House Bill 3418

Sponsored by Representative MAURER, Senators BATES, MORSE; Representatives BAILEY, BRUUN, GREENLICK, STIEGLER, Senators MONNES ANDERSON, TELFER

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Requires Department of Human Services to develop payment system to promote health care delivery through integrated health homes for medical assistance recipients. Requires department to create Integrated Health Home Collaborative Program pilot project for testing new system for payment to fee-for-service primary care providers.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to reimbursement for health care delivered through an integrated health home model; and declaring an emergency.

Whereas the Legislative Assembly directs the purchase of billions of dollars of health care, the state government is the biggest consumer of health care in Oregon and it is time for the state to pay for health care in an intelligent way; and

Whereas starting with primary care, we need to reform what and how we pay for health services, and it is time to see primary care as an investment with a financial return of fewer visits to the emergency department and episodes of acute care; and

Whereas it is time to buy primary care that is focused on prevention and case management that will promote good health; and

Whereas it is time to reward culturally competent, patient-centered health coordination; and

Whereas it is time to integrate physical, behavioral and oral health; and

Whereas it is time to include public health, school-based health centers and mental health services in our insurance-based payment system; and

Whereas people will make most of their health choices at home, but payment for health care ends at the clinic door; and

Whereas active case management is a way to maintain a connection between clinics and patients, from assisting patients in making choices as significant as follow-up on medication or physical therapy, to coaching patients on good eating habits and coping with depression, encouraging exercise and providing support for anger management; and

Whereas effective case management brings health care into its most timely and appropriate setting, namely the home and community, and reduces the costs associated with any health care visit; and

Whereas the current reimbursement structure rewards medical interventions as revenue generators and discourages primary and preventative care services by nonpayment or underpayment; and

Whereas the current primary care workforce is in crisis, due in part to the reimbursement levels for primary care; and

Whereas reforming this system to reward primary and preventative care as revenue generators

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

will translate into better health outcomes, fewer medical interventions and a system with less overall expense; and

Whereas we have the research and evidence to know what works well, and Oregon has examples of primary care successes at the local level; and

Whereas, when primary care is well organized, a patient visit is an opportunity to spend time assessing and addressing all of a patient's needs, not just the need that prompted the visit, thereby reducing the incidents of delayed care, which add cost to the system; and

Whereas it is time to set a clear direction for the state to expect quality care to become the norm; and

Whereas any transition will take some time, as these reforms will need to be phased into any purchasing strategy; and

Whereas the current health care system in the United States is not sustainable due to rising costs and an increasing number of uninsured individuals; and

Whereas the number of visits to hospital emergency rooms continues to grow, and a significant number of these visits are for nonurgent or preventable conditions; and

Whereas the health care system is fragmented, access to care is episodic and relationships between patients and providers are strained; and

Whereas current systems for financing primary care emphasize 10-minute to 15-minute office visits and fail to support patient-centered care that could improve patients' health status and lower overall costs to the broader health care system; now, therefore,

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) As used in this section, "integrated health home" means a health care delivery system that has the following elements:

(a) The patient and the patient-provider relationship are at the center of all health care activities.

(b) Patients, rather than having to return for many separate visits, are assigned to a team of providers that coordinate care to address all of a patient's health needs during each visit. Physical, mental and oral health care services are integrated.

(c) The system includes case management to assist the patient in tasks such as adhering to a medication regimen, following through on physical therapy, maintaining healthy eating habits and coping with depression. Case managers coordinate care with other community services so that all of the patient's health needs are met.

(d) The system provides end-of-life case management that links primary care, in-home services, hospice care, pain management and behavioral health services.

(e) A patient may access care when and in the manner the patient needs the care, including by telephone, electronic mail and same-day visits.

(f) Provider teams provide care in a culturally competent manner. Translation and other services that reflect cultural sensitivity are provided as needed.

(g) The system provides services necessary to address barriers to accessing health care, such as limited access to transportation.

(h) The system provides services necessary to address barriers to healthy lifestyles, such as homelessness, behavioral health issues and limited access to healthy food.

(2) No later than January 1, 2010, the Department of Human Services shall develop and implement a system for the reimbursement of health care provided to recipients of medical assistance that encourages and rewards the use of integrated health homes. The system

must:

(a) Be incorporated into the capitation payments for managed care;

(b) Establish fee-for-service payment codes for all of the services provided by an integrated health home; and

(c) Incorporate into the capitation payment or payment codes the costs of:

(A) Health care delivered by telemedicine.

(B) Home visits for case management services, including home visits for environmental health interventions related to hygiene, air quality, water quality, diet, allergies, asthma, abuse, physical health risks, exposures to toxins and promotion of exercise and physical therapy.

(C) Team-based care that links the patient to a personal health care provider who identifies the patient's health needs, helps the patient access appropriate care and works with a team of health professionals to address all of the patient's health care needs.

(D) Services performed by nurses.

(E) Preventive, educational, social or diagnostic care, care management or follow-up care provided by any qualified member of the patient care team.

(F) End-of-life care.

(3) The department may adopt additional incentive payments for fee-for-service providers and for managed care systems that are based on performance, including:

(a) Incentives to encourage the integration of primary, oral and behavioral health care;

(b) Bonus payments that are based on the health of the entire patient population of the provider or system;

(c) Incentives for providers to utilize evidence-based best practices; and

(d) Incentives to reward team providers who operate at the top of their licenses.

(4)(a) The department shall develop the Integrated Health Home Collaborative Program pilot project for primary care providers reimbursed on a fee-for-service basis who voluntarily participate in the new payment system described in this subsection.

(b) The pilot project shall include reimbursement mechanisms to reward primary care providers who demonstrate improved patient outcomes achieved through measures including, but not limited to, the following:

(A) Ensuring that all patients have access to and know how to use the services of a nurse consultant;

(B) Encouraging female patients to have a mammogram on the evidence-based recommended schedule;

(C) Effectively implementing strategies designed to reduce patients' use of emergency room care in cases that are not emergencies;

(D) Communicating with patients through electronic means; and

(E) Effectively managing the blood sugar levels of patients with diabetes.

(c) Pilot project participants must agree to provide data on patients' experiences with the program and health outcome measures.

(d) Pilot project participants shall be selected based on their ability to promote:

(A) The development of common core program components intended to promote consistency among integrated health homes in this state;

(B) The use of standard outcome measurements; and

(C) The adoption and use of the latest medical techniques in effective and cost-efficient

patient-centered integrated health care.

SECTION 2. This 2009 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2009 Act takes effect on its passage.