HOUSE BILL REPORT
HB 2572

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to improving the effectiveness of health care purchasing and transforming the health care delivery system by advancing value-based purchasing, promoting community health, and providing greater integration of chronic illness care and needed social supports.

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 History:
Committee Activity:
Health Care & Wellness: 1/27/14, 2/3/14, 2/5/14 [DPS].

Brief Summary of Substitute Bill

- Requires the Health Care Authority (HCA) to create a process to designate nonprofit or public-private partnerships as "accountable collaboratives for health."
- Requires the Department of Health to establish a health extension program to disseminate tools, training, and resources to providers.
- Establishes a statewide all-payer claims database and requires health carriers and state agencies to submit claims data to the database. Directs a lead organization to prepare reports based on the data.
- Directs a stakeholder committee to develop and recommend statewide measures of health performance to inform purchasing and set benchmarks.
- Requires the HCA and the Department of Social and Health Services to restructure Medicaid procurement of health care services and agreements with managed care systems to better support integration of physical health, mental health, and substance use treatment.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

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.

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Cody, Chair; Riccelli, Vice Chair; Clibborn, Green, Jinkins, Moeller, Morrell, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 8 members: Representatives Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; DeBolt, G. Hunt, Manweller, Rodne, Ross and Short.

Staff: Alexa Silver (786-7190).

Background:

Procurement of State-Purchased Health Care.

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 chemical dependency 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 Chemical Dependency Programs*. The DSHS contracts with counties to provide outpatient chemical dependency 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; and
- 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 Substitute 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 actions taken to implement the Innovation Plan, progress toward achieving the aims of the Innovation Plan, anticipated future implementation efforts, and any recommendations for legislation.

Accountable Collaboratives for Health.

An "accountable collaborative for health" (ACH) is a regionally based collaborative designated by the HCA, the purpose of which is to align actions and initiatives of a diverse coalition of members to achieve healthy communities, improve health care quality, and lower costs. By September 1, 2014, the HCA must establish boundaries for up to nine regions for ACHs. Counties must be given the opportunity to propose the boundaries, but if the counties do not submit recommendations by July 1, 2014, the Task Force on the Adult Behavioral Health System must submit proposed boundaries by August 1, 2014. Boundaries must be based on county borders and must be consistent with Medicaid procurement regions.

The HCA must develop a process for designating an entity as an ACH. An entity is eligible to be designated if it is a nonprofit or public-private partnership, incorporates broad membership, and demonstrates an ongoing capacity to, among other things, lead health improvement activities within the region with other local systems and act in alignment with

statewide health care initiatives. The HCA may designate more than one ACH in a region, but ACHs may not overlap or cross regional boundaries.

An entity designated as an ACH must convene stakeholders to:
- review existing data;
- evaluate the region's progress toward certain objectives;
- assess the region's capacity to address chronic care needs;
- review available funding and resources; and
- identify and prioritize regional health care needs, and develop a plan to address those needs.

The HCA may award up to one grant per region to support the development and operation of ACHs. Criteria for awarding grants include whether the entity will provide matching funds, base decisions on public input and collaboration, and further the purposes of the Innovation Plan. The HCA's rulemaking authority with respect to the ACHs extends only to those rules necessary to implement the provisions in the bill related to the ACHs.

Health Extension Program.

The Department of Health (DOH), subject to available funds, must establish a health extension program to provide training, tools, and technical assistance to health care providers. The program must emphasize high quality preventive, chronic disease, and behavioral health care that is comprehensive and evidence-based. The program must coordinate dissemination of resources that promote, among other things, integration of physical and behavioral health, reports of the Robert Bree collaborative, and practice transformation. The DOH may adopt rules necessary to implement the program, but may not adopt rules, policies, or procedures beyond the identified scope of authority.

Statewide All-Payer Health Care Claims Database and Performance Measures.

The HCA must establish a statewide all-payer health care claims database. The database must support transparent public reporting of health care information to: assist patients, providers, and hospitals to make informed choices about care; enable providers and communities to benchmark their performance; enable purchasers to identify value, build expectations into their purchasing strategies, and reward improvements over time; and promote competition based on quality and cost. The Legislature finds that the benefit of collaboration among purchasers and providers, together with active state supervision, outweighs potential adverse impacts. Therefore, the Legislature intends to exempt and provide immunity from antitrust laws for certain activities, but not for *per se* violations of the antitrust laws.

Lead Organization. The HCA 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;
- design collection mechanisms with consideration for time, cost, and benefits;
- ensure protection of collected data;
- make the database available as a resource;

- develop policies to ensure quality of data releases;
- develop a plan for financial sustainability, with any fees comparable across data requests and users; and
- appoint advisory committees on data policy and the data release process.

Submissions to Database. Health carriers must submit claims data to the database, and any paid claims data related to health care coverage and services funded in the budget must be included in the database. A local government, private employer, self-insured employer, or Taft-Hartley plan may submit claims data to the database. A self-insured employer or Taft-Hartley plan that chooses to participate must require any third-party administrator to release, at no additional cost, any claims data related to persons receiving coverage from the plan. The HCA establishes the time frames and the lead organization establishes the procedures for submission of data. Data suppliers must submit an annual status report to the HCA regarding their compliance, and this information must be included in the report to the Legislature.

