

Calendar No. **175**

AMENDMENT NO. 2786

Purpose: In the nature of a substitute.

IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.

H. R. 3590

To amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

November 19, 2009

Ordered to lie on the table and to be printed

Amendment in the nature of a substitute intended to be proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN)

Viz:

1 Strike all after the enacting clause and insert the fol-
2 lowing:

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Patient Protection and Affordable Care Act”.

6 ~~(b) **TABLE OF CONTENTS.**—The table of contents of
7 this Act is as follows:~~

Sec. 1. Short title; table of contents.

~~TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL
AMERICANS~~

- ~~Sec. 3402. Temporary adjustment to the calculation of part B premiums.~~
~~Sec. 3403. Independent Medicare Advisory Board.~~

~~Subtitle F—Health Care Quality Improvements~~

- ~~Sec. 3501. Health care delivery system research; Quality improvement technical assistance.~~
~~Sec. 3502. Establishing community health teams to support the patient-centered medical home.~~
~~Sec. 3503. Medication management services in treatment of chronic disease.~~
~~Sec. 3504. Design and implementation of regionalized systems for emergency care.~~
~~Sec. 3505. Trauma care centers and service availability.~~
~~Sec. 3506. Program to facilitate shared decisionmaking.~~
~~Sec. 3507. Presentation of prescription drug benefit and risk information.~~
~~Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.~~
~~Sec. 3509. Improving women's health.~~
~~Sec. 3510. Patient navigator program.~~
~~Sec. 3511. Authorization of appropriations.~~

~~TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH~~

~~Subtitle A—Modernizing Disease Prevention and Public Health Systems~~

- ~~Sec. 4001. National Prevention, Health Promotion and Public Health Council.~~
~~Sec. 4002. Prevention and Public Health Fund.~~
~~Sec. 4003. Clinical and community preventive services.~~
~~Sec. 4004. Education and outreach campaign regarding preventive benefits.~~

~~Subtitle B—Increasing Access to Clinical Preventive Services~~

- ~~Sec. 4101. School-based health centers.~~
~~Sec. 4102. Oral healthcare prevention activities.~~
~~Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan.~~
~~Sec. 4104. Removal of barriers to preventive services in Medicare.~~
~~Sec. 4105. Evidence-based coverage of preventive services in Medicare.~~
~~Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.~~
~~Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.~~
~~Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.~~

~~Subtitle C—Creating Healthier Communities~~

- ~~Sec. 4201. Community transformation grants.~~
~~Sec. 4202. Healthy aging, living well; evaluation of community-based prevention and wellness programs for Medicare beneficiaries.~~
~~Sec. 4203. Removing barriers and improving access to wellness for individuals with disabilities.~~
~~Sec. 4204. Immunizations.~~
~~Sec. 4205. Nutrition labeling of standard menu items at chain restaurants.~~
~~Sec. 4206. Demonstration project concerning individualized wellness plan.~~
~~Sec. 4207. Reasonable break time for nursing mothers.~~

1 **SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES**
2 **FOR ENROLLEES WITH CHRONIC CONDI-**
3 **TIONS.**

4 (a) STATE PLAN AMENDMENT.—Title XIX of the So-
5 cial Security Act (42 U.S.C. 1396a et seq.), as amended
6 by sections 2201 and 2305, is amended by adding at the
7 end the following new section:

8 “SEC. 1945. STATE OPTION TO PROVIDE COORDI-
9 NATED CARE THROUGH A HEALTH HOME FOR INDIVID-
10 UALS WITH CHRONIC CONDITIONS.—

11 “(a) IN GENERAL.—Notwithstanding section
12 1902(a)(1) (relating to statewideness), section
13 1902(a)(10)(B) (relating to comparability), and any other
14 provision of this title for which the Secretary determines
15 it is necessary to waive in order to implement this section,
16 beginning January 1, 2011, a State, at its option as a
17 State plan amendment, may provide for medical assistance
18 under this title to eligible individuals with chronic condi-
19 tions who select a designated provider (as described under
20 subsection (h)(5)), a team of health care professionals (as
21 described under subsection (h)(6)) operating with such a
22 provider, or a **health team** (as described under subsection
23 (h)(7)) as the individual’s health home for purposes of
24 providing the individual with health home services.

25 “(b) HEALTH HOME QUALIFICATION STANDARDS.—
26 The Secretary shall establish standards for qualification

1 as a designated provider for the purpose of being eligible
2 to be a health home for purposes of this section.

3 “(c) PAYMENTS.—

4 “(1) IN GENERAL.—A State shall provide a des-
5 ignated provider, a team of health care professionals
6 operating with such a provider, or a health team
7 with payments for the provision of health home serv-
8 ices to each eligible individual with chronic condi-
9 tions that selects such provider, team of health care
10 professionals, or health team as the individual’s
11 health home. Payments made to a designated pro-
12 vider, a team of health care professionals operating
13 with such a provider, or a health team for such serv-
14 ices shall be treated as medical assistance for pur-
15 poses of section 1903(a), except that, during the
16 first 8 fiscal year quarters that the State plan
17 amendment is in effect, the Federal medical assist-
18 ance percentage applicable to such payments shall be
19 equal to 90 percent.

20 “(2) METHODOLOGY.—

21 “(A) IN GENERAL.—The State shall speci-
22 fy in the State plan amendment the method-
23 ology the State will use for determining pay-
24 ment for the provision of health home services.
25 Such methodology for determining payment—

1 “(i) may be tiered to reflect, with re-
2 spect to each eligible individual with chron-
3 ic conditions provided such services by a
4 designated provider, a team of health care
5 professionals operating with such a pro-
6 vider, or a **health team**, as well as the se-
7 verity or number of each such individual’s
8 chronic conditions or the specific capabili-
9 ties of the provider, team of health care
10 professionals, or **health team**; and

11 “(ii) shall be established consistent
12 with section 1902(a)(30)(A).

13 “(B) ALTERNATE MODELS OF PAYMENT.—
14 The methodology for determining payment for
15 provision of health home services under this
16 section shall not be limited to a per-member
17 per-month basis and may provide (as proposed
18 by the State and subject to approval by the
19 Secretary) for alternate models of payment.

20 “(3) PLANNING GRANTS.—

21 “(A) IN GENERAL.—Beginning January 1,
22 2011, the Secretary may award planning grants
23 to States for purposes of developing a State
24 plan amendment under this section. A planning

1 grant awarded to a State under this paragraph
2 shall remain available until expended.

