SENATE BILL REPORT
ESHB 1311

As Reported by Senate Committee On:
Health & Long-Term Care, March 23, 2011

Title: An act relating to establishing a public/private collaborative to improve health care quality, cost-effectiveness, and outcomes in Washington state.

Brief Description: Improving health care in the state using evidence-based care.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Bailey, Green, Clibborn, Appleton, Moeller, Frockt, Seaquist and Dickerson).

Brief History: Passed House: 3/04/11, 62-35.
Committee Activity: Health & Long-Term Care: 3/14/11, 3/23/11 [DPA, w/oRec].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass as amended.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Kline, Murray, Pflug and Pridemore.

Minority Report: That it be referred without recommendation.
Signed by Senators Becker, Ranking Minority Member; Carrell and Parlette.

Staff: Mich'l Needham (786-7442)

Background: The Health Care Authority (HCA) administers state employee health benefit programs through the Public Employees Benefits Board, as well as health care programs targeted at low-income individuals, such as the Basic Health Plan and the Community Health Services Grants. In addition, the HCA coordinates initiatives related to state-purchased health care, such as the Prescription Drug Program and the Health Technology Assessment Program. Through the Prescription Drug Program, the state contracts for independent reviews of prescription drugs to compare the safety, efficacy, and effectiveness of drug classes from which recommendations are made by a clinical committee for the development of a preferred drug list. The Health Technology Assessment program reviews scientific, evidence-based reports about the safety and effectiveness of medical devices, procedures, and tests, and a clinical committee determines whether or not the state should pay for them.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Legislation passed in 2009 (Engrossed Substitute House Bill 2105) established a workgroup to be appointed by the HCA, responsible for identifying evidence-based best practices guidelines and decision support tools related to advanced diagnostic imaging services. The workgroup included physicians and private and public health care purchasers. All state-purchased health care programs that purchase services directly were required to implement the guidelines by September 1, 2009. The workgroup expired on July 1, 2010.

Summary of Bill (Recommended Amendments): The Robert Bree Collaborative (Collaborative) is established to provide a mechanism for public and private health care purchasers, health carriers, and providers to work together to identify effective means to improve quality health outcomes and cost-effectiveness of care.

The Collaborative consists of 20 members appointed by the Governor. The members include:

- two representatives of health carriers or third party administrators;
- one representative of a health maintenance organization;
- one representative of a national health carrier;
- two physicians representing large multispecialty clinics with 50 or more physicians, one of which is a primary care provider;
- two physicians representing clinics with fewer than 50 physicians, one of which is a primary care provider;
- one osteopathic physician;
- two physicians representing the largest hospital-based physician groups in the state;
- three representatives of hospital systems, at least one of whom is responsible for quality;
- three representatives of self-funded purchasers;
- two representatives of state-purchased health care programs; and
- one representative of the Puget Sound Health Alliance.

The Governor must appoint the chair of the Collaborative, and the HCA must convene the Collaborative. The Collaborative must add members or establish clinical committees to acquire clinical expertise for each particular health care service area under review. No member may be compensated for his or her service. Members of the Collaborative and clinical committees are immune from civil liability for any decisions made in good faith while conducting work related to the Collaborative or its clinical committees. The guidelines established by the Collaborative must not be construed to establish a standard of care or duty of care in any cause of action for health care. The Collaborative's proceedings must be open to the public and notice of meetings must be provided at least 20 days in advance. The Collaborative may not begin its work unless there are sufficient federal or private funds or state funds available through other ongoing health care service review efforts. Private funds must not be accepted if receipt of such funding could present a potential conflict of interest or bias in the Collaborative's deliberations.

The Collaborative must annually identify up to three health care services for which there are substantial variations in practice patterns or high utilization trends in Washington that do not produce better care outcomes and may be indicators of poor quality and potential waste in the health care system.

Upon the identification of such health care services, the Collaborative must identify evidence-based best practices to improve quality and reduce variation in the use of the service. The Collaborative must also identify data collection and reporting for the development of baseline utilization rates and ways to measure the impact of strategies to promote the use of the best practices. To the extent possible, the reporting should minimize cost and administrative effort and use existing data resources.

