



Telemedicine in the Patient Protection and Affordable Care Act (2010)

The new national health insurance reform legislation contains several advances for telemedicine that are listed below. There are numerous other provisions, such as those addressing health information technologies, that may contain additional opportunities for telemedicine.

For Medicare

- Directs the new Center for Medicare and Medicaid Innovation (CMI), to explore as a care model how to, “Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems;”
- Allows CMI, in developing new care models, to explore whether the model utilizes technology, such patient-based remote monitoring systems to coordinate care over time and across settings;
- Directs CMI to study the use of entities located in medically underserved areas and facilities of the Indian Health Service to provide telehealth services in treating behavioral health problems (such as post-traumatic stress disorder) and stroke and to study ways to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic conditions;
- Requires new “accountable care organizations” to create ways to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies;
- Includes use of remote monitoring for eligible medical practices in the Independence at Home Demonstration Program;
- Allows physicians to use telehealth to certify the need for home health services or durable medical equipment; and
- Allows telehealth technologies to be used by a pharmacist or other qualified provider in performing an annual comprehensive medication review of Medicare drug plan medication therapy management programs as well as needed follow-up interventions.
- For the new Community-Based Collaborative Care Network Program, the legislation recognizes the role of telehealth to expanding the program’s capacity.

For Medicaid

The legislation provides states a “health home” option for chronic conditions that includes “a proposal for the use of health information technology in providing health home services...and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)”

The following is verbatim text of major telehealth sections of the PPACA. The 4 highlighted sections most seriously impact telemedicine:

- [Medicaid “health home” option for chronic care \(section 2703\)](#)
- [Medicare “accountable care organization” demonstration \(section 3022\)](#)
- [Medicare “Independence at Home” demonstration \(section 3024\)](#)
- [Center for Medicare and Medicaid Innovation \(section 3021\)](#)

SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) State Plan Amendment- Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

`Sec. 1945. State Option To Provide Coordinated Care Through a Health Home for Individuals With Chronic Conditions-

`(a) In General- Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under subsection (h)(7)) as the individual's health home for purposes of providing the individual with health home services.

`(b) Health Home Qualification Standards- The Secretary shall establish standards for qualification as a designated provider for the purpose of being eligible to be a health home for purposes of this section.

`(c) Payments-

`(1) IN GENERAL- A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each eligible individual with chronic conditions that selects such provider, team of health care professionals, or health team as the individual's health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

`(2) METHODOLOGY-

`(A) IN GENERAL- The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment--

`(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

`(ii) shall be established consistent with section 1902(a)(30)(A).

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

`(3) PLANNING GRANTS-

`(A) IN GENERAL- Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

`(B) STATE CONTRIBUTION- A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111-5) for each fiscal year for which the grant is awarded.

`(C) LIMITATION- The total amount of payments made to States under this paragraph shall not exceed \$25,000,000.

`(d) Hospital Referrals- A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any

eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

`(e) Coordination- A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

`(f) Monitoring- A State shall include in the State plan amendment--

`(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

`(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

`(g) Report on Quality Measures- As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accordance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

`(h) Definitions- In this section:

`(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS-

`(A) IN GENERAL- Subject to subparagraph (B), the term 'eligible individual with chronic conditions' means an individual who--

`(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

`(ii) has at least--

`(I) 2 chronic conditions;

`(II) 1 chronic condition and is at risk of having a second chronic condition; or

`(III) 1 serious and persistent mental health condition.

`(B) RULE OF CONSTRUCTION- Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

`(2) CHRONIC CONDITION- The term 'chronic condition' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

`(A) A mental health condition.

`(B) Substance use disorder.

`(C) Asthma.

`(D) Diabetes.

`(E) Heart disease.

