2SHB 2572 - H AMD **809**
By Representative Cody

ADOPTED 02/19/2014

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** (1) The legislature finds that the state of Washington has an opportunity to transform its health care delivery system through multipayer payment reform, the development of a statewide comprehensive prevention framework, and other state-led initiatives in line with the state health care innovation plan.

(2) The state health care innovation plan establishes the following primary drivers of health transformation, each with individual key actions that are necessary to achieve the objective:

(a) Improve health overall by building healthy communities and people through prevention and early mitigation of disease throughout the lifespan;

(b) Improve chronic illness care through better integration and strengthening of linkages between the health care delivery system and community, particularly for individuals with physical and behavioral comorbidities; and

(c) Advance value-based purchasing across the community, and lead by example in transforming how the state purchases health care services.

(3) The legislature intends to facilitate the implementation of these improvements by:

(a) Establishing an all-payer claims database that improves transparency for patients, providers, hospitals, and purchasers;

(b) Developing standard statewide performance and quality measures to inform purchasing and set benchmarks;

(c) Supporting the initiatives of regional collaboratives to achieve healthy communities and populations, improve health care quality, and lower costs;

(d) Disseminating evidence-based training, tools, and other resources to providers and hospitals; and

(e) Supporting integration of services for physical health, behavioral health, and chemical dependency by restructuring medicaid procurement.

NEW SECTION. **Sec. 2.** (1) The health care authority is responsible for coordination, implementation, and administration of interagency efforts and local collaborations of public and private organizations to implement the state health care innovation plan.

(2) By January 1, 2015, and January 1st of each year through January 1, 2019, the health care authority shall coordinate and submit a status report to the appropriate committees of the legislature regarding implementation of the innovation plan. The report must summarize any actions taken to implement the innovation plan, progress toward achieving the aims of the innovation plan, and anticipated future implementation efforts. In addition, the health care authority shall submit any recommendations for legislation necessary to implement the innovation plan.

NEW SECTION. **Sec. 3.** A new section is added to chapter 41.05 RCW to read as follows:

(1) An accountable collaborative for health is a regionally based, voluntary collaborative designated by the authority, the purpose of which is to align actions and initiatives of a diverse coalition of members to achieve healthy communities and populations, improve health care quality, and lower costs. "Accountable collaborative for health" is a term used to recognize entities that are currently active and those that may become active that perform the functions described in this section. This term is used only to assist in directing funding or other support that may be available to these local entities. The designation of an entity as an accountable collaborative for health is not intended to create an additional government entity.

(2) By September 1, 2014, the authority shall establish boundaries for up to nine regions for accountable collaboratives for health as provided in this subsection. Counties, through the Washington state association of counties, must be given the opportunity to propose the boundaries of the regions. If counties do not submit proposed

boundaries for the regions by July 1, 2014, the task force on the adult behavioral health system created by section 1, chapter 338, Laws of 2013 shall submit proposed boundaries to the authority by August 1, 2014. The boundaries must be based on county borders and must be consistent with medicaid procurement regions.

(3) The authority shall develop a process for designating an entity as an accountable collaborative for health. An entity seeking designation is eligible if:

(a) It is a nonprofit or public-private partnership;

(b) Its membership is broad and incorporates key stakeholders, such as the long-term care system, the health care delivery system, behavioral health, social supports and services, primary care and specialty providers, hospitals, consumers, small and large employers, health plans, and public health, with no single entity or organizational cohort serving in a majority capacity; and

(c) It demonstrates an ongoing capacity to:

(i) Lead health improvement activities within the region with other local systems to improve health outcomes and the overall health of the community, improve health care quality, and lower costs;

(ii) Distribute tools and resources from the health extension program created in section 6 of this act; and

(iii) Act in alignment with statewide health care initiatives by using the statewide all-payer health care claims database created in section 9 of this act, the statewide health performance and quality measures developed pursuant to section 13 of this act, and outcome measures reflecting local health needs as identified by the accountable collaborative for health.

(4) The authority may designate more than one accountable collaborative for health in any region that consists of more than one county, but an accountable collaborative for health may not cross the regional boundaries defined by the authority or overlap with another accountable collaborative for health.

