2011 State Legislation: Medical Homes

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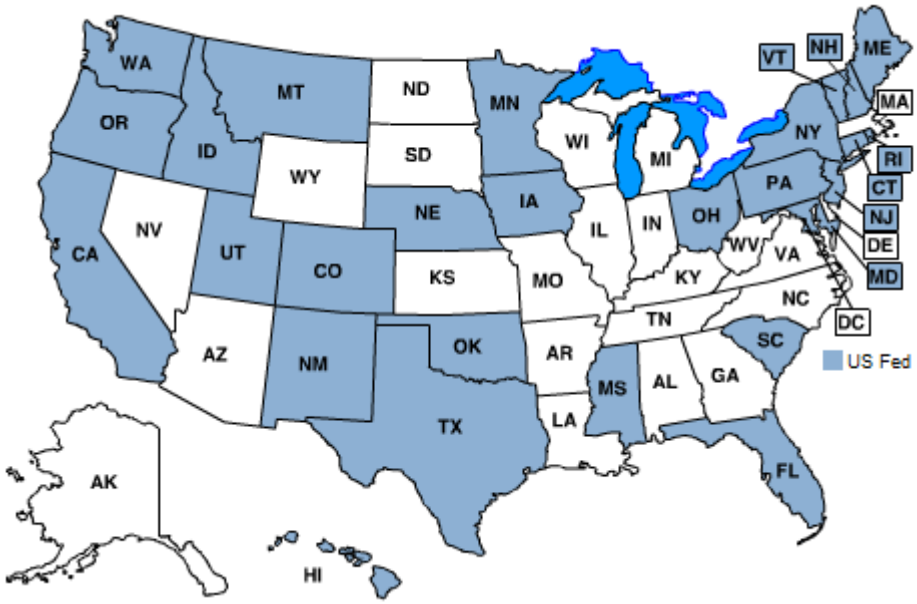
As of December 31, 2011, 50 states convened for legislative session with 115 bills in 34 states referring to the medical home. The 64 bills in 29 states listed below define, test, implement or promote the use of medical homes in the state.

All 50 states convened for session in 2011 with **Virginia**, **Wyoming**, **Kentucky**, **Utah**, **West Virginia** and **New Mexico** the first to adjourn from regular session. Only **New Jersey** and **Virginia** carry over bills from 2010 to 2011. The medical home is expected to gain attention of legislators in many states again this year—including creating demonstration projects, integrating medical homes into state Medicaid programs, and adopting the NCQA joint PCMH principles.

States Considering Legislation
Referring to the Medical Home, 2011



Source: American Academy of Family Physicians, 2011.

This summary is only informational intended to provide background on the scope of projects currently before state legislatures. The reader should not consider this document to be comprehensive or to reflect AAFP policy.

For bill text and status of all active state exchanges legislation, please visit the AAFP bill tracking webpage: http://www.aafp.org/online/en/home/policy/state/statetrack.html

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**States Considering Legislation to Define,
Create a Demonstration Project or Otherwise Promote
the Patient-Centered Medical Home**

CALIFORNIA

2011 AB 604 – Medical Home Multipayer Program

Status: Introduced in House – 2/16/2011

- Establishes a medical home multipayer program to improve patient access to health care services and improve the continuity and coordination of health care services.

2011 AB 574 – Program of All-Inclusive Care for the Elderly

*Status: **PASSED** Chaptered by Secretary of State – Chapter 367, Statutes of 2011 – 9/30/2011*

- Chapter 367 – Establishes medical homes to which enrollees are assigned that include a number of elements that must be considered in the provider contracting process
- The department of health may alter the medical home elements in order to increase federal financial participation associated with the provision of medical assistance in conjunction of a health home under the federal PPACA as amended by the federal Health Care & Education Reconciliation Act of 2010.
  The department MUST notify the appropriate policy and fiscal committees of the state Legislature of its intent to alter any medical home elements under this section (Chapter 367, Section B) at least five (5) days in advance of taking action.

2011 AB 1023 – Maintenance of the codes

*Status: **PASSED** Chaptered by Secretary of State – Chapter 296, Statutes of 2011 – 9/21/2011*

- Similar to above bill (AB 574), but includes assignment of eligible individuals to a medical home.
- Includes provisions on care coordination for the beneficiary across the service delivery system, as agreed to between the medical home and the CEED project. Also covering care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and the CEED project.
- The CEED project must collect data that demonstrate that the medical homes within the project network for which the enrollee can select are successful.

2011 AB 1066 – Public health care: Medi-Cal: demonstration project waivers

*Status: **PASSED** Chaptered by Secretary of State – Chapter 86, Statutes of 2011 – 7/15/2011*

- Similar to AB 574 and AB 1023, but adds medical home provisions applicable to the LIHP (Low Income Health Program)

2011 AJR 10 – School-based health centers

*Status: **PASSED** Chaptered by Secretary of State – Res. Chapter 68, Statutes of 2011 – 7/28/2011*

- A bill to include school-based health centers as partners in creating a medical home for all children.

2011 SB 393 – Medical Homes

Status: Referred to Committee on Health – 6/16/2011

- Defines “medical home,” “patient-centered medical home,” “advanced practice primary care,” “health home,” “person-centered health care home,” and “primary care home” to all mean a health care delivery model in which a patient establishes an ongoing relationship with a physician or other licensed health care provider acting within the scope of his or her practice, working in a physician-directed practice team to provide comprehensive, accessible, and continuous evidence-based primary and preventative care, and to coordinate the patient’s health care needs across the system in order to improve quality and health outcomes in a cost-effective manner.
- Requires medical homes to provide:
    - individual patients with an ongoing relationship with a physician or other licensed health care provider acting within his or her cope of practice, who is trained to provide first contact and continuous and comprehensive care, or if appropriate, provide referrals to health care professionals that provide continuous and comprehensive care;
    - a team of individuals at the practice level collectively taking responsibility for the ongoing health care of patients, who takes responsibility for providing all of a patient’s health care needs or for appropriately arranging health care by other qualified professionals including making appropriate referrals;
    - coordinated care that is integrated across all elements of the complex health care system—including mental health and substance use disorder care, and the patient’s community—and that is facilitated, if possible, by registries, information technology, health information exchanges, and other means to ensure that patients receive the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner;
    - quality and safety components, including: (1) optimal, patient-centered outcomes, (2) evidence-based medicine and clinical decision support tools to guide decisionmaking, (3) accountability of providers for continuous quality improvement through voluntary engagement in performance measurement and improvement, (4) patient participation in decisionmaking and sought feedback to ensure patients’ expectations are met, (5) information technology utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication, (6) a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has capabilities to provide patient-centered services consistent with the medical home model, (7) patient and family participation in quality improvement activities at the practice level, and (8) enhanced access to health care available through systems such as open scheduling, expanded hours and new options for communication between the patient, the provider and staff.

