SENATE BILL REPORT
E2SHB 2572

As Reported by Senate Committee On:
Health Care, February 27, 2014
Ways & Means, March 10, 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 [DPA-WM, DNP].
Ways & Means: 3/10/14 [DPA, w/oRec].

SENATE COMMITTEE ON HEALTH CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Becker, Chair; Dammeier, Vice Chair; Pedersen, Ranking Member; Cleveland and Keiser.

Minority Report: Do not pass.
Signed by Senators Angel, Bailey and Parlette.

Staff: Mich'l Needham (786-7442)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass as amended.
Signed by Senators Hill, Chair; Honeyford, Capital Budget Chair; Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Ranker, Assistant Ranking Member on the Operating Budget; Bailey, Becker, Billig, Braun, Conway, Dammeier, Fraser, Frockt, Hasegawa, Hatfield, Hewitt, Kohl-Welles and Rivers.

Minority Report: That it be referred without recommendation.

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.

Signed by Senators Padden, Parlette and Schoesler.

Staff: Michael Bezanson (786-7449)

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.

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 (Recommended Amendments): 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. Before the agency applies for a federal innovation grant, they must present information to the Joint Select Committee on Health Care Oversight (JSC), including an additional actuarial review.

JSC. The JSC that was established in Engrossed Substitute Senate Concurrent Resolution 8401 in 2013 is established in statute and continued through December 31, 2022, to provide ongoing oversight of the innovation plan.

A Community of Health. HCA may provide grants to support regionally based, voluntary collaboratives known as a community of health for two pilot projects. The community of health must 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. Grants may only be used for start-up costs. 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. The section related to communities for health expires 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 evidence-based tools that promote integration of physical and behavioral health, clinical decision support, methods of formal assessment, and resources that are available in the community.

Performance Measures. A performance measures committee is established to identify and recommend standard statewide measures of health performance to inform healthcare purchasers and propose 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, and 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. State agencies must use the measure set to inform purchasing decisions.

Medicaid Procurement. HCA and 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 2SSB 6312 (laws of 2014) and recommendations of the Behavioral Health Task Force. HCA and 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.

HCA must increase the use of value-based contracting, alternative quality contracting, and other payment incentives that promote quality, efficiency, cost savings, and health improvement. The purchasing improvements apply across all state-purchased care and are intended to reduce medical costs when fully phased in by fiscal year 2017 to generate budget savings identified in the budget act.

Statewide All-Payer Health Care Claims Database and Performance Measures. OFM must establish a statewide all-payer health care claims database, with required reporting for the Medicaid and Public Employees Benefits Board program, and voluntary reporting allowed by other entities. 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. The lead organization must prepare health care data reports. 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 includes 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, 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.

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Recommended Amendments):

- Modifies the intent section.
- HCA must have a neutral actuarial firm review the estimated savings in the innovation plan prior to application.
- Before 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, as opposed to December 31, 2017, as established in ESSB 8401 in 2013.
- Changes the accountable collaborative for health to community of health and modifies some components for the community of health grant criteria and reporting requirements, removes regional boundaries, and limits 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 the Health Technology Assessment, adds information on evidence-based models to effectively treat depression and other conditions such as the Advancing Integrated Mental Health Solutions programs at UW.
- Restores the Performance Measures Committee to recommend statewide measures and benchmarks, and modifies membership. The third-party administrator for UMP participates on the governance committee and only those organizations providing data may participate in the governance and advisory committees.
- Modifies the Medicaid purchasing, changing the integration of behavioral health from shall to may, and modifies guiding;
- Links the contracting to assumptions included in 2SSB 6312 (2014) and recommendations of the Behavioral Health Task Force, and removes the January 2019 date for the full phase-in.
- Add a 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 in the budget bill.
- Restores references to the all-payer claims database, but modifies the reporting to include Medicaid and the Public Employees' Benefits Board and others that volunteer to provide data.

EFFECT OF CHANGES MADE BY HEALTH CARE COMMITTEE (Recommended Amendments):

- Modifies the intent section.
- Removes all references to the all-payer claims database and related data protections.
- HCA must have a neutral actuarial firm review the estimated savings in the innovation plan prior to application.
- Before 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.
- If an innovation grant is awarded, HCA must come before the Joint Committee and seek approval for implementation of the plan, and the agency must provide quarterly status reports to the Joint Committee.
- 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, as opposed to December 31, 2017, established in ESSB 8401, in 2013.
- Changes the accountable collaborative for health to community of health and modifies some components for the community of health grant criteria and reporting requirements.
- Modifies the elements of the Health Extension Program disseminates to providers, and removes the reference to contract limitations.
- Removes the Performance Measures Committee to recommend statewide measures and benchmarks.
- Modifies the Medicaid purchasing, changing the integration of behavioral health from shall to may, and modifies guiding principles and makes them permissive.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

