HOUSE BILL REPORT
SSB 5394

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to primary care health homes and chronic care management.

Brief Description: Concerning primary care health homes and chronic care management.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Keiser, Becker, Pflug, Conway, Kline and Parlette).

Brief History:
Committee Activity:
Health Care & Wellness: 3/10/11, 3/23/11 [DPA].

Brief Summary of Substitute Bill
(As Amended by House)

- Requires the Department of Social and Health Services and the Health Care Authority to incorporate health homes and chronic care management incentives into certain state-purchased health care contracts.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 7 members: Representatives Cody, Chair; Jinkins, Vice Chair; Clibborn, Green, Kelley, Moeller and Van De Wege.

Minority Report: Do not pass. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Hinkle, Assistant Ranking Minority Member; Bailey and Harris.

Staff: Chris Blake (786-7392).

Background:

Legislation passed in 2008 directed the Department of Health to create a medical home learning collaborative to support the adoption of medical homes in a variety of primary care practice settings. The same legislation directed the Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) to assess opportunities for changing

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payment practices in ways that would better support development and maintenance of primary care medical homes. The three agencies jointly submitted a report on their efforts December 31, 2008. Legislation passed in 2009 directed the HCA and the DSHS to design and implement one or more primary care medical home reimbursement pilot projects.

The federal Patient Protection and Affordable Care Act authorizes states to pay for health home services provided to Medicaid patients with chronic conditions. Chronic conditions are to be defined by the federal Department of Health and Human Services and include a mental health condition, substance abuse disorder, asthma, diabetes, heart disease, and being overweight. Payments for health home services may be made to a designated provider, a team of health care providers operating with that provider, or a health team on a per-member per-month basis or another methodology proposed by the state and approved by the federal Department of Health and Human Services. During the first eight quarters that the state plan amendment is in effect, the federal matching rate for health home payments is 90 percent.

Summary of Amended Bill:

Health Homes and Chronic Care Management Terminology.

"Health home" is defined as coordinated health care provided by a primary care provider who coordinates medical care services and a multidisciplinary health care team. Primary care providers include general practice physicians, family practitioners, internists, pediatricians, osteopaths, naturopathic physicians, physician assistants, osteopathic physician assistants, and advanced registered nurse practitioners. The multidisciplinary health team includes medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers, doctors of chiropractic, physical therapists, physician assistants, home care and other long-term care providers, and complementary and alternative medicine practitioners.

Health home services must include: comprehensive care management; extended hours of service; multiple ways for the patient to communicate with the health care team; patient education regarding self-care, prevention, and health promotion; coordinated transitions between health care settings; individual and family support; the use of information technology for coordination and clinical data; and performance reporting and quality improvement.

"Chronic care management" is defined as health care management within a health home for people with one or more chronic conditions or who are at high risk for chronic conditions. Chronic conditions are prolonged conditions such as a mental health condition, a substance abuse disorder, asthma, diabetes, heart disease, and being overweight. Effective chronic care management is stated to include assistance to patients in obtaining self-care skills to slow the progression of the disease, evidence-based clinical practices, coordinated care across health care settings, ready access to behavioral health services that are integrated with primary care, and usage of community resources to support patients and families.

State-Purchased Health Care Contracts.

The Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) must incorporate health home and chronic care management incentives into the managed care programs and certain other plans that they operate. The health home services may be prioritized to enrollees with complex, high-cost, or multiple chronic conditions. Contracts for Medicaid managed care programs, the Basic Health Plan program, and managed care and self-insured plans administered by the Public Employee Benefits Board must include:

- provider reimbursement methods that incentivize chronic care management within health homes;
- provider reimbursement methods that reward health homes that reduce emergency department and inpatient use through chronic care management; and
- the promotion of provider participation in the Department of Health's (DOH) program of training and technical assistance regarding care for people with chronic conditions.

Contracts that include health homes and chronic care management models must not cost more than they would have without these models. The DSHS must consult with the federal Center for Medicare and Medicaid Innovation and seek funding to support health homes.

The DOH is directed to collaborate with the HCA to promote the adoption of primary care health homes in state-purchased health care programs.