3 “(B) STATE CONTRIBUTION.—A State
4 awarded a planning grant shall contribute an
5 amount equal to the State percentage deter-
6 mined under section 1905(b) (without regard to
7 section 5001 of Public Law 111–5) for each fis-
8 cal year for which the grant is awarded.

9 “(C) LIMITATION.—The total amount of
10 payments made to States under this paragraph
11 shall not exceed \$25,000,000.

12 “(d) HOSPITAL REFERRALS.—A State shall include
13 in the State plan amendment a requirement for hospitals
14 that are participating providers under the State plan or
15 a waiver of such plan to establish procedures for referring
16 any eligible individuals with chronic conditions who seek
17 or need treatment in a hospital emergency department to
18 designated providers.

19 “(e) COORDINATION.—A State shall consult and co-
20 ordinate, as appropriate, with the Substance Abuse and
21 Mental Health Services Administration in addressing
22 issues regarding the prevention and treatment of mental
23 illness and substance abuse among eligible individuals with
24 chronic conditions.

1 “(f) MONITORING.—A State shall include in the State
2 plan amendment—

3 “(1) a methodology for tracking avoidable hos-
4 pital readmissions and calculating savings that re-
5 sult from improved chronic care coordination and
6 management under this section; and

7 “(2) a proposal for use of health information
8 technology in providing health home services under
9 this section and improving service delivery and co-
10 ordination across the care continuum (including the
11 use of wireless patient technology to improve coordi-
12 nation and management of care and patient adher-
13 ence to recommendations made by their provider).

14 “(g) REPORT ON QUALITY MEASURES.—As a condi-
15 tion for receiving payment for health home services pro-
16 vided to an eligible individual with chronic conditions, a
17 designated provider shall report to the State, in accord-
18 ance with such requirements as the Secretary shall specify,
19 on all applicable measures for determining the quality of
20 such services. When appropriate and feasible, a designated
21 provider shall use health information technology in pro-
22 viding the State with such information.

23 “(h) DEFINITIONS.—In this section:

24 “(1) ELIGIBLE INDIVIDUAL WITH CHRONIC
25 CONDITIONS.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the term ‘eligible individual with
3 chronic conditions’ means an individual who—

4 “(i) is eligible for medical assistance
5 under the State plan or under a waiver of
6 such plan; and

7 “(ii) has at least—

8 “(I) 2 chronic conditions;

9 “(II) 1 chronic condition and is
10 at risk of having a second chronic
11 condition; or

12 “(III) 1 serious and persistent
13 mental health condition.

14 “(B) RULE OF CONSTRUCTION.—Nothing
15 in this paragraph shall prevent the Secretary
16 from establishing higher levels as to the number
17 or severity of chronic or mental health condi-
18 tions for purposes of determining eligibility for
19 receipt of health home services under this sec-
20 tion.

21 “(2) CHRONIC CONDITION.—The term ‘chronic
22 condition’ has the meaning given that term by the
23 Secretary and shall include, but is not limited to, the
24 following:

25 “(A) A mental health condition.

1 “(B) Substance use disorder.

2 “(C) Asthma.

3 “(D) Diabetes.

4 “(E) Heart disease.

5 “(F) Being overweight, as evidenced by
6 having a Body Mass Index (BMI) over 25.

7 “(3) HEALTH HOME.—The term ‘health home’
8 means a designated provider (including a provider
9 that operates in coordination with a team of health
10 care professionals) or a **health team** selected by an
11 eligible individual with chronic conditions to provide
12 health home services.

13 “(4) HEALTH HOME SERVICES.—

14 “(A) IN GENERAL.—The term ‘health
15 home services’ means comprehensive and timely
16 high-quality services described in subparagraph
17 (B) that are provided by a designated provider,
18 a team of health care professionals operating
19 with such a provider, or a **health team.**

20 “(B) SERVICES DESCRIBED.—The services
21 described in this subparagraph are—

22 “(i) comprehensive care management;

23 “(ii) care coordination and health pro-
24 motion;

1 “(iii) comprehensive transitional care,
2 including appropriate follow-up, from inpa-
3 tient to other settings;

4 “(iv) patient and family support (in-
5 cluding authorized representatives);

6 “(v) referral to community and social
7 support services, if relevant; and

8 “(vi) use of health information tech-
9 nology to link services, as feasible and ap-
10 propriate.

11 “(5) DESIGNATED PROVIDER.—The term ‘des-
12 ignated provider’ means a physician, clinical practice
13 or clinical group practice, rural clinic, community
14 health center, community mental health center,
15 home health agency, or any other entity or provider
16 (including pediatricians, gynecologists, and obstetri-
17 cians) that is determined by the State and approved
18 by the Secretary to be qualified to be a health home
19 for eligible individuals with chronic conditions on the
20 basis of documentation evidencing that the physi-
21 cian, practice, or clinic—

22 “(A) has the systems and infrastructure in
23 place to provide health home services; and

1 “(B) satisfies the qualification standards
2 established by the Secretary under subsection
3 (b).

4 “(6) TEAM OF HEALTH CARE PROFES-
5 SIONALS.—The term ‘team of health care profes-
6 sionals’ means a team of health professionals (as de-
7 scribed in the State plan amendment) that may—

8 “(A) include physicians and other profes-
9 sionals, such as a nurse care coordinator, nutri-
10 tionist, social worker, behavioral health profes-
11 sional, or any professionals deemed appropriate
12 by the State; and

13 “(B) be free standing, virtual, or based at
14 a hospital, community health center, community
15 mental health center, rural clinic, clinical prac-
16 tice or clinical group practice, academic health
17 center, or any entity deemed appropriate by the
18 State and approved by the Secretary.

19 “(7) HEALTH TEAM.—The term ‘health team’
20 has the meaning given such term for purposes of
21 section 3502 of the Patient Protection and Afford-
22 able Care Act.”.

23 (b) EVALUATION.—

24 (1) INDEPENDENT EVALUATION.—

1 **PART III—ENCOURAGING DEVELOPMENT OF**
2 **NEW PATIENT CARE MODELS**
3 **SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE**
4 **AND MEDICAID INNOVATION WITHIN CMS.**

5 (a) IN GENERAL.—Title XI of the Social Security Act
6 is amended by inserting after section 1115 the following
7 new section:

8 “CENTER FOR MEDICARE AND MEDICAID INNOVATION
9 “SEC. 1115A. (a) CENTER FOR MEDICARE AND
10 MEDICAID INNOVATION ESTABLISHED.—

11 “(1) IN GENERAL.—There is created within the
12 Centers for Medicare & Medicaid Services a Center
13 for Medicare and Medicaid Innovation (in this sec-
14 tion referred to as the ‘CMI’) to carry out the duties
15 described in this section. The purpose of the CMI is
16 to test innovative payment and service delivery mod-
17 els to reduce program expenditures under the appli-
18 cable titles while preserving or enhancing the quality
19 of care furnished to individuals under such titles. In
20 selecting such models, the Secretary shall give pref-
21 erence to models that also improve the coordination,
22 quality, and efficiency of health care services fur-
23 nished to applicable individuals defined in paragraph
24 (4)(A).

