

111TH CONGRESS  
1ST SESSION

# S. 1114

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.

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IN THE SENATE OF THE UNITED STATES

MAY 20, 2009

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

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## 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 2009".

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

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

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

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

12 (a) DEFINITIONS.—In this section:

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

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

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

22 (C) seeks guidance from—

23 (i) a steering committee; and

24 (ii) a medical management committee;

25 and

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

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

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

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

16 (A) provides services in the community in  
17 which the practice or health center is located;

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

20 (C) selects targeted disease and care proc-  
21 esses that address health conditions in the com-  
22 munity (as identified in the National or State  
23 health assessment or as outlined in “Healthy  
24 People 2010”, or any subsequent similar report  
25 (as determined by the Secretary));

1 (D) defines programs to target disease and  
2 care processes;

3 (E) establishes standards and measures for  
4 patient-centered medical homes, taking into ac-  
5 count nationally-developed standards and meas-  
6 ures; and

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

11 (5) PATIENT-CENTERED MEDICAL HOME.—

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

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

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

23 (iii) the medical management com-  
24 mittee determines has the capability to  
25 achieve improvements in the management

1 and coordination of care for targeted bene-  
2 ficiaries (as defined by statewide quality  
3 improvement standards and outcomes);  
4 and

5 (iv) meets the requirements imposed  
6 on a covered entity for purposes of apply-  
7 ing part C of title XI of the Social Security  
8 Act (42 U.S.C. 1320d et seq.) and all reg-  
9 ulatory provisions promulgated thereunder,  
10 including regulations (relating to privacy)  
11 adopted pursuant to the authority of the  
12 Secretary under section 264(e) of the  
13 Health Insurance Portability and Account-  
14 ability Act of 1996 (42 U.S.C. 1320d–2  
15 note).

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

20 (i) ACCESS AND COMMUNICATION  
21 WITH PATIENTS.—Whether the practice or  
22 health center applies both standards for  
23 access to care for, and standards for com-  
24 munication with, targeted beneficiaries who

1 receive care through the practice or health  
2 center.

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

6 Whether the practice or health center has  
7 readily accessible, clinically useful informa-  
8 tion on such beneficiaries that enables the  
9 practice or health center to provide com-  
10 prehensive and systematic treatment.

11 (iii) MANAGING AND COORDINATING  
12 CARE ACCORDING TO INDIVIDUAL  
13 NEEDS.—Whether the practice or health  
14 center—

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

22 (II) assists in the early identifica-  
23 tion of health care needs;

24 (III) provides ongoing primary  
25 care;

1 (IV) coordinates with a broad  
2 range of other specialty, ancillary, and  
3 related services; and

4 (V) provides health care services  
5 and consultations in a culturally and  
6 linguistically appropriate manner, as  
7 well as at a time and location that is  
8 convenient to the patient.

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

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

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

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

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

1 management and coordination of care for  
2 targeted beneficiaries who receive care  
3 through the practice or health center.

4 (vi) MONITORING PERFORMANCE.—

5 Whether the practice or health center—

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

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

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

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

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

23 (ii) has been trained to provide first  
24 contact, continuous, and comprehensive  
25 care for the whole person, not limited to a

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

5 (B) a health center that—

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

7 and

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

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

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

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

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

1           (11) STEERING COMMITTEE.—The term “steer-  
2           ing committee” means a local management group  
3           comprised of collaborating local health care practi-  
4           tioners or a local not-for-profit network of health  
5           care practitioners—

6                   (A) that implements State-level initiatives;

7                   (B) that develops local improvement initia-  
8           tives;

9                   (C) whose mission is to—

10                   (i) investigate questions related to  
11           community-based practice; and

12                   (ii) improve the quality of primary  
13           care; and

14                   (D) whose membership—

15                   (i) represents the health care delivery  
16           system of the community it serves; and

17                   (ii) includes physicians (with an em-  
18           phasis on primary care physicians) and at  
19           least 1 representative from each part of  
20           the collaborative or network (such as a  
21           representative from a health center, a rep-  
22           resentative from the health department, a  
23           representative from social services, and a  
24           representative from each public and private

1 hospital in the collaborative or the net-  
2 work).