(5) An entity designated by the authority as an accountable collaborative for health must convene key stakeholders to:

(a) Review existing data, including data collected through the community health assessment process;

(b) Evaluate the region's progress toward the objectives of the

national healthy people 2020 initiative and the priorities identified in community health assessments and community health improvement plans;

(c) Assess the region's capacity to address chronic care needs, including the needs of persons with co-occurring disorders;

(d) Review available funding and resources; and

(e) Identify and prioritize or reaffirm regional health care needs and prevention strategies and develop a plan or use an existing plan to address those needs.

(6) For purposes of this section and section 4 of this act, the authority may only adopt rules that are necessary to implement this section and section 4 of this act.

NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The authority shall, subject to the availability of amounts appropriated or grants received for this specific purpose, award grants to support the development of accountable collaboratives for health. Grants may only be used for start-up costs.

(2) An entity may be eligible for a grant under this section if it has been designated as an accountable collaborative for health under section 3 of this act. A grant application must, at a minimum:

(a) Identify the geographic region served by the applicant;

(b) Demonstrate how the applicant's structure and operation reflect the interests of and are accountable to the region and the state for health improvement; and

(c) Indicate the size of the grant being requested and describe how the money will be spent.

(3) In awarding grants under this section, the authority shall consider the extent to which the applicant will:

(a) Further the purposes of state health care purchasing as described in sections 1 and 17 of this act;

(b) Base decisions on public input and an active collaboration among key community partners, including, but not limited to, local governments, housing providers, school districts, early learning regional coalitions, large and small businesses, labor organizations, health and human service organizations, tribal governments, health carriers, providers, hospitals, public health agencies, and consumers;

(c) Match the grant funding with funds from other sources; and

(d) Demonstrate capability for sustainability without reliance on state general fund appropriations.

(4) The authority may prioritize applications that commit to providing at least one dollar in matching funds for each grant dollar awarded.

(5) Before grant funds are disbursed, the authority and the applicant must agree on performance requirements and the consequences for failing to meet those requirements. The performance requirements must be aligned with the purposes of state health care purchasing as described in sections 1 and 17 of this act.

NEW SECTION. **Sec. 5.** A new section is added to chapter 41.05 RCW to read as follows:

Any entity designated as an accountable collaborative for health pursuant to section 3 of this act shall submit a report to the appropriate committees of the legislature and the authority beginning December 1, 2015, and December 1st of each year through December 1, 2019. The report must:

(1) Describe the regional health care needs identified by the entity and key stakeholders to date, the plan developed to address those needs, any actions taken by the entity and other stakeholders pursuant to the plan, and any measurable progress toward meeting those needs;

(2) Identify any grant funds received by the entity pursuant to section 4 of this act; and

(3) For the final report, demonstrate the entity's capability for sustainability without reliance on state general fund appropriations.

NEW SECTION. **Sec. 6.** A new section is added to chapter 43.70 RCW to read as follows:

(1) Subject to the availability of amounts appropriated for this specific purpose, the department shall establish a health extension program to provide training, tools, and technical assistance to primary care, behavioral health, and other providers. The program must emphasize high quality preventive, chronic disease, and behavioral health care that is comprehensive and evidence-based. If the department contracts for services under this section, it may only

contract with an organization that has demonstrated the ability to provide educational services to providers, clinics, and hospitals on the topics listed in subsection (2) of this section.

(2) The health extension program must coordinate dissemination of evidence-based tools and resources that promote:

(a) Integration of physical and behavioral health;

(b) Clinical information systems with sharing and organization of patient data;

(c) Clinical decision support to promote evidence-based care;

(d) Reports of the Robert Bree collaborative created by RCW 70.250.050 and findings of health technology assessments under RCW 70.14.080 through 70.14.130;

(e) Methods of formal assessment;

(f) Support for patients managing their own conditions;

(g) Identification and use of resources that are available in the community for patients and their families, including community health workers; and

(h) Practice transformation, including, but not limited to, team-based care, shared decision making, use of population level health data and management, and quality improvement linked to common statewide performance measures.

(3) The department may adopt rules necessary to implement this section, but may not adopt rules, policies, or procedures beyond the scope of authority granted in this section.

NEW SECTION. **Sec. 7.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Authority" means the health care authority.

