

111TH CONGRESS
1ST SESSION

S. 652

To authorize the Secretary of Health and Human Services to make grants to community health coalitions to assist in the development of integrated health care delivery, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 19, 2009

Mrs. MURRAY introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To authorize the Secretary of Health and Human Services to make grants to community health coalitions to assist in the development of integrated health care delivery, and for other purposes.

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

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Community Coalitions
5 for Access and Quality Improvement Act of 2009”.

6 **SEC. 2. PURPOSE.**

7 The purpose of this Act is to provide assistance to
8 community health coalitions as described in section 3(b)

1 with a clearly defined local need to increase access to and
 2 improve the quality of health care services through activi-
 3 ties which—

4 (1) develop or strengthen coordination of serv-
 5 ices to allow all individuals, including the uninsured
 6 and low-income, to receive efficient and higher qual-
 7 ity care and to gain entry into and receive services
 8 from a comprehensive system of medical, dental,
 9 pharmaceutical, and behavioral health care;

10 (2) develop efficient and sustainable infrastruc-
 11 ture for a health care delivery system characterized
 12 by effective collaboration, information sharing, and
 13 clinical and financial coordination among all types of
 14 providers of care in the community; and

15 (3) develop or strengthen activities related to
 16 providing coordinated care for individuals with
 17 chronic conditions.

18 **SEC. 3. GRANTS TO STRENGTHEN THE EFFECTIVENESS, EF-**
 19 **FICIENCY, AND COORDINATION OF SERVICES.**

20 (a) IN GENERAL.—The Secretary of Health and
 21 Human Services (in this Act referred to as the “Sec-
 22 retary”) shall award grants to assist in the development
 23 of integrated health care delivery systems to serve defined
 24 communities of individuals—

1 (1) to improve the efficiency of and coordina-
2 tion among the providers providing services through
3 such systems;

4 (2) to assist local communities in developing
5 programs targeted toward preventing and managing
6 chronic diseases; and

7 (3) to expand and enhance the services provided
8 through such systems.

9 (b) ELIGIBLE ENTITIES.—To be eligible to receive a
10 grant under this section, an entity shall be an entity
11 that—

12 (1) represents a balanced consortium—

13 (A) whose principal purpose is to ensure
14 the sustainable capacity for the provision of a
15 broad range of coordinated services for all resi-
16 dents within a community defined in the enti-
17 ty's grant application as described in paragraph
18 (2); and

19 (B) that includes at least one of each of
20 the following providers that serve the commu-
21 nity (unless such provider does not exist within
22 the community, declines or refuses to partici-
23 pate, or places unreasonable conditions on their
24 participation)—

1 (i) a federally qualified health center
 2 (as defined in section 1861(aa) of the So-
 3 cial Security Act (42 U.S.C. 1395x(aa)));

4 (ii) rural health clinics and rural
 5 health networks (as defined in sections
 6 1861(aa) and 1820(d) of the Social Secu-
 7 rity Act, respectively (42 U.S.C.
 8 1395x(aa), 1395i-4(d)));

9 (iii) a hospital with a low-income utili-
 10 zation rate that is greater than 25 percent
 11 (as defined in section 1923(b)(3) of the
 12 Social Security Act (42 U.S.C. 1396r-
 13 4(b)(3))) or a critical access hospital (as
 14 defined in section 1820(c)(2) of the Social
 15 Security Act (42 U.S.C. 1395i-4(c)(2)));

16 (iv) a public health department; and

17 (v) an interested public or private sec-
 18 tor health care provider or an organization
 19 that has traditionally served the medically
 20 uninsured and low-income individuals; and

21 (2) submits to the Secretary an application, in
 22 such form and manner as the Secretary shall pre-
 23 scribe, that—

24 (A) clearly defines the community to be
 25 served;

1 (B) identifies the providers who will par-
2 ticipate in the community coalition under the
3 grant and specifies each provider's contribution
4 to the care of individuals in the community;

5 (C) describes the activities that the appli-
6 cant and the community coalition propose to
7 perform under the grant to further the objec-
8 tives of this section;

9 (D) demonstrates that it is an established
10 coalition with ability to build on the current
11 system for serving the community by involving
12 providers who have traditionally provided a sig-
13 nificant volume of care for uninsured and low-
14 income individuals for that community;

