SENATE AMENDMENTS TO SENATE BILL 456

By COMMITTEE ON HEALTH CARE AND VETERANS' AFFAIRS

May 5

On page 1 of the printed bill, after line 2, insert:

"Whereas strong primary health systems have been found to improve health outcomes and quality and to reduce overall health system costs; and

"Whereas the Oregon Health Fund Board was tasked with developing a comprehensive health reform plan for Oregon and found that the state's primary care health system is severely faltering and must be revitalized as part of any sustainable reform plan; and

"Whereas primary care is most effective when a single team of providers is responsible for providing coordinated primary care, defined as comprehensive and coordinated primary care that encompasses a range of prevention and disease management services; and

"Whereas the Oregon Health Fund Board found that the patient centered primary care home, also known as the patient centered medical home and health care home, can best deliver a patient centered approach that can manage chronic disease, address acute illnesses and provide effective prevention. The model is characterized by established and continuous relationships with patients, team-based care, whole person orientation, coordinated and integrated care, improved quality and safety, enhanced access and payment policies that recognize the value to patients of services provided under this model; now, therefore,".

Delete lines 4 through 24.

On page 2, delete lines 1 through 31 and insert:

"**SECTION 1. (1) There is established in the Office for Oregon Health Policy and Research the patient centered primary care home program. Through this program, the office shall:**

"(a) Define core attributes of the patient centered primary care home to promote a reasonable level of consistency of services provided by patient centered primary care homes in this state. In defining core attributes related to ensuring that care is coordinated, the office shall focus on determining whether these patient centered primary care homes offer comprehensive primary care, including prevention and disease management services;

"(b) Establish a simple and uniform process to identify patient centered primary care homes that meet the core attributes defined by the office under paragraph (a) of this subsection;

"(c) Develop uniform quality measures that build from nationally accepted measures and allow for standard measurement of patient centered primary care home performance;

"(d) Develop uniform quality measures for acute care hospital and ambulatory services that align with the patient centered primary care home quality measures developed under paragraph (c) of this subsection; and

"(e) Develop policies that encourage the retention of, and the growth in the numbers of, primary care providers.

"(2)(a) The Director of Human Services shall appoint an advisory committee to advise the office in carrying out subsection (1) of this section.

"(b) The director shall appoint to the advisory committee 15 individuals who represent a diverse constituency and are knowledgeable about patient centered primary care home delivery systems and health care quality.

"(c) Members of the advisory committee are not entitled to compensation, but may be reimbursed for actual and necessary travel and other expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for expenses shall be paid out of funds appropriated to the office for the purposes of the advisory committee.

"(d) The advisory committee shall use public input to guide policy development.

"(3) The office will also establish, as part of the patient centered primary care home program, a learning collaborative in which state agencies, private health insurance carriers, third party administrators and patient centered primary care homes can:

"(a) Share information about quality improvement;

"(b) Share best practices that increase access to culturally competent and linguistically appropriate care;

"(c) Share best practices that increase the adoption and use of the latest techniques in effective and cost-effective patient centered care;

"(d) Coordinate efforts to develop and test methods to align financial incentives to support patient centered primary care homes;

"(e) Share best practices for maximizing the utilization of patient centered primary care homes by individuals enrolled in medical assistance programs, including culturally specific and targeted outreach and direct assistance with applications to adults and children of racial, ethnic and language minority communities and other underserved populations;

"(f) Coordinate efforts to conduct research on patient centered primary care homes and evaluate strategies to implement the patient centered primary care home to improve health status and quality and reduce overall health care costs; and

"(g) Share best practices for maximizing integration to ensure that patients have access to comprehensive primary care, including preventative and disease management services.

"(4) The Legislative Assembly declares 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 in the best interest of the public. The Legislative Assembly therefore declares its intent to exempt from state antitrust laws, and to provide immunity from federal antitrust laws, the collaborative and associated payment reforms designed and implemented under subsection (3) of this section that might otherwise be constrained by such laws. The Legislative Assembly 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.

"(5) The office may contract with a public or private entity to facilitate the work of the learning collaborative described in subsection (3) of this section and may apply for, receive and accept grants, gifts, payments and other funds and advances, appropriations, properties and services from the United States, the State of Oregon or any governmental body or

agency or from any other public or private corporation or person for the purpose of establishing and maintaining the collaborative.

"**SECTION 2.** **(1) As funds are available, the Department of Human Services may provide reimbursement in the state's medical assistance program for services provided by patient centered primary care homes. If practicable, efforts to align financial incentives to support patient centered primary care homes for enrollees in medical assistance programs should be aligned with efforts of the learning collaborative described in section 1 (3)(d) of this 2009 Act.**

"(2) The department may reimburse patient centered primary care homes for interpretive services provided to people in the state's medical assistance programs if interpretive services qualify for federal financial participation.

"(3) The department shall require patient centered primary care homes receiving these reimbursements to report on quality measures described in section 1 (1)(c) of this 2009 Act.

"**SECTION 3.** **(1) The Department of Human Services, in collaboration with health insurers and purchasers of health plans including the Public Employees' Benefit Board, the Oregon Educators Benefit Board and other members of the patient centered primary care home learning collaborative and the patient centered primary care home program advisory committee, shall:**

"(a) Develop, test and evaluate strategies that reward enrollees in publicly funded health plans for:

"(A) Receiving care through patient centered primary care homes that meet the core attributes established in section 1 of this 2009 Act;

"(B) Seeking preventative and wellness services;

"(C) Practicing healthy behaviors; and

"(D) Effectively managing chronic diseases.

"(b) Develop, test and evaluate community-based strategies that utilize community health workers to enhance the culturally competent and linguistically appropriate health services provided by patient centered primary care homes in underserved communities.

"(2) The department shall focus on patients with chronic health conditions in developing strategies under this section.

"(3) The department, in collaboration with the Public Employees' Benefit Board and the Oregon Educators Benefit Board, shall establish uniform standards for contracts with health benefit plans providing coverage to public employees to promote the provision of patient centered primary care homes, especially for enrollees with chronic medical conditions, that are consistent with the uniform quality measures established by the Office for Oregon Health Policy and Research under section 1 (1)(c) of this 2009 Act.

"(4) The standards established under subsection (3) of this section may direct health benefit plans to provide incentives to primary care providers who serve vulnerable populations to partner with health-focused community-based organizations to provide culturally specific health promotion and disease management services.".

In line 45, after "input" insert ", including the input of communities most affected by health disparities".

On page 3, line 1, after "partners" insert ", including a range of multicultural community providers".

In line 4, after "demonstrate" insert ", including for communities most affected by health disparities as well as individuals who are participating in the community-based primary and secondary

1 activity proposal,".

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