H-1109.1

HOUSE BILL 1739

State of Washington 62nd Legislature 2011 Regular Session

By Representatives Jinkins, Cody, and Kagi

Read first time 02/01/11. Referred to Committee on Health Care & Wellness.

AN ACT Relating to primary care health homes and chronic care management; amending RCW 43.70.533, 70.47.100, and 41.05.021; reenacting and amending RCW 74.09.010 and 74.09.522; adding a new section to chapter 74.09 RCW; adding a new section to chapter 41.05 RCW; and adding a new section to chapter 48.43 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 74.09 RCW to read as follows:

The legislature finds that:

(1) Health care costs are growing rapidly, exceeding the consumer price index year after year. Consequently, state health programs are capturing a growing share of the state budget, even as state revenues have declined. Sustaining these critical health programs will require actions to effectively contain health care cost increases in the future; and

(2) The primary care health home model has been demonstrated to successfully constrain costs, while improving quality of care. Chronic care management, occurring within a primary care health home, has been shown to be especially effective at reducing costs and improving

quality. However, broad adoption of these models has been impeded by a fee-for-service system that reimburses volume of services and does not adequately support important primary care health home services, such as case management and patient outreach. Furthermore, successful implementation will require a broad adoption effort by private and public payers, in coordination with providers.

Therefore the legislature intends to promote the adoption of primary care health homes and, within them, advance the practice of chronic care management to improve health outcomes and reduce unnecessary costs. The legislature also intends for the methods and approach of the primary care health home become part of basic primary care medical education.

Sec. 2. RCW 74.09.010 and 2010 1st sp.s. c 8 s 28 are each reenacted and amended to read as follows:

((~~As used in this chapter:~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Children's health program" means the health care services program provided to children under eighteen years of age and in households with incomes at or below the federal poverty level as annually defined by the federal department of health and human services as adjusted for family size, and who are not otherwise eligible for medical assistance or the limited casualty program for the medically needy.

(2) ((~~"Committee" means the children's health services committee created in section 3 of this act.~~

~~(3)~~)) "Chronic care management" means the medical management within a primary care health home of patients identified with, or at high risk for, one or more chronic conditions. Effective chronic care management:

(a) Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;

(b) Employs evidence-based clinical practices;

(c) Coordinates care across medical settings and providers, including tracking referrals;

(d) Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and

(e) Uses appropriate community resources to support individual patients and families in managing chronic conditions.

(3) "Chronic condition" means a prolonged condition requiring ongoing treatment for a period of at least three months. A chronic condition includes, but is not limited to:

(a) A serious mental health condition;

(b) A substance use disorder;

(c) Asthma;

(d) Diabetes;

(e) Heart disease;

(f) HIV/AIDS; and

(g) Obesity, as evidenced by a body mass index over thirty.

(4) "County" means the board of county commissioners, county council, county executive, or tribal jurisdiction, or its designee. A combination of two or more county authorities or tribal jurisdictions may enter into joint agreements ((~~to fulfill the requirements of RCW 74.09.415 through 74.09.435~~)).

((~~(4)~~)) (5) "Department" means the department of social and health services.

((~~(5)~~)) (6) "Department of health" means the Washington state department of health created pursuant to RCW 43.70.020.

((~~(6)~~)) (7) "Full benefit dual eligible beneficiary" means an individual who, for any month: Has coverage for the month under a medicare prescription drug plan or medicare advantage plan with part D coverage; and is determined eligible by the state for full medicaid benefits for the month under any eligibility category in the state's medicaid plan or a section 1115 demonstration waiver that provides pharmacy benefits.

((~~(7)~~)) (8) "Internal management" means the administration of medical assistance, medical care services, the children's health program, and the limited casualty program.

((~~(8)~~)) (9) "Limited casualty program" means the medical care program provided to medically needy persons as defined under Title XIX of the federal social security act, and to medically indigent persons who are without income or resources sufficient to secure necessary medical services.

((~~(9)~~)) (10) "Medical assistance" means the federal aid medical

care program provided to categorically needy persons as defined under Title XIX of the federal social security act.

((~~(10)~~)) (11) "Medical care services" means the limited scope of care financed by state funds and provided to disability lifeline benefits recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW.

((~~(11)~~)) (12) "Nursing home" means nursing home as defined in RCW 18.51.010.

((~~(12)~~)) (13) "Poverty" means the federal poverty level determined annually by the United States department of health and human services, or successor agency.