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

`(3) HEALTH HOME- The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

`(4) HEALTH HOME SERVICES-

`(A) IN GENERAL- The term 'health home services' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

`(B) SERVICES DESCRIBED- The services described in this subparagraph are--

`(i) comprehensive care management;

`(ii) care coordination and health promotion;

`(iii) comprehensive transitional care, including appropriate followup, from inpatient to other settings;

- (iv) patient and family support (including authorized representatives);
 - (v) referral to community and social support services, if relevant; and
 - (vi) use of health information technology to link services, as feasible and appropriate.
- (5) DESIGNATED PROVIDER- The term 'designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic--
 - (A) has the systems and infrastructure in place to provide health home services; and
 - (B) satisfies the qualification standards established by the Secretary under subsection (b).
- (6) TEAM OF HEALTH CARE PROFESSIONALS- The term 'team of health care professionals' means a team of health professionals (as described in the State plan amendment) that may--
 - (A) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and
 - (B) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.
- (7) HEALTH TEAM- The term 'health team' has the meaning given such term for purposes of section 3502 of the Patient Protection and Affordable Care Act.'.

(b) Evaluation-

(1) INDEPENDENT EVALUATION-

- (A) IN GENERAL- The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under section 1945 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.
- (B) EVALUATION REPORT- Not later than January 1, 2017, the Secretary shall report to Congress on the evaluation and assessment conducted under subparagraph (A).

(2) SURVEY AND INTERIM REPORT-

- (A) IN GENERAL- Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to--
 - (i) hospital admission rates;
 - (ii) chronic disease management;
 - (iii) coordination of care for individuals with chronic conditions;
 - (iv) assessment of program implementation;
 - (v) processes and lessons learned (as described in subparagraph (B));
 - (vi) assessment of quality improvements and clinical outcomes under such option; and
 - (vii) estimates of cost savings.
- (B) IMPLEMENTATION REPORTING- A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

SHARED SAVINGS PROGRAM

Sec. 1899. (a) Establishment-

(1) IN GENERAL- Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program--

- (A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO'); and
- (B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

(b) Eligible ACOs-

(1) IN GENERAL- Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

- (A) ACO professionals in group practice arrangements.
- (B) Networks of individual practices of ACO professionals.
- (C) Partnerships or joint venture arrangements between hospitals and ACO professionals.
- (D) Hospitals employing ACO professionals.
- (E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

(2) REQUIREMENTS- An ACO shall meet the following requirements:

- (A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- (B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the 'agreement period').
- (C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.
- (D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 25,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.
- (E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).
- (F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.
- (G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

`(H) The ACO shall demonstrate to the Secretary that it meets patientcenteredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

`(3) QUALITY AND OTHER REPORTING REQUIREMENTS-

`(A) IN GENERAL- The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of--

`(i) clinical processes and outcomes;

`(ii) patient and, where practicable, caregiver experience of care; and

`(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

`(B) REPORTING REQUIREMENTS- An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

`(C) QUALITY PERFORMANCE STANDARDS- The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

`(D) OTHER REPORTING REQUIREMENTS- The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d). 3

`(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS- A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

`(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

`(B) The independence at home medical practice pilot program under section 1866E.

`(c) Assignment of Medicare Fee-for-service Beneficiaries to ACOs- The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

`(d) Payments and Treatment of Savings-

`(1) PAYMENTS-

`(A) IN GENERAL- Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if--

`(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

`(ii) the ACO meets the requirement under subparagraph (B)(i).

`(B) SAVINGS REQUIREMENT AND BENCHMARK-

`(i) DETERMINING SAVINGS- In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at

least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

`(ii) ESTABLISH AND UPDATE BENCHMARK- The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

`(2) PAYMENTS FOR SHARED SAVINGS- Subject to performance with respect to the quality performance standards established by the Secretary under subsection 4(b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

`(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS- If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

`(4) TERMINATION- The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

`(e) Administration- Chapter 35 of title 44, United States Code, shall not apply to the program.

`(f) Waiver Authority- The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

`(g) Limitations on Review- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of--

`(1) the specification of criteria under subsection (a)(1)(B);

`(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

`(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

`(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

`(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

`(6) the termination of an ACO under subsection (d)(4).

