''(h) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of funding in equal amounts each State demonstration project conducted under this section, there is authorized to be appropriated not to exceed $1,500,000 for each of the fiscal years 1990, 1991, and 1992.''

CONTINUATION OF FEDERAL FINANCIAL PARTICIPATION IN EXPERIMENTAL, PILOT, OR DEMONSTRATION PROJECTS APPROVED BEFORE OCTOBER 1, 1973, FOR PERIOD ON-AND-AFTER DECEMBER 31, 1973, WITHOUT DENIAL OR REDUCTION ON ACCOUNT OF SUBCHAPTER XVI PROVISIONS FOR SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND AND DISABLED; WAIVER OF SUBCHAPTER XVI RESTRICTIONS FOR INDIVIDUALS; FEDERAL PAYMENTS OF NON-FEDERAL SHARE AS SUPPLEMENTARY PAYMENTS

Pub. L. 93–233, § 11, Dec. 31, 1973, 87 Stat. 958, provided that:

''(a) If any State (other than the Commonwealth of Puerto Rico, the Virgin Islands, or Guam) has any experimental, pilot, or demonstration project (referred to in section 1115 of the Social Security Act [this section])—

''(1) which (prior to October 1, 1973) has been approved by the Secretary of Health, Education, and Welfare [now Health and Human Services] (hereinafter in this section referred to as the 'Secretary'), for a period which ends on or after December 31, 1973, as being a project with respect to which the authority conferred upon him by subsection (a) or (b) of such section 1115 [subsec. (a) or (b) of this section] will be exercised, and

''(2) with respect to the costs of which Federal financial participation would (except for the provisions of this section) be denied or reduced on account of the enactment of section 301 of the Social Security Amendments of 1972 [enacting subchapter XVI of this chapter],

then, for any period (after December 31, 1973) with respect to which such project is approved by the Secretary, Federal financial participation in the costs of such project shall be continued in like manner as if—

''(3) such section 301 [enacting subchapter XVI of this chapter] had not been enacted, and

''(4) such State (for the month of January 1974 and any month thereafter) continued to have in effect the State plan (approved under title XVI [subchapter XVI of this chapter]) which was in effect for the month of October 1973, or the State plans (approved under titles I, X, and XIV of the Social Security Act [subchapters I, X, and XIV of this chapter]) which were in effect for such month, as the case may be.

''(b) With respect to individuals—

''(1) who are participants in any project to which the provisions of subsection (a) are applicable, and

''(2) with respect to whom supplemental security income benefits are (or would, except for their participation in such project, be) payable under title XVI of the Social Security Act, or who meet the requirements for aid or assistance under a State plan approved under title I, X, XIV, or XVI of the Social Security Act of the State in which such project is conducted (as such State plan was in effect for July 1973),

the Secretary may waive such requirements of title XVI of such Act (as enacted by section 301 of the Social Security Amendments of 1972) to such extent as he determines to be necessary to the successful operation of such project.

''(c) In the case of any State which has entered into an agreement with the Secretary under section 1616 of the Social Security Act [section 1382e of this title] (or which is deemed, under section 212(d) of Public Law 93–66 [set out as a note under section 1382 of this title], to have entered into such an agreement), then, of the costs of any project of such State with respect to which there is (solely by reason of the provisions of subsection (a)) Federal financial participation, the non-Federal share thereof shall—

''(1) be paid, from time to time, to such State by the Secretary, and

''(2) shall, for purposes of section 1616(d) of the Social Security Act [section 1382e(d) of this title] and section 401 of the Social Security Amendments of 1972 [set out as a note under section 1382e of this title] be treated in like manner as if such non-Federal share were supplementary payments made by the Secretary on behalf of such State pursuant to such agreement.''

§ 1315a. Center for Medicare and Medicaid Innovation

(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 subchapters while preserving or enhancing the quality of care furnished to individuals under such subchapters. 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 subchapter XVIII or enrolled for benefits under part B of such subchapter;

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

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

(B) Applicable subchapter

The term ''applicable subchapter'' means subchapter XVIII, subchapter 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 cri-

teria under paragraph (2) to determine the effect of applying such models under the applicable subchapter (as defined in subsection (a)(4)(B)) on program expenditures under such subchapters and the quality of care received by individuals receiving benefits under such subchapter.

(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 subchapter while preserving or enhancing the quality of care received by individuals receiving benefits under such subchapter. 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[1] 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 1395m(e)(1)(B) of this title) 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 299b–35 of this title.

