E2SHB 2572 - S COMM AMD
By Committee on Ways & Means

ADOPTED AS AMENDED 03/13/2014

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.

(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 stressing prevention and early detection of disease and integration of behavioral health;

(b) Developing linkages between the health care delivery system and community; and

(c) Supporting regional collaboratives for communities and populations, improve health care quality, and lower costs.

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) Prior to the authority submitting a grant application for innovation plan funding, the authority must consult a neutral actuarial firm not currently contracted with the agency to review the estimated savings with the innovation plan prior to application submission. The plan and the actuarial information must be presented to the joint select committee on health care oversight, including the scope and details of the grant application and any request for proposal, prior to an application submission. The joint committee must review the application in a timely fashion that enables the grant application, if approved, to be submitted within the required time frame.

(3) The grant application cannot commit the state to any financial

obligations beyond the actual grant award amount.

(4) All required federal reporting related to a grant award must be shared with the joint committee at the same time it is submitted to the federal government.

(5) 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.** (1) The joint select committee on health care oversight is established in statute, continuing the committee created in Engrossed Substitute Senate Concurrent Resolution No. 8401 passed in 2013.

(2) The membership of the joint select committee on health care oversight must consist of the following: (a) The chairs of the health care committees of the senate and the house of representatives, who must serve as cochairs; (b) four additional members of the senate, two each appointed by the leadership of the two largest political parties in the senate; and (c) four additional members of the house of representatives, two each appointed by the leadership of the two largest political parties in the house of representatives. The governor must be invited to appoint, as a liaison to the joint select committee, a person who must be a nonvoting member.

(3) The joint select committee on health care oversight must provide oversight between the health care authority, health benefit exchange, the office of the insurance commissioner, the department of health, and the department of social and health services. The goal must be to ensure that these entities are not duplicating their efforts and are working toward a goal of increased quality of services which will lead to reduced costs to the health care consumer.

(4) The joint select committee on health care oversight must, as necessary, propose legislation to the health care committees and budget

recommendations to the ways and means committees of the legislature that aids in their coordination of activities and that leads to better quality and cost savings.

(5) The joint select committee on health care oversight expires on December 31, 2022.

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 two pilot projects for a community of health. A community of health is a regionally based, voluntary collaborative. The purpose of the collaborative is to align actions to achieve healthy communities and populations, improve health care quality, and lower costs. Grants may only be used for start-up costs.

(2) The authority shall develop a process for designating an entity as a community of health. An entity seeking designation is eligible if:

(a) It is a nonprofit or public-private partnership, including those led by local public health agencies;

(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; and

(ii) Distribute tools and resources from the health extension program created in section 5 of this act.

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

(a) Base decisions on public input and an active collaboration among key community partners, which can include, but are 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;

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

(c) 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.

NEW SECTION. **Sec. 5.** 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.

(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 decision support to promote evidence-based care;

(c) 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;

(d) Methods of formal assessment;

(e) Support for patients managing their own conditions;

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

(g) Identification of evidence-based models to effectively treat depression and other conditions in primary care settings, such as the program advancing integrated mental health solutions, and others.

(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. 6.** A new section is added to chapter 41.05 RCW to read as follows:

(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 to propose benchmarks to track costs and improvements in health outcomes.

(2) Members of the committee must include representation from state agencies, small and large employers, health plans, patient groups, federally recognized tribes, 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 preventive care and acute and chronic 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 state agencies that purchase health care or commercial health plans;

(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. 7.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The authority and the department may 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, consistent with assumptions in Second Substitute Senate Bill No. 6312, Laws of 2014, and recommendations provided by the behavioral health task force. The authority and the department may develop and utilize innovative mechanisms to promote and sustain integrated clinical models of physical and behavioral health care.

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

(a) 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;

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

(c) Medicaid benefit design must recognize that adequate preventive

care, crisis intervention, and support services promote a recovery-focused approach;

(d) Evidence-based care interventions and continuous quality improvement must be enforced through contract specifications and performance measures that provide meaningful integration at the patient care level with broadly distributed accountability for results;

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

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

(g) 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.

