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1730 M Street NW, Suite 500, Washington, DC 20036-4561 ■ 202-785-3910 ■ www.nationalhealthcouncil.org ■ info@nhcouncil.org

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July 30, 2009

The Honorable Max Baucus
The Honorable Charles Grassley
United States Senate
Washington, DC 20510

Dear Senators Baucus and Grassley:

The National Health Council (NHC) strongly supports the efforts of the Senate Finance Committee to enact meaningful health care reform in this Congress.

The NHC is the only organization of its kind that brings together all segments of the health care community to provide a united voice for people with chronic diseases and disabilities. Made up of approximately 115 member organizations from across the health care community, we provide a united voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers.

The Institute of Medicine has stated that the goal of any health care delivery system is to get "the right care at the right time to the right patient for the right price." We could not agree more. Under the auspices of the NHC, the patient advocacy community has come together in support of five health reform principles:

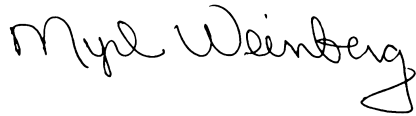
- Achieves Health Care Coverage for Everyone
- Curbs Costs Responsibly
- Guarantees Coverage Despite Pre-Existing Conditions
- Eliminates Lifetime Caps on Health Insurance
- Ensures Access to Quality Long-Term Care and Respect at the End of Life

The NHC supports your efforts to promote innovation in health care delivery as a part of the greater health reform effort. However, the NHC believes the current delivery reform discussion should be focused on how delivery models can integrate best evidence, comprehensive care assessment, coordinated care, and reduced cost sharing burden. While programs conceived under various health reform bills address these components individually, there is currently no proposal to integrate all four components. As such, we propose the Patient-Centered Care Model, which we describe in the attached statement and draft legislative language.

National Health Council Delivery System Proposal
Page Two

This legislative language would represent a meaningful step in creating a health care delivery system that can meet the challenges of patients with chronic disease. We look forward to working with you throughout the legislative process to turn this legislation into law.

Sincerely,

A handwritten signature in black ink that reads "Myrl Weinberg". The signature is written in a cursive style with a large, looping 'M' and a long, sweeping tail on the 'g'.

Myrl Weinberg, CAE
President

Patient-Centered Care Model: A New Health Care Delivery Model for People with Chronic Conditions

Problem

Chronic conditions are a leading driver of rising health care costs. Almost 133 million people, nearly half of the US population, have at least one chronic disease, such as arthritis, heart disease, and diabetes.¹ Seventy five cents of every dollar spent on health care in the US is spent on patients with chronic conditions.² In Medicare, the percentage is far greater, with people with chronic conditions accounting for 96% of spending.³

As the debate continues on how best to achieve the goals of health care reform, it is clear that management of chronic conditions is integral to the sustainability of our health care system and that any reform must address the needs of these patients. Our current health care system is designed to meet the challenges of an acute health crisis, but struggles to provide effective and efficient care to people with ongoing needs. The fragmentation of our health care system requires those with chronic conditions to seek care from multiple providers who are often uncoordinated in their care delivery. Under the current delivery system, patients with chronic conditions assume greater cost-sharing burdens, creating disincentives to utilize cost-effective, beneficial treatment services, further undermining a patient's ability to live with a chronic condition.

Solution

The NHC supports Congress and the Administration in their efforts to promote innovation in health care delivery as a part of the greater health care reform effort. However, the NHC believes that the current health care reform discussion is overly focused on how each of these new models (namely, care coordination, accountable care organizations, medical home, value-based insurance design, evidence-based medicine, patient decision aids and decision support, prevention and wellness, and comprehensive care and health risk assessments) can individually promote better care for patients. Rather, we believe that the delivery reform discussion should be focused on how these individual components can be utilized in an integrated and patient-focused way.