COLORADO

2011 HB 1245 – Patient-Centered Medical Home for Adults

*Status: **FAILED** to pass House State, Veterans & Military Affairs Committee – 2/24/2011*

- Amends current state statutes (10-16; 25.5-1-103; 25.5-1).
- Defines the “Patient-Centered Medical Home” as a health care team that provides high-quality, safe, continuous, coordinated, comprehensive, and evidence-based care to adults, facilitating a partnership between adult patients and their personal health care team and meeting the criteria of a nationally recognized accrediting organization that develops performance measures and quality standards for health care entities based upon core principles, including enhanced access to care; comprehensive, culturally competent, evidence-based and patient centered care; care management and coordination; cost effectiveness and efficiency; quality and safety; continuity of care; and whole-person orientation with the aim of preventing conditions or complications.
- Requires, no later than January 1, 2014, all carriers and public payors to make care coordination payments to health care providers who provide services as part of a patient-centered medical home.

2011 SB 168 – Colorado Health Care Cooperative

Status: Senate Second Reading Special Order – Laid Over to 5/10/2011-5/9/2011
Committee amendments were technical in nature.

- Creates the Colorado Health Care Authority to design the Colorado Health Care Cooperative, the benefits administrator and payer for health care services to all Colorado residents.
- Requires the Authority recommend the health care cooperative design to the General Assembly, and if approved, the measure shall be referred to voters for approval.
- Defines a "medical home" as an appropriately qualified, community-based and culturally sensitive model of primary care that ensures that every Coloradan has a personal provider who coordinates the provision of accessible, coordinated, comprehensive, and continuous health care across all stages of life, ensuring, at a minimum:
    - health maintenance and preventive care;
    - anticipatory guidance and health education;
    - acute and chronic illness care; and
    - coordination of medications, specialists, hospitalizations, and therapies.
- Defines "integrated delivery system" as a nonprofit corporation that:
    - provides a medical home for enrollees;
    - is capable of contracting to provide all enrollees with all designated necessary health services in return for receiving actuarially adjusted per member per month payments from the cooperative;
    - provides all designated services to enrollees through contracts with employees or other entities;
    - agrees that employees, providers and contractors shall not be awarded any bonus payments based on system savings; and
    - includes in its mission: (1) the delivery of quality health care services that increase value by seeking lower costs while making services readily available; and (2) the goal of returning surplus funds to the cooperative when possible and fairly compensating all employees and contractors.

CONNECTICUT

2011 HB 6305 – An Act Concerning Implementation of the SustiNet Plan

Status: House Recommitted to Human Services – 6/3/2011

- Provides that "Patient-Centered Medical Home" has the same meaning as set forth in Section 3502 of the *Affordable Care Act*.
- Defines the "SustiNet Plan" as a health insurance program that consists of multiple, coordinated individual health insurance plans that provide or offer, over a phased-in period of time, health insurance products to state employees, Medicaid enrollees, HUSKY Plan, Part A and Part B enrollees, HUSKY Plus enrollees, municipalities, municipal-related employers, nonprofit employers, small employers, other employers and individuals in the state and which, with respect to all health plans offered, implements innovative, cost-controlling mechanisms and measures to improve the quality of health care services and improve the health of SustiNet Plan enrollees.
- Authorizes the SustiNet Authority to:
    - strongly encourage the use of patient-centered medical care by implementing both primary care case management and patient-centered medical homes for all SustiNet Plan members;
    - work in coordination with other public and private entities as appropriate, to develop provider capacity to function within these patient-centered models of care;
    - make or facilitate grants and loans that (1) assist providers in transitioning to a primary care case management system and patient-centered medical home system, including, where appropriate obtaining certification as a patient-centered medical home; (2) provide technical assistance and training for community teams certified or sponsored by the authority; and (3) establish regional pilot programs;
    - establish a service delivery plan to include provider eligibility criteria that shall be met by any provider seeking to qualify for reimbursement under a primary care case management system or as a patient-centered medical home;
    - establish provider payment mechanisms to encourage payment for quality care and greater access to providers, including multi-payer pilot programs, value-based purchasing pilot programs, bundled payments, global payments, increasing and decreasing Medicaid reimbursement for specific services or other innovations, which may involve alternatives to utilization of fee-for-service payments; and

- establish, by July 1, 2012, goals for increasing the percentage of SustiNet expenditures made under alternative payment methodologies.

- Requires a provider serving as a patient-centered medical home provide services that include:
  - assisting plan members to safeguard and improve their own health by: (1) advising plan members with chronic health conditions of methods to monitor and manage their own conditions; (2) working with plan members to set and accomplish goals related to exercise, nutrition, use of tobacco and other addictive substances, sleep and other behaviors that directly affect such member's health; (3) implementing best practices to ensure that plan members understand medical instructions and are able to follow such directions; and (4) providing translation services and using culturally competent communication strategies in appropriate cases;
  - providing care coordination that includes: (1) managing transitions between home and the hospital; (2) proactive monitoring that ensures that a plan member receives all recommended primary and preventive care services; (3) the provision of basic mental health care, including screening for depression, with referral relationships in place for those plan members who require additional assistance; (4) strategies to address stresses that arise in the workplace, home, school and the community, including coordination with and referrals to available employee assistance programs; (5) referrals, in appropriate cases, to nonmedical services such as housing and nutrition programs, domestic violence resources and other support groups; and (6) for a plan member with complex health conditions that involve receiving care from multiple providers, ensuring that such providers share information about the plan member, as appropriate, and pursue a single, integrated treatment plan on behalf of the plan member; and
  - providing readily accessible, 24-hour consultative services by telephone, secure electronic mail or quickly scheduled office appointments for purposes that include reducing the need for hospital emergency room visits.

2011 HB 6652 – An act implementing the revenue items in the budget and making budget adjustments, deficiency appropriations, certain revisions to bills of the current session and miscellaneous changes to the general statutes

*Status: **PASSED** Signed by Governor – 6/21/2011*

- Declares that the Commissioner of Social Services shall contract with a patient-centered medical home, health home, or a pharmacy organization, which may include a school of pharmacy, to provide Medicaid therapy management services, including, but not limited to, (1) a review of the medical and prescription history of recipients of benefits under the Medicaid program, and (2) the development of patient medication action plans to reduce adverse meacdication interaction and related health problems. **(similar to SB 1244)**

2011 SB 851 – An act concerning the legislative commissioners' recommendations for technical revisions to the human services statutes

*Status: **PASSED** Signed by Governor – 6/3/2011*

- Allows the Commissioner of Public Health, in consultation with the Commissioner of Social Services to establish a medical home pilot program in one region of the state to be determined by the Commissioner of Public Health in order to enhance health outcomes for children.