(4) The authority shall increase the use of value based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement, for medicaid and public employee purchasing. The authority shall also implement additional chronic disease management techniques that reduce the subsequent need for hospitalization or readmissions. It is the intent of the legislature that the reforms the authority implements under this subsection are anticipated to reduce extraneous medical costs, across all medical programs, when fully phased in by fiscal year 2017 to generate budget savings identified in the omnibus appropriations act.

NEW SECTION. **Sec. 8.** 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 11 of this act to be submitted to the database, as defined by the director in rule. "Claims data" includes, but is not limited to, 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, for medicaid programs and the public employees benefits board program.

(4) "Database" means the statewide all-payer health care claims database established in section 10 of this act.

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

(6) "Lead organization" means the organization selected under section 10 of this act.

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

NEW SECTION. **Sec. 9.** 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. 10.** (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 11 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 6 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.

(3) The lead organization governance structure and advisory committees must include representation of the third-party administrator

of the uniform medical plan. A payer, health maintenance organization, or third-party administrator must be a data supplier to the all-payer health care claims database to be represented on the lead organization governance structure or advisory committees.

NEW SECTION. **Sec. 11.** (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. 12.** (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. 13.** (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. 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 10 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.

Sec. 17. 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 12 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. 18. 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 22 of this act) and to the extent that health care providers are authorized to do so under RCW 70.02.050.

NEW SECTION. **Sec. 19.** 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. 20.** Section 3 of this act constitutes a new chapter in Title 44 RCW.

NEW SECTION. **Sec. 21.** Section 4 of this act expires July 1, 2020.

NEW SECTION. **Sec. 22.** Sections 8 through 15 of this act constitute a new chapter in Title 43 RCW."

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By Committee on Ways & Means

ADOPTED AS AMENDED 03/13/2014

On page 1, line 5 of the title, after "supports;" strike the remainder of the title and insert "amending RCW 42.56.360 and 70.02.045; adding new sections to chapter 41.05 RCW; adding a new section to chapter 43.70 RCW; adding a new section to chapter 74.09 RCW; adding a new section to chapter 48.02 RCW; adding a new chapter to Title 44 RCW; adding a new chapter to Title 43 RCW; creating new sections; and providing an expiration date."

EFFECT: Modifies intent section.
HCA must have a neutral actuarial firm review the estimated savings in the innovation plan prior to application.
Before the HCA applies for a federal innovation grant, the

application and actuarial review must be presented to the Joint Select Committee on Health Care Oversight for review and approval.

All required federal reporting related to the grant award must be shared with the Joint Committee at the same time it is submitted to the federal government.

The Joint Select Committee on Health Care Oversight is established in statute, and continued to December 31, 2022 (from December 31, 2017, established in Engrossed Substitute Senate Concurrent Resolution No. 8401, in 2013).

Changes the "accountable collaborative for health" to "community of health", removes the establishment of regional boundaries, modifies the community of health grant criteria, and reduces it to two pilot programs.

Modifies the elements the Health Extension Program disseminates to providers, and removes the reference to contract limitations, restores the information on the Bree Collaborative and Health Technology Assessment program, and inserts information on evidence-based models to effectively treat depression and other conditions such as the AIMS program.

Restores and modifies the Performance Measures Committee to recommend statewide measures and benchmarks; adds a representative of the federally recognized tribes.

Modifies the Medicaid purchasing, changing the integration of behavioral health from shall to may, modifies guiding principles and makes them permissive.

Adds reference to HCA purchasing with value based contracting, alternative quality contracting, and other incentives, as well as chronic disease management techniques that reduce hospital admissions, that are assumed in the budget savings. Removes the reference to integration by January 1, 2019, and adds a link to the assumptions in 2SSB 6312 and recommendations of the Behavioral Health Task Force.

Restores the references to the all-payer claims database and related data protections, but modifies the reporting to include the state funded claims in the Medicaid programs and Public Employees' Benefits Board program.

Ensures the third-party administrator for the UMP participates in the governance structure and advisory committees for the all-payer health care claims database; and provides that only organizations that provide data to the database can be represented on the governance or advisory committees.

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