HOUSE BILL 710

49TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2009

INTRODUCED BY

Danice Picraux

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH CARE; DIRECTING THE HUMAN SERVICES DEPARTMENT TO APPLY FOR A WAIVER OR STATE PLAN AMENDMENT TO IMPLEMENT THE MEDICAL HOME PROGRAM; DIRECTING THE SUPERINTENDENT OF INSURANCE TO CONVENE AN INSURANCE TASK FORCE TO EXPLORE INCENTIVES FOR A MEDICAL HOME-BASED MANAGED CARE MODEL.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. A new section of the Public Assistance Act is enacted to read:

"[NEW MATERIAL] MEDICAID, STATE CHILDREN'S HEALTH INSURANCE PROGRAM AND STATE COVERAGE INITIATIVE PROGRAM MEDICAL HOME WAIVER--RULEMAKING--APPLICATION FOR WAIVER OR STATE PLAN AMENDMENT.--

A. Subject to the availability of state funds and

consistent with the federal Social Security Act, the department shall create a medicaid, state children's health insurance and state coverage initiative waiver program entitled the "medical home program", and establish a program promoting medical homes for medicaid, state children's health insurance and state coverage initiative program recipients. The "medical home" is an integrated care management model that emphasizes primary medical care that is continuous, comprehensive, coordinated, accessible, compassionate and culturally appropriate. Care within the medical home includes primary care, preventive care and care management services and uses quality improvement techniques and information technology for clinical decision support. Components of the medical home model include:

(1) assignment of recipients to a primary care provider, clinic or practice that will serve as a medical home;

(2) promotion of the health commons model of service delivery, whereby the medical home tracks recipients' primary care, specialty, behavioral health, dental health and social services needs as much as practicable;

(3) health education, health promotion, peer support and other services that may integrate with health care services to promote overall health;

(4) health risk or functional needs assessments for recipients;

(5) a method for reporting on the

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effectiveness of the medical home model and its effect upon recipients' utilization of health care services and the associated cost of utilization of those services;

(6) mechanisms to reduce inappropriate emergency department utilization by recipients;

(7) financial incentives for the provision of after-hours primary care;

(8) mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating and monitoring recipients with complex, chronic or high-cost health care or social support needs, including attendant care and other services needed to remain in the community;

(9) implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system, including the use of community health workers or promotoras;

(10) strategies to prevent or delay institutionalization of recipients through the effective utilization of home- and community-based support services;

(11) a primary care provider for each recipient, who advocates for and provides ongoing support, oversight and guidance to implement an integrated, coherent, cross-disciplinary plan for ongoing health care developed in partnership with the recipient and including all other health care providers furnishing care to the recipient;

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(12) implementation of evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based upon recipient-specific factors;

(13) use of comparative effectiveness to make a cost-benefit analysis of health care practices;

(14) use of health information technology, including remote supervision, recipient monitoring and recipient registries, to monitor and track the health status of recipients;

(15) development and use of safe and secure health information technology to promote convenient recipient access to personal health information, health services and web sites with tools for patient self-management;

(16) implementation of training programs for personnel involved in the coordination of care for recipients;

(17) implementation of equitable financial incentive and compensation systems for primary care providers and other staff engaged in care management and the medical home model; and

(18) any other components that the secretary determines will improve a recipient's health outcome and that are cost-effective.

B. The department shall apply for if approved, and obtain any necessary waivers or state plan amendments from the United States department of health and human services' centers

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for medicare and medicaid services and promulgate rules necessary to implement the medical home program.

C. For the purposes of this section, "primary care provider" means a medical doctor or physician assistant licensed under the Medical Practice Act to practice medicine in New Mexico or a certified nurse practitioner as defined in the Nursing Practice Act who provides first contact and continuous care for individuals under the physician's care and who has the staff and resources to manage the comprehensive and coordinated health care of each individual under the primary care provider's care."

Section 2. TEMPORARY PROVISION--PATIENT-CENTERED PRIMARY CARE MEDICAL HOME TASK FORCE.--By July 1, 2009, the superintendent of insurance shall convene a "patient-centered primary care medical home task force" and work with representatives from the human services department, the New Mexico health policy commission, the New Mexico medical society, the New Mexico primary care association and representatives from the insurance industry and health maintenance organizations to devise incentives for insurers and managed care organizations to promote a medical home model of managed care. The task force shall devise a three-year strategic plan and report on its strategic plan to the interim legislative health and human services committee by August 1, 2010. The strategic plan shall contain recommendations

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regarding:

A. the feasibility of implementing financial incentives to encourage greater numbers of health professionals to specialize in primary care;

B. incentives for managed care plans to utilize a medical home model of case management, whereby the medical home model incorporates the following practices:

(1) incentives for the promotion of medical homes where insured individuals have a primary health care or social service provider, who advocates for and provides ongoing support, oversight and guidance to implement an integrated, coherent, cross-discipline plan for ongoing health care and service delivery developed in partnership with the individual and including all other health care and social service providers furnishing care to the individual;

(2) utilization management designed to assure appropriate access and utilization of services, including prescription drugs;

(3) health risk or functional needs assessments for patients;

(4) a method for reporting on the effectiveness of the medical home model and its effect upon recipients' utilization of health care services and the associated cost of utilization of those services;

(5) mechanisms to reduce inappropriate

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emergency department utilization by recipients;

(6) mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating and monitoring recipients with complex, chronic or high-cost health care or social support needs, including attendant care and other services needed to remain in the community;

(7) a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system, including the use of community health workers or promotoras;

(8) strategies to prevent or delay institutionalization of recipients through the effective utilization of home- and community-based support services; and

(9) any other components the task force determines that will improve a patient's health outcome and that are cost-effective;

C. promotion of the health commons model of integrated primary care, specialty, behavioral health and dental health care services;

D. incentives for encouraging longer hours for primary care services, including weekend and evening hours; and

E. recommendations for designing and implementing a comprehensive pay-for-performance system whereby providers receive financial incentives for measurable improvements in the health of their patients, including recommendations for quality

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evaluation and measurement protocols and for increasing community support for quality health care outcomes.