(2) "Carrier" and "health carrier" have the same meaning as in RCW 48.43.005.

(3) "Claims data" means the data required by section 10 of this act to be submitted to the database, as defined by the director in rule. "Claims data" includes, but is not limited to:

(a) Claims data for fully insured plans; and

(b) Claims data related to health care coverage and services funded, in whole or in part, in the omnibus appropriations act, including coverage and services funded by appropriated and nonappropriated state and federal moneys.

(4) "Data supplier" means a health carrier or an employer that provides health insurance to its employees. It does not include any entity, other than a state or local governmental entity, that is self-insured.

(5) "Database" means the statewide all-payer health care claims database established in section 9 of this act.

(6) "Director" means the director of financial management.

(7) "Lead organization" means the organization selected under section 9 of this act.

(8) "Office" means the office of financial management.

NEW SECTION. **Sec. 8.** The legislature finds that:

(1) The activities authorized by this chapter will require collaboration among state agencies and local governments that purchase health care, private health carriers, third-party purchasers, health care providers, and hospitals. These activities will identify strategies to increase the quality and effectiveness of health care delivered in Washington state and are therefore in the best interest of the public.

(2) The benefits of collaboration, together with active state supervision, outweigh potential adverse impacts. Therefore, the legislature intends to exempt from state antitrust laws, and provide immunity through the state action doctrine from federal antitrust laws, activities that are undertaken, reviewed, and approved by the office pursuant to this chapter that might otherwise be constrained by such laws. The legislature does not intend and does not authorize any person or entity to engage in activities not provided for by this chapter, and the legislature neither exempts nor provides immunity for such activities including, but not limited to, agreements among competing providers or carriers to set prices or specific levels of reimbursement for health care services.

NEW SECTION. **Sec. 9.** (1) The office shall establish a statewide all-payer health care claims database to support transparent public reporting of health care information. The database must improve transparency to: Assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to improve by benchmarking their performance against that

of others by focusing on best practices; enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost.

(2) The director shall select a lead organization to coordinate and manage the database. The lead organization is responsible for internal governance, management, funding, and operations of the database. At the direction of the office, the lead organization shall:

(a) Collect claims data from data suppliers as provided in section 10 of this act;

(b) Design data collection mechanisms with consideration for the time and cost involved in collection and the benefits that measurement would achieve;

(c) Ensure protection of collected data and store and use any data with patient-specific information in a manner that protects patient privacy;

(d) Consistent with the requirements of this chapter, make information from the database available as a resource for public and private entities, including carriers, employers, providers, hospitals, and purchasers of health care;

(e) Report performance on cost and quality pursuant to section 14 of this act using, but not limited to, the performance measures developed under section 13 of this act;

(f) Develop protocols and policies to ensure the quality of data releases;

(g) Develop a plan for the financial sustainability of the database and charge fees not to exceed five thousand dollars for reports and data files as needed to fund the database. Any fees must be approved by the office and must be comparable across data requesters and users; and

(h) Convene advisory committees with the approval and participation of the office, including: (i) A committee on data policy development; and (ii) a committee to establish a data release process consistent with the requirements of this chapter and to provide advice regarding formal data release requests. The advisory committees must include representation from key provider, hospital, payer, public health, health maintenance organization, purchaser, and consumer organizations.

NEW SECTION. **Sec. 10.** (1) Data suppliers must submit claims data to the database within the time frames established by the director in rule and in accordance with procedures established by the lead organization.

(2) An entity that is not a data supplier but that chooses to participate in the database shall require any third-party administrator utilized by the entity's plan to release, at no additional cost, any claims data related to persons receiving health coverage from the plan.

(3) Each data supplier shall submit an annual status report to the office regarding its compliance with this section. The report to the legislature required by section 2 of this act must include a summary of these status reports.

NEW SECTION. **Sec. 11.** (1) The claims data provided to the database, the database itself, including the data compilation, and any raw data received from the database are not public records and are exempt from public disclosure under chapter 42.56 RCW.

(2) Claims data obtained in the course of activities undertaken pursuant to or supported under this chapter are not subject to subpoena or similar compulsory process in any civil or criminal, judicial, or administrative proceeding, nor may any individual or organization with lawful access to data under this chapter be compelled to testify with regard to such data, except that data pertaining to a party in litigation may be subject to subpoena or similar compulsory process in an action brought by or on behalf of such individual to enforce any liability arising under this chapter.

