SENATE BILL REPORT
SB 5394

As Reported by Senate Committee On:
Health & Long-Term Care, February 14, 2011
Ways & Means, February 24, 2011

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: Senators Keiser, Becker, Pflug, Conway, Kline and Parlette.

Brief History:
Committee Activity: Health & Long-Term Care: 1/27/11, 2/10/11, 2/14/11 [DPS-WM, w/oRec].
Ways & Means: 2/24/11 [DPS(HEA)].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 5394 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Kline, Murray and Pridemore.

Minority Report: That it be referred without recommendation.
Signed by Senators Becker, Ranking Minority Member; Carrell, Parlette and Pflug.

Staff: Mich'l Needham (786-7442)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Substitute Senate Bill No. 5394 as recommended by Committee on Health & Long-Term Care be substituted therefor, and the substitute bill do pass.
Signed by Senators Murray, Chair; Kilmer, Vice Chair, Capital Budget Chair; Zarelli, Ranking Minority Member; Parlette, Ranking Minority Member Capital; Baumgartner, Baxter, Brown, Conway, Fraser, Hatfield, Hewitt, Holmquist Newbry, Honeyford, Kastama, Keiser, Kohl-Welles, Pflug, Pridemore, Regala, Rockefeller, Schoesler and Tom.

Staff: Tim Yowell (786-7435)

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Background: Legislation passed in 2008 directed the Department of Health (DOH) to create a medical home learning collaborative as an opportunity 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 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 DSHS to design and implement one or more primary care medical home reimbursement pilot projects. The agencies facilitated discussions with private payers and providers to collaborate and identify reimbursement methods that would align incentives to support primary care medical homes. The multi-payer pilot project has been designed, and the pilot project is on track to begin with the payment demonstration this spring.

Summary of Bill (Recommended Substitute): State health care purchasing efforts for the Medicaid, Basic Health, and Public Employees Benefits Board programs must include provisions in contracts that encourage broad implementation of primary care health homes. Contracts 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; and promote provider participation in the training program (medical home learning collaborative) developed by the DOH. Contract expenses must not be more than they would otherwise be without the health home provisions. DSHS must work with the federal Center for Medicare and Medicaid Innovation and seek funding opportunities to support health homes.

A health home is defined to mean primary care provided by a primary care provider who coordinates all medical care, with a multi-disciplinary health care team. A health care team includes, but is not limited to, medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers including substance use disorder prevention and treatment providers, chiropractors, physical therapists, alternative medicine practitioners and physicians assistants.

Services must include comprehensive care management including chronic care treatment and management; extended hours of service; multiple ways for patients to communicate with the team; education of patients on self-care, prevention and health promotion, including the use of patient decision aids; coordination of transitions from inpatient care; individual and family support; use of information technology; and on-going performance reporting.

The HCA must establish a collaborative workgroup to encourage input from insurance carriers, self-insured plans and Taft-Hartley plans, third-party payers, public payers, and providers to promote primary care health homes for employees with chronic and multiple conditions. The discussion and development of any payment reforms are provided immunity from federal antitrust laws through the state action doctrine. Beginning in December 2012, the HCA must report annually to the Legislature on the efforts of the collaborative workgroup to implement health homes. The report must include information from private insurance carriers and progress made in the publicly purchased health programs.

Insurance carriers must participate in the collaborative workgroup and provide information the HCA needs for annual reports to the Legislature.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended Substitute): The intent section is expanded to mention primary care health homes are for children and adults, and that health homes are encouraged to collaborate with other providers currently outside the medical insurance model, such as dental providers and senior service providers.

The terms and conditions are tightened up to reflect the terms used in the Affordable Care Act (ACA): primary care health homes is changed to health homes; chronic condition definition mirrors the federal ACA language; the health care team is defined following ACA language and now includes most health professions; the primary care provider definition removes references to physician assistants and specialists, however they remain part of the health care team.