((~~(13)~~)) (14) "Primary care health home" means coordinated primary care provided by a designated medical professional coordinating all medical care, and a multidisciplinary health care team comprised of clinical and nonclinical staff. At a minimum, primary care health home services include:

(a) Comprehensive care management including, but not limited to, chronic care treatment and management;

(b) Extended hours of service;

(c) Multiple ways for patients to communicate with the team, including electronically and by phone;

(d) Education of patients on self-care, prevention, and health promotion, including the use of patient decision aids;

(e) Coordination of transitions from inpatient to other settings;

(f) Individual and family support;

(g) The use of information technology to link services, track tests, generate patient registries, and provide clinical data; and

(h) Ongoing performance reporting and quality improvement.

(15) "Primary care provider" means a general practice physician, family practitioner, internist, pediatrician, osteopath, naturopathic physician, advanced practice nurse, and physician assistant licensed under Title 18 RCW. A primary care provider may also include a specialist who is treating a person with a chronic medical condition, disability, or special health care needs for which regular treatment by a specialist is medically necessary.

(16) "Secretary" means the secretary of social and health services.

Sec. 3. RCW 43.70.533 and 2007 c 259 s 5 are each amended to read as follows:

(1) The department shall conduct a program of training and technical assistance regarding care of people with chronic conditions for providers of primary care. The program shall emphasize evidence-based high quality preventive and chronic disease care and shall collaborate with the health care authority to promote the adoption of primary care health homes established under this act. The department may designate one or more chronic conditions to be the subject of the program.

(2) The training and technical assistance program shall include the following elements:

(a) Clinical information systems and sharing and organization of patient data;

(b) Decision support to promote evidence-based care;

(c) Clinical delivery system design;

(d) Support for patients managing their own conditions; and

(e) Identification and use of community resources that are available in the community for patients and their families.

(3) In selecting primary care providers to participate in the program, the department shall consider the number and type of patients with chronic conditions the provider serves, and the provider's participation in the medicaid program, the basic health plan, and health plans offered through the public employees' benefits board.

(4) For the purposes of this section, "primary care health home" has the same meaning as in RCW 74.09.010.

Sec. 4. RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are each reenacted and amended to read as follows:

(1) For the purposes of this section, "managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under RCW 74.09.520 and rendered by licensed providers, on a prepaid capitated basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act or

federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act.

(2) The department of social and health services shall enter into agreements with managed health care systems to provide health care services to recipients of temporary assistance for needy families under the following conditions:

(a) Agreements shall be made for at least thirty thousand recipients statewide;

(b) Agreements in at least one county shall include enrollment of all recipients of temporary assistance for needy families;

(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act, recipients shall have a choice of systems in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That the department may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed twelve months: AND PROVIDED FURTHER, That the department shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the department by rule;

(d) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except as authorized by the department under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(e) In negotiating with managed health care systems the department shall adopt a uniform procedure to negotiate and enter into contractual arrangements, including:

(i) Standards regarding the quality of services to be provided; ((~~and~~))

(ii) The financial integrity of the responding system;

(iii) Provider reimbursement methods that incentivize chronic care management within primary care health homes;

(iv) Provider reimbursement methods that reward primary care health

homes that, by using chronic care management, reduce emergency department and inpatient use; and

(v) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions for primary care providers described in RCW 43.70.533. The department shall annually report the information required under section 7 of this act to the Puget Sound health alliance;

(f) The department shall seek waivers from federal requirements as necessary to implement this chapter;

(g) The department shall, wherever possible, enter into prepaid capitation contracts that include inpatient care. However, if this is not possible or feasible, the department may enter into prepaid capitation contracts that do not include inpatient care;

(h) The department shall define those circumstances under which a managed health care system is responsible for out-of-plan services and assure that recipients shall not be charged for such services; and

(i) Nothing in this section prevents the department from entering into similar agreements for other groups of people eligible to receive services under this chapter.

(3) The department shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate as managed health care systems are seriously considered as contractors. The department shall coordinate its managed care activities with activities under chapter 70.47 RCW.

(4) The department shall work jointly with the state of Oregon and other states in this geographical region in order to develop recommendations to be presented to the appropriate federal agencies and the United States congress for improving health care of the poor, while controlling related costs.

(5) The legislature finds that competition in the managed health care marketplace is enhanced, in the long term, by the existence of a large number of managed health care system options for medicaid clients. In a managed care delivery system, whose goal is to focus on prevention, primary care, and improved enrollee health status, continuity in care relationships is of substantial importance, and disruption to clients and health care providers should be minimized.