`(h) Definitions- In this section:

`(1) ACO PROFESSIONAL- The term 'ACO professional' means--

`(A) a physician (as defined in section 1861(r)(1)); and

`(B) a practitioner described in section 1842(b)(18)(C)(i).

`(2) HOSPITAL- The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

`(3) MEDICARE FEE-FOR-SERVICE BENEFICIARY- The term 'Medicare fee-for-service beneficiary' means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.'

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

Sec. 1866D. (a) Establishment-

(1) IN GENERAL- The Secretary shall conduct a demonstration program (in this section referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed homebased primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

(2) REQUIREMENT- The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in--

(A) reducing preventable hospitalizations;

(B) preventing hospital readmissions;

(C) reducing emergency room visits;

(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

(F) reducing the cost of health care services covered under this title; and

(G) achieving beneficiary and family caregiver satisfaction.

(b) Independence at Home Medical Practice-

(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED- In this section:

(A) IN GENERAL- The term 'independence at home medical practice' means a legal entity that--

(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a);

(ii) is organized at least in part for the purpose of providing physicians' services;

(iii) has documented experience in providing home-based primary care services to high-cost chronically ill beneficiaries, as determined appropriate by the Secretary;

(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

(v) has entered into an agreement with the Secretary;

(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program. The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(B) PHYSICIAN- The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services

and has the medical training or experience to fulfill the physician's role described in subparagraph (A)(i).

`(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS- Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if--

`(A) all the requirements of this section are met;

`(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

`(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

`(3) INCLUSION OF PROVIDERS AND PRACTITIONERS- Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the demonstration program and shares in any savings under the demonstration program.

`(4) QUALITY AND PERFORMANCE STANDARDS- The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

`(c) Payment Methodology-

`(1) ESTABLISHMENT OF TARGET SPENDING LEVEL- The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent in the absence of the demonstration, for items and services covered under parts A and B furnished to applicable beneficiaries for each qualifying independence at home medical practice under this section. Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the size of the corridor being related to the number of applicable beneficiaries furnished services by each independence at home medical practice. The spending targets may also be adjusted for other factors as the Secretary determines appropriate.

`(2) INCENTIVE PAYMENTS- Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the amount by which actual expenditures (including incentive payments under this paragraph) for applicable beneficiaries under parts A and B for such year are estimated to be less than 5 percent less than the estimated spending target for such year, as determined under paragraph (1).

`(d) Applicable Beneficiaries-

`(1) DEFINITION- In this section, the term 'applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined--

`(A) is entitled to benefits under part A and enrolled for benefits under part B;

`(B) is not enrolled in a Medicare Advantage plan under part C or a PACE program under section 1894;

`(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

`(D) within the past 12 months has had a nonelective hospital admission;

`(E) within the past 12 months has received acute or subacute rehabilitation services;

`(F) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

`(G) meets such other criteria as the Secretary determines appropriate.

`(2) PATIENT ELECTION TO PARTICIPATE- The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice under the demonstration program. Enrollment in the demonstration program shall be voluntary.

`(3) BENEFICIARY ACCESS TO SERVICES- Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

`(e) Implementation-

`(1) STARTING DATE- The demonstration program shall begin no later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

`(2) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION- The Secretary shall not pay an independence at home medical practice under this section that participates in section 1899.

`(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION- The Secretary shall ensure that no applicable beneficiary enrolled in an independence at home medical practice under this section is participating in the programs under section 1899.

`(4) PREFERENCE- In approving an independence at home medical practice, the Secretary shall give preference to practices that are--

`(A) located in high-cost areas of the country;

`(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

`(C) use electronic medical records, health information technology, and individualized plans of care.

`(5) LIMITATION ON NUMBER OF PRACTICES- In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

`(6) WAIVER- The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

`(7) ADMINISTRATION- Chapter 35 of title 44, United States Code, shall not apply to this section.

`(f) Evaluation and Monitoring-

`(1) IN GENERAL- The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

`(2) MONITORING APPLICABLE BENEFICIARIES- The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discontinues receiving services under this title through a qualifying independence at home medical practice.