15 (E) demonstrates the coalition's ability to
16 develop coordinated systems of care that either
17 directly provide or ensure the prompt provision
18 of a broad range of high-quality, accessible
19 services, including, as appropriate, primary, sec-
20 ondary, and tertiary services as well as phar-
21 macy, substance abuse, behavioral health and
22 oral health services, in a manner that ensures
23 continuity of care in the community;

24 (F) provides evidence of community in-
25 volvement, including the business community, in

1 the development, implementation, and direction
2 of the system of care that the coalition proposes
3 to ensure;

4 (G) demonstrates the coalition's ability to
5 ensure that participating individuals are en-
6 rolled in health care coverage programs, both
7 public and private, for which the individuals are
8 eligible;

9 (H) presents a plan for leveraging other
10 sources of revenue, which may include State
11 and local sources and private grant funds, and
12 integrating current and proposed new funding
13 sources in a manner to ensure long-term sus-
14 tainability of the system of care;

15 (I) describes a plan for evaluation of the
16 activities carried out under the grant, including
17 measurement of progress toward the goals and
18 objectives of the program and the use of evalua-
19 tion findings to improve system performance;

20 (J) demonstrates fiscal responsibility
21 through the use of appropriate accounting pro-
22 cedures and management systems;

23 (K) demonstrates commitment to serve the
24 community without regard to the ability of an
25 individual or family to pay by arranging for or

1 providing free or reduced charge care for the
 2 poor; and

3 (L) includes such other information as the
 4 Secretary may prescribe.

5 (c) LIMITATIONS.—

6 (1) IN GENERAL.—An eligible entity may re-
 7 ceive a grant under this section for 3 consecutive fis-
 8 cal years and may receive such a grant award for 2
 9 additional years if—

10 (A) the eligible entity submits to the Sec-
 11 retary a request for a grant for such additional
 12 years;

13 (B) the Secretary determines that current
 14 performance justifies the granting of such a re-
 15 quest; and

16 (C) the Secretary determines that granting
 17 such request is necessary to further the objec-
 18 tives described in subsection (a).

19 (d) PRIORITIES.—In awarding grants under this sec-
 20 tion, the Secretary—

21 (1) may accord priority to applicants that dem-
 22 onstrate the greatest extent of unmet need in the
 23 community for a more coordinated system of care;
 24 and

1 (2) shall accord priority to applicants that best
2 promote the objectives of this section, taking into
3 consideration the extent to which the applicant—

4 (A) identifies a community whose geo-
5 graphical area has a high or increasing percent-
6 age of individuals who are uninsured or low-in-
7 come;

8 (B) demonstrates that the applicant has
9 included in its community coalition providers,
10 support systems, and programs that have a tra-
11 dition of serving individuals and families in the
12 community who are uninsured or earn below
13 200 percent of the Federal poverty level;

14 (C) shows evidence that the proposed coali-
15 tion activities would expand utilization of pre-
16 ventive and primary care services for uninsured
17 and underinsured individuals and families in
18 the community, including pharmaceuticals, be-
19 havioral and mental health services, oral health
20 services, or substance abuse services;

21 (D) proposes approaches that would im-
22 prove coordination between health care pro-
23 viders and appropriate social service providers;

24 (E) demonstrates collaboration with State
25 and local governments;

1 (F) demonstrates that the applicant makes
2 use of non-Federal contributions to the greatest
3 extent possible; or

4 (G) demonstrates likelihood that the pro-
5 posed activities will lead to sustainable inte-
6 grated delivery system as additional efforts of
7 health systems development evolve.

8 (e) USE OF FUNDS.—

9 (1) USE BY GRANTEES.—

10 (A) IN GENERAL.—Except as provided in
11 paragraphs (2) and (3), a grantee may use
12 amounts provided under this section only for—

13 (i) direct expenses associated with
14 achieving the greater integration of a
15 health care delivery system so that the sys-
16 tem either directly provides or ensures the
17 provision of a broad range of culturally
18 competent services, including as appro-
19 priate primary, secondary, and tertiary
20 care and oral health, substance abuse, be-
21 havioral and mental health, and pharma-
22 ceutical services; and

23 (ii) direct patient care and service ex-
24 pansions to fill identified or documented
25 gaps within an integrated delivery system.

1 (B) SPECIFIC USES.—The following are ex-
2 amples of purposes for which a grantee may use
3 grant funds under this section, when such use
4 meets the conditions stated in subparagraph
5 (A):

6 (i) Increases in outreach activities and
7 closing gaps in health care service, includ-
8 ing referral to specialty services and pre-
9 scription drugs and conducting ongoing
10 outreach to health disparity populations.