To help ensure these goals are met, the following principles shall guide the department in its healthy options managed health care purchasing efforts:

(a) All managed health care systems should have an opportunity to contract with the department to the extent that minimum contracting requirements defined by the department are met, at payment rates that enable the department to operate as far below appropriated spending levels as possible, consistent with the principles established in this section.

(b) Managed health care systems should compete for the award of contracts and assignment of medicaid beneficiaries who do not voluntarily select a contracting system, based upon:

(i) Demonstrated commitment to or experience in serving low-income populations;

(ii) Quality of services provided to enrollees;

(iii) Accessibility, including appropriate utilization, of services offered to enrollees;

(iv) Demonstrated capability to perform contracted services, including ability to supply an adequate provider network;

(v) Payment rates; and

(vi) The ability to meet other specifically defined contract requirements established by the department, including consideration of past and current performance and participation in other state or federal health programs as a contractor.

(c) Consideration should be given to using multiple year contracting periods.

(d) Quality, accessibility, and demonstrated commitment to serving low-income populations shall be given significant weight in the contracting, evaluation, and assignment process.

(e) All contractors that are regulated health carriers must meet state minimum net worth requirements as defined in applicable state laws. The department shall adopt rules establishing the minimum net worth requirements for contractors that are not regulated health carriers. This subsection does not limit the authority of the department to take action under a contract upon finding that a contractor's financial status seriously jeopardizes the contractor's ability to meet its contract obligations.

(f) Procedures for resolution of disputes between the department and contract bidders or the department and contracting carriers related to the award of, or failure to award, a managed care contract must be clearly set out in the procurement document. In designing such procedures, the department shall give strong consideration to the negotiation and dispute resolution processes used by the Washington state health care authority in its managed health care contracting activities.

(6) The department may apply the principles set forth in subsection (5) of this section to its managed health care purchasing efforts on behalf of clients receiving supplemental security income benefits to the extent appropriate.

Sec. 5. RCW 70.47.100 and 2009 c 568 s 5 are each amended to read as follows:

(1) A managed health care system participating in the plan shall do so by contract with the administrator and shall provide, directly or by contract with other health care providers, covered basic health care services to each enrollee covered by its contract with the administrator as long as payments from the administrator on behalf of the enrollee are current. A participating managed health care system may offer, without additional cost, health care benefits or services not included in the schedule of covered services under the plan. A participating managed health care system shall not give preference in enrollment to enrollees who accept such additional health care benefits or services. Managed health care systems participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion. The administrator may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from enrollees, but nothing in this chapter empowers the administrator to impose any sanctions under Title 18 RCW or any other professional or facility licensing statute.

(2) The plan shall allow, at least annually, an opportunity for enrollees to transfer their enrollments among participating managed health care systems serving their respective areas. The administrator shall establish a period of at least twenty days in a given year when

this opportunity is afforded enrollees, and in those areas served by more than one participating managed health care system the administrator shall endeavor to establish a uniform period for such opportunity. The plan shall allow enrollees to transfer their enrollment to another participating managed health care system at any time upon a showing of good cause for the transfer.

(3) Prior to negotiating with any managed health care system, the administrator shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health care services, expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different areas of the state.

(4) In negotiating with managed health care systems for participation in the plan, the administrator shall adopt a uniform procedure that includes at least the following:

(a) The administrator shall issue a request for proposals, including standards regarding the quality of services to be provided; financial integrity of the responding systems; and responsiveness to the unmet health care needs of the local communities or populations that may be served;

(b) The administrator shall then review responsive proposals and may negotiate with respondents to the extent necessary to refine any proposals;

(c) The administrator may then select one or more systems to provide the covered services within a local area; and

(d) The administrator may adopt a policy that gives preference to respondents, such as nonprofit community health clinics, that have a history of providing quality health care services to low-income persons.

(5)(a) The administrator may contract with a managed health care system to provide covered basic health care services to subsidized enrollees, nonsubsidized enrollees, health coverage tax credit eligible enrollees, or any combination thereof. At a minimum, such contracts must include:

(i) Provider reimbursement methods that incentivize chronic care management within primary care health homes;

(ii) Provider reimbursement methods that reward primary care health

homes that, by using chronic care management, reduce emergency department and inpatient use; and

(iii) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions for primary care providers described in RCW 43.70.533.

(b) The administrator shall annually report the information required under section 7 of this act to the Puget Sound health alliance.

