee(a)).

11 (B) ADDITIONAL PAYMENTS TO PERSONAL
12 PRIMARY CARE PROVIDERS AND STEERING COM-
13 MITTEES.—

14 (i) PAYMENTS TO PERSONAL PRIMARY
15 CARE PROVIDERS.—

16 (I) IN GENERAL.—Subject to
17 subsection (d)(6)(B), a State partici-
18 pating in the project shall pay a per-
19 sonal primary care provider not less
20 than \$2.50 per month per targeted
21 beneficiary assigned to the personal
22 primary care provider, regardless of
23 whether the provider saw the targeted
24 beneficiary that month.

1 (II) FEDERAL MATCHING PAY-
2 MENT.—Subject to subparagraph
3 (A)(ii), amounts paid to a personal
4 primary care provider under subclause
5 (I) shall be considered medical assist-
6 ance or child health assistance for
7 purposes of section 1903(a) or
8 2105(a), respectively, of the Social Se-
9 curity Act (42 U.S.C. 1396b(a);
10 1397ee(a)).

11 (III) PATIENT POPULATION.—In
12 determining the amount of payment
13 to a personal primary care provider
14 per month with respect to targeted
15 beneficiaries under this clause, a State
16 participating in the project shall take
17 into account the care needs of such
18 targeted beneficiaries.

19 (ii) PAYMENTS TO STEERING COMMIT-
20 TEES.—

21 (I) IN GENERAL.—Subject to
22 subsection (d)(6)(B), a State partici-
23 pating in the project shall pay a steer-
24 ing committee not less than \$2.50 per
25 targeted beneficiary per month.

1 (II) FEDERAL MATCHING PAY-
2 MENT.—Subject to subparagraph
3 (A)(ii), amounts paid to a steering
4 committee under subclause (I) shall
5 be considered medical assistance or
6 child health assistance for purposes of
7 section 1903(a) or 2105(a), respec-
8 tively, of the Social Security Act (42
9 U.S.C. 1396b(a); 1397ee(a)).

10 (III) USE OF FUNDS.—Amounts
11 paid to a steering committee under
12 subclause (I) shall be used to pur-
13 chase health information technology,
14 pay primary care case managers, sup-
15 port network initiatives, and for such
16 other uses as the steering committee
17 determines appropriate.

18 (4) TECHNICAL ASSISTANCE.—The Secretary
19 shall make available technical assistance to States,
20 physician practices, and health centers participating
21 in the project during the duration of the project.

22 (5) BEST PRACTICES INFORMATION.—The Sec-
23 retary shall collect and make available to States par-
24 ticipating in the project information on best prac-
25 tices for patient-centered medical homes.

1 (d) PATIENT-CENTERED MEDICAL HOME PRO-
2 GRAM.—

3 (1) IN GENERAL.—For purposes of this section,
4 a patient-centered medical home program meets the
5 requirements of this subsection if, under such pro-
6 gram, targeted beneficiaries designate a personal
7 primary care provider in a patient-centered medical
8 home as their source of first contact, comprehensive,
9 and coordinated care for the whole person.

10 (2) ELEMENTS.—

11 (A) MANDATORY ELEMENTS.—

12 (i) IN GENERAL.—Such program shall
13 include the following elements:

14 (I) A steering committee.

15 (II) A medical management com-
16 mittee.

17 (III) A network of physician
18 practices and health centers that have
19 volunteered to participate as patient-
20 centered medical homes to provide
21 high-quality care, focusing on preven-
22 tive care, at the appropriate time and
23 place in a cost-effective manner.

24 (IV) Hospitals and local public
25 health departments that will work in

1 cooperation with the network of pa-
2 tient-centered medical homes to co-
3 ordinate and provide health care.

4 (V) Primary care case managers
5 to assist with care coordination.

6 (VI) Health information tech-
7 nology to facilitate the provision and
8 coordination of health care by network
9 participants.

10 (ii) MULTIPLE LOCATIONS IN THE
11 STATE.—In the case where a State oper-
12 ates a patient-centered medical home pro-
13 gram in 2 or more areas in the State, the
14 program in each of those areas shall in-
15 clude the elements described in clause (i).

16 (B) OPTIONAL ELEMENTS.—Such program
17 may include a non-profit organization that—

18 (i) includes a steering committee and
19 a medical management committee; and

20 (ii) manages the payments to steering
21 committees described in subsection
22 (c)(3)(B)(ii).