NEW SECTION. **Sec. 12.** (1) Except as otherwise required by law, claims or other data from the database shall only be available for retrieval in original or processed form to public and private requesters pursuant to this section and shall be made available within a reasonable time after the request.

(2) Except as otherwise required by law, the office shall direct the lead organization to maintain the confidentiality of claims or other data it collects for the database that include direct and indirect patient identifiers. Any agency, researcher, or other person that receives claims or other data under this section containing direct or indirect patient identifiers must also maintain confidentiality and

may not release such claims or other data except as consistent with this section. The office shall oversee the lead organization's release of data as follows:

(a) Claims or other data that include direct or indirect patient identifiers, as specifically defined in rule, may be released to:

(i) Federal, state, and local government agencies upon receipt of a signed data use agreement with the office and the lead organization; and

(ii) Researchers with approval of an institutional review board upon receipt of a signed confidentiality agreement with the office and the lead organization.

(b) Claims or other data that do not contain direct patient identifiers but that may contain indirect patient identifiers may be released to agencies, researchers, and other persons upon receipt of a signed data use agreement with the lead organization.

(c) Claims or other data that do not contain direct or indirect patient identifiers may be released upon request.

(3) Recipients of claims or other data under subsection (2)(a) or (b) of this section must agree in a data use agreement or a confidentiality agreement to, at a minimum:

(a) Take steps to protect direct and indirect patient identifying information as described in the agreement; and

(b) Not redisclose the data except as authorized in the agreement consistent with the purpose of the agreement or as otherwise required by law.

(4) Recipients of the claims or other data under subsection (2)(b) of this section must not attempt to determine the identity of persons whose information is included in the data set or use the claims or other data in any manner that identifies the individuals or their families.

(5) For purposes of this section, the following definitions apply unless the context clearly requires otherwise.

(a) "Direct patient identifier" means information that identifies a patient.

(b) "Indirect patient identifier" means information that may identify a patient when combined with other information.

NEW SECTION. **Sec. 13.** (1) There is created a performance measures committee, the purpose of which is to identify and recommend standard statewide measures of health performance to inform public and private health care purchasers and set benchmarks to track costs and improvements in health outcomes. The committee shall coordinate its activities and recommendations with the lead organization selected under section 9 of this act.

(2) Members of the committee must include representation from state agencies, small and large employers, health plans, patient groups, consumers, academic experts on health care measurement, hospitals, physicians, and other providers. The governor shall appoint the members of the committee, except that a statewide association representing hospitals may appoint a member representing hospitals and a statewide association representing physicians may appoint a member representing physicians. The governor shall ensure that members represent diverse geographic locations and both rural and urban communities. The chief executive officer of the lead organization must also serve on the committee. The committee must be chaired by the director of the authority.

(3) The committee shall develop a transparent process for selecting performance measures, and the process must include opportunities for public comment.

(4) By January 1, 2015, the committee shall submit the performance measures to the authority. The measures must include dimensions of:

(a) Prevention and screening;

(b) Effective management of chronic conditions;

(c) Key health outcomes;

(d) Care coordination and patient safety; and

(e) Use of the lowest cost, highest quality care for acute conditions.

(5) The committee shall develop a measure set that:

(a) Is of manageable size;

(b) Is based on readily available claims and clinical data;

(c) Gives preference to nationally reported measures and, where nationally reported measures may not be appropriate, measures used by the health benefit exchange and state agencies that purchase health care;

(d) Focuses on the overall performance of the system, including outcomes and total cost;

(e) Is aligned with the governor's performance management system measures and common measure requirements specific to medicaid delivery systems under RCW 70.320.020 and 43.20A.895;

(f) Considers the needs of different stakeholders and the populations served; and

(g) Is usable by multiple payers, providers, hospitals, purchasers, public health, and communities as part of health improvement, care improvement, provider payment systems, benefit design, and administrative simplification for providers and hospitals.

(6) State agencies shall use the measure set developed under this section to inform purchasing decisions and set benchmarks.

(7) The committee shall establish a public process to periodically evaluate the measure set and make additions or changes to the measure set as needed.