Contracts for health homes must be accomplished within the existing funding, for all the publicly purchased health care. The managed care contracts must include allocation of funds to support provider participation in the DOH training collaboratives, unless a managed care system is an integrated health delivery system that has programs in place for chronic care management. DSHS must work with the federal Center for Medicare and Medicaid Innovation and seek funding opportunities to support health homes.

It is clarified that the PEBB contracts include all managed care plans and the self-insured plans, and the PEBB contracts must be implemented as soon as possible but no later than 2013.

All references to reporting data to the Puget Sound Health Alliance are removed. As part of managing the collaborative workgroup with multiple payers, the HCA must report to the Legislature annually on the efforts to implement health homes in publicly-purchased care and privately-purchased care. The HCA may write rules to outline the information carriers must submit for the report. Insurance carriers must participate in the collaborative workgroup and submit information to the HCA to report on the efforts to implement health homes. Other carrier reporting to the Legislature and the Puget Sound Health Alliance is removed.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill (Health & Long-Term Care): PRO: There is a growing body of evidence that coordinated care leads to more satisfied patients with better health outcomes and overall savings with reductions in emergency room use and hospital inpatient days. The bill attempts to bring more standardization to definitions and procedures and broaden the use of the primary care health home to ensure better management

of chronic health conditions. It is important to integrate oral health care with primary care. The mouth is an integral part of the body and the overall health, and better coordination of periodontal disease would lead to better outcomes. Please add the intent that primary care health homes should coordinate with elder care services. Please consider refining the definitions to tighten up the primary care provider and medical care services references, and remove specialists from the definition or very narrowly define it to maintain the principles of focusing on primary care. Premera is submitting an amendment to tighten up the reporting of information to protect proprietary information. It is important to recognize the development of primary care and the shift to different payment mechanisms is a journey that may take us a while. We don't know what the right model looks like yet; but with time and experimentation, we will find the right model for everybody. The definition of designated professionals should include registered nurses – they are a core component and are trained with this model in mind. Please ensure the PEBB sections apply to all plans and explore alternatives to allow incentives for enrollees not just providers. The benefit design should be modified to include incentives and ban any financial disincentive to access care. New payment systems should reward for outcomes, not volume. Critical mental health is an integral part of primary care and chronic care management. We have models all over with primary care and mental health care integrating, and it results in better coordinated care. Consider adding pharmacists to the health care team, and add medication therapy management to the bill as a component of chronic care management. Add pediatric patients with chronic disease and reimbursement for pediatric providers. Add physical therapists as primary care providers.

OTHER: Please add direct practice providers in the model – we would like to have insurance wrap around the direct primary care we provide now. We already provide primary care medical homes, and we have great outcomes, with significant reductions in emergency room use and hospital use.

Persons Testifying (Health & Long-Term Care): PRO: Senator Keiser, prime sponsor; Russell Maier, WA Dental Service Foundation; Jennifer Estroff, Children's Alliance; Jerry Reilly, Eldercare Alliance; Michael Transue, WA Academy of Family Physicians; Jack McRae, Premera Blue Cross; Joe Gifford, Regence Blue Shield; Joe King, Group Health; Sofia Aragon, WA State Nurses Assn.; Jonathan Rosenbloom, SEIU 1199 NW; Ann Christian, WA Community Mental Health Council; Dedi Hitchens, WA State Pharmacy Assn.; Lis Houchen, National Assn. of Chain Drug Stores; Chris Olson, WA Chapter American Academy of Pediatrics; Melissa Johnson, Physical Therapy Assn.; Rashi Gupta, Assn. of WA Counties.

OTHER: Erika Bliss, Lisa Thatcher, Qliance.

Staff Summary of Public Testimony on Recommended Substitute (Ways & Means): PRO: The bill was inspired by reports on the very effective chronic care management program operated for Boeing employees by Regence Blue Shield and the Everett Clinic, which reduced expenditures by 20 percent. We need to bring that kind of cost control to state-purchased medical programs. Less than half of all children presently have a primary care medical home.

Persons Testifying (Ways & Means): PRO: Senator Keiser, prime sponsor; Beth Harvey, Washington Chapter of the American Academy of Pediatrics.