Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2572

Brief Description: Concerning the effectiveness of health care purchasing and transforming the health care delivery system.

Sponsors: Representative Cody; by request of Governor Inslee.

Brief Summary of Bill

- Requires the Office of Financial Management to establish an all-payer health care claims database, and requires health insurance issuers and state-purchased health care to submit paid claims data to the database.
- Requires the Health Care Authority (HCA) to certify "accountable collaboratives for health" and provide for implementation on a phased basis.
- Requires the HCA and the Department of Social and Health Services to restructure Medicaid procurement on a phased basis to support integration of services for physical health, mental health, and substance abuse.
- Requires the HCA to develop standard statewide measures of health performance.
- Directs state-purchased health care to develop common procurement methodologies, best practices, and payer and delivery system organization, and directs state-purchased health care to use the standard health performance and quality measure set.
- Requires the Department of Health to establish a health regional extension program to provide training and tools.

Hearing Date: 1/27/14

Staff: Alexa Silver (786-7190).

Background:

Procurement of State-Purchased Health Care.

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.

The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) purchase medical assistance, mental health services, long-term care case management services, and substance abuse treatment services from several types of entities that coordinate with providers to deliver the services to clients.

- *Medical Assistance*: Medical assistance is available to eligible low-income state residents and their families from the HCA, primarily through the Medicaid program. Coverage is provided through fee-for-service and managed care systems. Managed care is a prepaid, comprehensive system of medical and health care delivery. Healthy Options is the HCA Medicaid managed care program for low-income people in Washington. Healthy Options offers eligible families, children under age 19, low-income adults, certain disabled individuals, and pregnant women a complete medical benefits package.
- *Regional Support Networks*: The DSHS contracts with regional support networks to oversee the delivery of mental health services for adults and children who suffer from mental illness or severe emotional disturbance. The regional support networks contract with local providers to provide an array of mental health services, monitor the activities of local providers, and oversee the distribution of funds under the state managed care plan.
- *County Substance Abuse Programs*: The DSHS contracts with counties to provide outpatient substance abuse treatment services, either directly or by subcontracting with certified providers. The DSHS contracts directly with providers for residential treatment services.

Several other state agencies, including the Department of Labor and Industries and the Department of Corrections, also purchase health care services.

All-Payer Claims Databases.

Several states have established all-payer claims databases to collect claims information from public and private payers. Payers may include health carriers, third-party administrators, pharmacy benefit managers, Medicaid agencies, and public employee health benefit programs. Generally, the databases collect medical, pharmacy, and dental claims data, as well as information about eligibility, benefit design, and providers. In Washington, the Washington Health Alliance maintains a voluntary all-payer claims database.

In September 2013 the Office of Financial Management received a federal grant to expand collection and analysis of medical claims data from multiple payers, complete an information technology infrastructure assessment, develop web-enabled analytic capabilities to provide access to health pricing data, and develop a state website that integrates price and quality information.

State Health Care Innovation Plan.

The Affordable Care Act established the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services to test innovative payment and service delivery models without reducing the quality of care. As part of the State Innovation Models Initiative, Washington received approximately $1 million from the CMMI to continue work on the State Health Care Innovation Plan (Innovation Plan). The Innovation Plan includes three strategies:

- Encourage value-based purchasing, beginning with state-purchased health care.
- Build healthy communities through prevention and early mitigation of disease.
- Improve chronic illness care through better integration of care and social supports, in particular for people with both physical and behavioral health issues.

Summary of Bill:

State Health Care Innovation Plan.

The Health Care Authority (HCA) is responsible for coordinating, implementing, and administering interagency efforts and local collaborations to implement the State Health Care Innovation Plan (Innovation Plan). By January 1, 2015, and each January 1 through 2019, the HCA must coordinate and issue a report to the Legislature summarizing progress and actions to implement the Innovation Plan, as well as any recommendations for legislation. Other agencies must submit status reports to the HCA for inclusion in the report to the Legislature.

All-Payer Health Care Claims Database.

The Office of Financial Management (OFM) must establish an all-payer health care claims database. The database must support transparent public reporting of health care information to facilitate a comprehensive view of variation in cost and quality, advanced web-enabled analytic capabilities, and integrated cost, quality, and outcome information.

Lead Organization: The OFM Director selects a lead organization to coordinate and manage the database, and the lead organization is responsible for collecting claims data and reporting performance on cost and quality. The lead organization must: be responsible for internal governance, management, funding, and operations; appoint advisory committees; ensure protection of collected data; develop a plan for financial sustainability; and charge reasonable fees for reports and data files as needed.

The OFM Director may appoint an interagency steering committee to provide oversight, direction, and assistance.

To the extent fees are levied, the fees must be comparable across data requesters and users.

Submissions to Database: Health insurance issuers and state-purchased health care must submit claims data to the database in compliance with a timeline and criteria established by the OFM. In addition, paid claims data related to health care coverage and services funded in the operating budget must be included in the database. The Office of the Insurance Commissioner may adopt rules and impose penalties for noncompliance by health insurance issuers.