NEW SECTION. **Sec. 14.** (1) Under the supervision of the office, the lead organization shall prepare health care data reports using the database and the statewide health performance and quality measure set, including only those measures that can be completed with readily available claims data. Prior to releasing any health care data reports that use claims data, the lead organization must submit the reports to the office for review and approval.

(2)(a) Health care data reports prepared by the lead organization that use claims data must assist the legislature and the public with awareness and promotion of transparency in the health care market by reporting on:

(i) Whether providers and health systems deliver efficient, high quality care; and

(ii) Geographic and other variations in medical care and costs as demonstrated by data available to the lead organization.

(b) Measures in the health care data reports should be stratified by demography, income, language, health status, and geography when feasible with available data to identify disparities in care and successful efforts to reduce disparities.

(c) Comparisons of costs among providers and health care systems must account for differences in acuity of patients, as appropriate and

feasible, and must take into consideration the cost impact of subsidization for uninsured and governmental patients, as well as teaching expenses, when feasible with available data.

(3) The lead organization may not publish any data or health care data reports that:

(a) Directly or indirectly identify patients; or

(b) Disclose specific terms of contracts, discounts, or fixed reimbursement arrangements or other specific reimbursement arrangements between an individual provider and a specific payer.

(4) The lead organization may not release a report that compares and identifies providers, hospitals, or data suppliers unless it:

(a) Allows the data supplier, the hospital, or the provider to verify the accuracy of the information submitted to the lead organization and submit to the lead organization any corrections of errors with supporting evidence and comments within forty-five days of receipt of the report; and

(b) Corrects data found to be in error within a reasonable amount of time.

(5) The office and the lead organization may use claims data to identify and make available information on payers, providers, and facilities, but may not use claims data to recommend or incentivize direct contracting between providers and employers.

(6) The lead organization shall ensure that no individual data supplier comprises more than twenty-five percent of the claims data used in any report or other analysis generated from the database. For purposes of this subsection, a "data supplier" means a carrier and any self-insured employer that uses the carrier's provider contracts.

NEW SECTION. **Sec. 15.** (1) The director shall adopt any rules necessary to implement this chapter, including:

(a) Definitions of claim and data files that data suppliers must submit to the database, including: Files for covered medical services, pharmacy claims, and dental claims; member eligibility and enrollment data; and provider data with necessary identifiers;

(b) Deadlines for submission of claim files;

(c) Penalties for failure to submit claim files as required;

(d) Procedures for ensuring that all data received from data

suppliers are securely collected and stored in compliance with state and federal law; and

(e) Procedures for ensuring compliance with state and federal privacy laws.

(2) The director may not adopt rules, policies, or procedures beyond the authority granted in this chapter.

NEW SECTION. **Sec. 16.** A new section is added to chapter 48.02 RCW to read as follows:

(1) The commissioner may not use data acquired from the statewide all-payer health care claims database created in section 9 of this act for purposes of reviewing rates pursuant to this title.

(2) The commissioner's authority to access data from any other source for rate review pursuant to this title is not otherwise curtailed, even if that data may have been separately submitted to the statewide all-payer health care claims database.

NEW SECTION. **Sec. 17.** A new section is added to chapter 74.09 RCW to read as follows:

(1) Consistent with the implementation of the state health care innovation plan and the provisions of RCW 70.320.020, the authority and the department shall restructure medicaid procurement of health care services and agreements with managed care systems on a phased basis to better support integrated physical health, mental health, and chemical dependency treatment. By January 1, 2019, medicaid services provided under this chapter and chapters 71.24, 71.36, and 70.96A RCW must be fully integrated in a managed health care system that provides mental health, chemical dependency, and medical care services to medicaid clients. The authority and the department shall develop and utilize innovative mechanisms to promote and sustain integrated clinical models of physical and behavioral health care such as: Practice transformation support and resources; workforce capacity and flexibility; shared clinical information sharing, tools, resources, and training; and outcome-based payments to providers and hospitals.

