# SENATE BILL REPORT
# E2SHB 2572

As of February 26, 2014

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

**Brief History:** Passed House: 2/19/14, 55-41.
**Committee Activity**: Health Care: 2/27/14.

## SENATE COMMITTEE ON HEALTH CARE

**Staff**: Mich'l Needham (786-7442)

**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 HCA, primarily through the Medicaid program. Coverage is provided through fee-for-service and managed care systems. Healthy Options or Apple Health is the 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*. 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*. DSHS contracts with counties to provide outpatient chemical dependency treatment services, either directly or by subcontracting with certified providers. DSHS contracts directly with providers for residential treatment services.

State Health Care Innovation Plan (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 CMMI to continue work on the 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.

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 (OFM) 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.

**Summary of Bill**: Innovation Plan. HCA is responsible for coordinating, implementing, and administering interagency efforts and local collaborations to implement the Innovation Plan. By January 1, 2015, and each January 1 through 2019, 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 Collaborative for Health (ACH). HCA must establish boundaries for up to nine regions for ACHs. An ACH is a regionally based collaborative to align actions and stakeholders to achieve healthy communities, improve health care quality, and lower costs. The term is used to recognize entities that are currently active or that may become active for purposes of directing funding. HCA may award grants to support the development of ACHs. Grants may only be used for start-up costs.

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. An entity is eligible to be designated if it is a nonprofit or public-private partnership, its membership

includes key stakeholders, and it demonstrates an ongoing capacity to lead health improvement activities within the region.

ACH entities must submit a report to the Legislature and HCA by December 1, 2015, and each year through 2019. The report must describe regional needs, plans developed, actions taken, and any measurable progress. It must also identify grant funds received and, for the final report, demonstrate capability for sustainability. The sections related to ACHs expire July 1, 2020.

Health Extension Program. The Department of Health (DOH) 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.

Performance Measures. A performance measures committee is established to identify and recommend standard statewide measures of health performance to inform healthcare purchasers and set benchmarks. The committee must coordinate with the lead organization established for the all-payer claims database. 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 is chaired by the director of 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 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 acute 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 the Health Benefit Exchange and state agencies;
- 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, and communities.

Statewide All-Payer Health Care Claims Database and Performance Measures. 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. Certain activities undertaken, reviewed, and approved by OFM are exempt from antitrust laws.

OFM must select 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. A health insurance carrier or employer that provides health insurance to its employees must provide claims data. A data supplier does not include a self-insured entity, other than a state or local governmental entity. Claims data must be submitted for health care coverage and services funded, in whole or in part, in the operating budget, including coverage and services funded by appropriated and non-appropriated state and federal monies.

The lead organization must prepare health care data reports. Prior to releasing reports that use claims data, the lead organization must submit the reports to OFM for review and approval. 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. 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 the errors.

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. 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 bill.

OFM may adopt rules as necessary to implement and enforce requirements related to the database and the performance measures, including the following: 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. HCA and 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 chemical dependency treatment. By January 1, 2019, Medicaid services must be fully integrated in a managed health care system that provides mental health, chemical dependency, and medical care services to Medicaid clients.

HCA and 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 the following:

- 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; and
- 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.

**Appropriation**: None.

**Fiscal Note**: Partial fiscal note is available.

**Committee/Commission/Task Force Created**: No.

**Effective Date**: Ninety days after adjournment of session in which bill is passed.