1 “(2) DEADLINE.—The Secretary shall ensure
2 that the CMI is carrying out the duties described in
3 this section by not later than January 1, 2011.

4 “(3) CONSULTATION.—In carrying out the du-
5 ties under this section, the CMI shall consult rep-
6 resentatives of relevant Federal agencies, and clin-
7 ical and analytical experts with expertise in medicine
8 and health care management. The CMI shall use
9 open door forums or other mechanisms to seek input
10 from interested parties.

11 “(4) DEFINITIONS.—In this section:

12 “(A) APPLICABLE INDIVIDUAL.—The term
13 ‘applicable individual’ means—

14 “(i) an individual who is entitled to,
15 or enrolled for, benefits under part A of
16 title XVIII or enrolled for benefits under
17 part B of such title;

18 “(ii) an individual who is eligible for
19 medical assistance under title XIX, under
20 a State plan or waiver; or

21 “(iii) an individual who meets the cri-
22 teria of both clauses (i) and (ii).

23 “(B) APPLICABLE TITLE.—The term ‘ap-
24 plicable title’ means title XVIII, title XIX, or
25 both.

1 “(b) TESTING OF MODELS (PHASE I).—

2 “(1) IN GENERAL.—The CMI shall test pay-
3 ment and service delivery models in accordance with
4 selection criteria under paragraph (2) to determine
5 the effect of applying such models under the applica-
6 ble title (as defined in subsection (a)(4)(B)) on pro-
7 gram expenditures under such titles and the quality
8 of care received by individuals receiving benefits
9 under such title.

10 “(2) SELECTION OF MODELS TO BE TESTED.—

11 “(A) IN GENERAL.—The Secretary shall
12 select models to be tested from models where
13 the Secretary determines that there is evidence
14 that the model addresses a defined population
15 for which there are deficits in care leading to
16 poor clinical outcomes or potentially avoidable
17 expenditures. The models selected under the
18 preceding sentence may include the models de-
19 scribed in subparagraph (B).

20 “(B) OPPORTUNITIES.—The models de-
21 scribed in this subparagraph are the following
22 models:

23 “(i) Promoting broad payment and
24 practice reform in primary care, including
25 patient-centered medical home models for

1 high-need applicable individuals, medical
2 homes that address women’s unique health
3 care needs, and models that transition pri-
4 mary care practices away from fee-for-serv-
5 ice based reimbursement and toward com-
6 prehensive payment or salary-based pay-
7 ment.

8 “(ii) Contracting directly with groups
9 of providers of services and suppliers to
10 promote innovative care delivery models,
11 such as through risk-based comprehensive
12 payment or salary-based payment.

13 “(iii) Utilizing geriatric assessments
14 and comprehensive care plans to coordinate
15 the care (including through interdiscipli-
16 nary teams) of applicable individuals with
17 multiple chronic conditions and at least
18 one of the following:

19 “(I) An inability to perform 2 or
20 more activities of daily living.

21 “(II) Cognitive impairment, in-
22 cluding dementia.

23 “(iv) Promote care coordination be-
24 tween providers of services and suppliers
25 that transition health care providers away

1 from fee-for-service based reimbursement
2 and toward salary-based payment.

3 “(v) Supporting care coordination for
4 chronically-ill applicable individuals at high
5 risk of hospitalization through a health in-
6 formation technology-enabled provider net-
7 work that includes care coordinators, a
8 chronic disease registry, and home tele-
9 health technology.

10 “(vi) Varying payment to physicians
11 who order advanced diagnostic imaging
12 services (as defined in section
13 1834(e)(1)(B)) according to the physi-
14 cian’s adherence to appropriateness criteria
15 for the ordering of such services, as deter-
16 mined in consultation with physician spe-
17 cialty groups and other relevant stake-
18 holders.

19 “(vii) Utilizing medication therapy
20 management services, such as those de-
21 scribed in section 935 of the Public Health
22 Service Act.

23 “(viii) Establishing community-based
24 health teams to support small-practice
25 medical homes by assisting the primary

1 care practitioner in chronic care manage-
2 ment, including patient self-management,
3 activities.

4 “(ix) Assisting applicable individuals
5 in making informed health care choices by
6 paying providers of services and suppliers
7 for using patient decision-support tools, in-
8 cluding tools that meet the standards de-
9 veloped and identified under section
10 936(c)(2)(A) of the Public Health Service
11 Act, that improve applicable individual and
12 caregiver understanding of medical treat-
13 ment options.

14 “(x) Allowing States to test and
15 evaluate fully integrating care for dual eli-
16 gible individuals in the State, including the
17 management and oversight of all funds
18 under the applicable titles with respect to
19 such individuals.

20 “(xi) Allowing States to test and
21 evaluate systems of all-payer payment re-
22 form for the medical care of residents of
23 the State, including dual eligible individ-
24 uals.

1 “(xii) Aligning nationally recognized,
2 evidence-based guidelines of cancer care
3 with payment incentives under title XVIII
4 in the areas of treatment planning and fol-
5 low-up care planning for applicable individ-
6 uals described in clause (i) or (iii) of sub-
7 section (a)(4)(A) with cancer, including the
8 identification of gaps in applicable quality
9 measures.

10 “(xiii) Improving post-acute care
11 through continuing care hospitals that
12 offer inpatient rehabilitation, long-term
13 care hospitals, and home health or skilled
14 nursing care during an inpatient stay and
15 the 30 days immediately following dis-
16 charge.

17 “(xiv) Funding home health providers
18 who offer chronic care management serv-
19 ices to applicable individuals in cooperation
20 with interdisciplinary teams.

21 “(xv) Promoting improved quality and
22 reduced cost by developing a collaborative
23 of high-quality, low-cost health care insti-
24 tutions that is responsible for—

1 “(I) developing, documenting,
2 and disseminating best practices and
3 proven care methods;

4 “(II) implementing such best
5 practices and proven care methods
6 within such institutions to dem-
7 onstrate further improvements in
8 quality and efficiency; and

9 “(III) providing assistance to
10 other health care institutions on how
11 best to employ such best practices and
12 proven care methods to improve
13 health care quality and lower costs.