(2) The authority and the department shall incorporate the following principles into future medicaid procurement efforts aimed at integrating the delivery of physical and behavioral health services:

(a) Facilitating equitable access to effective behavioral health services for adults and children is a state priority;

(b) Recognition that the delivery of better integrated, person-centered care to meet enrollees' physical and behavioral health care needs is a shared responsibility of contracted regional support networks, managed health care systems, service providers, hospitals, the state, and communities;

(c) Medicaid purchasing must support delivery of integrated, person-centered care that addresses the spectrum of individuals' health needs in the context of the communities in which they live and with the availability of care continuity as their health needs change;

(d) Accountability for the client outcomes established in RCW 43.20A.895 and 71.36.025 and performance measures linked to those outcomes;

(e) Medicaid benefit design must recognize that adequate preventive care, crisis intervention, and support services promote a recovery-focused approach;

(f) Evidence-based care interventions and continuous quality improvement must be enforced through contract specifications and performance measures, including the statewide measure set under section 13 of this act, that provide meaningful integration at the patient care level with broadly distributed accountability for results;

(g) Active purchasing and oversight of medicaid managed care contracts is a state responsibility;

(h) A deliberate and flexible system change plan with identified benchmarks and periodic readiness reviews will promote system stability, provide continuity of treatment for patients, and protect essential existing behavioral health system infrastructure and capacity; and

(i) Community and organizational readiness are key determinants of implementation timing; a phased approach is therefore desirable.

(3) The principles identified in subsection (2) of this section are not intended to create an individual entitlement to services.

Sec. 18. RCW 42.56.360 and 2013 c 19 s 47 are each amended to read as follows:

(1) The following health care information is exempt from disclosure under this chapter:

(a) Information obtained by the pharmacy quality assurance commission as provided in RCW 69.45.090;

(b) Information obtained by the pharmacy quality assurance commission or the department of health and its representatives as provided in RCW 69.41.044, 69.41.280, and 18.64.420;

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, a notification of an incident under RCW 70.56.040(5), and reports regarding adverse events under RCW 70.56.020(2)(b), regardless of which agency is in possession of the information and documents;

(d)(i) Proprietary financial and commercial information that the submitting entity, with review by the department of health, specifically identifies at the time it is submitted and that is provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

(ii) If a request for such information is received, the submitting entity must be notified of the request. Within ten business days of receipt of the notice, the submitting entity shall provide a written statement of the continuing need for confidentiality, which shall be provided to the requester. Upon receipt of such notice, the department of health shall continue to treat information designated under this subsection (1)(d) as exempt from disclosure;

(iii) If the requester initiates an action to compel disclosure under this chapter, the submitting entity must be joined as a party to demonstrate the continuing need for confidentiality;

(e) Records of the entity obtained in an action under RCW 18.71.300 through 18.71.340;

(f) Complaints filed under chapter 18.130 RCW after July 27, 1997, to the extent provided in RCW 18.130.095(1);

(g) Information obtained by the department of health under chapter 70.225 RCW;

(h) Information collected by the department of health under chapter 70.245 RCW except as provided in RCW 70.245.150;

(i) Cardiac and stroke system performance data submitted to national, state, or local data collection systems under RCW 70.168.150(2)(b); ((~~and~~))

(j) All documents, including completed forms, received pursuant to a wellness program under RCW 41.04.362, but not statistical reports that do not identify an individual; and

(k) Data and information exempt from disclosure under section 11 of this act.

(2) Chapter 70.02 RCW applies to public inspection and copying of health care information of patients.

(3)(a) Documents related to infant mortality reviews conducted pursuant to RCW 70.05.170 are exempt from disclosure as provided for in RCW 70.05.170(3).

(b)(i) If an agency provides copies of public records to another agency that are exempt from public disclosure under this subsection (3), those records remain exempt to the same extent the records were exempt in the possession of the originating entity.

(ii) For notice purposes only, agencies providing exempt records under this subsection (3) to other agencies may mark any exempt records as "exempt" so that the receiving agency is aware of the exemption, however whether or not a record is marked exempt does not affect whether the record is actually exempt from disclosure.

Sec. 19. RCW 70.02.045 and 2000 c 5 s 2 are each amended to read as follows:

Third-party payors shall not release health care information disclosed under this chapter, except as required by chapter 43.--- RCW (the new chapter created in section 21 of this act) and to the extent that health care providers are authorized to do so under RCW 70.02.050.