We believe an effective health care delivery model integrates four specific elements:

- **The best in medical research and clinical expertise:** Health care decisions should be based on the best available evidence and patients and providers should be equipped with decision aids, including health information technology, which would enable them to make informed choices regarding their treatment planning.
- **Recognition of individual patient preferences:** People have different life goals, process health information differently, and require different treatment plans that address their conditions and their own particular biological make-up. Factors such as the patient's age, gender, ethnicity, co-morbid health conditions, support systems, cultural and religious beliefs, ability or willingness to make changes in nutrition or exercise, and the ability to take on complex medication regimens or other therapies must be considered when making treatment decisions. Doing so would ensure the creation of individualized care plans that are focused on the needs of patients.
- **Limits on out-of-pocket costs:** High cost-sharing is associated with lower consumption of health care services and has the potential to cause negative clinical outcomes for people with chronic conditions. Innovative plan designs can provide incentives that encourage the utilization of high-value care, while discouraging the utilization of low-value care. Eliminating or drastically reducing copayments and coinsurance can spur the adoption of health-promoting practices.
- **Care coordination:** Hand-in-hand with the medical research, personal patient preferences, and plan design is the need for care coordinators to bring all the elements into alignment. The patient care

¹Centers for Disease Control and Prevention. Chronic Disease Overview. Available at <http://www.cdc.gov/nccdphp/overview.htm>. Accessed on July 15, 2009.

²Ibid.

³Partnership for Solutions. Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update. Available at: <http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf>. Accessed on July 15, 2009.

coordinator may be a physician in some instances. In other cases, it might be a nurse or social worker. At times, the focus could be on strengthening the patient’s body. At other times, focus could be on preparing the patient’s mind for inevitable death. Flexibility must be a key element of any care coordination plan.

From the patient’s perspective, true value in health care incorporates both best evidence and the patient’s unique circumstances (e.g. the individual’s genetic, ethnic, religious, and socio-economic status) at the point of care. Only when *combined* with financial incentives like reimbursement for coordinated care and value-based insurance design that lowers the cost sharing burden to patients, can these tools serve as the foundation for an effective health care delivery system.

Innovative programs that combine these elements are being implemented by the private sector. These programs are demonstrating success in improving health outcomes for patients with chronic conditions and in slowing the rate of health care spending growth. Some of these initiatives include:

- **Johns Hopkins Health Care’s Guided Care Program**, a comprehensive model of care administered by Johns Hopkins Health Care LLC, in which a Guided Care Nurse works with several primary care physicians to provide coordinated, patient-centered, cost-effective care to patients with chronic disease. Preliminary data shows that during the first six months of the one-year pilot, Guided Care patients had fewer hospital admissions, hospital days, emergency visits, and 23% lower insurance expenditures, than patients not in the program.
- **Geisinger’s Personal Health Navigator**, a patient-centered medical home model that delivers value by improving care coordination and individual health status. During 2007, members enrolled in the program saw a 12% decrease in acute hospital admissions, an 11.7% decrease in hospital readmissions and an 8% difference in medical cost trend for primary care sites that offered the Personal Health Navigator program versus non-Navigator sites.
- **Hotel Employees and Restaurant Employees International Union Welfare=Pension Funds**, an integrated model of value-based benefit design and increased personalized care that includes a Health Risk Assessment, reduced barriers to chronic care treatment, personalized health coaching, and no-cost supplies and reduced-cost treatments for diabetes, high cholesterol and high blood pressure. Total medical costs were reduced from 14.5% per year at baseline to 4.5% each of the following two years.

Other promising initiatives, such as UnitedHealthcare and IBM’s collaboration in Arizona, continue to be launched. Additional examples of programs that embody the essence of the Patient-Centered Care Model (PCCM) are listed at the end of this document.

The NHC urges Congress to promote best evidence, comprehensive care assessment and planning, coordinated care, and reduced cost sharing burden by patients in an integrated manner. The NHC believes this multi-pronged approach to health care delivery reform can most effectively improve outcomes for patients, while lowering costs.

Policy Options

The National Health Council proposes the following:

Mechanism	Description
Essential Benefits Package	▪ Expand the criteria for an essential benefits package for plans participating in the Insurance Exchange to include PCCM for patients with chronic conditions.
Financial Initiatives	▪ Utilize innovative financial mechanisms targeting providers and patients to promote integrated and patient-centered care in the public health option plan.
Incentives for Innovation	▪ Expand the functions of the best practices centers established in health reform proposals to identify, develop, and disseminate new health delivery models.
Pilot project	▪ Mandate a pilot project by CMS that tests the framework described above for integration in Medicare, Medicaid and CHIP.

Pending Legislation Creates Multiple Avenues to Identify and Develop New Delivery Models

Congress has recognized the value of these models in recent health care reform proposals, by establishing research centers tasked with identifying and promoting innovation in health care delivery and funding initiatives to explore new models through demonstration and pilot projects.