(c) For the purposes of this subsection, "chronic care management," "chronic condition," "primary care health home," and "primary care provider" have the same meaning as in RCW 74.09.010.

(6) The administrator may establish procedures and policies to further negotiate and contract with managed health care systems following completion of the request for proposal process in subsection (4) of this section, upon a determination by the administrator that it is necessary to provide access, as defined in the request for proposal documents, to covered basic health care services for enrollees.

(7) The administrator may implement a self-funded or self-insured method of providing insurance coverage to subsidized enrollees, as provided under RCW 41.05.140. Prior to implementing a self-funded or self-insured method, the administrator shall ensure that funding available in the basic health plan self-insurance reserve account is sufficient for the self-funded or self-insured risk assumed, or expected to be assumed, by the administrator. If implementing a self-funded or self-insured method, the administrator may request funds to be moved from the basic health plan trust account or the basic health plan subscription account to the basic health plan self-insurance reserve account established in RCW 41.05.140.

Sec. 6. RCW 41.05.021 and 2009 c 537 s 4 are each amended to read as follows:

(1) The Washington state health care authority is created within the executive branch. The authority shall have an administrator appointed by the governor, with the consent of the senate. The administrator shall serve at the pleasure of the governor. The administrator may employ up to seven staff members, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The administrator may delegate

any power or duty vested in him or her by this chapter, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW. The primary duties of the authority shall be to: Administer state employees' insurance benefits and retired or disabled school employees' insurance benefits; administer the basic health plan pursuant to chapter 70.47 RCW; study state-purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care; implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-purchased health services; and administer grants that further the mission and goals of the authority. The authority's duties include, but are not limited to, the following:

(a) To administer health care benefit programs for employees and retired or disabled school employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

(b) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs, including, but not limited to:

(i) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

(ii) Utilization of provider arrangements that encourage cost containment, including but not limited to prepaid delivery systems, utilization review, and prospective payment methods, and that ensure access to quality care, including assuring reasonable access to local providers, especially for employees residing in rural areas;

(iii) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

(iv) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis;

(v) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost centers, utilization patterns, provider and hospital practice patterns, and

procedure costs, utilizing the information obtained pursuant to RCW 41.05.031; and

(vi) In collaboration with other state agencies that administer state purchased health care programs, private health care purchasers, health care facilities, providers, and carriers:

(A) Use evidence-based medicine principles to develop common performance measures and implement financial incentives in contracts with insuring entities, health care facilities, and providers that:

(I) Reward improvements in health outcomes for individuals with chronic diseases, increased utilization of appropriate preventive health services, and reductions in medical errors; and

(II) Increase, through appropriate incentives to insuring entities, health care facilities, and providers, the adoption and use of information technology that contributes to improved health outcomes, better coordination of care, and decreased medical errors;

(B) Through state health purchasing, reimbursement, or pilot strategies, promote and increase the adoption of health information technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020(4), integrated delivery systems, and providers that:

(I) Facilitate diagnosis or treatment;

(II) Reduce unnecessary duplication of medical tests;

(III) Promote efficient electronic physician order entry;

(IV) Increase access to health information for consumers and their providers; and

(V) Improve health outcomes;

(C) Coordinate a strategy for the adoption of health information technology systems using the final health information technology report and recommendations developed under chapter 261, Laws of 2005;

(c) To analyze areas of public and private health care interaction;

(d) To provide information and technical and administrative assistance to the board;

(e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205 and (g) of this subsection, setting the premium contribution for approved groups as outlined in RCW 41.05.050;

(f) To review and approve or deny the application when the governing body of a tribal government applies to transfer their employees to an insurance or self-insurance program administered under this chapter. In the event of an employee transfer pursuant to this subsection (1)(f), members of the governing body are eligible to be included in such a transfer if the members are authorized by the tribal government to participate in the insurance program being transferred from and subject to payment by the members of all costs of insurance for the members. The authority shall: (i) Establish the conditions for participation; (ii) have the sole right to reject the application; and (iii) set the premium contribution for approved groups as outlined in RCW 41.05.050. Approval of the application by the authority transfers the employees and dependents involved to the insurance, self-insurance, or health care program approved by the authority;

(g) To ensure the continued status of the employee insurance or self-insurance programs administered under this chapter as a governmental plan under section 3(32) of the employee retirement income security act of 1974, as amended, the authority shall limit the participation of employees of a county, municipal, school district, educational service district, or other political subdivision, or a tribal government, including providing for the participation of those employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities;