The Collaborative must also identify strategies to increase the use of the evidence-based practices. The strategies may include:

- goals for appropriate utilization rates;
- peer-to-peer consultation; provider feedback reports;
- use of patient decision aids;
- incentives for the appropriate use of health services;
- centers of excellence or other provider qualification standards;
- quality improvement systems; and
- service utilization and outcome reporting.

In the event that a health care service identified for review lacks evidence-based best practice approaches, the Collaborative may consider strategies that will promote improved care outcomes, such as patient decision aids, provider feedback reports, centers of excellence, or other provider qualification standards and research. The Collaborative must strongly consider the efforts of other organizations when developing strategies. The Collaborative must submit information to the HCA on the health services reviewed, and strategies proposed. The HCA administrator must review the recommendations and make decisions related to the adoption of the recommended strategies by state purchased health care programs. Following the administrator's review, the Collaborative must report its findings and recommendations to the Governor and Legislature annually.

All state-purchased health care programs, including health carriers and third party administrators that contract with state programs, must implement the evidence-based practice guidelines and strategies by January 1, 2012, and every subsequent year, after the administrator, in consultation with participating agencies, has affirmatively reviewed and endorsed the recommendations. If the Collaborative does not reach consensus, state purchased health care programs may implement evidence-based strategies on their own initiative.

The statutory reference to the HCA workgroup that was established to identify evidence-based practices related to advanced diagnostic imaging services for all state-purchased health care programs is repealed.

EFFECT OF CHANGES MADE BY HEALTH & LONG-TERM CARE COMMITTEE (Recommended Amendments): Ultrasound is removed from the definition of advanced diagnostic imaging services. The collaborative must establish clinical committees for each therapy under review. The guidelines established by the collaborative must not be construed to establish a standard of care or duty of care in any cause of action. The public notice of meetings is extended from at least ten days to at least 20 prior to a collaborative meeting. Additional responsibilities are inserted for the HCA administrator, to review the proposed strategies and recommendations of the collaborative and make decision on adoption of the

recommended strategies for state purchased health care programs. Implementation of the collaborative recommendations in the state purchased health programs is after the administrator, in consultation with participating agencies, has affirmatively reviewed and endorsed the recommendations. The language allowing the collaborative to endorse coverage of selected health services when there is a lack of evidence, to allow evidence development, is removed and replaced with language allowing the collaborative to consider strategies that will promote improved care outcomes, such as patient decision aids, provider feedback reports, centers of excellence or other provider qualification standards and research. The collaborative may not accept private funding if the funding could present a conflict of interest or bias in the collaborative's deliberations.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Engrossed Substitute House Bill: PRO: This is based on the advanced imaging workgroup that was established in 2009 and provided a good collaborative opportunity for private carriers and physicians to work together on evidence based criteria. This collaborative is being compared to the health technology assessment program, but it is very different and focused on sharing evidence based best practices. We are exploring some concerns about the anti-trust language, and we want to make sure that the bill does provide a safe table for these collaborative discussions. These efforts align with our on-going work to address unwarranted variation in health care and the development of patient decision aids. It fits with our commitment to continue to work with our community partners. This is continuing the Legislatures efforts to reduce costs and improve quality care. The advanced imaging workgroup was a very worthwhile process and we support this effort to provide even broader participation in these quality discussions. Projects like this include the surgical care and outcomes assessment program (SCOAP) that has demonstrated great success.

OTHER: The anti-trust protections that are provided in the bill may need more work to ensure the anti-trust protections are strong enough. We also have concerns with the language added on the House floor regarding coverage of the services without adequate evidence. We believe this bill should not be about coverage but remain focused on identifying strategies, guidelines, and protocols. We appreciate that additional physicians have been included in the participation of the collaborative. We are concerned about the immunity language and would like to see the state add language indicating the state will pay for the legal costs of a physician that is accused of acting in bad faith. We would also like to see language added that says a physician should not be found liable if they do not follow the guidelines. We would like to see involvement of the national medical specialist societies.

Persons Testifying: PRO: Representative Cody, prime sponsor; Amber Ulvenes, Group Health Cooperative; Len Sorrin, Premera Blue Cross; Jackie Der, University of Washington Surgical Care and Outcomes Assessment Program.

OTHER: Bill Alkire, Medtronic Corporation; Susie Tracy, Washington State Medical Association, Washington Ambulatory Surgery Center.