110TH CONGRESS
1ST SESSION

S. 2065

To provide assistance to community health coalitions to increase access to and improve the quality of health care services.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 18, 2007

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

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A BILL

To provide assistance to community health coalitions to increase access to and improve the quality of health care services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Community Coalitions for Access and Quality Improvement Act of 2007''.

SEC. 2. PURPOSE.

Is it the purpose of this Act to provide assistance to community health coalitions (as defined in section (c)(1)) that have a clearly defined local need to increase access

to and improve the quality of health care services through activities that—

(1) develop or strengthen the coordination of services to allow all individuals, including uninsured and low-income individuals, to receive efficient and higher quality care and to gain entry into and receive services from a comprehensive system of medical, dental, pharmaceutical, and behavioral health care;

(2) develop efficient and sustainable infrastructure for a healthcare delivery system characterized by effective collaboration, information sharing, and clinical and financial coordination among all types of providers of care in the community; and

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

SEC. 3. COMMUNITY COALITIONS FOR ACCESS AND QUALITY IMPROVEMENT.

(a) GRANTS TO STRENGTHEN THE EFFECTIVENESS, EFFICIENCY, AND COORDINATION OF SERVICES.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall award grants to eligible entities assist in the development of integrated health

care delivery systems to serve defined communities of individuals to—

(1) improve the efficiency of and coordination among the providers providing services through such systems;

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

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

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

(1) represent a balanced consortium—

(A) whose principal purpose is to assure the sustainable capacity for the provision of a broad range of coordinated services for all residents within a community defined in the entity's grant application as described in paragraph (2); and

(B) that includes at least one of each of the following providers that serve the community (unless such provider does not exist within the community, declines or refuses to participate, or places unreasonable conditions on their participation)—

(i) a federally qualified health center (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)));

(ii) rural health clinics and rural health networks (as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)));

(iii) a hospital with a low-income utilization rate that is greater than 25 percent (as defined in section 1923(b)(3) of the Social Security Act (42 U.S.C. 1396r-4(b)(3))), or a Critical Access Hospital (as defined in section 19(c)(2) of such Act (42 U.S.C. 1395i-4(c)(2)));

(iv) a public health department; and

(v) an interested public or private sector health care provider or an organization that has traditionally served the medically uninsured and low-income individuals; and

(2) submit to the Secretary an application, at such time, in such manner, and containing such information and the Secretary may require, including—

(A) a clear description of the community to be served and access, quality, and efficiency outcomes to be achieved under the grant;

(B) a description of the providers who will participate in the community coalition under the grant and each provider's contribution to the care of individuals in the community;

(C) a description of the activities that the applicant and the community coalition propose to perform under the grant to further the objectives of this section;

(D) evidence demonstrating that the applicant is an established coalition with an ability to build on the current system for serving the community by involving providers who have traditionally provided a significant volume of care for uninsured and low-income individuals for that community;

(E) evidence demonstrating the coalition's ability to develop coordinated systems of care that either directly provide or ensure the prompt provision of a broad range of high quality, accessible services, including, as appropriate, primary, secondary, and tertiary services as well as pharmacy, substance abuse, behav-

ioral health and oral health services, in a manner that assures continuity of care in the community;

(F) evidence of community involvement, including the business community, in the development, implementation, and direction of the system of care that the coalition proposes to assure;

(G) evidence demonstrating the coalition's ability to ensure that participating individuals are enrolled in health care coverage programs, both public and private, for which the individuals are eligible;

(H) a plan for leveraging other sources of revenue, which may include State and local sources and private grant funds, and integrating current and proposed new funding sources in a manner to assure long-term sustainability of the system of care;

(I) a plan for the evaluation of the activities carried out under the grant, including measurement of progress toward the goals and objectives of the program and the use of evaluation findings to improve system performance;

(J) evidence demonstrating fiscal responsibility through the use of appropriate accounting procedures and management systems;

(K) evidence demonstrating commitment to serve the community without regard to the ability of an individual or family to pay by arranging for or providing free or reduced charge care for the poor; and

(L) such other information as the Secretary may require.

(c) LIMITATIONS.—The term of an initial grant to an eligible entity under this section shall be 3 fiscal years. An entity may receive an extension for 2 additional years if—

(1) the eligible entity submits to the Secretary a request for a grant for such additional period;

(2) the Secretary determines that current performance justifies the granting of such an extension; and

(3) the Secretary determines that granting such extension is necessary to further the objectives described in subsection (a).