23 (3) GOALS.—Such program shall be designed—

24 (A) to increase—

1 (i) cost efficiencies of health care de-
2 livery;

3 (ii) access to appropriate health care
4 services, especially wellness and prevention
5 care, at times convenient for patients;

6 (iii) patient satisfaction;

7 (iv) communication among primary
8 care providers, hospitals, and other health
9 care providers;

10 (v) school attendance; and

11 (vi) the quality of health care services
12 (as determined by the relevant steering
13 committee and medical management com-
14 mittee, taking into account nationally-de-
15 veloped standards and measures); and

16 (B) to decrease—

17 (i) inappropriate emergency room uti-
18 lization, which can be accomplished
19 through initiatives, such as expanded hours
20 of care throughout the program network;

21 (ii) avoidable hospitalizations; and

22 (iii) duplication of health care services
23 provided.

24 (4) PAYMENT.—Under the program, payment
25 shall be provided to personal primary care providers

1 and steering committees (in accordance with sub-
 2 section (c)(3)(B)).

3 (5) NOTIFICATION.—The State shall notify in-
 4 dividuals enrolled in Medicaid or SCHIP about—

5 (A) the patient-centered medical home pro-
 6 gram;

7 (B) the providers participating in such
 8 program; and

9 (C) the benefits of such program.

10 (6) TREATMENT OF STATES WITH A MANAGED
 11 CARE CONTRACT.—

12 (A) IN GENERAL.—In the case where a
 13 State contracts with a private entity to manage
 14 parts of the State Medicaid program, the State
 15 shall—

16 (i) ensure that the private entity fol-
 17 lows the care management model; and

18 (ii) establish a medical management
 19 committee and a steering committee in the
 20 community.

21 (B) ADJUSTMENT OF PAYMENT
 22 AMOUNTS.—The State may adjust the amount
 23 of payments made under (c)(3)(B), taking into
 24 consideration the management role carried out
 25 by the private entity described in subparagraph

1 (A) and the cost effectiveness provided by such
2 entity in certain areas, such as health informa-
3 tion technology.

4 (e) EVALUATION AND PROJECT REPORT.—

5 (1) IN GENERAL.—

6 (A) EVALUATION.—The Secretary, in con-
7 sultation with appropriate health care profes-
8 sional associations, shall evaluate the project in
9 order to determine the effectiveness of patient-
10 centered medical homes in terms of quality im-
11 provement, patient and provider satisfaction,
12 and the improvement of health outcomes.

13 (B) PROJECT REPORT.—Not later than 12
14 months after completion of the project, the Sec-
15 retary shall submit to Congress a report on the
16 project containing the results of the evaluation
17 conducted under subparagraph (A). Such report
18 shall include—

19 (i) an assessment of the differences, if
20 any, between the quality of the care pro-
21 vided through the patient-centered medical
22 home program conducted under the project
23 in the States that provide medical assist-
24 ance for primary care case management
25 services and those that do not;

1 (ii) an assessment of quality improve-
2 ments and clinical outcomes as a result of
3 such program;

4 (iii) estimates of cost savings resulting
5 from such program; and

6 (iv) recommendations for such legisla-
7 tion and administrative action as the Sec-
8 retary determines to be appropriate.

9 (2) SENSE OF THE SENATE.—It is the sense of
10 the Senate that, during the next authorization of
11 SCHIP, titles XIX and XXI of the Social Security
12 Act (42 U.S.C. 1396 et seq.; 1397aa et seq.) should
13 be amended, based on the results of the evaluation
14 and report under paragraph (1), to establish a pa-
15 tient-centered medical home program under such ti-
16 tles on a permanent basis.

17 (f) WAIVER.—

18 (1) IN GENERAL.—Subject to paragraph (2),
19 the Secretary shall waive compliance with such re-
20 quirements of titles XI, XIX, and XXI of the Social
21 Security Act (42 U.S.C. 1301 et seq.; 1396 et seq.;
22 1397aa et seq.) to the extent and for the period the
23 Secretary finds necessary to conduct the project.

24 (2) LIMITATION.—In no case shall the Sec-
25 retary waive compliance with the requirements of

1 subsections (a)(10)(A), (a)(15), and (bb) of section
2 1902 of the Social Security Act (42 U.S.C. 1396a)
3 under paragraph (1), to the extent that such re-
4 quirements require the provision of, and reimburse-
5 ment for services described in section 1905(a)(2)(C)
6 of such Act (42 U.S.C. 1396d(a)(2)(C)).

○