Senate HELP Bill	House Bill	Senate Finance Bill
New vehicles for innovation		
<p>Creates the AHRQ Patient Safety Research Center</p> <ul style="list-style-type: none"> ▪ Conduct research, and identify and disseminate best practices to providers and patients that will improve health care quality, safety, and value 	<p>Establishes the Center for Quality Improvement</p> <ul style="list-style-type: none"> ▪ Identify, develop, evaluate and implement best practices for quality improvement activities in the delivery of health services 	TBD
New programs to promote coordinated care		
<ul style="list-style-type: none"> ▪ Provides for grants to establish community health teams to support a medical home model ▪ Establishes grants to implement medication management services in the treatment of chronic disease 	<ul style="list-style-type: none"> ▪ Establishes pilot program for accountable care organization ▪ Creates a medical home pilot program 	TBD
Additional mechanisms		
	<ul style="list-style-type: none"> ▪ Authorizes the Secretary to utilize innovative payment mechanisms and policies to determine payments for items and services under the public health insurance option 	TBD

Legislative Language

The legislative language is based on the House Tri-Committee bill, released on July 14, 2009. The draft language below would include the Patient-Centered Care Model in the Exchange benefits package and establish pilot programs on the Patient-Centered Care Model for the Medicare, Medicaid, and CHIP programs.

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED HEALTH BENEFITS PLANS

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 122. ESSENTIAL BENEFITS PACKAGE DEFINED.

(a) IN GENERAL.—In this division, the term “essential benefits package” means health benefits coverage, consistent with standards adopted under section 124 to ensure the provision of quality health care and financial security, that—

- (1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;
- (2) limits cost-sharing for such covered health care items and services in accordance with such benefit standards, consistent with subsection (c);
- (3) does not impose any annual or lifetime limit on the coverage of covered health care items and services;
- (4) complies with section 115(a) (relating to network adequacy); and
- (5) is equivalent, as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services, to the average prevailing employer-sponsored coverage.

(b) MINIMUM SERVICES TO BE COVERED.—The items and services described in this subsection are the following:

- (1) Hospitalization.
- (2) Outpatient hospital and outpatient clinic services, including emergency department services.
- (3) Professional services of physicians and other health professionals.
- (4) Such services, equipment, and supplies incident to the services of a physician’s or a health professional’s delivery of care in institutional settings, physician offices, patients’ homes or place of residence, or other settings, as appropriate.
- (5) Prescription drugs.
- (6) Rehabilitative and habilitative services.
- (7) Mental health and substance use disorder services.
- (8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services and those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.
- (9) Maternity care.
- (10) Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies at least for children under 21 years of age.

(c) REQUIREMENTS RELATING TO COST-SHARING AND MINIMUM ACTUARIAL VALUE.—

- (1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under the essential benefits package for preventive items and services (as specified under the benefit standards), including well baby and well child care.
- (2) ANNUAL LIMITATION.—
 - (A) ANNUAL LIMITATION.—The cost-sharing incurred under the essential benefits package with respect to an individual (or family) for a year does not exceed the applicable level specified in subparagraph (B).
 - (B) APPLICABLE LEVEL.—The applicable level specified in this subparagraph for Y1 is \$5,000 for an individual and \$10,000 for a family. Such levels shall be increased (rounded to the

nearest \$100) for each subsequent year by the annual percentage increase in the Consumer Price Index (United States city average) applicable to such year.

(C) USE OF COPAYMENTS.—In establishing cost-sharing levels for basic, enhanced, and premium plans under this subsection, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance. LIMITATION ON PRESCRIPTION DRUG COST-SHARING.—The Secretary shall establish additional limitations on cost-sharing for prescription drugs under the essential benefits package to promote medication adherence and improved health outcomes.

(3) MINIMUM ACTUARIAL VALUE.—

(A) IN GENERAL.—The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is designed to provide benefits that are actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in sub5 paragraph (B).

(B) REFERENCE BENEFITS PACKAGE DESCRIBED.—The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

(d) PATIENT-CENTERED CARE MODEL BENEFIT PACKAGE FOR HIGH NEED BENEFICIARIES WITH CHRONIC CONDITIONS.—

(1) IN GENERAL.—For high need beneficiaries with chronic conditions as described in subparagraph (2), items and services covered under the essential health benefits package shall include those described in subparagraph (3).

(2) HIGH NEED BENEFICIARY WITH CHRONIC CONDITIONS DEFINED.—For purposes of this subsection, the term ‘targeted high need beneficiary with chronic conditions’ means a high need beneficiary who, based on a risk score as specified by the Secretary, is generally within the upper 50th percentile of plan enrollees.