(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 299b–36(c)(2)(A) of this title, 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 subchapters 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 subchapter 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

[1] So in original. Probably should be ''Promoting''.

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 1603 of title 25)), telehealth services—

(I) in treating behavioral health issues (such as post-traumatic 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 subchapter.

(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 subchapter, 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 subchapter;

(ii) reduce spending under the applicable subchapter 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 subchapters by reason of the model.

(B) Information

The Secretary shall make the results of each evaluation under this paragraph avail-

able 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[2] 1395aaa(b)(7)(B) of this title.

(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 1395cc–3 of this title, to the extent determined appropriate by the Secretary, if—

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

(A) reduce spending under applicable[3] subchapter 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 subchapters; and

(3) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable subchapter 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 subchapters XI and XVIII and of sections 1396a(a)(1), 1396a(a)(13), and 1396b(m)(2)(A)(iii) of this title 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 1395ff of this title, section 1395*oo* of this title, 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 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 subchapter XXI in the same manner as provided under this section with respect to the program under the applicable subchapters.

(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 subchapters 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.

(Aug. 14, 1935, ch. 531, title XI, § 1115A, as added and amended Pub. L. 111–148, title III, § 3021(a), title X, § 10306, Mar. 23, 2010, 124 Stat. 389, 939.)

[2] So in original. Probably should be ''in section''.

[3] So in original. Probably should be preceded by ''the''.

REFERENCES IN TEXT

Section 4016 of the Balanced Budget Act of 1997, referred to in subsec. (b)(2)(B)(xx), is section 4016 of Pub. L. 105–33, which is set out as a note under section 1395b–1 of this title.

AMENDMENTS

2010—Subsec. (a)(5). Pub. L. 111–148, § 10306(1), added par. (5).

Subsec. (b)(2)(A). Pub. L. 111–148, § 10306(2)(A), inserted ''The Secretary shall focus on models expected to reduce program costs under the applicable subchapter while preserving or enhancing the quality of care received by individuals receiving benefits under such subchapter.'' after the first sentence and substituted ''this subparagraph may include, but are not limited to,'' for ''the preceding sentence may include''.

Subsec. (b)(2)(B)(xix), (xx). Pub. L. 111–148, § 10306(2)(B), added cls. (xix) and (xx).

Subsec. (b)(2)(C)(viii). Pub. L. 111–148, § 10306(2)(C), added cl. (viii).

Subsec. (b)(4)(C). Pub. L. 111–148, § 10306(3), added subpar. (C).

Subsec. (c). Pub. L. 111–148, § 10306(4)(C), inserted concluding provisions.

Subsec. (c)(1)(B). Pub. L. 111–148, § 10306(4)(A), substituted ''patient care without increasing spending;'' for ''care and reduce spending; and''.

Subsec. (c)(2). Pub. L. 111–148, § 10306(4)(B), substituted ''reduce (or would not result in any increase in) net program spending under applicable subchapters; and'' for ''reduce program spending under applicable subchapters.''

Subsec. (c)(3). Pub. L. 111–148, § 10306(4)(C), added par. (3).

MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT

Pub. L. 111–148, title II, § 2705, Mar. 23, 2010, 124 Stat. 324, provided that:

''(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the 'Secretary') shall, in coordination with the Center for Medicare and Medicaid Innovation (as established under section 1115A of the Social Security Act [42 U.S.C. 1315a], as added by section 3021 of this Act), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

''(b) DURATION AND SCOPE.—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

''(c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR NETWORK.—For purposes of this section, the term 'eligible safety net hospital system or network' means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

''(d) EVALUATION.—

''(1) TESTING.—The Innovation Center shall test and evaluate the demonstration project conducted under this section to examine any changes in health care quality outcomes and spending by the eligible safety net hospital systems or networks.

''(2) BUDGET NEUTRALITY.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act [42 U.S.C. 1315a(b)(3)] (as so added) shall not be applicable.

''(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

''(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.''

§ 1315b. Providing Federal coverage and payment coordination for dual eligible beneficiaries

(a) Establishment of Federal Coordinated Health Care Office

(1) In general

Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Federal Coordinated Health Care Office.

(2) Establishment and reporting to CMS administrator

The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office[1] a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) Purpose

The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to—

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act [42 U.S.C. 1395 et seq.] and the Medicaid program under title XIX of such Act [42 U.S.C. 1396 et seq.]; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) Goals

The goals of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

[1] So in original.