FINAL BILL REPORT
E2SHB 2572

PARTIAL VETO
C 223 L 14
Synopsis as Enacted

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

Sponsors: House Committee on Appropriations (originally sponsored by Representative Cody; by request of Governor Inslee).

House Committee on Health Care & Wellness
House Committee on Appropriations
Senate Committee on Health Care
Senate Committee on Ways & Means

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.

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.

- *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.

Joint Select Committee on Health Care Oversight.

In 2013 the Joint Select Committee on Health Care Oversight (Joint Select Committee) was established by a concurrent resolution. The Joint Select Committee provides oversight between the HCA, the Health Benefit Exchange, the Office of the Insurance Commissioner, the Department of Health, and the DSHS. The goals of the Joint Select Committee are to ensure that these entities do not duplicate efforts and that they work toward a goal of increased quality of services, leading to reduced costs to health care consumers. The Joint Select Committee expires December 31, 2017.

Summary:

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). Prior to submitting an application for Innovation Plan funding, the HCA must consult a neutral actuarial firm not currently contracted with the agency to review the estimated savings and present the actuarial information and the plan to the Joint Select Committee on Health Care Oversight (Joint Select Committee). The Joint Select Committee must review the application in a timely fashion to enable the application, if approved, to be submitted within the required time frame. The grant application may not commit the state to any financial obligations beyond the grant amount. All federally required reporting related to a grant award must be shared with the Joint Select Committee when it is submitted to the federal government.

By January 1, 2015, and each January 1 through 2019, the HCA must coordinate and issue a status 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.

Joint Select Committee on Health Care Oversight.

The Joint Select Committee is established in statute as a continuation of the committee created in 2013. Its membership consists of the chairs of the health care committees of the Senate and the House of Representatives, four additional members of the Senate (two each appointed by the two largest political parties in the Senate), and four additional members of the House of Representatives (two each appointed by the two largest political parties in the House of Representatives). The Governor may appoint a liaison to serve as a non-voting member.

The Joint Select Committee provides oversight between the HCA, the Health Benefit Exchange, the Office of the Insurance Commissioner, the Department of Health (DOH), and the Department of Social and Health Services (DSHS) to ensure that they do not duplicate efforts and that they work toward a goal of increased quality of services, leading to reduced costs to health care consumers. The Joint Select Committee must, as necessary, propose legislation and budget recommendations to the Legislature. The section creating the Joint Select Committee expires December 31, 2022.

Health Extension Program.

The DOH, subject to amounts appropriated, 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, clinical decision support, reports of the Robert Bree Collaborative, and identification of evidence-based models to effectively treat depression and other conditions in primary care settings. The DOH may adopt rules necessary to implement the program, but may not adopt rules, policies, or procedures beyond the identified scope of authority.

Communities of Health.

The HCA, subject to amounts appropriated, must award grants to support the development of two pilot projects for communities of health. A community of health is a regionally based, voluntary collaborative, the purpose of which is to align actions to achieve healthy communities and populations, improve health care quality, and lower costs.

The HCA must develop a process for designating an entity as a community of health. An entity is eligible for designation if: (1) it is a nonprofit or public-private partnership, including those led by local public health agencies; (2) its membership incorporates key stakeholders; and (3) it demonstrates an ongoing capacity to lead health improvement activities and distribute resources from the DOH health extension program.

Grants may only be used for start-up costs. Criteria for awarding grants include whether the entity will provide matching funds, base decisions on public input and collaboration, and demonstrate capability for sustainability. Before grant funds are disbursed, the HCA and the applicant must agree on performance measures.

The HCA may adopt rules necessary to implement the requirements related to communities of health, but may not adopt rules, policies, or procedures beyond the identified scope of authority. The section related to communities of health expires July 1, 2020.

Standard Statewide Measures of Health Performance.

A performance measures committee is established to identify and recommend standard statewide measures of health performance to inform health care purchasers and set benchmarks. Members of the committee must represent state agencies, small and large employers, health plans, federally recognized tribes, 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 is chaired by the director of the HCA.

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. 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 preventive care and acute and chronic conditions.

The committee must develop a measure set that:

- is of a manageable size;
- is based on readily available claims and clinical data;
- gives preference to nationally reported measures and, when those may not be appropriate, measures used by state agencies and commercial health plans;
- focuses on overall performance of the system;

- is aligned with the Governor's performance management system measures and common measure requirements specific to Medicaid delivery systems;
- considers needs of different stakeholders and populations; and
- is usable by multiple payers, providers, purchasers, public health, and communities.

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

Medicaid Procurement.