NEW SECTION. **Sec. 20.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 21.** Sections 7 through 15 of this act constitute a new chapter in Title 43 RCW.

NEW SECTION. **Sec. 22.** Sections 3 through 5 of this act expire July 1, 2020."

Correct the title.

EFFECT: (1) Deletes the limit of one grant per region. Requires the Health Care Authority (HCA) to consider the extent to which the grant applicant will further the purposes of state health care purchasing of Medicaid and the intent section of the bill (instead of the State Health Care Innovation Plan). Requires grant applicants to collaborate with housing providers in addition to other stakeholders. Subjects the requirement to award grants to availability of amounts appropriated or grants received. Requires an accountable collaborative for health to submit an annual report to the Legislature and the HCA (instead of the Governor).

(2) Modifies the exemption and immunity from antitrust laws to state that the Legislature does not authorize a person to engage in activities that are not provided for in the bill and does not exempt or provide immunity for such activities, including agreements to set prices.

(3) Deletes language providing that claims data are strictly confidential and that any use, release, or publication must be done so that no person is directly or indirectly identifiable. Requires the Office of Financial Management (OFM) to direct the lead organization to maintain the confidentiality of the data it collects for the database that include direct or indirect patient identifiers. Requires any agency, researcher, or other person who receives data with patient identifiers to also maintain confidentiality and not release the information except as consistent with the requirements of the bill.

(a) Permits release of data with direct or indirect patient identifiers, as specifically defined in rule, to: (i) Federal, state, and local government agencies upon receipt of a signed data use agreement; and (ii) researchers with approval of an institutional review board upon receipt of a signed confidentiality agreement. Permits release of data with indirect patient identifiers to an agency, researcher, and other person upon receipt of a signed data use agreement. Permits release of data that do not contain direct or indirect patient identifiers upon request. Defines "direct patient identifier" and "indirect patient identifier."

(b) Requires recipients of data with patient identifiers to agree in a data use agreement and confidentiality agreement to, at a minimum, take steps to protect patient identifying information and not redisclose the data except as authorized in the agreement or as otherwise required by law. Prohibits recipients of data from attempting to determine patients' identity or using the data in a manner that identifies the individuals or their families.

(c) Requires data to be made available within a reasonable time after request.

(4) Requires the performance measures committee to identify (instead of develop) standard statewide measures of health performance

to inform public and private health care purchasers (instead of state purchasing of health care). Requires the committee to coordinate its activities and recommendations with the lead organization. Requires the director of the HCA to chair the committee and the committee to submit the measures to the HCA (instead of the OFM and the lead organization). Requires the committee (instead of the lead organization) to develop the measure set and make additions or changes as needed. Requires the measure set to give preference to measures used by the Health Benefit Exchange and state agencies only where nationally reported measures may not be appropriate. Deletes the provision terminating the committee on January 31, 2015.

(5) Deletes the requirement that the lead organization report on providers' rate and price increases that exceed the Consumer Price Index - Medical Care. Prohibits the lead organization from publishing a report that identifies a hospital (in addition to providers and data suppliers) without providing the hospital 45 days to verify the accuracy of the information and submit any corrections. Deletes the requirement that the lead organization allow a data supplier a reasonable amount of time prior to publication to prepare a response to the lead organization's interpretation.

(6) Permits the lead organization and the OFM to use claims data to make available information on payers, providers, and facilities (instead of allowing them to compare payers, providers, and facilities). Prohibits them from using claims data to recommend or incentivize direct contracting between providers and employers (instead of prohibiting them from recommending that consumers direct business to avoid directing business to particular providers and facilities).

(7) Requires the lead organization to ensure that no single data supplier comprises more than 25 percent of the data used in a report or other analysis generated by the database. Defines data supplier to mean, for this purpose only, the carrier and any self-insured employer that uses that carrier's provider contracts.

(8) Prohibits the Insurance Commissioner from using data acquired from the database for purposes of reviewing rates, and provides that the Insurance Commissioner's authority to access data from any other source for rate review is not otherwise curtailed even if it was separately submitted to the database.

(9) Requires Medicaid services to be fully integrated in a managed health care system that provides mental health, chemical dependency, and medical care services by January 1, 2019.

(10) Modifies language in the intent section.

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