11 (ii) Improvements to care manage-
12 ment and delivery of patient-centered care,
13 including patient navigation services.

14 (iii) Improvements to coordination of
15 transportation to health care facilities.

16 (iv) Development of provider networks
17 and other innovative models to engage phy-
18 sicians in voluntary efforts to serve the
19 medically underserved within a community.

20 (v) Recruitment, training, and com-
21 pensation of necessary personnel.

22 (vi) Coordinate the acquisition or
23 interconnected use of technology within a
24 community for the purpose of coordinating
25 care and improving provider communica-

tion, including implementation of shared information systems or shared clinical systems to improve the quality of health care.

(vii) Development of common processes such as mechanisms for determining eligibility for the programs provided through the system, common identification cards, sliding scale discounts, and monitoring and tracking of outcomes.

(viii) Development of specific prevention and disease management tools and processes.

(ix) Language access services.

(x) Facilitating the involvement of community organizations to provide better access to high-quality health care services to individuals at risk for or who have chronic diseases or cancer.

(xi) Helping patients overcome barriers within the health care system to ensure prompt diagnostic and treatment resolution of an abnormal finding of cancer or chronic disease.

(2) DIRECT PATIENT CARE LIMITATION.—Not more than 20 percent of the funds provided under

1 a grant awarded under this section may be used for
 2 providing direct patient care and services.

3 (3) RESERVATION OF FUNDS FOR NATIONAL
 4 PROGRAM PURPOSES.—The Secretary may use not
 5 more than 7 percent of funds appropriated to carry
 6 out this section for providing technical assistance to
 7 grantees, obtaining assistance of experts and con-
 8 sultants, holding meetings, developing of tools, dis-
 9 seminating of information, and evaluation.

10 (f) REPORTING BY GRANTEE.—A grantee under this
 11 section shall report to the Secretary annually regarding—

12 (1) progress in meeting the goals and measur-
 13 able objectives set forth in the grant application sub-
 14 mitted by the grantee under subsection (b); and

15 (2) the extent to which activities conducted by
 16 such grantee have—

17 (A) improved the effectiveness, efficiency,
 18 and coordination of services for uninsured and
 19 low-income individuals in the community served
 20 by such grantee, using commonly accepted out-
 21 come measures;

22 (B) resulted in the provision of better qual-
 23 ity health care for individuals and families in
 24 the community served; and

1 (C) resulted in the provision of health care
2 to such individuals at lower cost than would
3 have been possible in the absence of the activi-
4 ties conducted by such grantee.

5 (g) MAINTENANCE OF EFFORT.—With respect to ac-
6 tivities for which a grant under this section is authorized,
7 the Secretary may award such a grant only if the applicant
8 and each of the participating providers agree that the
9 grantee and each such provider will maintain its expendi-
10 tures of non-Federal funds for such activities at a level
11 that is not less than the level of such expenditures during
12 the fiscal year immediately preceding the fiscal year for
13 which the applicant is applying to receive such grant.

14 (h) TECHNICAL ASSISTANCE.—The Secretary may
15 provide any entity that receives a grant under this section
16 with technical and other nonfinancial assistance necessary
17 to meet the requirements of this section. The Secretary
18 may choose to provide such assistance by awarding a grant
19 to, or entering into a contract with, a State or national
20 not-for-profit organization with expertise in building suc-
21 cessful community coalitions.

22 (i) EVALUATION OF PROGRAM.—Not later than Sep-
23 tember 30, 2014, the Secretary shall prepare and submit
24 to the appropriate committees of Congress a report that
25 describes the extent to which projects funded under this

1 section have been successful in improving the effective-
2 ness, efficiency, and coordination of services in the com-
3 munities served by such projects, including whether the
4 projects resulted in the provision of better quality health
5 care for such individuals, and whether such care was pro-
6 vided at lower costs than would have been provided in the
7 absence of such projects.

8 (j) AUTHORIZATION OF APPROPRIATIONS.—There
9 are authorized to be appropriated to carry out this sec-
10 tion—

- 11 (1) \$75,000,000 for fiscal year 2010;
- 12 (2) \$100,000,000 for fiscal year 2011;
- 13 (3) \$125,000,000 for fiscal year 2012;
- 14 (4) \$150,000,000 for fiscal year 2013; and
- 15 (5) \$175,000,000 for fiscal year 2014.

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