2011 SB 1240 – An act concerning the bureau of rehabilitative services and implementation of provisions of the budget concerning human services and public health

*Status: **PASSED** Signed by Governor – 6/13/2011*

- Allows The Commissioner of Social Services to establish medical homes as a model for delivering care to recipients of assistance under medical assistance programs administered by the Department of Social Services.

FLORIDA

2011 S 566 – Special Health Care Needs / Adolescents / Young Adults

Status: S. Died in Health Regulation – 5/7/2011

- Establishes the Florida Health and Transition Services for adolescents and young adults with special health care needs.
- Directs the Department of Health to work in partnership with:
    - the Agency for Health Care Administration to identify potential waiver or state plan options that address health care provider compensation strategies, including a medical home;
    - the Office of Insurance Regulation to explore and recommend effective policies that address medical management and health care transition services that are based on a patient-centered medical home model for adolescents and young adults who have special needs; and
    - community-based pediatric and adult health care providers to explore and recommend the development of local health and transition services programs in each of the eight regions of the Children's Medical Services Network that includes a medical home to provide coordinated and multidisciplinary care and focus on engaging adult health care providers in the care and treatment of adolescents or young adults.

2011 S 1972 – Health and Human Services

Status: S. Laid on Table - 05/05/2011

- Establishes that the Health and Human Services agency develop a plan to implement a medical home pilot project that uses primary care case management enhanced by medical home networks to provide coordinated and cost-effective care that is reimbursed on a fee-for-service basis and to compare the performance of the medical home networks with other existing Medicaid managed care models.

2012 – HB 279 – Health Care Transition Programs and Services for Adolescents and Young Adults Who Have Special Health Care Needs

Status: H Referred to Health and Human Services Access Subcommittee; Health Care Appropriations Subcommittee; Health and Human Services Committee – 10/17/2011

- Requires that the Department of Health work with the Agency for Health Care Administration to identify potential waiver or state plan options that address health care provider compensation strategies, including medical homes.
- Also requires that the Department of Health work with the Office of Insurance Regulation to explore and recommend effective policies that address medical management and health care transition services that are based on a patient-centered medical home model for adolescents and young adults who have special health care needs.
- Requires that the medical home model provides for coordinated and multidisciplinary care and focuses on engaging adult health care providers in the care and treatment of adolescents or young adults.
- *This bill is directly related to SB 282.*

HAWAII

2011 SB 1468 – Hawaii Patient Centered Health Home Pilot Program

Status: H The committees recommends that the measure be deferred – 4/6/2011

- Defines a patient centered medical home as:
    - a model of delivering comprehensive, integrated, and holistic health care services to patients, including preventative and lifestyle health services;
    - not necessarily a physical structure, but rather a collection of health care providers and community organizations that work collectively to provide and manage patient health;
    - providing primary providers who work with a health care team—including other primary care providers, behavioral health providers, care managers or patient care coordinators, and allied health professionals—to provide comprehensive and integrated services to patients;
    - reducing long-term costs by focusing on wellness, education, and preventive services by having patients take an active and informed role in their own health, and partnering them with a proactive health care team that works collectively to encourage healthy lifestyles;
    - employing health information technology—including electronic health record systems that meet the Centers for Medicare and Medicaid Services' federal meaningful use guidelines—that enables

sharing of patient and treatment data and collection and reporting at the patient and provider level; and
    - providing a comprehensive reimbursement model that pays for services provided and outcomes produced, including consistent fee-for-service reimbursement based on existing prospective payment system guidelines, reimbursement for enhanced health care home services, based on a per member per month formula, and organizational incentive payments for improving total population health in the chronic diseases areas identified.
- Establishes a Hawaii Medicaid modernization and innovation council to establish a patient centered health home pilot program within the Medicaid program, as provided in the *Affordable Care Act.*
- Requires the Department of Human Services, by January 1, 2012, to establish and implement the Hawaii Patient Centered Health Home Pilot program within the Medicaid program to provide comprehensive, person-centered, and integrated primary care services to state health care program members using a health home model of care delivery.
- Terminates the program no later than June 30, 2013, unless continued upon the council's recommendation and approval by the legislature and the governor.

2011 HB 326 – QUEST Telehealth Services; Hawaii Patient Centered Health Home Pilot Program; Hawaii Medicaid Modernization and Innovation Council

Status: H Received notice of Senate conferees (Sen. Com. No. 648) – 4/19/2011

- Establishes that the creation of the patient centered medical home model under the PPACA that will help support the “Triple Aim” approach, which focuses on improving the individual experience of care, improving the health of populations, and reducing per capita costs of care for populations in health care.
- Section 4 declares that beginning January 1, 2012, members of the state health care program will receive care through certified health homes provided by medical home teams, through the pilot program.
- Defines a set of criteria that the council designated to institute the patient centered health home pilot program must adhere to. This includes:
    - Adopt a definition, criteria, and standards for health homes that take into consideration the recommendations of the Patient-Centered Primary Care Collaborative Joint Principles of the Patient-Centered Medical Home and the National Committee for Quality Assurance Patient-Centered Medical Home Certification Standards, and are consistent with the definition of “health home services” continued in Title 42 United States Code Section 1396w-4;
    - Consult with any local health plan or provider that has implemented a medical home or health home model of care in Hawaii, consider the criteria and standards utilized by the health plan or provider, and determine whether the criteria and standards are appropriate for inclusion in the council’s criteria and standards for the Hawaii patient centered health home pilot program;
    - Certify health homes that meet the standards established by the council;
    - Adopt a definition of the medical home team that includes providers within the medical home, including; a primary care provider; behavioral health provider; care manager or patient care coordinator; nursing staff; nutritionists and dieticians; oral health care provider; pharmaceutical provider; ambulatory care providers; and other specialty care providers.
    - Develop quality and performance measures that certified health homes in the pilot program must report to the council, health plans, and department of human services;
    - Develop a payment methodology for certified health homes that shall include a per member per month care coordination fee, consistent fee-for-service reimbursement, payment for any services not reimbursed under current Medicaid or prospective payment system guidelines but that are recommended as a covered service in the health home pilor program developed by the council, and organizational incentive payments for improving total health among chronic disease populations and other metrics as adopted by the council; provided that for federally qualified community health centers, the payment methodology is in addition to, and no less than, existing prospective payment system rates
    - Develop annual reporting requirements for certified health homes and health plans to report to the council, department of human services, and legislature on:
        - The number of members in the program and characteristics of members including income, ethnicity, language, complex or chronic condition, age, and sex

- The number and geographic distribution of health home providers
- The performance and quality of health homes in treating complex chronic condition patient populations
- Measures of preventative care
- Health home payment methology arrangements compared with costs related to implementation and payment of care coordination fees; and
- Estimated and actual impact of health homes on health disparities.