Performance Measures. A performance measures committee is established to develop and recommend standard statewide measures of health performance to inform state purchasing and set benchmarks. Members of the committee must represent state agencies, employers, health plans, patient groups, consumers, academic experts, hospitals, physicians, and other providers. Members must represent diverse geographic locations and rural and urban communities. The Governor appoints members to the committee, except that statewide associations representing hospitals and physicians appoint those members. The chief executive officer of the lead organization also serves on the committee.

The committee must develop a transparent process to select performance measures, including an opportunity for public comment. By January 1, 2015, the committee must submit the measures to the HCA and the lead organization. The measures must include dimensions of prevention and screening, effective management of chronic conditions, key health outcomes, care coordination and patient safety, and use of the lowest cost, highest quality care for acute conditions.

The lead organization must develop a measure set based on the committee's recommendations. The measure set must:

- be of a manageable size;
- be based on readily available claims and clinical data;
- give preference to nationally reported measures and measures used by the Health Benefit Exchange and state agencies;
- 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;
- consider needs of different stakeholders and populations; and
- be usable by multiple payers, providers, purchasers, and communities.

State agencies must use the measure set to inform purchasing decisions and set benchmarks. The lead organization must establish a public process to periodically evaluate and make additions or changes to the measure set.

Reports. The lead organization must use the measure set and the database to prepare health care data reports. The HCA reviews the reports, and the lead organization may only release the reports with the HCA's approval. Reports must assist the Legislature and the public by reporting on: providers and systems that deliver efficient, high-quality care; geographic and other variations in care and costs; and rate and price increases by providers that exceed the Consumer Price Index-Medical Care.

Measures in the report should be stratified to identify disparities and efforts to reduce disparities, and comparisons of costs among systems must account for differences in acuity of patients, the cost impact of subsidization, and teaching expenses.

The lead organization may not publish data or reports that directly or indirectly identify patients or disclose specific reimbursement arrangements between a provider and a payer. The HCA and the lead organization may not use the data provided by third-party payers, providers, or facilities to make recommendations with respect to a single provider or facility or a group of providers or facilities. The lead organization may not release a report comparing or identifying providers or data suppliers unless it allows the provider or data supplier to verify the accuracy of the information and submit corrections, corrects errors, and allows a data supplier or provider a reasonable amount of time to prepare a response.

Privacy and Administration. Data provided to the database, the database itself, and raw data received from the database are not public records within the meaning of the Public Records Act. All information received by the lead organization is strictly confidential. Any use, release, or publication must be done so that no person is identifiable. Data obtained through activities related to the database and performance measures are not subject to subpoena in a civil, criminal, judicial, or administrative proceeding, and a person with access to the data may not be compelled to testify.

The HCA may adopt rules as necessary to implement and enforce requirements related to the database and the performance measures, including:

- definitions of claim and data files that data suppliers must submit (including: files for covered medical services, pharmacy claims, and dental claims; member eligibility and enrollment data; and provider data);
- deadlines for submitting claim files and penalties for failure to submit claim files;
- procedures for ensuring data are securely collected and stored in compliance with law; and
- procedures for ensuring compliance with privacy laws.

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 develop and use innovative mechanisms to promote and sustain integrated clinical models of physical and behavioral health care.

The agencies must incorporate specified principles into their Medicaid procurement efforts, including:

- Facilitating equitable access to effective behavioral health services for adults and children is a state priority.
- Delivery of better integrated, person-centered care is a shared responsibility of regional support networks, managed health care systems, service providers, hospitals, the state, and communities.
- Medicaid purchasing must support delivery of integrated care that addresses the spectrum of individuals' health needs in the context of their communities and with the availability of care continuity as their health needs change.

Substitute Bill Compared to Original Bill:

The substitute bill defines accountable collaboratives for health (ACH) and their objectives, requires the Health Care Authority (HCA) to designate (rather than certify) ACHs, and allows counties and the Task Force on the Adult Behavioral Health System to recommend boundaries for the ACH regions to the HCA. It modifies eligibility to be designated as an ACH to include public-private partnerships (rather than quasi-governmental organizations) and to remove certain requirements, including capacity to provide shared leadership and involvement in developing Medicaid procurement criteria. It authorizes grants without replacing an existing grant program.

For the health extension program, the substitute bill expands the list of resources that the program must disseminate and deletes references to program hubs. It creates the extension program without replacing an existing program on training and technical assistance for chronic conditions.

The substitute bill requires the HCA, rather than the Office of Financial Management, to establish the all-payer claims database. It modifies the antitrust safe harbor to include active supervision by the HCA and to require the HCA to review the lead organization's reports prior to publication. It removes the authority to establish an interagency steering committee for the database. It also restructures the requirement to submit data to the database and grants the HCA (rather than the Office of the Insurance Commissioner) authority to adopt penalties for failure to submit data.