14 “(xvi) Facilitate inpatient care, in-
15 cluding intensive care, of hospitalized ap-
16 plicable individuals at their local hospital
17 through the use of electronic monitoring by
18 specialists, including intensivists and crit-
19 ical care specialists, based at integrated
20 health systems.

21 “(xvii) Promoting greater efficiencies
22 and timely access to outpatient services
23 (such as outpatient physical therapy serv-
24 ices) through models that do not require a
25 physician or other health professional to

1 refer the service or be involved in estab-
2 lishing the plan of care for the service,
3 when such service is furnished by a health
4 professional who has the authority to fur-
5 nish the service under existing State law.

6 “(xviii) Establishing comprehensive
7 payments to Healthcare Innovation Zones,
8 consisting of groups of providers that in-
9 clude a teaching hospital, physicians, and
10 other clinical entities, that, through their
11 structure, operations, and joint-activity de-
12 liver a full spectrum of integrated and
13 comprehensive health care services to ap-
14 plicable individuals while also incorporating
15 innovative methods for the clinical training
16 of future health care professionals.

17 “(C) ADDITIONAL FACTORS FOR CONSID-
18 ERATION.—In selecting models for testing
19 under subparagraph (A), the CMI may consider
20 the following additional factors:

21 “(i) Whether the model includes a
22 regular process for monitoring and updat-
23 ing patient care plans in a manner that is
24 consistent with the needs and preferences
25 of applicable individuals.

1 “(ii) Whether the model places the ap-
2 plicable individual, including family mem-
3 bers and other informal caregivers of the
4 applicable individual, at the center of the
5 care team of the applicable individual.

6 “(iii) Whether the model provides for
7 in-person contact with applicable individ-
8 uals.

9 “(iv) Whether the model utilizes tech-
10 nology, such as electronic health records
11 and patient-based remote monitoring sys-
12 tems, to coordinate care over time and
13 across settings.

14 “(v) Whether the model provides for
15 the maintenance of a close relationship be-
16 tween care coordinators, primary care
17 practitioners, specialist physicians, commu-
18 nity-based organizations, and other pro-
19 viders of services and suppliers.

20 “(vi) Whether the model relies on a
21 team-based approach to interventions, such
22 as comprehensive care assessments, care
23 planning, and self-management coaching.

24 “(vii) Whether, under the model, pro-
25 viders of services and suppliers are able to

1 share information with patients, caregivers,
2 and other providers of services and sup-
3 pliers on a real time basis.

4 “(3) BUDGET NEUTRALITY.—

5 “(A) INITIAL PERIOD.—The Secretary
6 shall not require, as a condition for testing a
7 model under paragraph (1), that the design of
8 such model ensure that such model is budget
9 neutral initially with respect to expenditures
10 under the applicable title.

11 “(B) TERMINATION OR MODIFICATION.—
12 The Secretary shall terminate or modify the de-
13 sign and implementation of a model unless the
14 Secretary determines (and the Chief Actuary of
15 the Centers for Medicare & Medicaid Services,
16 with respect to program spending under the ap-
17 plicable title, certifies), after testing has begun,
18 that the model is expected to—

19 “(i) improve the quality of care (as
20 determined by the Administrator of the
21 Centers for Medicare & Medicaid Services)
22 without increasing spending under the ap-
23 plicable title;

1 “(ii) reduce spending under the appli-
2 cable title without reducing the quality of
3 care; or

4 “(iii) improve the quality of care and
5 reduce spending.

6 Such termination may occur at any time after
7 such testing has begun and before completion of
8 the testing.

9 “(4) EVALUATION.—

10 “(A) IN GENERAL.—The Secretary shall
11 conduct an evaluation of each model tested
12 under this subsection. Such evaluation shall in-
13 clude an analysis of—

14 “(i) the quality of care furnished
15 under the model, including the measure-
16 ment of patient-level outcomes and patient-
17 centeredness criteria determined appro-
18 priate by the Secretary; and

19 “(ii) the changes in spending under
20 the applicable titles by reason of the
21 model.

22 “(B) INFORMATION.—The Secretary shall
23 make the results of each evaluation under this
24 paragraph available to the public in a timely
25 fashion and may establish requirements for

1 States and other entities participating in the
2 testing of models under this section to collect
3 and report information that the Secretary de-
4 termines is necessary to monitor and evaluate
5 such models.

6 “(c) EXPANSION OF MODELS (PHASE II).—Taking
7 into account the evaluation under subsection (b)(4), the
8 Secretary may, through rulemaking, expand (including im-
9 plementation on a nationwide basis) the duration and the
10 scope of a model that is being tested under subsection (b)
11 or a demonstration project under section 1866C, to the
12 extent determined appropriate by the Secretary, if—

13 “(1) the Secretary determines that such expan-
14 sion is expected to—

15 “(A) reduce spending under applicable title
16 without reducing the quality of care; or

17 “(B) improve the quality of care and re-
18 duce spending; and

19 “(2) the Chief Actuary of the Centers for Medi-
20 care & Medicaid Services certifies that such expan-
21 sion would reduce program spending under applica-
22 ble titles.

23 “(d) IMPLEMENTATION.—

24 “(1) WAIVER AUTHORITY.—The Secretary may
25 waive such requirements of titles XI and XVIII and

1 of sections 1902(a)(1), 1902(a)(13), and
2 1903(m)(2)(A)(iii) as may be necessary solely for
3 purposes of carrying out this section with respect to
4 testing models described in subsection (b).

5 “(2) LIMITATIONS ON REVIEW.—There shall be
6 no administrative or judicial review under section
7 1869, section 1878, or otherwise of—

8 “(A) the selection of models for testing or
9 expansion under this section;

10 “(B) the selection of organizations, sites,
11 or participants to test those models selected;

12 “(C) the elements, parameters, scope, and
13 duration of such models for testing or dissemi-
14 nation;

15 “(D) determinations regarding budget neu-
16 trality under subsection (b)(3);

17 “(E) the termination or modification of the
18 design and implementation of a model under
19 subsection (b)(3)(B); and

20 “(F) determinations about expansion of
21 the duration and scope of a model under sub-
22 section (c), including the determination that a
23 model is not expected to meet criteria described
24 in paragraph (1) or (2) of such subsection.

1 “(3) ADMINISTRATION.—Chapter 35 of title 44,
2 United States Code, shall not apply to the testing
3 and evaluation of models or expansion of such mod-
4 els under this section.