(d) PRIORITIES.—In awarding grants under this section, the Secretary—

(1) may provide priority to applicants that demonstrate the greatest extent of unmet need in the community to be served for a more coordinated system of care; and

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

(A) identifies a community whose geographical area has a high or increasing percentage of individuals who are uninsured or low-income;

(B) demonstrates that the applicant has included in its community coalition providers, support systems, and programs that have a tradition of serving individuals and families in the community who are uninsured or earn below 200 of the Federal poverty level;

(C) demonstrates that the proposed coalition activities would expand the utilization of preventive and primary care services for uninsured and underinsured individuals and families in the community, including pharmaceuticals, behavioral and mental health services, oral health services, or substance abuse services;

(D) proposes approaches that would improve coordination between health care providers and appropriate social service providers;

(E) demonstrates collaboration with State and local governments;

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

(G) demonstrates the likelihood that the proposed activities will lead to sustainable integrated delivery systems as additional efforts of health systems development evolve.

(e) USE OF FUNDS.—

(1) USE BY GRANTEES.—

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

(i) direct expenses associated with achieving the greater integration of a health care delivery system so that the system either directly provides or ensures the provision of a broad range of culturally competent services, including, as appropriate, primary, secondary, and tertiary care as well as oral health, substance

abuse, behavioral and mental health, and pharmaceutical services; and

(ii) direct patient care and service expansions to fill identified or documented gaps within an integrated delivery system.

(B) SPECIFIC USES.—Upon compliance with subparagraph (A) a grantees may use amounts provided under this section for the following:

(i) To provide increases in outreach activities and to close gaps in health care service, including referrals to specialty services and prescription drugs and conducting ongoing outreach to health disparity populations.

(ii) To make improvements to care management and delivery of patient-centered care, including patient navigation services.

(iii) To make improvements to coordinate transportation to health care facilities.

(iv) The development of provider networks and other innovative models to engage physicians in voluntary efforts to

serve the medically underserved within a community.

(v) Recruitment, training, and compensation of necessary personnel.

(vi) The acquisition of technology for the purpose of coordinating care and improving provider communication, including the implementation of shared information systems or shared clinical systems.

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

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

(ix) Language access services.

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

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

(2) DIRECT PATIENT CARE LIMITATION.—Not to exceed 20 percent of the amounts received under a grant under this section may be used for providing direct patient care and services.

(3) RESERVATION OF FUNDS FOR NATIONAL PROGRAM PURPOSES.—The Secretary may use not to exceed 7 percent of the amount appropriated to carry out this section each fiscal year to enter into contracts with an organization that has expertise in facilitating peer to peer technical assistance among grantees, to obtain assistance of experts and consultants, to hold meetings, to develop tools, to disseminate information, to demonstrate access, quality and efficiency outcomes for sustainability, and for evaluations.

(f) REQUIREMENTS.—

(1) EVALUATION OF EFFECTIVENESS.—An entity that receive a grant under this section shall annually submit to the Secretary a report concerning—

(A) the progress made in meeting the goals and measurable objectives set forth in the grant application submitted by the entity under subsection (b);

(B) the extent to which activities carried out by the entity under the grant have—

(i) improved the effectiveness, efficiency, and coordination of services for uninsured and low-income individuals in the community served by such entity, using commonly accepted outcome measures;

(ii) resulted in the provision of better quality health care for individuals and families in the community served; and

(iii) resulted in the provision of health care to such individuals at lower cost than would have been possible in the absence of the activities conducted by such entity; and

(C) the findings of an independent financial audit conducted on all records that relate to the disposition of funds received under the grant.

(2) PROGRESS.—The Secretary may not renew a grant under this section unless the Secretary determines that the coalition has made reasonable and

demonstrable progress in meeting the goals and objectives set forth in the grant application for the preceding fiscal year.

(g) MAINTENANCE OF EFFORT.—With respect to activities for which a grant under this section is authorized, the Secretary may award such a grant only if the applicant and each of the participating providers agree that the grantee and each such provider will maintain its expenditures of non-Federal funds for such activities at a level that is not less then the level of such expenditures during the fiscal year immediately preceding the fiscal year for which the applicant is applying to receive such grant.

(h) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other nonfinancial assistance necessary to enable the entity to comply with the requirements of this section. The purposes of this section may be achieved by grant or contract with State and national not-for-profit organizations with expertise in building successful community coalitions.

(i) EVALUATION OF PROGRAM.—Not later than September 30, 2012, the Secretary shall prepare and submit to the appropriate committees of Congress a report that describes the extent to which projects funded under this section have been successful in improving the effective-

ness, efficiency, and coordination of services in the communities served by such projects, including whether the projects resulted in the provision of better quality health care for such individuals, and whether such care was provided at lower costs than would have been provided in the absence of such projects.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $75,000,000 for fiscal year 2008;

(2) $100,000,000 for fiscal year 2009;

(3) $125,000,000 for fiscal year 2010;

(4) $150,000,000 for fiscal year 2011; and

(5) $175,000,000 for fiscal year 2012.

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