The Administrator of the HCA must establish a collaborative work group to receive input from health plans regarding incentives to promote health homes. All health carriers that provide a comprehensive health plan in Washington shall participate in the work group. The HCA must report to the Legislature annually beginning December 1, 2012, regarding efforts to integrate health homes into publicly purchased health programs for low-income residents.

Amended Bill Compared to Substitute Bill:

The amended bill adds physician assistants and osteopathic physician assistants to the definition of "primary care provider" and adds home care and other long-term care providers to the definition of "multi-disciplinary health care team."

Health home services may be limited to those Medicaid, Basic Health Plan, and Public Employee Benefits Board enrollees with complex, high-cost, or multiple chronic conditions. Third party health plan administering the public employee's health plan are not required to expend any resources, beyond appropriated levels, to fund the health homes and chronic care management programs.

It is specified that the coordinated care provided by a primary care provider in a health home does not mean that prior authorization is required for a patient to receive treatment for optometry services.

Legislative findings are made regarding the need for primary care providers to coordinate with long-term care providers and providers of oral health services. Changes are made to terminology.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on March 24, 2011.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill is an outgrowth of the Joint Select Committee on Health Reform Implementation. Boeing and Regence recently did a pilot project similar to this that resulted in a 20 percent savings in spending on individuals with chronic conditions as well as improved outcomes and patient satisfaction. There may be federal funds available to operate the program. The bill should include a definition of medication therapy management as a part of chronic care management to allow pharmacists to work with a patient to review their whole drug regimen. Physical therapists should stay as a part of the "multidisciplinary care team" since they have expertise in musculoskeletal and neurological conditions. There are many efforts at the local level to integrate care to people with chronic mental illness and substance abuse issues to keep them out of expensive crisis services and the criminal justice system. Community health centers have effectively used health homes with the Disability Lifeline population and there are similar opportunities for case management for aged, blind, or disabled patients in Medicaid. This is a good step forward, but it is not a full patient-centered medical home model. Using the Affordable Care Act definitions will help to bring in federal funding, but the Institute of Medicine definitions are better. It is good to have advanced registered nurse practitioners in the definition of primary care providers and registered nurses on the multidisciplinary teams. This bill allows nurses to practice at their full training capacity which will help in retaining them. Only 42 percent of children in Washington with special medical needs have access to a medical home, yet this population accounts for 48 percent of health care spending on children overall. There are cost savings in investing in chronic care management in the medical home by ensuring that services are not duplicated, keeping children out of the emergency department, and preparing them for school.

(In support with amendment) This bill moves closer to ensuring coordinated access to care for parents, adults, and caregivers. Coordinated care should also include oral health which has a link to whole-body health.

(In support with concerns) Chiropractors should be included in the definition of a "health team" because they work in rural and suburban areas where there are not many primary care physicians and have been proven to be able to keep health care costs down for chronic conditions. The direct access model that currently exists needs to be maintained. The concept of coordinated care is good, however, long-term care savings would accrue to the state rather than the carrier that is taking on the cost of implementing the program for the state.

(With concerns) Physician assistants are primarily primary care providers and they should be included in the definition of "primary care providers." Carriers will sometimes use language like this to require a referral for eye care for a patient who has been diagnosed with an

optometric condition, so there should be a clarification that a preauthorization is not needed for receiving services from an optometrist.

(Opposed) None.

Persons Testifying: (In support) Senator Keiser, prime sponsor; Dedi Hitchins, Washington State Pharmacy Association; Melissa Johnson, Physical Therapy Association of Washington; Rashi Gupta, Washington State Association of Counties; Kate White Tudor, Washington Association of Community and Migrant Health Centers; Michael Transue, Washington Academy of Family Physicians; Sofia Aragon, Washington State Nurses Association; and Beth Harvey, Washington Chapter of American Pediatrics.

(In support with amendment) Jen Estroff, Children's Alliance.

(In support with concerns) Lori Bielinski, Washington State Chiropractic Association; and Chris Bandoli, Regence BlueShield.

(With concerns) Carl Nelson, Washington State Medical Association and Washington Academy of Physician Assistants; and Brad Tower, Optometric Physicians of Washington.

Persons Signed In To Testify But Not Testifying: None.