2011 SB 240 – Physician Workforce Assessment Fee: John A. Burns School of Medicine

Status: S Conference committee meeting to reconvene on 4/29/2011

- This bill extends the Physician Workforce Assessment Fee to July 1, 2015.
- It requires one hundred percent of the assessment fees be used to support health care reform, the medical home model, and physician reimbursements for the John A. Burns School of Medicine.

IDAHO

2011 HB 221 – Medicaid

Status: Referred to House Health and Welfare Committees – 3/4/2011

- Amends current state statutes (56-255) replacing "primary care case management" with "medical homes" in the medical services covered for all Medicaid participants.
- Requires the Department of Health and Welfare to present to the legislature a plan for Medicaid managed care that shall include improving coordination of care through primary care medical homes and medical home development with focus on populations with chronic disease using a tiered case management fee.

2011 HB 260 – Medicaid

Status: Referred to Senate Health and Welfare Committees – 3/18/2011

- This measure is similar to the above 2011 HB 221, and the current versions have the same bill summary.

IOWA

2011 SF 348 (formerly SSB 1063) **– A Bill Relating to Establishment of Health Benefit Exchange**

Status: Referred tp State Government S.J. 851 – 03/31/2011

- Establishes the Iowa Health Benefit Exchange to comply with the requirement of the federal *Patient Protection and Affordable Care Act*.
- Directs the Board of Directors to submit an annual report—to the Secretary of the U.S. Department of Health and Human Services, the Governor, the Insurance Commissioner, the General Assembly, and the public—examining the operations of the exchange and the demographics of those enrolled.
- Requires the board, by August 1, 2012, to research, investigate, produce and submit one or more reports on a variety of issues, including development of strategies to reduce health care costs, such as encouraging the use of accountable care organizations and the medical home model, and the effect of such changes on health care costs and health insurance premiums for exchange enrollees.

2011 SF 481 (formerly 2011 SSB 1077) **– Reforming State and County Responsibilities for Adult Mental Health, Mental Retardation and Developmental Disabilities Services**

Status: Referred to Senate Human Appropriations Committee – 3/9/2011

- *This measure was amended, removing the medical home provisions. The following is a summary of the bill's original version.*
- Designates the Department of Human Services as the state's adult mental health and substance abuse services authority.
  - Directs the authority to develop a regional structure that is designed to maintain county and other local investment and involvement in addressing the needs of adults with mental illness and substance abuse problems and consider developing a delivery system for meeting such needs to include the adaptation

of the physical health medical home model for use in addressing mental health and substance abuse treatment needs.

2011 HF 649 – An Act Relating to and Making Appropriations for Health and Human Services Including Other Related Provisions and Appropriations, and Including Effective, Retroactive, and Applicability Date Provisions.

*Status: **PASSED** Item Vetoed, signed by Governor H.J. 1322 – 7/26/2011*

- This bill makes appropriations for the 2011-2012 year for health and human services programs executed by the department of veterans affairs, the Iowa veterans home, the department of aging, the department of public health, Iowa finance authority, state board of regents, department of inspections and appeals, and the department of human services.
- The bill denotes the allocation of funds to the appropriate medical home programs, that include rural health clinics, provider recruitment, provision assistance to patients, and limited continuity of care services for an expansion populations member, for pilot programs, and to pay for the costs of a medical home system advisory council. Ideally, the state initiative for prevention and chronic care management will be the medical home model.

2011 HF 697 – Committee On

Status: Fiscal note. HCS – 06/07/2911

- A bill for an act relating to state and local finances by providing for funding of property tax credits and reimbursements, by making and adjusting appropriations, providing for salaries and compensation of state employees, providing for matters relating to taxation, providing for fees and penalties, providing for legal responsibilities, and providing for properly related matters, and including effective date and retroactive and other applicability provisions.
- This bill indicates the amount of grant money awarded to each pilot program, including medical homes, special maternal and child health center medical homes, assistance to patients in determining an appropriate medical home, rural health clinics, continuity of care measures, and to fund the system advisory council.

2011 SSB 1218 – A study bill for an act relating to and making appropriations for health and human services and including other related provisions, providing penalties, and including effective, retroactive, and applicability date provisions.

Voted – Appropriations. – 6/20/2011

- This bill relates to and makes appropriations for health and human services for fiscal years 2011=2012 and 2012-2013 to the department of veterans affairs, the Iowa veterans home, the department on aging, the department of public health, the Iowa finance authority, the state board of regents, the department of inspections and appeals, and the department of human services. The bill is organized in divisions.
- This bill indicates the amount of grant money awarded to each pilot program, including medical homes, special maternal and child health center medical homes, assistance to patients in determining an appropriate medical home, rural health clinics, continuity of care measures, and to fund the system advisory council.

IDAHO

2011 H 221 – Health and Welfare Committee

Status: Rpt prt to Health/Welfare Committee 03/04/2011

- This bill establishes that the Medicaid managed care plan should include improved coordination of care through primary care medical homes.
- Also declares that medical home development focus on populations with chronic disease using a tiered case management fee

2011 H 260 – Ways and Means Committee

- *Status: **PASSED** Governor signed Session Law Chapter 164 - 04/05/2011*
  This bill establishes that the Medicaid managed care plan should include improved coordination of care through primary care medical homes.
- Also declares that medical home development focus on populations with chronic disease using a tiered case management fee

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MARYLAND

2011 HB 193 – Creation of a State Debt – Baltimore City – Substance Abuse, Medical Home, and Clinical Building

Status: H Unfavorable Report by Appropriations – 4/11/2011

- This bill authorizes a state debt (not to exceed $150,000) that gives the Board of Directors of the Institutes for Behavior Resources, Inc. authority to plan, design, construct, repair and capital equip a Substance Abuse Medical Home and Clinical Building to be located in Baltimore City.
- This money will be acquired through a State of Maryland State loan entitled the "Baltimore City Substance Abuse, Medical Home, and Clinical Building Loan of 2011."
- Also similar to SB 350.