The substitute bill modifies the privacy requirements applicable to the database by declaring that all data submitted to the database, the database itself, and any raw data received from the database are not public records and that all information is strictly confidential. It also provides that data are not subject to subpoena and a person with access to the data may not be compelled to testify. The substitute bill imposes various requirements and limitations on reports prepared and released by the lead organization. For example, it prohibits the lead organization from publishing data or reports that disclose specific reimbursement arrangements.

The substitute bill tasks a performance measures committee of stakeholders (rather than the HCA) with developing statewide measures of health performance, specifies what the measures must include, and requires state agencies to use the measures.

With respect to Medicaid procurement, the substitute bill modifies the principles that must be incorporated into procurement efforts and removes the requirement that the HCA and the

Department of Social and Health Services facilitate and use ACHs and a regional extension service infrastructure to support integration of services and transformation of provider payment systems. With respect to state-purchased health care, the substitute bill removes certain requirements, including the requirements that procurement methodologies be aligned and that initiatives and purchasing strategies be aligned with the State Health Care Innovation Plan.

The substitute bill requires the report to the Legislature to include anticipated future implementation efforts. It also makes a variety of structural, clarifying, and technical changes.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available. New fiscal note requested on February 5, 2014.

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

Staff Summary of Public Testimony:

(In support) This bill represents a year-long process of vetting ideas statewide. State-purchased health care must be the first mover, because the way the state pays for health care will improve the quality and cost of health care for residents. Whole-person care is needed for the Medicaid population. This bill requires a phased approach to procurement to deliver integrated physical, mental, and substance use treatment.

Local communities have begun collaborating, knowing that good health occurs when communities come together to address health care and other health essentials, especially for vulnerable populations. There are currently 11 collaboratives in various stages of development. Members include business partnerships, public health districts, and behavioral health organizations, among others. The collaborative approach gets the community engaged in determining metrics and prevents unnecessary hospitalization and incarceration. Many cost, quality, and access problems are a function of people getting lost in the intersections between different organizations. It is vital for successful reform that rural and urban communities work side by side. The ACHs need access to data to make informed decisions.

Transparency is a key driver for improvement. Creating the all-payer claims database is necessary to provide transparent information to patients and employer purchasers with respect to price, quality, and utilization. In recent surveys, Washington was rated an "A" for physician transparency but an "F" for price transparency because of the lack of access to pricing data for medical claims. Vast pricing variation exists across hospital delivery systems. The voluntary approach for pricing data has not worked. The Office of Financial Management has received a grant to increase price transparency, but enabling legislation is necessary. There are concerns about privacy with the database, because data sets about collusion are not addressed. There must be a comprehensive solution for all health plans,

because cost transparency is difficult to tackle as a single health plan. Cost calculators for patients are helpful but do not deal with the real cost of care. One reason cost varies is because quality of care varies. Common state performance measures will ensure consistent health improvement efforts.

(In support with amendments) The all-payer claims database provisions in the bill impact small business. Consumers need better information to make better purchasing decisions, and this bill represents a step forward in that process. It will allow consumers access to real-time or recent data on important cost and quality measures. When trying to decide which clinic, hospital, or other facility to use, the database will help get the best quality coverage for an affordable price. Provider data should be confidential. Physicians want equal access to data and representation on advisory committees. The concepts in the bill must be implemented in a staged approach so changes can be handled at the local level. The extension program looks creatively at options for delivering care on the ground.

(In support with concerns) It is important to work at the local level, and many communities are already doing that. Hospitals are looking for better information on cost and quality of health care. The administrative burden associated with additional data requests should be streamlined. The accountable collaboratives for health should not be involved in Medicaid contracting.

(Opposed) Legislatively mandated all-payer claims databases have not been proven to improve quality or reduce cost, even after significant initial investments. They pose a serious problem for competition. Most carriers are moving toward a value-based payment model. Aggregated data that a consumer might access would not apply to the consumer's plan and benefits. Tools currently offered provide meaningful and personalized cost information to make price and quality shopping decisions across a range of providers and provider types. The database will require providers to make substantial investments in order to submit data.

Persons Testifying: (In support) Dr. Bob Crittenden, Office of the Governor; Dorothy Teeter, Health Care Authority; John Wiesman, Department of Health; Mary McWilliams, Washington Health Alliance; Eric Schinfeld, Seattle Metropolitan Chamber of Commerce; Larry Thompson, Whatcom Alliance; Jesus Hernandez, Community Choice; Sue Dietz, Critical Access Hospital Network; Reese Edwards, United Health; and David Grossman, Group Health.

(In support with amendments) Patrick Connor, National Federation of Independent Business; and Katie Kolan, Washington State Medical Association.

(In support with concerns) Claudia Sanders, Washington State Hospital Association.

(Opposed) Chris Bandoli, Regence Blue Shield; and Len Sorrin, Premera Blue Cross.

Persons Signed In To Testify But Not Testifying: Mary Clogston, American Association of Retired Persons; Len McComb, Community Health Network of Washington; Joe Avalos, Thurston County; Lindsey Grad, Service Employees International Union 1199 NW; Lisa Thatcher, GlaxoSmithKline; and Michael Shaw, King County.