(h) To establish billing procedures and collect funds from school districts in a way that minimizes the administrative burden on districts;

(i) To publish and distribute to nonparticipating school districts and educational service districts by October 1st of each year a description of health care benefit plans available through the authority and the estimated cost if school districts and educational service district employees were enrolled;

(j) To apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and make arrangements as to the use of these receipts to implement initiatives and strategies developed under this section;

(k) To issue, distribute, and administer grants that further the mission and goals of the authority;

(l) To adopt rules consistent with this chapter as described in RCW 41.05.160 including, but not limited to:

(i) Setting forth the criteria established by the board under RCW 41.05.065 for determining whether an employee is eligible for benefits;

(ii) Establishing an appeal process in accordance with chapter 34.05 RCW by which an employee may appeal an eligibility determination;

(iii) Establishing a process to assure that the eligibility determinations of an employing agency comply with the criteria under this chapter, including the imposition of penalties as may be authorized by the board.

(2) On and after January 1, 1996, the public employees' benefits board may implement strategies to promote managed competition among employee health benefit plans. Strategies may include but are not limited to:

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced qualified plan within a geographical area;

(d) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of managed care plans statewide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans.

(3)(a) Beginning with the 2012 plan year, the authority must enter into contracts with managed care plans and for the self-insured plan or plans that include:

(i) Provider reimbursement methods that incentivize chronic care management within primary care health homes;

(ii) Provider reimbursement methods that reward primary care health homes that, by using chronic care management, reduce emergency department and inpatient use; and

(iii) Promoting provider participation in the program of training and technical assistance regarding care of people with chronic conditions for primary care providers described in RCW 43.70.533.

(b) The authority shall annually report the information required under section 7 of this act to the Puget Sound health alliance.

(c) For the purposes of this subsection, "chronic care management," "primary care provider," and "primary care health home" have the same meaning as in RCW 74.09.010.

NEW SECTION. **Sec. 7.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The legislature finds that collaboration among public payers, private health carriers, third-party purchasers, and providers to identify appropriate reimbursement methods to align incentives in support of patient centered primary care homes is necessary to implement the requirements of this act. The legislature therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws, through the state action doctrine, the collaborative and associated payment reforms designed and implemented under this section that might otherwise be constrained by such laws. The legislature does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of state or federal antitrust laws including, but not limited to, agreements among competing health care providers or health carriers as to the prices of specific levels of reimbursement for health care services.

(2) The legislature recognizes that many Washingtonians are covered by health plans regulated by the federal government, including self-insured and Taft-Hartley plans. While such plans are largely outside the state's purview, they share with the state an interest in containing health care costs and promoting quality of care. The legislature recognizes that the participation of such plans in the state's efforts to promote primary care health homes and reform payment methods would greatly increase the likelihood of success of such efforts.

(3) The administrator shall establish a collaborative work group process to encourage input from and participation by such plans to work with the state and carriers to promote primary care health homes and to learn from the experience of the health care authority for successful implementation of primary care health homes for employees with chronic and multiple conditions.

(4) The administrator shall execute an agreement with the Puget Sound health alliance to compile data on the implementation of RCW 74.09.522, 70.47.100, 41.05.021, and section 8 of this act. By December 31, 2011, and annually thereafter through December 31, 2016, the Puget Sound health alliance shall report to the appropriate committees of the legislature on the progress made in implementing primary care health homes in the state, including:

(a) Number of providers participating in primary care health homes;

(b) Types of provider reimbursement methods employed by private and public payers; and

(c) Performance outcomes, including reductions in inappropriate emergency department, inpatient and specialty care, and other measures identified by the alliance that are consistent with national standards for primary care.

(5) No state funds may be appropriated for the implementation of the provisions of this section. However, the authority and the Puget Sound health alliance are encouraged to seek grants and other sources of funding to implement the provisions of this section.

(6) For the purposes of this section, "chronic condition" and "primary care health home" have the same meaning as in RCW 74.09.010.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Each carrier licensed under this title and providing a comprehensive health plan in the state shall, by December 1, 2011, report to the appropriate committees of the legislature how the carrier will modify its provider reimbursement methods starting July 1, 2012 to:

(a) Incentivize chronic care management within primary care health homes; and

(b) Reward primary care health homes that, by using chronic care management, reduce emergency department and inpatient use.

(2) Each carrier shall annually report the information required under section 7 of this act to the Puget Sound health alliance.

(3) For the purposes of this section, "chronic care management" and "primary care health home" have the same meaning as in RCW 74.09.010.

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