(3) PATIENT-CENTERED CARE MODEL DEFINED.—A patient-centered care model is a plan that (i) integrates evidence-based guidelines; (ii) applies comprehensive assessment tools to consider a patient’s unique health history and lifestyle to develop a treatment regimen; (iii) implements incentives to encourage the use of high-value services; and (iv) coordinates the care by a team of individuals at the practice level across office, institutional, and home settings led by a patient care coordinator.

SEC. 123. HEALTH BENEFITS ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established a private-public advisory committee which shall be a panel of medical and other experts to be known as the Health Benefits Advisory Committee to recommend covered benefits and essential, enhanced, and premium plans.

(2) CHAIR.—The Surgeon General shall be a member and the chair of the Health Benefits Advisory Committee.

(3) MEMBERSHIP.—The Health Benefits Advisory Committee shall be composed of the following members, in addition to the Surgeon General:

(A) 9 members who are not Federal employees or officers and who are appointed by the President.

(B) 9 members who are not Federal employees or officers and who are appointed by the Comptroller General of the United States in a manner similar to the manner in which the Comptroller General appoints members to the Medicare Payment Advisory Commission under section 1805(c) of the Social Security Act.

(C) Such even number of members (not to exceed 8) who are Federal employees and officers, as the President may appoint.

Such initial appointments shall be made not later than 60 days after the date of the enactment of this Act.

(4) TERMS.—Each member of the Health Benefits Advisory Committee shall serve a 3-year term on the Committee, except that the terms of the initial members shall be adjusted in order to provide for a staggered term of appointment for all such members.

(5) PARTICIPATION.—The membership of the Health Benefits Advisory Committee shall at least reflect providers, patient representatives, consumer representatives, employers, labor, health insurance issuers, experts in health care financing and delivery, experts in racial and ethnic disparities, experts in care for those with disabilities, representatives of relevant governmental agencies. and at least one practicing physician or other health professional and an expert on children’s health and shall represent a balance among various sectors of the health care system so that no single sector unduly influences the recommendations of such Committee.

(b) DUTIES.—

(1) RECOMMENDATIONS ON BENEFIT STANDARDS.—The Health Benefits Advisory Committee shall recommend to the Secretary of Health and Human Services (in this subtitle referred to as the “Secretary”) benefit standards (as defined in paragraph (4)), and periodic updates to such standards. In developing such recommendations, the Committee shall take into account innovation in health care and consider how such standards could reduce health disparities.

(2) DEADLINE.—The Health Benefits Advisory Committee shall recommend initial benefit standards to the Secretary not later than 1 year after the date of the enactment of this Act.

(3) PUBLIC INPUT.—The Health Benefits Advisory Committee shall allow for public input as a part of developing recommendations under this subsection.

(4) BENEFIT STANDARDS DEFINED.—In this subtitle, the term “benefit standards” means standards respecting—

(A) the essential benefits package described in section 122, including categories of covered treatments, items and services within benefit classes, the patient-centered care model and cost-sharing; and

(B) the cost-sharing levels for enhanced plans and premium plans (as provided under section 203(c)) consistent with paragraph (5).

Subtitle B—Public Health Insurance Option

SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIVERY SYSTEM REFORM.

(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. For individuals with chronic conditions, the Secretary shall provide payments for items and services provided under the Patient-Centered Care Model as described in paragraph (c).

(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) PATIENT-CENTERED CARE MODEL FOR INDIVIDUALS WITH CHRONIC CONDITIONS—The Secretary shall provide payments for items and services provided under the Patient-Centered Care Model as described in subparagraph (1)

- (1) PATIENT-CENTERED CARE MODEL DEFINED. A patient-centered care model is a plan that
- (A) integrates evidence-based guidelines;
 - (B) applies comprehensive assessment tools to consider a patient’s unique health history and lifestyle to develop a treatment regimen;
 - (C) implements incentives to encourage the use of high-value services; and
 - (D) coordinates the care by a team of individuals at the practice level across office, institutional, and home settings led by a patient care coordinator.

(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.

TITLE IV—QUALITY AND SURVEILLANCE

SEC. 931. CENTER FOR QUALITY IMPROVEMENT.

(a) IN GENERAL.—There is established the Center for Quality Improvement (referred to in this part as the ‘Center’), to be headed by the Director.