MAINE

2011 LD 540 – An Act to Implement the Insurance Payment Recommendations of the Advisory Council on Health Systems Development

*Status: **PASSED** Signed by Governor – 6/9/2011*

- Requires the council to adopt principles for the review of pilot projects to require that payment reform strategies:
  - support integrated, efficient and effective systems of care delivery and payment;
  - promote a patient-centered approach to service payment and delivery;
  - encourage and reward the prevention and management of disease;
  - promote the value of care over volume to measurably lower costs; and
  - support payments and processes that are transparent, easy to understand and simple to administer for patients, providers, purchasers and other stakeholders.
- Allows the Superintendent of Insurance, as of January 1, 2012, to authorize pilot projects that allow a health insurance carrier that offers health plans in the state to implement payment reform strategies with providers to reduce costs and improve quality of patient care, including but not limited to, alternatives to fee-for-service models such as blended capitation rates, episodes of care payments, medical home models and global budgets; pay-for-performance programs; tiering of providers; and evidence-based purchasing strategies.

MICHIGAN

2011 HB 4526 – Appropriations; zero budget; omnibus budget appropriations bill; provide for. Creates appropriations act. Disapproved line item(s)

Status: Re-referred to Committee on Appropriations – 6/22/2011

- Section 495 of this bill requires that legislators work together with CMS to create a program that develops a medical home for individuals receiving Medicaid mental health benefits.

2011 SR 83 – A resolution to memorialize Congress to adopt legislation expressing the sense that national health care reform should ensure that the health care needs of women in the United States are met.

Status: Referred to Committee on Health Policy – 10/6/2011

- This bill declares that an established medical home should ensure each woman in Michigan direct access to women's health care providers and care coordination throughout their lifetime.

- This bill is similar or the same as HR 106.

MINNESOTA

2011 HF 278 – Children with Autism Spectrum Disorders Medical Homes Created

Status: Referred to House Health and Human Services Reform – 1/31/2011

- Requires the Commissioner of Health to issue a request for proposals for development of a medical home specializing in the diagnosis and treatment of autism spectrum disorders in Somali children.
- Requires that the medical home provide early identification and intervention to Somali children with an autism spectrum disorder and work to develop community providers who can provide treatment for Somali children.

MISSISSIPPI

2011 HB 651 – Medicaid; Directs the Division to Establish a Medical Home

*Status: **FAILED** to pass House Medicaid Committee – 2/1/2011*

- Amends current state statutes concerning the state's Medicaid program (§ 43-13-117).
- Directs the Division of Medicaid to establish a Medicaid medical home program, subject to federal approval and availability of federal financial participation under Title XIX of the Social Security Act, no later than September 1, 2011.
- Requires the division to:
    - restructure its payment system to support primary care providers that participate in a medical home—rewarding quality and improved patient outcomes—including (1) coordinating care through multidisciplinary teams, (2) encouraging services such as disease management, (3) educating patients and families of patients with chronic diseases, and (4) providing access to home-based services, telephonic communication to patients, and culturally and linguistically appropriate care;
    - develop a system to support primary care providers in developing a program organizational structure necessary to provide a medical home; and
    - provide for the development of a network of primary care providers for participating in the program that provide care using the medical home model, including, at a minimum, using a multidisciplinary team that provides patient-centered care coordination through the use of health information technology and chronic disease registries across the patient's lifespan and across all domains of the health care system and the patient's community.
- Defines "primary care provider" to include general practitioners, family practice physicians, pediatricians, internal medicine, rural health centers, federally qualified or community health centers, and a primary care outpatient clinic operated by a general hospital.
- Requires the executive director of the division to:
    - evaluate the medical home program annually to assess (1) cost-savings achieved, (2) the rates of health screening, and (3) the outcomes and hospitalization rates for persons with chronic illness; and
    - apply for any state plan amendments or waivers as necessary.

2011 HB 966 – Medicaid; Require Participation in Medical Home Concept and Require Obese Persons to Participate in Online Program on Obesity

*Status: **FAILED** to pass House Medicaid Committee – 2/1/2011*

- Amends current state statutes concerning the state's Medicaid program (§ 43-13-117).
- Requires beneficiaries, upon determination of Medicaid eligibility and in association with annual redetermination of Medicaid eligibility, to undertake a physical examination that will establish a base-line level of health and identification of a usual and customary source of care (a medical home) to aid utilization of disease management tools.

2011 SB 2447 – Medicaid Program; Direct DOM to Establish a Medical Home Program to Support Primary Care Providers

*Status: **FAILED** to pass Senate Public Health & Welfare and Appropriates Committees – 2/1/2011*

- This measure is similar to above 2011 HB 651. The current versions have the same bill summary.

MONTANA

2011 HB 124 – An Act Creating a Montana Health Insurance Exchange Authority

*Status: **FAILED** to pass House Business and Labor Committee – 4/28/2011*

- Creates a Montana Health Insurance Exchange Authority and establishes an oversight board.
- Charges the board and the Commissioner of Insurance with jointly researching, investigating and producing reports by August 31, 2010 on strategies—to reduce health care costs and an assessment of how implementation of such strategies would affect health care costs and health insurance premiums for exchange enrollees—which must include (but are not limited to) encouraging the use of accountable care organizations and patient-centered medical homes.

NEBRASKA

2011 LB 662 – Provide for a Demonstration Project Regarding Bundling Payments under the Medical Assistance Act

Status: Referred to Health and Human Services Committee, Notice of hearing 2/9/2011

- Amends current state statutes concerning the Medical Assistance Act (68-901 to 68-969).
- Defines "payment bundling" as a payment method that includes payment for furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as established by the U.S. Department of Health and Human Services.
- Requires the state Department of Health and Human Services, by January 1, 2012, to:
    - develop a voluntary demonstration program available until January 1, 2017, to encourage primary care physicians providing a medical home to improve patient care and achieve savings for the medical assistance program through bundled payment models;
    - consult with representatives of public health clinics that use a medical home model regarding participating in a demonstration program;
    - develop payment methods for participating entities, including bundled payments and bid from entities for episodes of care;
    - report to the legislature by January 1, 2017 with a recommendation on expanding the demonstration project, reducing expenditures, and maintaining delivery of quality health care services; and
    - determine whether the demonstration program has been a success based on comparing the previous per patient cost history under medical assistance program to the cost for the period of the demonstration project.
- Authorizes the department to expand the demonstration project if the program improves the quality of health care services and reduces the costs to the medical assistance program.