`(g) Reports to Congress- The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program. Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

`(h) Funding- For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in proportions determined appropriate by the Secretary) \$5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

`(i) Termination-

- `(1) MANDATORY TERMINATION- The Secretary shall terminate an agreement with an independence at home medical practice if--
- `(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or
 - `(B) such practice fails to meet quality standards during any year of the demonstration program.
- `(2) PERMISSIVE TERMINATION- The Secretary may terminate an agreement with an independence at home medical practice for such other reasons determined appropriate by the Secretary.'

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

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

“CENTER FOR MEDICARE AND MEDICAID INNOVATION

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

“(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the ‘CMI’) to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals defined in paragraph (4)(A).

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

“(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

“(4) DEFINITIONS.—In this section:

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

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

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

“(iii) an individual who meets the criteria of both clauses (i) and (ii).

“(B) APPLICABLE TITLE.—The term ‘applicable title’ means title XVIII, title XIX, or both.

“(5) TESTING WITHIN CERTAIN GEOGRAPHIC AREAS.—For purposes of testing payment and service delivery models under this section, the Secretary may elect to limit testing of a model to certain geographic areas.

“(b) TESTING OF MODELS (PHASE I).—

“(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

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

“(A) IN GENERAL.— The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Secretary shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals

receiving benefits under such title. The models selected under this subparagraph may include, but are not limited to, the models described in subparagraph (B).

“(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

“(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women’s unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

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

“(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

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

“(II) Cognitive impairment, including dementia.

“(iv) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

“(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home tele-health technology.

“(vi) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B))

according to the physician’s adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

“(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

“(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

“(ix) Assisting applicable individuals in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that meet the standards developed and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve applicable individual and caregiver understanding of medical treatment options.

“(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

“(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

“(xii) Aligning nationally recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for applicable individuals described in clause (i) or (iii) of subsection (a)(4)(A) with cancer, including the identification of gaps in applicable quality measures.

“(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

“(xiv) Funding home health providers who offer chronic care management services to applicable individuals in cooperation with interdisciplinary teams.

“(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

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

“(II) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

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

“(xvi) Facilitate inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

“(xvii) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

“(xviii) Establishing comprehensive payments to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

“(xix) Utilizing, in particular in entities located in medically underserved areas and facilities of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), telehealth services—

“(I) in treating behavioral health issues (such as posttraumatic stress disorder) and stroke; and

“(II) to improve the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.

“(xx) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note).

“(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

“(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

“(ii) Whether the model places the applicable individual, including family members and other informal caregivers of the applicable individual, at the center of the care team of the applicable individual.

“(iii) Whether the model provides for in-person contact with applicable individuals.

“(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

“(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers.

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

“(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

“(viii) Whether the model demonstrates effective linkage with other public sector or private sector payers.

“(3) BUDGET NEUTRALITY.—

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

“(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

“(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

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

“(iii) improve the quality of care and reduce spending. Such termination may occur at any time after such testing has begun and before completion of the testing.

“(4) EVALUATION.—

“(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

“(i) the quality of care furnished under the model, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

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

“(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect and report information that the Secretary determines is necessary to monitor and evaluate such models.

“(C) MEASURE SELECTION.— To the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and patient-centered care consistent with the measures described in 1890(b)(7)(B).

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

“(1) the Secretary determines that such expansion is expected to—

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

“(B) improve the quality of patient care without increasing spending;

“(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and

“(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals. In determining which models or

demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.

“(d) IMPLEMENTATION.—

“(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

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

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

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

“(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

“(D) determinations regarding budget neutrality under subsection (b)(3);

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

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

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

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

“(f) FUNDING.—

“(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

“(A) \$5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

“(B) \$10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

“(C) the amount described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020). Amounts appropriated under the preceding sentence shall remain available until expended.

“(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than \$25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

“(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.”

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

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

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

(3) by inserting after paragraph (82) the following new paragraph: “(83) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.”

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.— Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking “5-year” each place it appears.