(b) PRIORITIZATION.—

(1) IN GENERAL.—The Director shall prioritize areas for the identification, development, evaluation, and implementation of best practices (including innovative methodologies and strategies) for quality improvement activities in the delivery of health care services (in this section referred to as ‘best practices’).

- (2) CONSIDERATIONS.—In prioritizing areas under paragraph (1), the Director shall consider—
- (A) the priorities established under section 1191 of the Social Security Act; and
 - (B) the key health indicators identified by the Assistant Secretary for Health Information under section 1709
 - (C) innovative methodologies and strategies for integrating patient preferences and medical research with plan design and reimbursement for care coordination in the delivery of health care services

(c) OTHER RESPONSIBILITIES.—The Director, acting directly or by awarding a grant or contract to an eligible entity, shall—

- (1) identify existing best practices under subsection (e);
- (2) develop new best practices under subsection (f);
- (3) evaluate best practices under subsection (g);
- (4) implement best practices under subsection (h);
- (5) ensure that best practices are identified, developed, evaluated, and implemented under this section consistent with standards adopted by the Secretary under section 3004 for health information technology used in the collection and reporting of quality information (including for purposes of the demonstration of meaningful use of certified electronic health record (EHR) technology by physicians and hospitals under the Medicare program (under sections 1848(o)(2) and 1886(n)(3), respectively, of the Social Security Act)); and
- (6) provide for dissemination of information and reporting under subsections (i) and (j).

(d) ELIGIBILITY.—To be eligible for a grant or contract under subsection (c), an entity shall—

- (1) be a nonprofit entity;
- (2) agree to work with a variety of institutional health care providers, physicians, nurses, and other health care practitioners; and
- (3) if the entity is not the organization holding a contract under section 1153 of the Social Security Act for the area to be served, agree to cooperate with and avoid duplication of the activities of such organization.

- (e) IDENTIFYING EXISTING BEST PRACTICES.—The Secretary shall identify best practices that are—
- (1) currently utilized by health care providers (including hospitals, physician and other clinician practices, community cooperatives, and other health care entities) that deliver consistently high-quality, efficient health care services; and
 - (2) easily adapted for use by other health care providers and for use across a variety of health care settings.
 - (3) aligned with the unique needs and preferences of patients
- (e) DEVELOPING NEW BEST PRACTICES.—
- (1) The Secretary shall develop best practices that are—
 - (A) based on a review of existing scientific evidence;
 - (B) sufficiently detailed for implementation and incorporation into the workflow of health care providers; and
 - (C) designed to be easily adapted for use by health care providers across a variety of health care settings.
 - (2) The Secretary shall encourage innovation in health care delivery systems that integrate patient preferences and medical research with plan design and reimbursement for care coordination
- (h) EVALUATION OF BEST PRACTICES.—The Director shall evaluate best practices identified or developed under this section. Such evaluation—
- (1) shall include determinations of which best practices—
 - (A) most reliably and effectively achieve significant progress in improving the quality of patient care; and
 - (B) are easily adapted for use by health care providers across a variety of health care settings;
 - (C) consider individual patient preferences
 - (2) shall include regular review, updating, and improvement of such best practices; and
 - (3) may include in-depth case studies or empirical assessments of health care providers (including hospitals, physician and other clinician practices, community cooperatives, and other health care entities) and simulations of such best practices for determinations under paragraph (1).
- (i) IMPLEMENTATION OF BEST PRACTICES.—
- (1) IN GENERAL.—The Director shall enter into voluntary arrangements with health care providers (including hospitals and other health facilities and health practitioners) in a State or region to implement best practices identified or developed under this section. Such implementation—
 - (A) may include forming collaborative multi-institutional teams; and
 - (B) shall include an evaluation of the best practices being implemented, including the measurement of patient outcomes before, during, and after implementation of such best practices.
 - (2) PREFERENCES.—In carrying out this subsection, the Director shall give priority to health care providers implementing best practices that—
 - (A) have the greatest impact on patient outcomes and satisfaction;
 - (B) are the most easily adapted for use by health care providers across a variety of health care settings;
 - (C) promote coordination of health care practitioners across the continuum of care; and
 - (D) engage patients and their families in improving patient care and outcomes.
- (j) PUBLIC DISSEMINATION OF INFORMATION.—
- The Director shall provide for the public dissemination of information with respect to best practices and activities under this section. Such information shall be made available in appropriate formats and languages to reflect the varying needs of consumers and diverse levels of health literacy.
- (k) REPORT.—
- (1) IN GENERAL.—The Director shall submit an annual report to the Congress and the Secretary on activities under this section.