NEVADA

2011 SB 278 – Revises provisions relating to health care and health insurance (BDR 57-253)

*Status: **PASSED** – 6/15/2011*

- This act relates to the implementation of health care and health insurance, including a charge to the Department of Health and Human Services to conduct a study and submit reports concerning medical homes (Section 24.5).
- The study will include; the progress made in the development of medical homes in the state of Nevada, the manner in which insurers work with medical homes concerning the adequacy of health care networks, models for reimbursement of medical homes and any options for different methods of preauthorization for the care and services provided by medical homes.

- The report, complete with findings and recommendations, is due to the state Legislative Committee on Health Care on January 1, 2013, but progress reports must be made for the committee throughout the 2012 calendar year.

NEW HAMPSHIRE

2011 SB 147 – Relative to Medicaid Managed Care

*Status: **PASSED** Signed by Governor — 6/2/2011*

- Requires that all Medicaid recipients receive care through a medical home.

2011 HB 652 – Establishing a commission relative to Medicaid managed care

Status: H Ought to Pass: MA RC 259-111: HJ 68, PG.2052-2054 – 10/12/2011

- Establishes that vendors providing managed care to Medicaid recipients must establish medical homes so that all Medicaid recipients will receive their care though a medical home.

NEW JERSEY

2011 AB 3636 – Establishes Medicaid Accountable Care Organization Project in DHS

Status: Assembly Health and Senior Services Committee – 1/6/2011

- Establishes a three-year Medicaid Accountable Care Organization (ACO) Demonstration Project in the Department of Human Services.
- Specifies participants in the demonstration project to be nonprofit corporations organized and operated for the primary purpose of improving the quality and efficiency of care provided to Medicaid recipients residing in a designated area.
- Requires inclusion—in the specific criteria to be considered by Medicaid in approving the gain-sharing plan of a Medicaid ACO—whether the plan promotes expansion of the medical home model.

2010 SB 2443 – Establishes Medicaid Accountable Care Organization Project in DHS

*Status: **PASSED** Approved P.L. 2011, c.114 – 8/18/2011*

- This measure is a companion of the above 2011 AB 3636, the original versions have the same bill summary, and the two are still similar.
- Committee amendments made various technical changes to the legislation.

2011 A 226 – Concerning the Medicaid program and supplementing P.L. 1968, c.

*Status: **PASSED** Approved P.L. 2010, c.74. – 9/10/2010*

- Chapter 74, under Title XIX of the Social Security Act, establishes a three-year Medicaid medical home demonstration project.
- The medical home must develop a system to support primary care providers in an appropriate organizational structure conductive to a medical home model.
- This bill substituted S 665

NEW MEXICO

2011 HB 34 – Health Insurance Medical Home Requirements

Status: Passed Senate – 3/18/2011, Pocket Veto by Governor – 4/11/2011

- Amends state statutes (27-2-12.15 the Public Assistance Act) that created a medical home program under the state's Medicaid, State Children's Health Insurance Program and State Coverage Initiative Program Medical Home waiver by allowing home care services to be provided as a component of the medical home model.
- Requires the state Human Services Department, as of FY 2012, to specify in contracts that a contractor allocate funds to establish and maintain a medical home program.

NEW YORK

2011 AB 3637 – An Act to Amend the Public Health Law, In Relation to Medical Home Multipayor Programs

Status: Amended and recommitted to Assembly Ways and Means Committee – 3/2/2011

- Amends current state statutes (Public Health Article 27-L).
- Authorizes the Commissioner of Health to:
  - establish medical home multipayor programs;
  - certify clinicians and clinics as medical homes eligible for Medicaid payments to improve health care outcomes and efficiency through improved access, patient care continuity, and coordination of health services;
  - engage in appropriate state supervision necessary to promote state action immunity under state and federal antitrust laws and to inspect or request documentation to verify that a program is implemented in accordance with its intent and purpose; and
  - participate in, actively supervise, facilitate and approve a primary care medical home collaborative including providers and payors to establish: (1) boundaries of the programs and provider eligibility, (2) practice standards consistent with NCQA Joint Principles, (3) methodologies by which payors will provide enhanced rates of payment to certified medical homes; (4) methodologies to pay additional amounts for medical homes that meet specific process or outcome standards, (5) alternative methodologies, (6) payment provisions that vary by size or form of organization to accommodate different levels of resources and difficulty of meeting program standards, (7) payment provisions to not-for-profit entities that assist providers in meeting standards, (8) data collecting requirements, and (9) provisions under which the Commissioner may terminate the program.
- Determines that it is the policy of the state relating to the programs to encourage cooperative, collaborative and integrative arrangements between payors of health care services and health care providers who might otherwise be competitors, providing state action immunity under state and federal antitrust laws with respect to the planning, implementation and operation of the programs and payors of health care services and providers in order to promote improved quality and efficiency of, and access to, health care services and promote improved clinical outcomes.
- Requires that patient and provider participation in the program be on a voluntary basis.
- Prohibits participating providers from being eligible for additional enhancements or bonuses under the statewide medical home program.

2011 AB 4009 – An Act to Amend the Public Health Law, In Relation to Individualized Family Plans

Status: Signed Chap.59 – 3/31/2011

- The medical home provisions in this measure are similar to those in the above 2011 AB 3637, and the current versions have the same bill summary.

2011 AB 6261 – An Act to Amend the Public Health Law, the Social Services Law, the Public Authorities Law

Status: Referred to Assembly Health Committee – 3/11/2011

- The medical home provisions in this measure are similar to those in the above 2011 AB 3637, and the current versions have the same bill summary.

2011 SB 2809 – An Act to Amend the Elder Law, in Relation to Medicare Part D

Status: Amended and recommitted to Senate Finance Committee – 3/12/2011

- The medical home provisions in this measure are similar to those in the above 2011 AB 3637, and the current versions have the same bill summary.

NORTH CAROLINA

2011 H 926 – State Health Plan / P.C.M.H. Pilot Program

Status: Referred to Committee on State Personnel, if favorable, Finance – 5/5/2011

- This bill creates a Patient-Centered Medical Home pilot project for the State Health Plan for Teachers and State Employees by January 1, 2011.

OHIO

2011 HB 139 – To rename the Northeastern Ohio Universities Colleges of Medicine and Pharmacy as the Northeast Ohio Medical University and to declare an emergency.