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

Staff Summary of Public Testimony on Engrossed Second Substitute House Bill (Health Care): PRO: This bill sets up the next steps for the agency to seek further federal grants on innovation. It includes critical components on transparency that help contain costs with the all-payer claims database. It is especially important that we improve our transparency efforts since we earned an "F" grade on transparency of costs. The performance committee was also a recommendation of the Miller Commission that would help the state bring down costs of health care. As a primary care provider I participate in a medical home and believe we should build robust primary care and medical home models. The efforts in this bill support providers to transition their practices. We support the performance committee with the development of statewide performance standards and benchmarks. There are a number of quality efforts underway across the state and with the insurance plans but there is very little coordination. The committee would provide coordination and improve quality which will

drive down costs. It is important to have a common set of definitions and approaches. The extension program would provide important tools to support providers especially in our rural areas. We would like to ensure that remains flexible to accommodate different approaches. The Washington State Medical Association (WSMA) strongly supports the all-payer claims data base and building transparency into our health care system to improve quality. We believe the House version has adequate protections while ensuring access to the data. We support the collaboratives and the local dialogue that forms those voluntary collaboratives. They are successful in many areas like Spokane, Whatcom County, Vancouver, and other areas. Empire is interested in partnering with the state to continue the voluntary, robust dialogue in each community. We bring the consumer voice to the table to help build support for transparency. It is difficult to shop for health care. There is no single source of data that displays costs and quality and it is important to consolidate the information for consumers. This bill is a good first step to moving the state forward to improve health care quality and contain costs. There are many elements that help improve quality of care, and elements that help the state budget as well with cost controls. I am representing the public that is often over shadowed by the voices of big business. The all-payer claims database is an important consumer tool to help provide cost and quality information, and it will help contain costs. Vote for people to have access to information. The tribes provide a lot of health care services and they would bring an important perspective to the discussion on the performance measures and benchmarks. Please add a tribal representative to the committee. King County and the Health Alliance support the all-payer claims database to allow us all to make better purchasing decisions. The Alliance has had good experience with the claims data with voluntary participation. We also support having flexibility with the regional collaboratives to allow different approaches that reflect the diverse local approaches. We would like to add local health jurisdictions to the list. The National Federation of Independent Business (NFIB) strongly supports the all-payer claims database and oppose the striking amendment. I have reached out to our membership in states that have the claims databases and have found no problems. None of the concerns the industry has expressed have proven to be issues in those states. The database would allow businesses and consumers to make informed decisions and you should not trade the concerns of consumers and small business for the interest of big business.

OTHER: We would like to have you add nurses to the list of participants on the performance committee. The committee is to address care coordination and patient safety and nurses play a critical role. Regence was neutral on the bill as it came over from the house since they added the side boards and protections for the data they thought were critical. We also support the striking amendment since the legislative oversight of the grant work is appreciated.

Persons Testifying (Health Care): PRO: Representative Cody, prime sponsor; Kevin Haughton, Primary Care physician; Lisa Thatcher, Glaxosmithkline, WA State Hospital Assn.; Kathryn Kolan, WSMA; Amber Lewis, The Empire Health Foundation; Len Sorrin, Premera; Yanling Yu, WA Advocates for Patient Safety; Robert Crittenden, Governor's Office; Miguel Perez-Gibson, Colville Tribe; Genesee Adkins, King County, Health Alliance; Patrick Connor, NFIB WA; Rex Johnson, citizen.

OTHER: Melissa Johnson, WA State Nurses Assn.; Chris Bandoli, Regence BlueShield.

Staff Summary of Public Testimony as Heard in Committee (Ways & Means): PRO: This bill is a high priority for the Governor since it helps improve quality of health care and reduce costs. It is important to connect with communities and to establish performance goals. The database is very helpful for purchasing efforts to contain costs. We request an amendment that adds all the state-funded claims to the database. HCA purchases for 1.7 million people and spends approximately $8 billion per year purchasing care. This bill has essential tools to improve our efficiency for those purchases. First we need the transparency for price and quality information since they are not available today. Second we need the community involvement in improving health – we must engage our community partners. Third, we need integration of behavioral health to remove the fragmented approach to delivering health care and integrate the elements together to improve health and maximize savings. This bill aligns with the behavioral health bill and helps leverage the purchasing strategies for savings and better outcomes. Health care is a significant part of the state budget and family budgets. It is important to have access to quality and cost data to improve purchasing. This amendment is a good first step to restore the database and we suggest the full database be restored with the private sector participants. This bill has made good progress. We have an amendment request to ensure the third-party administrator for the UMP has a seat on the database governance structure, and to limit participation on the database advisory committees to those entities that provide data to the database. We would like to retain the reference to the data reports and the data suppliers not comprising more than 25 percent of the claims data.

OTHER: The timing of this amendment has not allowed our committee to review it, but we have some concerns with the data. It is important to have hard data to contain costs. We have some concerns with the language in the database on reporting that limits a report if a data supplier is more than 25 percent of the claims data; we think that should be removed now that the database does not include all payers.

Persons Testifying (Ways & Means): PRO: Bob Crittenden, Governor's Office; Dorothy Teeter, HCA; Patrick Connor, National Federation of Independent Business, WA; Carrie Tellefson, Regence Blue Shield.

OTHER: Sheri Nelson, Assn. of WA Business; Len McComb, WA State Hospital Assn.