- (2) CONTENT.—Each report under paragraph (1) shall include—
- (A) information on activities conducted pursuant to grants and contracts awarded;
 - (B) summary data on patient outcomes and satisfaction before, during, and after implementation of best practices; and
 - (C) recommendations on the adaptability of best practices for use by health providers.”.

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

SEC. ____ . PATIENT-CENTERED CARE MODEL PILOT PROGRAM (Medicare)

(a) IN GENERAL.— The Secretary shall conduct a pilot program (in this section referred to as a ‘pilot program’) to test the Patient-Centered Care Model described in subsection (b), designed to improve health outcomes for targeted high need Medicare beneficiaries with chronic conditions defined in subparagraph (b)(1)(C). The pilot program shall operate for a period of up to 5 years.

(b) PATIENT-CENTERED CARE MODEL.—

(1) IN GENERAL.—

(A) PAYMENT AUTHORITY.—Under the Patient-Centered Care Model, the Secretary shall make payments for services furnished under this program for targeted high needs beneficiaries as defined in subparagraph (C)

(B) PATIENT-CENTERED CARE MODEL DEFINED.—For purposes of this subsection, the term ‘Patient-Centered Care Model’ means a model that must:

- (i) Integrate evidence-based guidelines and health information technology in a manner that addresses the identified needs of beneficiaries;
- (ii) Use comprehensive assessment tools to consider a patient’s unique health history and lifestyle to develop a treatment regimen;
- (iii) Implement incentives, such as reduction of copayments or coinsurance, to encourage the use of high-value services by beneficiaries; and
- (iv) Coordinate the care provided to a patient by a team of individuals at the practice level across office, institutional, and home settings led by a patient care coordinator.

(C) TARGETED HIGH NEED BENEFICIARY WITH CHRONIC CONDITIONS DEFINED.—For purposes of this subsection, the term ‘targeted high need beneficiary with chronic conditions’ 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) PATIENT CARE COORDINATOR DEFINED.—The term ‘patient care coordinator’ 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, a physician who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine, a nurse practitioner, a physician assistant, or a social worker.

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

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

(G) WAIVER.—The Secretary may waive such provisions of titles XI and XVIII of the Social Security Act as may be necessary to carry out the pilot program under this section.

(2) STANDARD SETTING AND QUALIFICATION PROCESS.—The Secretary shall review alternative models for standard setting and qualification, and shall establish a process—

- (A) to establish standards to enable plans to qualify as a Patient-Centered Care Model; and
- (B) to initially provide for the review and certification of plans as meeting such standards.

(3) PAYMENT.—

(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a methodology for the payment for services furnished under the Patient-Centered Care Model. Under such methodology, the Secretary shall adjust payments based on beneficiary risk score 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 a monthly fee for each targeted high need beneficiary who consents to receive services under the Patient-Centered Care Model.

(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 services under the Patient-Centered Care Model.

(ii) 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 to providers under the Patient-Centered Care Model 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 and medical home pilot program under section 1866D shall not be eligible to participate under this subsection, unless the pilot program under this section has been implemented on a permanent basis under subsection (c)(3).

(c) EXPANSION OF PROGRAM.—

(1) EVALUATION.—The Secretary shall evaluate the pilot program to determine:

(A) the extent to which the Patient-Centered Care Model:

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

(ii) reduced health disparities;

(iii) reduced preventable hospitalizations;

(iv) prevented readmissions;

(v) reduced emergency room visits;

(vi) improved health outcomes, including patient functional status;

(vii) improved patient satisfaction; and

(viii) improved efficiency of care, such as reducing duplicative diagnostic tests and laboratory tests.

(B) the feasibility and advisability of reimbursing plans for services provided under the Patient-Centered Care Model 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 such paragraph.

(3) EXPANSION OF PROGRAM.—Subject to the results of the evaluation under paragraph (1), the Secretary may issue regulations to implement, on a permanent basis, the Patient-Centered Care Model, if, and to the extent that such model, is beneficial to the program under this title, including that such implementation will improve quality of care, as determined by the Secretary.

(d) 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 CARE MODEL 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 184 \$200,000,000 for each of fiscal years 2010 through 2014 for payments for services under subsection (b)(2). 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. Amounts available under this paragraph for a fiscal year shall be available until expended.