5 “(e) APPLICATION TO CHIP.—The Center may carry
6 out activities under this section with respect to title XXI
7 in the same manner as provided under this section with
8 respect to the program under the applicable titles.

9 “(f) FUNDING.—

10 “(1) IN GENERAL.—There are appropriated,
11 from amounts in the Treasury not otherwise appro-
12 priated—

13 “(A) \$5,000,000 for the design, implemen-
14 tation, and evaluation of models under sub-
15 section (b) for fiscal year 2010;

16 “(B) \$10,000,000,000 for the activities
17 initiated under this section for the period of fis-
18 cal years 2011 through 2019; and

19 “(C) the amount described in subpara-
20 graph (B) for the activities initiated under this
21 section for each subsequent 10-year fiscal pe-
22 riod (beginning with the 10-year fiscal period
23 beginning with fiscal year 2020).

24 Amounts appropriated under the preceding sentence
25 shall remain available until expended.

1 “(2) USE OF CERTAIN FUNDS.—Out of
2 amounts appropriated under subparagraphs (B) and
3 (C) of paragraph (1), not less than \$25,000,000
4 shall be made available each such fiscal year to de-
5 sign, implement, and evaluate models under sub-
6 section (b).

7 “(g) REPORT TO CONGRESS.—Beginning in 2012,
8 and not less than once every other year thereafter, the
9 Secretary shall submit to Congress a report on activities
10 under this section. Each such report shall describe the
11 models tested under subsection (b), including the number
12 of individuals described in subsection (a)(4)(A)(i) and of
13 individuals described in subsection (a)(4)(A)(ii) partici-
14 pating in such models and payments made under applica-
15 ble titles for services on behalf of such individuals, any
16 models chosen for expansion under subsection (c), and the
17 results from evaluations under subsection (b)(4). In addi-
18 tion, each such report shall provide such recommendations
19 as the Secretary determines are appropriate for legislative
20 action to facilitate the development and expansion of suc-
21 cessful payment models.”.

22 (b) MEDICAID CONFORMING AMENDMENT.—Section
23 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),
24 as amended by section 8002(b), is amended—

1 (1) in paragraph (81), by striking “and” at the
2 end;

3 (2) in paragraph (82), by striking the period at
4 the end and inserting “; and”; and

5 (3) by inserting after paragraph (82) the fol-
6 lowing new paragraph:

7 “(83) provide for implementation of the pay-
8 ment models specified by the Secretary under section
9 1115A(c) for implementation on a nationwide basis
10 unless the State demonstrates to the satisfaction of
11 the Secretary that implementation would not be ad-
12 ministratively feasible or appropriate to the health
13 care delivery system of the State.”.

14 (c) REVISIONS TO HEALTH CARE QUALITY DEM-
15 ONSTRATION PROGRAM.—Subsections (b) and (f) of sec-
16 tion 1866C of the Social Security Act (42 U.S.C. 1395cc-
17 3) are amended by striking “5-year” each place it appears.

18 ~~SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.~~

19 Title XVIII of the Social Security Act (42 U.S.C.
20 1395 et seq.) is amended by adding at the end the fol-
21 lowing new section:

22 “SHARED SAVINGS PROGRAM

23 “SEC. 1899. (a) ESTABLISHMENT.—

24 “(1) IN GENERAL.—Not later than January 1,
25 2012, the Secretary shall establish a shared savings
26 program (in this section referred to as the ‘pro-

1 “(C) where practicable, better patient
2 health outcomes and lower cost resulting from
3 the assistance provided by such entity.

4 “(2) EFFECT OF EVALUATION.—Based on the
5 outcome of the evaluation of the entity under para-
6 graph (1), the Director shall determine whether to
7 renew a grant or contract with such entity under
8 this section.

9 “(f) COORDINATION.—The entities that receive a
10 grant or contract under this section shall coordinate with
11 health information technology regional extension centers
12 under section 3012(c) and the primary care extension pro-
13 gram established under section 399W regarding the dis-
14 semination of quality improvement, system delivery re-
15 form, and best practices information.”.

16 **SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO**
17 **SUPPORT THE PATIENT-CENTERED MEDICAL**
18 **HOME.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services (referred to in this section as the “Sec-
21 retary”) shall establish a program to provide grants to or
22 enter into contracts with eligible entities to establish com-
23 munity-based interdisciplinary, interprofessional teams
24 (referred to in this section as “health teams”) to support
25 primary care practices, including obstetrics and gyne-

1 cology practices, within the hospital service areas served
2 by the eligible entities. Grants or contracts shall be used
3 to—

4 (1) establish health teams to provide support
5 services to primary care providers; and

6 (2) provide capitated payments to primary care
7 providers as determined by the Secretary.

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

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

11 (B) be an Indian tribe or tribal organization, as
12 defined in section 4 of the Indian Health Care Im-
13 provement Act;

14 (2) submit a plan for achieving long-term finan-
15 cial sustainability within 3 years;

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

21 (4) ensure that the health team established by
22 the entity includes an interdisciplinary, interprofes-
23 sional team of health care providers, as determined
24 by the Secretary; such team may include medical
25 specialists, nurses, pharmacists, nutritionists, dieti-

1 cians, social workers, behavioral and mental health
2 providers (including substance use disorder preven-
3 tion and treatment providers), doctors of chiro-
4 practice, licensed complementary and alternative med-
5 icine practitioners, and physicians' assistants;

6 (5) agree to provide services to eligible individ-
7 uals with chronic conditions, as described in section
8 1945 of the Social Security Act (as added by section
9 2703), in accordance with the payment methodology
10 established under subsection (c) of such section; and

11 (6) submit to the Secretary an application at
12 such time, in such manner, and containing such in-
13 formation as the Secretary may require.

