

**H. B. 2743**

(By Delegates Perdue, Hatfield, Marshall,  
Michael, Moore, Rodighiero and Border)

[Introduced February 23, 2009; referred to the  
Committee on Health and Human Resources then Finance.]



A BILL to amend and reenact §16-2J-2 of the Code of West Virginia, 1931, as amended; and to amend said code by adding thereto a new article, designated §16-2L-1, §16-2L-2, §16-2L-3, §16-2L-4 and §16-2L-5, all relating generally to establishing pilot projects for patient centered medical homes; setting forth legislative findings; defining terms; establishing criteria for pilot projects for patient centered medical homes; defining three types of pilot projects; setting forth evaluation criteria and granting rule-making authority.

*Be it enacted by the Legislature of West Virginia:*

That §16-2J-2 of the Code of West Virginia, 1931, as amended, be amended and reenacted; and that said code be amended by adding thereto a new article, designated §16-2L-1, §16-2L-2, §16-2L-3, §16-2L-4 and §16-2L-5, all to read as follows:

**ARTICLE 2J. PREVENTIVE CARE PILOT PROGRAM.**

**16-2J-2. Definitions.**

For the purposes of this article, the following definitions apply:

(1) "Dependent" has the same meaning set forth in subsection (d), section one-a, article sixteen, chapter thirty-three of this code;

(2) "Family" means a subscriber and his or her dependents;

~~(3) "Medical home" means a team approach to providing health care and care management. Whether involving a primary care provider, specialist or sub-specialist, care management includes the development of a plan of care, the determination of the outcomes desired, facilitation and navigation of the health care system, provision of follow up and support for achieving the identified outcomes. The medical home maintains a centralized, comprehensive record of all health related services to provide continuity of care;~~

~~(4)~~ (3) "Participating provider" means a provider under this article that has been granted a license under this article to operate as part of the pilot program;

(4) "Patient centered medical home" means a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient centered medical home integrates patients as active participants in their own health and

well being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include but is not limited to nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence-based medicine and technology.

(5) "Primary care" means basic or general health care which emphasizes the point when the patient first seeks assistance from the medical care system and the care of the simpler and more common illnesses;

(6) "Provider" has the same meaning as "ambulatory health care facility" set forth in subsection (b), section two, article two-d of this chapter or "private office practice" as set forth in subsection (a)(1), section four of said article;

(7) "Qualifying event" means loss of coverage due to: (i) Emancipation and resultant loss of coverage under a parent or guardian's plan; (ii) divorce and loss of coverage under the former spouse's plan; (iii) termination of employment and resultant loss of coverage under an employer group plan: *Provided*, That any rights of coverage under a COBRA continuation plan as that term is defined in section three-m, article sixteen, chapter thirty-three of this code, shall not be considered coverage under an employer

group health plan; (iv) involuntary termination of coverage under a group health benefit plan except for termination due to nonpayment of premiums or fraud by the insured; or (v) exhaustion of COBRA benefits;

(8) "Subscriber" means any individual who subscribes to a prepaid program approved and operated in accordance with the provisions of this article, including an employee of any employer that has purchased a group enrollment on behalf of its employees.

**ARTICLE 2L. PATIENT CENTERED MEDICAL HOMES.**

**§16-2L-1. Legislative findings.**

The Legislature finds that:

(1) There is a need in the state to transform the health care services delivery model toward primary prevention and more proactive care management through the development of patient centered medical homes;

(2) The concept of a patient centered medical home would promote a partnership between the individual patient, the patients' various health care providers, the patients' family and, if necessary, the community. It integrates the patient as an active participant in their own health and well being;

(3) The patient centered medical home provides care through a multidisciplinary health team consisting of physicians, nurse practitioners, nurses, physicians assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental

and eye care providers and dieticians to meet the health care needs of a patient in all aspects of preventative, acute, chronic, and end-of-life care using evidence based medicine and technology;

(4) In a patient centered medical home each patient has an ongoing relationship with a personal physician. The physician would lead a team of health care providers who take responsibility for the care of the patient or for arranging care with other qualified professionals; and

(5) Transitioning health care delivery services to a patient centered medical home would provide greater quality of care, increase patient safety and ensure greater access to health care.