TITLE VII—MEDICAID AND CHIP

Subtitle C. Access

SEC. ____ . PATIENT-CENTERED CARE MODEL PILOT PROGRAM (Medicaid and CHIP)

(a) IN GENERAL.—The Secretary shall establish under this section a Patient-Centered Care Model pilot program under which a State may apply to the Secretary for approval of a pilot program described in subsection (b) (in this section, referred to as a “pilot project”). The pilot program shall operate for a period of up to 5 years.

(b) PATIENT-CENTERED CARE MODEL.—

(1) IN GENERAL.—

(A) PATIENT-CENTERED CARE MODEL DEFINED.—For purposes of this subsection, the term ‘Patient-Centered Care Model’ means a model that:

- (i) Integrates evidence-based guidelines and health information technology in a manner that addresses the identified needs of beneficiaries;
- (ii) Uses comprehensive assessment tools to consider a patient’s unique health history and lifestyle to develop a treatment regimen;
- (iii) Implements incentives, such as reduction of copayments or coinsurance, to encourage the use of high-value services by beneficiaries; and
- (iv) Coordinates the care provided to a patient by a team of individuals at the practice level across office, institutional, and home settings led by a patient care coordinator.

(B) TARGETED HIGH NEED BENEFICIARY WITH CHRONIC CONDITIONS DEFINED.—For purposes of this subsection, the term ‘targeted high need beneficiary with chronic conditions’ 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.

(C) PATIENT CARE COORDINATOR DEFINED.—The term ‘patient care coordinator’ 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, a physician who practices in the field of family medicine, general internal medicine, geriatric medicine, or pediatric medicine, a nurse practitioner, a physician assistant, or a social worker.

(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) 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) EVALUATION; REPORT.—

(1) EVALUATION.—The Secretary shall evaluate the pilot program to determine:

(A) the extent to which the Patient-Centered Care Model:

- (i) improved the quality and coordination of health care services, particularly with regard to complex patients;
- (ii) reduced health disparities;
- (iii) reduced preventable hospitalizations;
- (iv) prevented readmissions;
- (v) reduced emergency room visits;
- (vi) improved health outcomes, including patient functional status;
- (vii) improved patient satisfaction; and
- (viii) improved efficiency of care, such as reducing duplicative diagnostic tests and laboratory tests.

(B) the feasibility and advisability of reimbursing plans for services provided under the Patient-Centered Care Model 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 such paragraph.

(e) FUNDING.—The additional Federal financial participating 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.

Innovative Health Care Delivery Models and Their Impact

Initiative	Geographic Region	Start Date	Description	Program Outcomes and Impact
<p>Johns Hopkins: Bloomberg School of Public Health's Guided Care Program</p>	<p>Baltimore, MD/ Washington D.C. area</p>	<p>2003</p>	<p>A comprehensive model of care designed to improve quality of life and efficient use of resources for individuals with multiple chronic conditions. A Guided Care Nurse works with several primary care physicians (PCP) to provide coordinated, patient-centered, cost-effective care to 50-60 chronically ill patients.</p>	<p>Preliminary data shows that during the first six months of the one-year pilot, Guided Care patients had fewer hospital admissions, hospital days, emergency visits, and 23% lower insurance expenditures, than patients not in the program. A randomized controlled trial is expected to be completed by June 2009.</p>
<p>Community Care of North Carolina (CCNC)</p>	<p>North Carolina</p>	<p>1998</p>	<p>Builds upon North Carolina's Primary Care Case Management Program for Medicaid enrollees. Uses community physicians, hospitals, health departments, and departments of social services to provide preventive care and care management</p>	<p>In state FY 2001, the CCNC Program had a 34% lower hospital admission rate for enrollees under 21 than in the control group, 8% lower ED rate than in the control group. The average episode cost for children enrolled in CCNC was 24% lower than those not enrolled in the program. The asthma disease management program saved \$3.5 million from 2000-2002 from lower inpatient admissions and emergency department visits. The diabetes disease management program saved \$2.1 million during the same time period. The program saved overall approximately \$124 million in state costs for FY 2004.</p>
<p>Housing First Initiative for Chicago Homeless With Chronic Medical Illness (CHHP)</p>	<p>Chicago, Illinois</p>	<p>2003</p>	<p>First "hospital-to-housing" effort of its kind in the nation. CHHP identifies chronically ill homeless individuals at hospitals, moves them to permanent supportive housing, and provides them with intensive case management services so that they can maintain their health and secure long-term housing stability.</p>	<p>A study following 405 homeless people with chronic illness concluded that the intervention group had 29% fewer hospitalizations, 29% fewer days in the hospital, and 24% fewer emergency department visits after the 18 month study</p>
<p>Geisinger's Personal Health Navigator</p>	<p>Central and Northeast Pennsylvania</p>	<p>2005</p>	<p>A patient-centered medical home model that delivers value by improving care coordination and individual health status</p>	<p>During 2007, members enrolled in the program saw a 12% decrease in acute hospital admissions, an 11.7% decrease in hospital readmissions and an 8% difference in medical cost trend for primary care sites that offered the Personal Health Navigator program versus non-Navigator sites.</p>
<p>Pennsylvania Chronic Care Initiative</p>	<p>Pennsylvania</p>	<p>2008</p>	<p>Integration of a Chronic Care Model and the Patient-Centered Medical Home concepts with an initial focus is on diabetes and pediatric asthma. Doctors and other clinicians at the 32 practices in Southeastern Pennsylvania have financial support to redesign their practices into a more team-oriented system aimed at changing patient behaviors, in part by providing basic education, tracking patients' progress by computer and calling people who miss appointments.</p>	<p>First-year results show that the initial 32 medical practices to participate in the initiative reported that their diabetic patients were doing better than those that did not participate. Of the 15,000 diabetic patients in the program, 44% gained ideal control of their blood sugar, up from 33% in the year prior.</p>