3 (12) TARGETED BENEFICIARY.—

4 (A) IN GENERAL.—The term “targeted  
5 beneficiary” means an individual who is eligible  
6 for benefits under a State plan under Medicaid  
7 or a State child health plan under CHIP.

8 (B) PARTICIPATION IN PATIENT-CEN-  
9 TERED MEDICAL HOME.—Individuals who are  
10 eligible for benefits under Medicaid or CHIP in  
11 a State that has been selected to participate in  
12 the project shall receive care through a patient-  
13 centered medical home when available.

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

21 (b) ESTABLISHMENT.—The Secretary shall establish  
22 a demonstration project under Medicaid and CHIP for the  
23 implementation of a patient-centered medical home pro-  
24 gram that meets the requirements of subsection (d) to im-  
25 prove the effectiveness and efficiency in providing medical

1 assistance under Medicaid and CHIP to an estimated  
2 500,000 to 1,000,000 targeted beneficiaries.

3 (c) PROJECT DESIGN.—

4 (1) DURATION.—The project shall be conducted  
5 for a 3-year period, beginning not later than [Octo-  
6 ber 1, 2011].

7 (2) SITES.—

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

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

14 (ii) four of which do not provide such  
15 medical assistance.

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

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

25 (3) GRANTS AND PAYMENTS.—

1 (A) DEVELOPMENT GRANTS.—

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

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

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

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

1 the project by the State. Grant funds  
2 awarded under this clause shall be used by  
3 a participating State to assist in making  
4 the payments described in paragraph (B).  
5 To the extent a State uses such grant  
6 funds for such purpose, no matching pay-  
7 ment may be made to the State for the  
8 payments made with such funds under sec-  
9 tion 1903(a) or 2105(a) of the Social Se-  
10 curity Act (42 U.S.C. 1396b(a);  
11 1397ee(a)).

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

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

17 (I) IN GENERAL.—Subject to  
18 subsection (d)(6)(B), a State partici-  
19 pating in the project shall pay a per-  
20 sonal primary care provider not less  
21 than \$2.50 per month per targeted  
22 beneficiary assigned to the personal  
23 primary care provider, regardless of  
24 whether the provider saw the targeted  
25 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 (in accord-  
13 ance with any applicable Medicaid re-  
14 quirements) to purchase health infor-  
15 mation technology, pay primary care  
16 case managers, support network ini-  
17 tiatives, and for such other uses as  
18 the steering committee determines ap-  
19 propriate.

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

24 (5) BEST PRACTICES INFORMATION.—The Sec-  
25 retary shall collect and make available to States par-

1        participating in the project information on best prac-  
 2        tices for patient-centered medical homes.

3        (d) PATIENT-CENTERED MEDICAL HOME PRO-  
 4        GRAM.—

5            (1) IN GENERAL.—For purposes of this section,  
 6        a patient-centered medical home program meets the  
 7        requirements of this subsection if, under such pro-  
 8        gram, targeted beneficiaries have access to a per-  
 9        sonal primary care provider in a patient-centered  
 10       medical home as their source of first contact, com-  
 11       prehensive, and coordinated care for the whole per-  
 12       son.

13            (2) ELEMENTS.—

14            (A) MANDATORY ELEMENTS.—

15            (i) IN GENERAL.—Such program shall  
 16        include the following elements:

17            (I) A steering committee.

18            (II) A medical management com-  
 19        mittee.

20            (III) A network of physician  
 21        practices and health centers that have  
 22        volunteered to participate as patient-  
 23        centered medical homes to provide  
 24        high-quality care, focusing on preven-

1           tive care, at the appropriate time and  
2           place and in a cost-effective manner.

3                   (IV) Hospitals and local public  
4           health departments that will work in  
5           cooperation with the network of pa-  
6           tient-centered medical homes to co-  
7           ordinate and provide health care.

8                   (V) Primary care case managers  
9           to assist with care coordination.

10                   (VI) Health information tech-  
11           nology to facilitate the provision and  
12           coordination of health care by network  
13           participants.

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

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

22                   (i) includes a steering committee and  
23           a medical management committee; and

1                   (ii) manages the payments to steering  
2                   committees described in subsection  
3                   (c)(3)(B)(ii).