**§16-2L-2. Definition of a patient centered medical home.**

The patient centered medical home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patients' families and communities. A patient centered medical home integrates patients as active participants in their own health and well being. Patients are cared for by a physician or physician practice that leads a multidisciplinary health team, which may include but is not limited to nurse practitioners, nurses, physician's assistants, behavioral health providers, pharmacists, social workers, physical therapists, dental and eye care providers and dieticians to meet the needs of the patient in all aspects of preventive, acute, chronic care and end-of-life care using evidence based medicine and

technology.

**§16-2L-3. Authorization of patient centered medical home pilot projects; types of pilot projects.**

(a) The Governor's Office of Health Enhancement and Lifestyle Planning as set forth in article twenty-nine-h of this chapter, shall develop and implement during the fiscal year beginning July 1, 2009, pilot programs that permit the development of three varying types of pilots based upon the individual practices of physicians. These pilot programs will allow operation as a patient centered medical home.

(b) The three types of pilot programs shall be:

(1) Chronic Care Model Pilots. -- This model shall focus on smaller physician practices. Primary care providers shall work with payers and providers to identify various disease states. Through the collaborative effort of the primary care provider and the payers and providers, programs shall be developed to improve management of agreed-upon conditions of the patient. Through this model, the primary care provider may utilize current practices of multipayer workgroups. These groups shall be comprised of the medical directors of the major health care payers and the state payers along with medical providers and others.

(2) Individual Medical Homes Pilots. -- These pilots shall focus on larger physician practices. They shall seek certification from the National Committee on Quality Assurance. That initial

certification will be Level I certification. This would be granted by virtue of certifying the provider is in the process of attaining certification and currently have met provisional standards as set by the National Committee on Quality Assurance. This provisional certification lasts only one year with no renewal.

(3) *Community Centered Medical Home Pilots.* -- This approach shall link primary care practices with community health teams which would grow out of the current structure in place for federally qualified health centers. The community health teams shall include social and mental health workers, nurse practitioners, care coordinators and community health workers. These personnel largely exist in community hospitals, home health agencies and other settings. These pilots shall identify these resources as a separate team to collaborate with the primary care practices. The teams would focus on primary prevention such as smoking cessation programs and wellness interventions as well as working with the primary care practices to manage patients with multiple chronic conditions. Within this pilot all health care agencies are connected and share resources. Citizens can enter the system of care from any point and receive the most appropriate level of care or be directed to the most appropriate care. Any financial incentives in this model would involve all health care payers and could be used to encourage collaboration between primary care practices and the community health teams.

**§16-2L-4. Rule-making authority.**

The Governor's Office of Health Enhancement and Lifestyle Planning shall propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code as necessary to implement the provisions of this article. The Governor's Office of Health Enhancement and Lifestyle Planning may also promulgate emergency rules pursuant to the provision of section fifteen, article three, chapter twenty-nine-a of this code, if they deem them necessary.

**§16-2L-5. Guidelines for evaluation of the pilot program; report to Legislative Oversight Commission on Health and Human Resources Accountability.**

(a) The Governor's Office of Health Enhancement and Lifestyle Planning shall establish by guidelines, criteria to evaluate the pilot program and may require participating providers to submit such data and other information related to the pilot program as may be required by the Governor's Office of Health Enhancement and Lifestyle Planning. For purposes of this article, this information shall be exempt from disclosure under the Freedom of Information Act in article one, chapter twenty-nine-b of this code.

(b) No later than December 1, 2009 and annually thereafter during the operation of the pilot program, the Governor's Office of Health Enhancement and Lifestyle Planning must submit a report to the Legislative Oversight Commission of Health and Human Resources

Accountability as established in article twenty-nine-e of this chapter on progress made by the pilot project including suggested legislation, necessary changes to the pilot program and suggested expansion of the pilot program.

NOTE: The purpose of this bill is establish pilot projects to operate various types of patient centered medical homes throughout the state. This bill was recommended for passage during the 2009 Regular Session by Select Committee D on Health.

Strike-throughs indicate language that would be stricken from the present law, and underscoring indicates new language that would be added.