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

17 (1) establish contractual agreements with pri-
18 mary care providers to provide support services;

19 (2) support patient-centered medical homes, de-
20 fined as a mode of care that includes—

21 (A) personal physicians;

22 (B) whole person orientation;

23 (C) coordinated and integrated care;

24 (D) safe and high-quality care through evi-
25 dence-informed medicine, appropriate use of

1 health information technology, and continuous
2 quality improvements;

3 (E) expanded access to care; and

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

7 (3) collaborate with local primary care providers
8 and existing State and community based resources
9 to coordinate disease prevention, chronic disease
10 management, transitioning between health care pro-
11 viders and settings and case management for pa-
12 tients, including children, with priority given to
13 those amenable to prevention and with chronic dis-
14 eases or conditions identified by the Secretary;

15 (4) in collaboration with local health care pro-
16 viders, develop and implement interdisciplinary,
17 interprofessional care plans that integrate clinical
18 and community preventive and health promotion
19 services for patients, including children, with a pri-
20 ority given to those amenable to prevention and with
21 chronic diseases or conditions identified by the Sec-
22 retary;

23 (5) incorporate health care providers, patients,
24 caregivers, and authorized representatives in pro-
25 gram design and oversight;

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

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

5 (B) coordinate and provide access to pre-
6 ventive and health promotion services;

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

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

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

15 (F) provide coordination of the appropriate
16 use of complementary and alternative (CAM)
17 services to those who request such services;

18 (G) promote effective strategies for treat-
19 ment planning, monitoring health outcomes and
20 resource use, sharing information, treatment
21 decision support, and organizing care to avoid
22 duplication of service and other medical man-
23 agement approaches intended to improve qual-
24 ity and value of health care services;

1 (H) provide local access to the continuum
2 of health care services in the most appropriate
3 setting, including access to individuals that im-
4 plement the care plans of patients and coordi-
5 nate care, such as integrative health care prac-
6 titioners;

7 (I) collect and report data that permits
8 evaluation of the success of the collaborative ef-
9 fort on patient outcomes, including collection of
10 data on patient experience of care, and identi-
11 fication of areas for improvement; and

12 (J) establish a coordinated system of early
13 identification and referral for children at risk
14 for developmental or behavioral problems such
15 as through the use of infolines, health informa-
16 tion technology, or other means as determined
17 by the Secretary;

18 (7) provide 24-hour care management and sup-
19 port during transitions in care settings including—

20 (A) a transitional care program that pro-
21 vides onsite visits from the care coordinator, as-
22 sists with the development of discharge plans
23 and medication reconciliation upon admission to
24 and discharge from the hospitals, nursing home,
25 or other institution setting;

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

4 (C) assuring that post-discharge care plans
5 include medication management, as appro-
6 priate;

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

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

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

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

21 (10) where applicable, report to the Secretary
22 information on quality measures used under section
23 399JJ of the Public Health Service Act.

1 (d) REQUIREMENT FOR PRIMARY CARE PRO-
2 VIDERS.—A provider who contracts with a care team
3 shall—

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

6 (2) provide access to participant health records;
7 and

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

10 (e) REPORTING TO SECRETARY.—An entity that re-
11 ceives a grant or contract under subsection (a) shall sub-
12 mit to the Secretary a report that describes and evaluates,
13 as requested by the Secretary, the activities carried out
14 by the entity under subsection (c).

15 (f) DEFINITION OF PRIMARY CARE.—In this section,
16 the term “primary care” means the provision of inte-
17 grated, accessible health care services by clinicians who
18 are accountable for addressing a large majority of personal
19 health care needs, developing a sustained partnership with
20 patients, and practicing in the context of family and com-
21 munity.

1 **SEC. 3503. MEDICATION MANAGEMENT SERVICES IN**
2 **TREATMENT OF CHRONIC DISEASE.**

3 Title IX of the Public Health Service Act (42 U.S.C.
4 299 et seq.), as amended by section 3501, is further
5 amended by inserting after section 934 the following:

6 **“SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDI-**
7 **CATION MANAGEMENT SERVICES IN TREAT-**
8 **MENT OF CHRONIC DISEASES.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Patient Safety Research Center established in section
11 933 (referred to in this section as the ‘Center’), shall es-
12 tablish a program to provide grants or contracts to eligible
13 entities to implement medication management (referred to
14 in this section as ‘MTM’) services provided by licensed
15 pharmacists, as a collaborative, multidisciplinary, inter-
16 professional approach to the treatment of chronic diseases
17 for targeted individuals, to improve the quality of care and
18 reduce overall cost in the treatment of such diseases. The
19 Secretary shall commence the program under this section
20 not later than May 1, 2010.

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

23 “(1) provide a setting appropriate for MTM
24 services, as recommended by the experts described in
25 subsection (e);

1 “(2) submit to the Secretary a plan for achiev-
2 ing long-term financial sustainability;

3 “(3) where applicable, submit a plan for coordi-
4 nating MTM services through local community
5 health teams established in section 3502 of the Pa-
6 tient Protection and Affordable Care Act or in col-
7 laboration with primary care extension programs es-
8 tablished in section 399W;

9 “(4) submit a plan for meeting the require-
10 ments under subsection (c); and

11 “(5) submit to the Secretary such other infor-
12 mation as the Secretary may require.

13 “(c) MTM SERVICES TO TARGETED INDIVIDUALS.—
14 The MTM services provided with the assistance of a grant
15 or contract awarded under subsection (a) shall, as allowed
16 by State law including applicable collaborative pharmacy
17 practice agreements, include—

18 “(1) performing or obtaining necessary assess-
19 ments of the health and functional status of each
20 patient receiving such MTM services;

21 “(2) formulating a medication treatment plan
22 according to therapeutic goals agreed upon by the
23 prescriber and the patient or caregiver or authorized
24 representative of the patient;

1 “(3) selecting, initiating, modifying, recom-
2 mending changes to, or administering medication
3 therapy;

4 “(4) monitoring, which may include access to,
5 ordering, or performing laboratory assessments, and
6 evaluating the response of the patient to therapy, in-
7 cluding safety and effectiveness;

8 “(5) performing an initial comprehensive medi-
9 cation review to identify, resolve, and prevent medi-
10 cation-related problems, including adverse drug
11 events, quarterly targeted medication reviews for on-
12 going monitoring, and additional followup interven-
13 tions on a schedule developed collaboratively with
14 the prescriber;

15 “(6) documenting the care delivered and com-
16 municating essential information about such care,
17 including a summary of the medication review, and
18 the recommendations of the pharmacist to other ap-
19 propriate health care providers of the patient in a
20 timely fashion;

21 “(7) providing education and training designed
22 to enhance the understanding and appropriate use of
23 the medications by the patient, caregiver, and other
24 authorized representative;

1 “(8) providing information, support services,
2 and resources and strategies designed to enhance
3 patient adherence with therapeutic regimens;

4 “(9) coordinating and integrating MTM serv-
5 ices within the broader health care management
6 services provided to the patient; and

7 “(10) such other patient care services allowed
8 under pharmacist scopes of practice in use in other
9 Federal programs that have implemented MTM
10 services.