Initiative	Geographic Region	Start Date	Description	Program Outcomes and Impact
Cleveland Clinical Health Systems Employee Health Plan	Ohio	2006	Value-based benefit design program that offers a \$6 copay for a 90-day supply of generic statins and an \$8 copay for the same supply of branded Lipitor or Crestor. Usual copays for branded statins are \$100 for a 90-day supply. To get the lower copays, members must purchase their drugs from one of Cleveland Clinic's nine retail pharmacies and participate in a pill-splitting program.	Roughly 40% of the employee population's total 5,500 statin users were enrolled in the program by the end of 2007. The clinic found that 20% more members picked up all of their prescriptions in 2007.
Hotel Employees and Restaurant Employees International Union Welfare=Pension Funds	West Virginia	N/A	Integrated model of value-based benefit design and increased personalized care includes a Health Risk Assessment, reduced barriers to chronic care treatment, personalized health coaching, and no-cost supplies and reduced-cost treatments for diabetes, high cholesterol and high blood pressure.	Medication adherence improved due to the reduced cost of prescription drugs (Copays were removed for all generic and some brand name prescription drugs.) Total medical costs were reduced from 14.5% per year at baseline to 4.5% each of the following two years.
MedImpact Study on VBBD	California	N/A	MedImpact researchers and Health Alliance Medical Plans, a MedImpact client, evaluated the impact of value-based benefit design(VBBD) on adherence to diabetes medications in a pilot group of Carle Clinic enrollees.	Study results show that implementation of a VBBD program that reduced copayments by almost 50% resulted in significantly improved medication adherence. The program reduced copayments for diabetic medications by 47.6% and improved the odds of adherence by 73.3%. The number of non-adherent patients was reduced by 33.4%.
State of Colorado Employee Benefits Plan	Colorado	2006	Great-West Healthcare paired with the University of Colorado Health Sciences Center to pilot a study on a value-based approach to diabetes management.	After 2 years, there was a 13% increase in compliance levels of 80% or higher for diabetic prescription medications. Decreased medical utilization in outpatient, inpatient and emergency room visits was recorded.
Blue Care Network	Michigan	2006	Value-based benefit design program which lowers the \$40 copay for branded asthma-control medications to a \$10 generic copay levels. The program also allows members who take maintenance drugs for chronic conditions to purchase a 90-day supply at most retail pharmacies and pay only two copays instead of three.	The asthma-drug program has resulted in a 20% to 25% increase in utilization of controller medications as well as decreases in hospitalization and ER visits following the first year of program implementation
Institute for Clinical Systems Integration's DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) program	Minnesota	2008	Depression treatment program that integrates a collaborative care model with a reimbursement structure that enables medical groups to provide outreach and enhanced care support to patients with depression. More than 1,600 patients have been enrolled in DIAMOND to date.	Preliminary data shows that during the first six months, 43% of surveyed patients are in remission and 10% of surveyed patients have seen at least a 50% reduction in the severity of their depression.