Local governments and private employers are encouraged to actively support inclusion of their employee claims data in the database. Claims data related to health care coverage and services funded through self-insured employers or trusts are exempt, but to the extent they wish to participate, their third-party administrators must provide claims data.

Administration: The OFM may adopt policies, procedures, standards, timelines, and rules as necessary to implement and enforce requirements related to the database, including: a definition

of claims data submission and data files for all covered medical services; pharmacy claims and dental claims; member eligibility and enrollment data; and provider data with necessary identifiers. In choosing data collection mechanisms, the OFM must consider the time and cost involved and the benefits of measurement. The database must comply with state and federal privacy requirements, and data must be securely collected, compiled, and stored in compliance with law. The database is exempt from public disclosure, and federally protected confidential information is exempt from the Public Records Act.

Accountable Collaboratives for Health.

An "accountable collaborative for health" (ACH) is a regional organization responsible for aligning community actions to achieve healthy communities, improve health care quality, and lower costs. By September 1, 2014, after consulting with counties and other interested entities, the HCA must establish regional boundaries for up to nine ACHs, consistent with Medicaid procurement. Boundaries must be based on county borders, with population sufficient to support risk-based contracting for Medicaid services.

The HCA must develop certification criteria for establishing ACHs and must provide a phased implementation. A non-profit or quasi-governmental entity may seek certification. To qualify as an ACH, the entity must demonstrate an ongoing capacity to convene key stakeholders; lead health improvement activities within the region with other local systems; develop partnerships with state and local jurisdictions; act as regional host for the health regional extension program; act in alignment with statewide health care initiatives, including the all-payer health care claims database and statewide health performance and quality measures; and incorporate specific collective impact principles.

The purpose of the community health care collaborative grant program is modified to support ACHs. In awarding grants, the HCA must consider whether the entity will provide matching funds, whether the entity will base decisions on public input and collaboration, and whether the entity will be able to further the purposes of the Innovation Plan. The HCA may award one grant per region.

Medicaid Procurement.

The HCA and the DSHS must 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 substance use treatment. The HCA and the DSHS must facilitate and use ACHs and primary health regional extension services infrastructure to support integration and transformation to a provider payment system based on cost, quality, and effectiveness. The agencies must incorporate specified principles into their Medicaid procurement efforts, including:

- Equitable access to effective behavioral health services for adults and children is an essential state priority.
- Medicaid purchasing must support delivery of better integrated care.
- People with complex behavioral health conditions often do not receive comparable access to and quality of physical health care, leading to increased morbidity and mortality.

Standard Statewide Measures of Health Performance.

The HCA must develop standard statewide measures of health performance. In addition, the HCA must select a lead organization to develop, by January 1, 2015, an initial measure set that includes prevention, effective management of chronic disease, and the use of lowest-cost, highest-quality care for acute conditions. The lead organization's measure set must:

- be of a manageable size;
- give preference to nationally endorsed measures;
- be based on readily available claims and clinical data;
- focus on overall performance of the system;
- be aligned with the Governor's performance management system measures and common measure requirements specific to Medicaid delivery systems;
- be used by the Health Benefit Exchange and state-purchased health care;
- consider needs of different stakeholders and populations; and
- be usable by multiple payers, providers, purchasers, and communities.

The lead organization must use the measure set and the all-payer health care claims database to provide health care data reports with transparent access to reliable and comparable information about variation in quality and price. When possible, measures should be stratified to identify disparities and efforts to reduce disparities. Analyses must be conducted and shared to:

- identify and recognize providers and systems that deliver efficient, high-quality care and enable purchasers and consumers to direct business to these systems; and
- identify unnecessary variation in care and other opportunities to improve quality and reduce cost.

State-Purchased Health Care.

State-purchased health care, in coordination with other private and public purchasers, must develop common and aligned procurement methodologies, best practices, common payer and delivery system organization expectations, and aligned utilization of the statewide health performance and quality measures set. State-purchased health care initiatives and purchasing strategies must be consistent with the provisions in the bill.

Health Regional Extension Program.

The Department of Health (DOH), subject to available funds, must establish the health regional extension program to provide training and technical assistance to health care providers. The DOH must establish a program hub with agencies that conduct state-purchased health care and other appropriate entities. The program hub coordinates training, technical assistance, and distribution of tools and resources through local regional extensions that promote certain elements, including physical and behavioral health integration and practice transformation.

The DOH must continue to collaborate with the HCA to promote the adoption of primary care health homes.

Rule-Making Authority.

The HCA may adopt policies, procedures, standards, and rules as necessary to implement and enforce the provisions of the bill related to Medicaid procurement, state-purchased health care, and the standard statewide measures of health performance.

Appropriation: None.

Fiscal Note: Requested on January 21, 2014.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.