*Status: **PASSED** Signed by Govorner, effective 4/29/2011 – 4/29/2011*

- Section 185.03 of this bill establishes the patient centered medical home education advisory group for the purpose of implementing and administering the patient centered medical home pilot project.
- Section 185.05 declares that the group shall accept applications for inclusion in the pilot project from primary care practices with educational affiliations to various Ohio universities.
- Section 3333.611 declares that a medical student is eligible for a scholarship made available under the component by meeting specific requirements, including participating in an identified patient centered medical home training model during medical school
- SB 85 is a similar bill that was referred to the Comm. Senate Finance on 2/23/2011

2011 HB 153 – To make operating appropriations for the biennium beginning July 1, 2011, and ending June 30, 2013, and to provide authorization and conditions for the operation of state programs

*Status: **PASSED** Signed by Governor, 7 Line Item Vetos – 6/30/2011*

- Section 185.03 establishes the patient centered medical home education advisory group for the purpose of implementing and administering the patient centered medical home pilot project.
- Section 185.06 establishes the criteria by which physician practices must abide in order to be eligible for inclusion in the pcmh education pilot project.
- Section 185.10 lays the parameters by which the pcmh education advisory group must follow in otder to seek funding sources for the pilot project.
- Similar to HB 284 – To modify the laws governing physician assistants – referred to Comm. House Health & Aging – 7/12/2011

OKLAHOMA

2011 SB 777 – Oklahoma Health and Wellness Act

Status: Referred to Retirement and Insurance Committee – 2/8/2011

- Replaces the State and Education Employees Group Insurance Board with the Oklahoma Health and Wellness Board.
- Requires that the Board promote and coordinate medical home providers by expanding the existing medical home infrastructure and providers into a statewide, multipayer delivery system and requires the infrastructure to include an electronic medical records system with the capability to allow connectivity between medical home providers, a referral management process that emphasizes the full scope of practice by primary care doctors with appropriate input by specialists, and a robust clinical process and outcomes reporting package.

2011 SB 882 – Community Health Worker Certification Act

Status: Referred to Senate Health and Human Services Committee – 2/14/2011

- Directs the Oklahoma Board of Nursing to establish and maintain a pilot program to develop criteria for certification, develop standards, and encourage the development of training programs for community health workers.
- Includes in the definition of “community health worker” and “community health navigator,” as used in the pilot, a requirement to assist individuals in locating patient-centered medical home services.

OREGON

2011 HB 2401 – Relating to a Family Medicine Residency Network

*Status: **PASSED** (H) Chapter 289, (2011 Laws): Effective date June 9, 2011 – 6/9/2011*

- Directs the Area Health Education Center program to create a family medicine residency network that:
  - facilitates an increase in the number of family medicine residency positions in this state in order to train more highly qualified family physicians who are likely to practice in the state;
  - supports and assists hospital systems in this state to work collaboratively with existing family medicine residency programs to develop new family medicine residency programs throughout the state; and
  - helps family medicine residency programs in this state share resources through the creation of standardized curriculum, a common faculty development center, initiation of physician training in quality improvement, medical home development, chronic disease management, interprofessional team-based care and population care management, facilitation of primary care research projects through joint regulatory monitoring and other support and provision of grant writing resources for outside funding.

PENNSYLVANIA

2011 HB 342 – Establishing the Community-Based Health Care Provider Access Program

Status: Referred to House Health Committee – 1/31/2011

- Establishes the Community-Based Health Care Provider Access Program to provide access to quality community-based health care to improve the health of local residents.
- Determines that although community health centers serve millions of patients nationally with federally qualified health centers serving 521,194 individuals as medical homes and family physicians in the Commonwealth and only six states serve more individuals in FQHCs, Pennsylvania provides no direct funding of health centers.
- Establishes the Community-Based Health Care Provider Access Fund to provide grants to community-based health care providers who:
  - improve access to and the delivery and management of health care services;
  - reduce unnecessary and duplicative health care services; and
  - changes overall health indicators and utilizes health care services among communities including establishing a medical home.

2011 HB 863 – Establishing the Pennsylvania Health Information Exchange and Health Information Technology Fund

Status: Referred to House Insurance Committee – 3/1/2011

- Includes a free or partial-pay health clinic that provides medical home and primary care services by volunteer or nonvolunteer health care providers in the definition of "community-based health care clinic" in regards to the state's Health Information Exchange.

RHODE ISLAND

2011 S 770 – Rhode Island All-Payer Patient Centered Medical Home Act of 2011

*Status: **PASSED** Signed by Governor – 7/9/2011*

- Defines the "patient-centered medical home" as:
  - an approach to providing comprehensive primary care for children, youth and adults;
  - a health care setting that facilitates partnerships between individual patients and their personal physicians, physician assistants and advanced practice nurses, and when appropriate, the patient's family;
  - care facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want in a culturally and linguistically appropriate manner;
  - improved delivery of comprehensive primary care and focus on better outcomes for patients, more efficient payment to physicians and other clinicians, and better value, accountability and transparency to purchasers and consumers;

    - an ongoing two-relationship between patients and physicians—rather than a series of episodic office visits;
    - helping medical care providers work to keep patients healthy instead of just healing them when they are sick;
    - allowing patients to be active participants in managing their health with a shared goal of staying as healthy as possible;
    - emphasizing, enhancing and encouraging the use of primary care, including the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;
    - focusing on delivering high-quality, efficient and effective health care services;
    - encouraging patient-centered care, including active participation by the patient and family;
    - providing patients with consistent utilization of a range of qualified health care professions, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;
    - focusing initially on patients who have, or are at risk of developing, chronic conditions;
    - incorporating measures of quality, resource use, cost of care and patient experience;
    - ensuring the use of health information technology and systemic follow-up, including the use of patient registries; and
    - encouraging the use of evidence-based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs and comparative outcomes and other clinical decision support tools.
- Directs the Health Insurance Commissioner to convene a Patient-Centered Medical Home Collaborative made up of a community advisory council, incorporating participants in the existing Rhode Island Patient-Centered Medical Home Pilot Project, including but not limited to, health insurers, physicians and other clinicians, employers, the state health care program, relevant state agencies, community health centers, hospitals, other providers, patients, and patient advocates—which shall provide consultation and recommendations to the Director of Health and the Commissioner on all matters relating to proposed regulations, development of standards, and development of payment mechanisms.
- Requires all health insurers in the state to participate in the Collaborative.
- Requires the Collaborative, by July 1, 2012, to develop a payment system that requires all health insurers to make per-person care coordination payments to PCMHs for providing care coordination services and directly managing on-site or employing care coordinators as part of all health insurance plans offered in the state.
- Directs the Collaborative to: (1) provide guidance to the state health care program as to the appropriate payment system for the state health care program to the same patient-centered medical homes and (2) consider additional payment reforms to be implemented to support PCMHs, including but not limited to, payment structures that:
    - reward high-quality, low-cost providers;
    - create enrollee incentives to receive care from high-quality, low-cost providers;
    - foster collaboration among providers to reduce cost shifting from one part of the health continuum to another;
    - create incentives that health care be provided in the least restrictive, most appropriate setting; and
    - examine and make recommendations to the secretary regarding the designation of pcmh in order to promote diversity in the size of practices designated, geographic locations of practices designated and accessibility of the population throughout the state to pcmh
- The pcmh collaborative must also propose to the secretary for adoption, the standards for the pcmh to be used in the payment system, based on national models when feasible Allows care coordination payments to be modified as the Commissioner and the Collaborative determine necessary, but requires payments to be consistent among insurers and PCMHs and to be in addition to any other incentive payments such as quality incentive payments.
- Requires that the care coordination payment system be in place through at least July 1, 2016.