11 “(d) TARGETED INDIVIDUALS.—MTM services pro-
12 vided by licensed pharmacists under a grant or contract
13 awarded under subsection (a) shall be offered to targeted
14 individuals who—

15 “(1) take 4 or more prescribed medications (in-
16 cluding over-the-counter medications and dietary
17 supplements);

18 “(2) take any ‘high risk’ medications;

19 “(3) have 2 or more chronic diseases, as identi-
20 fied by the Secretary; or

21 “(4) have undergone a transition of care, or
22 other factors, as determined by the Secretary, that
23 are likely to create a high risk of medication-related
24 problems.

1 “(e) CONSULTATION WITH EXPERTS.—In designing
2 and implementing MTM services provided under grants or
3 contracts awarded under subsection (a), the Secretary
4 shall consult with Federal, State, private, public-private,
5 and academic entities, pharmacy and pharmacist organi-
6 zations, health care organizations, consumer advocates,
7 chronic disease groups, and other stakeholders involved
8 with the research, dissemination, and implementation of
9 pharmacist-delivered MTM services, as the Secretary de-
10 termines appropriate. The Secretary, in collaboration with
11 this group, shall determine whether it is possible to incor-
12 porate rapid cycle process improvement concepts in use
13 in other Federal programs that have implemented MTM
14 services.

15 “(f) REPORTING TO THE SECRETARY.—An entity
16 that receives a grant or contract under subsection (a) shall
17 submit to the Secretary a report that describes and evalu-
18 ates, as requested by the Secretary, the activities carried
19 out under subsection (e), including quality measures en-
20 dorsed by the entity with a contract under section 1890
21 of the Social Security Act, as determined by the Secretary.

22 “(g) EVALUATION AND REPORT.—The Secretary
23 shall submit to the relevant committees of Congress a re-
24 port which shall—

1 “(1) assess the clinical effectiveness of phar-
2 macist-provided services under the MTM services
3 program, as compared to usual care, including an
4 evaluation of whether enrollees maintained better
5 health with fewer hospitalizations and emergency
6 room visits than similar patients not enrolled in the
7 program;

8 “(2) assess changes in overall health care re-
9 source use by targeted individuals;

10 “(3) assess patient and prescriber satisfaction
11 with MTM services;

12 “(4) assess the impact of patient-cost sharing
13 requirements on medication adherence and rec-
14 ommendations for modifications;

15 “(5) identify and evaluate other factors that
16 may impact clinical and economic outcomes, includ-
17 ing demographic characteristics, clinical characteris-
18 tics, and health services use of the patient, as well
19 as characteristics of the regimen, pharmacy benefit,
20 and MTM services provided; and

21 “(6) evaluate the extent to which participating
22 pharmacists who maintain a dispensing role have a
23 conflict of interest in the provision of MTM services,
24 and if such conflict is found, provide recommenda-

1 tions on how such a conflict might be appropriately
2 addressed.

3 “(h) GRANTS OR CONTRACTS TO FUND DEVELOP-
4 MENT OF PERFORMANCE MEASURES.—The Secretary
5 may, through the quality measure development program
6 under section 931 of the Public Health Service Act, award
7 grants or contracts to eligible entities for the purpose of
8 funding the development of performance measures that as-
9 sess the use and effectiveness of medication therapy man-
10 agement services.”.

11 **SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONAL-**
12 **IZED SYSTEMS FOR EMERGENCY CARE.**

13 (a) IN GENERAL.—Title XII of the Public Health
14 Service Act (42 U.S.C. 300d et seq.) is amended—

15 (1) in section 1203—

16 (A) in the section heading, by inserting
17 “**FOR TRAUMA SYSTEMS**” after “**GRANTS**”;
18 and

19 (B) in subsection (a), by striking “Admin-
20 istrator of the Health Resources and Services
21 Administration” and inserting “Assistant Sec-
22 retary for Preparedness and Response”;

23 (2) by inserting after section 1203 the fol-
24 lowing:

1 for accelerated nursing degree programs, pre-
 2 entry preparation, advanced education prepara-
 3 tion, and retention activities”; and

4 (2) in subsection (b)—

5 (A) by striking “First” and all that follows
 6 through “including the” and inserting “Na-
 7 tional Advisory Council on Nurse Education
 8 and Practice and consult with nursing associa-
 9 tions including the National Coalition of Ethnic
 10 Minority Nurse Associations,”; and

11 (B) by inserting before the period the fol-
 12 lowing: “, and other organizations determined
 13 appropriate by the Secretary”.

14 **SEC. 5405. PRIMARY CARE EXTENSION PROGRAM.**

15 Part P of title III of the Public Health Service Act
 16 (42 U.S.C. 280g et seq.), as amended by section 5313,
 17 is further amended by adding at the end the following:

18 **“SEC. 399W. PRIMARY CARE EXTENSION PROGRAM.**

19 “(a) ESTABLISHMENT, PURPOSE AND DEFINI-
 20 TION.—

21 “(1) IN GENERAL.—The Secretary, acting
 22 through the Director of the Agency for Healthcare
 23 Research and Quality, shall establish a Primary
 24 Care Extension Program.

1 “(2) PURPOSE.—The Primary Care Extension
2 Program shall provide support and assistance to pri-
3 mary care providers to educate providers about pre-
4 ventive medicine, health promotion, chronic disease
5 management, mental and behavioral health services
6 (including substance abuse prevention and treatment
7 services), and evidence-based and evidence-informed
8 therapies and techniques, in order to enable pro-
9 viders to incorporate such matters into their practice
10 and to improve community health by working with
11 community-based health connectors (referred to in
12 this section as ‘Health Extension Agents’).

13 “(3) DEFINITIONS.—In this section:

14 “(A) HEALTH EXTENSION AGENT.—The
15 term ‘Health Extension Agent’ means any local,
16 community-based health worker who facilitates
17 and provides assistance to primary care prac-
18 tices by implementing quality improvement or
19 system redesign, incorporating the principles of
20 the patient-centered medical home to provide
21 high-quality, effective, efficient, and safe pri-
22 mary care and to provide guidance to patients
23 in culturally and linguistically appropriate ways,
24 and linking practices to diverse health system
25 resources.

1 “(B) PRIMARY CARE PROVIDER.—The
2 term ‘primary care provider’ means a clinician
3 who provides integrated, accessible health care
4 services and who is accountable for addressing
5 a large majority of personal health care needs,
6 including providing preventive and health pro-
7 motion services for men, women, and children
8 of all ages, developing a sustained partnership
9 with patients, and practicing in the context of
10 family and community, as recognized by a State
11 licensing or regulatory authority, unless other-
12 wise specified in this section.