The HCA and the DSHS 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 (2014) and recommendations of the Behavioral Health Task Force. The HCA and the DSHS may develop and use innovative mechanisms to promote and sustain integrated clinical models of physical and behavioral health care. The agencies may incorporate specified principles into their Medicaid procurement efforts, including:

- 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.
- Active purchasing and oversight of Medicaid managed care contracts is a state responsibility.
- Evidence-based care interventions and continuous quality improvement must be enforced through contract specifications and performance measures.

The principles are not intended to create an individual entitlement to services.

In addition, the HCA is required to 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.

Statewide All-Payer Health Care Claims Database.

The Office of Financial Management (OFM) 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, hospitals, 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 undertaken, reviewed, and approved by the OFM.

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. At the direction of the OFM, 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 information from the database available as a resource;
- develop policies to ensure quality of data releases;
- develop a plan for financial sustainability and charge fees up to $5,000 (unless otherwise negotiated), with any fees comparable across data requests and users and approved by the OFM; and
- appoint advisory committees on data policy and the data release process.

The lead organization governance structure and advisory committees must include representation of the third-party administrator for the Uniform Medical Plan. A payer, health maintenance organization, or third-party administrator must be a data supplier to be represented on the lead organization governance structure or advisory committees.

Submissions to the Database. Data suppliers must submit claims data to the database within the time frames established by the Director of the OFM and in accordance with procedures established by the lead organization. "Claims data" include: (1) claims data related to health care coverage and services funded in the operating budget, including coverage and services funded by appropriated and non-appropriated state and federal moneys, for Medicaid programs and the Public Employees Benefits Board program; and (2) claims data voluntarily provided by other data suppliers, including carriers and self-funded employers. An entity that is not a data supplier but that chooses to participate in the database must require any third-party administrator to release any claims data related to persons receiving health coverage from the entity's plan. Data suppliers must submit an annual status report to the OFM regarding their compliance, and this information must be included in the HCA's report to the Legislature regarding implementation of the Innovation Plan.

Reports. Under the supervision of the OFM, the lead organization must use the performance measures and the database to prepare health care data reports. Prior to releasing reports that use claims data, the lead organization must submit the reports to the OFM for review and approval. Reports must assist the Legislature and the public by reporting on whether providers and systems deliver efficient, high-quality care, as well as geographic and other variations in care and costs. Measures in the reports 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 when feasible with available data.

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. In addition, the lead organization may not compare performance in a report generated for the general public that includes any provider in a practice with fewer than five providers. The OFM 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. The lead organization may not release a report comparing or

identifying providers, hospitals, or data suppliers unless it allows them to verify the accuracy of the information and submit corrections within 45 days and unless it corrects errors.

The lead organization must ensure that no individual carrier or self-insured employer using the carrier's provider contracts comprises more than 25 percent of the claims data used in any report or other analysis generated from the database.

Use of Data. 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 and are exempt from public disclosure. 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 OFM must direct the lead organization to maintain the confidentiality of the data it collects for the database that include direct or indirect patient identifiers. Any agency, researcher, or other person who receives data with patient identifiers must also maintain confidentiality and may not release the information except as consistent with the requirements of the act.

Data must be made available within a reasonable time after request. Data with direct or indirect patient identifiers, as specifically defined in rule, may be released to: (1) federal, state, and local government agencies upon receipt of a signed data use agreement; and (2) researchers with approval of an institutional review board upon receipt of a signed confidentiality agreement. Data with indirect patient identifiers may be released to an agency, researcher, and other person upon receipt of a signed data use agreement. Data that do not contain direct or indirect patient identifiers may be released upon request. "Direct patient identifier" means information that identifies a patient, and "indirect patient identifier" means information that may identify a patient when combined with other information.

Recipients of data with patient identifiers must agree in a data use agreement and confidentiality agreement to, at a minimum, take steps to protect patient identifying information and not re-disclose the data except as authorized in the agreement or as otherwise required by law. Recipients of data may not attempt to determine patients' identity or use the data in a manner that identifies the individuals or their families.

The Insurance Commissioner may not use data acquired from the database for purposes of reviewing insurance rates, but the Insurance Commissioner's authority to access data from any other source for rate review is not otherwise curtailed, even if that data may have been separately submitted to the database.

Administration. The OFM may adopt rules as necessary to implement and enforce requirements related to the database, 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.

Votes on Final Passage:

House	55	41	
Senate	32	17	(Senate amended)
House	70	27	(House concurred)

Effective: June 12, 2014

Partial Veto Summary: Vetoes the provision requiring the HCA to coordinate efforts to implement the State Health Care Innovation Plan, submit information to the Joint Select Committee, and prepare an annual report. Vetoes the provision prohibiting the Office of the Insurance Commissioner from using data from the all-payer claims database to review rates.