2011 HB 5592 – An Act Relating to Human Services – Health Care for Families

*Status: Withdrawn at sponsor's request – 5/17/2011*Defines "managed care" as systems that integrate an efficient financing mechanism with quality service delivery; provide a "medical home" to assure appropriate care and deter unnecessary services; and place emphasis on preventive and primary care.

2011 SB 627 – An Act Relating to Human Services – Health Care for Families

Status: Referred to Senate Finance Committee – 3/10/2011

- This measure is similar to above 2011 HB 5592, and the current versions have the same bill summary.

TEXAS

2011 HB 13 – Relating to the Medicaid Program and Alternate Methods of Providing Health Services to Low-Income Persons

Status: S placed on intent calendar – 5/24/2011

- Requires the Health and Human Services Commission to develop an indigent care program for eligible residents whose net family incomes are at or below 300 percent of the federal poverty level and who do not have private health benefits coverage or receive benefits through medical assistance.
- Requires the program to:
    - provide financial assistance to an eligible person for health care services, including access to a primary care physician who serves as a medical home, through a monthly payment plan based on total household income and family size;
    - promoting patient responsibility and program viability;
    - paying providers on a fee-for-service bas is; and
    - and developing community partnerships.

2011 HB 2445 – Relating to Fostering Collaboration among Health Care Systems to Provide Indigent Health Care to Communities More Efficiently

Status: Referred to House Public Health Committee – 3/14/2011

- Requires the Health and Human Services Executive Commissioner to adopt rules to foster collaboration among and within systems that provide indigent health care services in the state.
- Requires the rules to:
    - emphasize community-based care to improve the continuity and quality of indigent health care;
    - address the variation in indigent health care services provided to urban and rural settings;
    - remove legal and practical barriers to collaboration;
    - provide guidance to systems for detecting and treating mental illness;
    - facilitate the creation of special programs to assist patients in navigating the systems that provide indigent health care services; and
    - adopt changes that maximize funding and increase the efficiency of indigent health care provided to communities in the state.
- Requires the Executive Commissioner, in adopting the rules, to consider recommending that the systems incorporate:
    - promoting patient responsibility and program viability;
    - provide a medical home for members;
    - make evidence-based health care decisions;
    - pay providers based on a fee-for-service basis;
    - ensure members receive necessary medication; and
    - develop community partnerships to expand indigent health care services.

2011 SB 23 – Relating to the administration of and efficiency, cost-saving, fraud prevention, and funding measures for certain health and human services and health benefits programs, including the medical assistance and child health plan programs

Status: H 1 hr. notice-to suspend rules – 5/29/2011

- Section 533.0029 Promotes and defines the principles of pcmh's for recipients. It also charges the Health and Human Services commission with working a to ensure that managed care organizations promote the development of pcmh's and provide payment incentives for providers that meet pcmh requirements.

- The HHS Commission must submit a report on the progress of the Medicaid managed care organizations and promotion of pcmh by December 1, 2013.
- This bill is similar to text in HB 7 - Relating to the administration, quality, and efficiency of health care, health and human services, and health benefits programs in this state.

2011 SB 7 - Relating to the administration, quality, and efficiency of health care, health and human services, and health benefits programs in this state; creating an offense; providing penalties.

*Status: **PASSED** Signed by Governor on 7/19/2011*

- Defines the Patient Centered Medical Home as a "medical relationship between a primary care physician and a child or adult patient in which the physician:
  - Facilitates partnerships between the physician, the patient, acute care and other care providers, and , when appropriate, the patient's family
  - Also encompasses numerous primary care principles
- The bill also encourages the HHS Commission to promote the development of patient-centered medical homes, including providing payment incentives for providers that meet the requirements of patient centered medical homes

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VERMONT

2011 HB 202 – An Act Relating to a Single-Payer and Unified System

*Status: **PASSED** Signed by Governor on 5/26/2011 – 5/6/2011*

- Sets forth a strategic plan to create a single-payer and unified health system that is transparent in design, efficient in operation, and accountable to the people it serves, requiring the state to ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.
- Establishes a board of directors to ensure cost-containment in health care, create a system-wide budget and pursue payment reform.
- Requires the board, by July 1, 2013, to review and approve plans on various issues, including global payments or capitated payments to accountable care organizations, health care professionals, or other provider arrangements.
- Requires all individuals enrolled in Green Mountain Care—the public-private single-payer health system established in the bill—to have a primary care professional involved with the Blueprint for Health, which includes patient-centered medical homes and multi-disciplinary community health teams to support well-coordinated health services.
- Directs the Agency of Human Services to determine a method to approve a specialist as a patient's primary health care professional for purposes of establishing a medical home for the patient.

2011 SB 57 – An Act Relating to a Single-Payer and Unified System

Status: Referred to Senate Health & Welfare Committee – 2/8/2011

- This measure is a companion of the above 2011 HB 202, and the current versions have the same bill summary.

WASHINGTON

2011 HB 1738 – Changing the designation of the Medicaid single state agency

Status: Effective date 7/1/2011 – 6/7/2011

- This bill transfers powers, duties, and functions of the department of social and health services, pertaining to the medical assistance program and the Medicaid purchasing administration to the state health care authority
- The Washington State Health Care Authority must work to develop and disseminate materials to engage and inform patients and families across the state on the value of medical homes,
- Section 30 declares that the authority submit a section 1115 demonstration waiver request to the federal department of health and human services to expand and revise the medical assistance program as codified

in Title XIX of the federal social security act. Waiver request should include enhanced medical home reimbursement and bundled payment methodologies among other things.

- Section 43 requires the authority to design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcoomes, access, and cost-effectiveness.
- Similar to SB 5477 – by resolution, reintroduced and retained in present status – 4/26/2011