13 “(b) GRANTS TO ESTABLISH STATE HUBS AND
14 LOCAL PRIMARY CARE EXTENSION AGENCIES.—

15 “(1) GRANTS.—The Secretary shall award com-
16 petitive grants to States for the establishment of
17 State- or multistate-level primary care Primary Care
18 Extension Program State Hubs (referred to in this
19 section as ‘Hubs’).

20 “(2) COMPOSITION OF HUBS.—A Hub estab-
21 lished by a State pursuant to paragraph (1)—

22 “(A) shall consist of, at a minimum, the
23 State health department, the entity responsible
24 for administering the State Medicaid program
25 (if other than the State health department), the

1 State-level entity administering the Medicare
2 program, and the departments of 1 or more
3 health professions schools in the State that
4 train providers in primary care; and

5 “(B) may include entities such as hospital
6 associations, primary care practice-based re-
7 search networks, health professional societies,
8 State primary care associations, State licensing
9 boards, organizations with a contract with the
10 Secretary under section 1153 of the Social Se-
11 curity Act, consumer groups, and other appro-
12 priate entities.

13 “(c) STATE AND LOCAL ACTIVITIES.—

14 “(1) HUB ACTIVITIES.—Hubs established under
15 a grant under subsection (b) shall—

16 “(A) submit to the Secretary a plan to co-
17 ordinate functions with quality improvement or-
18 ganizations and area health education centers if
19 such entities are members of the Hub not de-
20 scribed in subsection (b)(2)(A);

21 “(B) contract with a county- or local-level
22 entity that shall serve as the Primary Care Ex-
23 tension Agency to administer the services de-
24 scribed in paragraph (2);

1 “(C) organize and administer grant funds
2 to county- or local-level Primary Care Extension
3 Agencies that serve a catchment area, as
4 determined by the State; and

5 “(D) organize State-wide or multistate net-
6 works of local-level Primary Care Extension
7 Agencies to share and disseminate information
8 and practices.

9 “(2) LOCAL PRIMARY CARE EXTENSION AGENCY
10 ACTIVITIES.—

11 “(A) REQUIRED ACTIVITIES.—Primary
12 Care Extension Agencies established by a Hub
13 under paragraph (1) shall—

14 “(i) assist primary care providers to
15 implement a patient-centered medical home
16 to improve the accessibility, quality, and
17 efficiency of primary care services, includ-
18 ing health homes;

19 “(ii) develop and support primary care
20 learning communities to enhance the dis-
21 semination of research findings for evi-
22 dence-based practice, assess implementa-
23 tion of practice improvement, share best
24 practices, and involve community clinicians
25 in the generation of new knowledge and

1 identification of important questions for
2 research;

3 “(iii) participate in a national network
4 of Primary Care Extension Hubs and pro-
5 pose how the Primary Care Extension
6 Agency will share and disseminate lessons
7 learned and best practices; and

8 “(iv) develop a plan for financial sus-
9 tainability involving State, local, and pri-
10 vate contributions, to provide for the re-
11 duction in Federal funds that is expected
12 after an initial 6-year period of program
13 establishment, infrastructure development,
14 and planning.

15 “(B) DISCRETIONARY ACTIVITIES.—Pri-
16 mary Care Extension Agencies established by a
17 Hub under paragraph (1) may—

18 “(i) provide technical assistance,
19 training, and organizational support for
20 community health teams established under
21 section 3602 of the Patient Protection and
22 Affordable Care Act;

23 “(ii) collect data and provision of pri-
24 mary care provider feedback from stand-
25 ardized measurements of processes and

1 outcomes to aid in continuous performance
2 improvement;

3 “(iii) collaborate with local health de-
4 partments, community health centers,
5 tribes and tribal entities, and other com-
6 munity agencies to identify community
7 health priorities and local health workforce
8 needs, and participate in community-based
9 efforts to address the social and primary
10 determinants of health, strengthen the
11 local primary care workforce, and eliminate
12 health disparities;

13 “(iv) develop measures to monitor the
14 impact of the proposed program on the
15 health of practice enrollees and of the
16 wider community served; and

17 “(v) participate in other activities, as
18 determined appropriate by the Secretary.

19 “(d) FEDERAL PROGRAM ADMINISTRATION.—

20 “(1) GRANTS; TYPES.—Grants awarded under
21 subsection (b) shall be—

22 “(A) program grants, that are awarded to
23 State or multistate entities that submit fully-de-
24 veloped plans for the implementation of a Hub,
25 for a period of 6 years; or

1 “(B) planning grants, that are awarded to
2 State or multistate entities with the goal of de-
3 veloping a plan for a Hub, for a period of 2
4 years.

5 “(2) APPLICATIONS.—To be eligible for a grant
6 under subsection (b), a State or multistate entity
7 shall submit to the Secretary an application, at such
8 time, in such manner, and containing such informa-
9 tion as the Secretary may require.

10 “(3) EVALUATION.—A State that receives a
11 grant under subsection (b) shall be evaluated at the
12 end of the grant period by an evaluation panel ap-
13 pointed by the Secretary.

14 “(4) CONTINUING SUPPORT.—After the sixth
15 year in which assistance is provided to a State under
16 a grant awarded under subsection (b), the State may
17 receive additional support under this section if the
18 State program has received satisfactory evaluations
19 with respect to program performance and the merits
20 of the State sustainability plan, as determined by
21 the Secretary.

22 “(5) LIMITATION.—A State shall not use in ex-
23 cess of 10 percent of the amount received under a
24 grant to carry out administrative activities under

1 this section. Funds awarded pursuant to this section
2 shall not be used for funding direct patient care.

3 “(e) REQUIREMENTS ON THE SECRETARY.—In car-
4 rying out this section, the Secretary shall consult with the
5 heads of other Federal agencies with demonstrated experi-
6 ence and expertise in health care and preventive medicine,
7 such as the Centers for Disease Control and Prevention,
8 the Substance Abuse and Mental Health Administration,
9 the Health Resources and Services Administration, the
10 National Institutes of Health, the Office of the National
11 Coordinator for Health Information Technology, the In-
12 dian Health Service, the Agricultural Cooperative Exten-
13 sion Service of the Department of Agriculture, and other
14 entities, as the Secretary determines appropriate.

15 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
16 awards grants as provided in subsection (d), there are au-
17 thorized to be appropriated \$120,000,000 for each of fis-
18 cal years 2011 and 2012, and such sums as may be nec-
19 essary to carry out this section for each of fiscal years
20 2013 through 2014.”.