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

5                   (A) to increase—

6                           (i) cost efficiencies of health care de-  
7                           livery;

8                           (ii) access to appropriate health care  
9                           services, especially wellness and prevention  
10                          care, at times convenient for patients;

11                          (iii) patient satisfaction;

12                          (iv) communication among primary  
13                          care providers, hospitals, and other health  
14                          care providers;

15                          (v) school attendance; and

16                          (vi) the quality of health care services  
17                          (as determined by the relevant steering  
18                          committee and medical management com-  
19                          mittee, taking into account nationally de-  
20                          veloped standards and measures); and

21                   (B) to decrease—

22                           (i) inappropriate emergency room uti-  
23                           lization, which can be accomplished  
24                           through initiatives, such as expanded hours  
25                           of care throughout the program network;

- 1 (ii) avoidable hospitalizations; and  
2 (iii) duplication of health care services  
3 provided.

4 (4) PAYMENT.—Under the program, payment  
5 shall be provided to personal primary care providers  
6 and steering committees (in accordance with sub-  
7 section (c)(3)(B)).

8 (5) NOTIFICATION.—The State shall notify in-  
9 dividuals enrolled in Medicaid or CHIP about—

10 (A) the patient-centered medical home pro-  
11 gram;

12 (B) the providers participating in such  
13 program; and

14 (C) the benefits of such program.

15 (6) TREATMENT OF STATES WITH A MANAGED  
16 CARE CONTRACT.—

17 (A) IN GENERAL.—In the case where a  
18 State contracts with a private entity to manage  
19 parts of the State Medicaid program, the State  
20 shall—

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

23 (ii) establish a medical management  
24 committee and a steering committee in the  
25 community.

1           (B)     ADJUSTMENT     OF     PAYMENT  
2           AMOUNTS.—The State may adjust the amount  
3           of payments made under (c)(3)(B), taking into  
4           consideration the management role carried out  
5           by the private entity described in subparagraph  
6           (A) and the cost effectiveness provided by such  
7           entity in certain areas, such as health informa-  
8           tion technology.

9           (e) EVALUATION AND PROJECT REPORT.—

10          (1) IN GENERAL.—

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

18               (B) PROJECT REPORT.—Not later than 12  
19               months after completion of the project, the Sec-  
20               retary shall submit to Congress a report on the  
21               project containing the results of the evaluation  
22               conducted under subparagraph (A). Such report  
23               shall include—

24                       (i) an assessment of the differences, if  
25                       any, between the quality of the care pro-

1           vided through the patient-centered medical  
2           home program conducted under the project  
3           in the States that provided medical assist-  
4           ance for primary care case management  
5           services and those that did not;

6           (ii) an assessment of quality improve-  
7           ments and clinical outcomes as a result of  
8           such program;

9           (iii) estimates of cost savings resulting  
10          from such program; and

11          (iv) recommendations for such legisla-  
12          tion and administrative action as the Sec-  
13          retary determines to be appropriate.

14           (2) SENSE OF THE SENATE.—It is the sense of  
15          the Senate that titles XIX and XXI of the Social Se-  
16          curity Act (42 U.S.C. 1396 et seq.; 1397aa et seq.)  
17          should be amended, based on the results of the eval-  
18          uation and report under paragraph (1), to establish  
19          a patient-centered medical home program under  
20          such titles on a permanent basis.

21          (f) WAIVER.—

22           (1) IN GENERAL.—Subject to paragraph (2),  
23          the Secretary shall waive compliance with such re-  
24          quirements of titles XI, XIX, and XXI of the Social  
25          Security Act (42 U.S.C. 1301 et seq.; 1396 et seq.;

1 1397aa et seq.) to the extent and for the period the  
2 Secretary finds necessary to conduct the project.

3 (2) LIMITATION.—In no case shall the Sec-  
4 retary waive compliance with the requirements of  
5 subsections (a)(10)(A), (a)(15), and (bb) of section  
6 1902 of the Social Security Act (42 U.S.C. 1396a)  
7 under paragraph (1), to the extent that such re-  
8 quirements require the provision of and reimburse-  
9 ment for services described in section 1905(a)(2)(C)  
10 of such Act (42 U.S.C. 1396d(a)(2)(C)).

○