H-3981.1

SUBSTITUTE HOUSE BILL 2572

State of Washington 63rd Legislature 2014 Regular Session

By House Health Care & Wellness (originally sponsored by Representative Cody; by request of Governor Inslee)

READ FIRST TIME 02/05/14.

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; adding new sections to chapter 41.05 RCW; adding a new section to chapter 43.70 RCW; adding a new section to chapter 74.09 RCW; and creating new sections.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** (1) The legislature finds that the state of Washington has an unprecedented opportunity to implement a five-year state health care innovation plan developed through the center for medicare and medicaid innovation state innovation model program. The innovation plan describes the state's strategy to transform its health care delivery system through multipayer payment reform and other state-led initiatives.

(2) The state health care innovation plan establishes the following primary drivers of health transformation, each with individual key actions that are necessary to achieve the objective:

(a) Improve health overall by building healthy communities and people through prevention and early mitigation of disease throughout the lifespan;

(b) Improve chronic illness care through better integration and strengthening of linkages between the health care delivery system and community, particularly for individuals with physical and behavioral comorbidities; and

(c) Advance value-based purchasing across the community, and lead by example in transforming how it purchases health care services.

(3) The legislature intends to facilitate the implementation of the state health care innovation plan by:

(a) Establishing an all-payer claims database that improves transparency for patients, providers, hospitals, and purchasers;

(b) Developing standard statewide performance and quality measures to inform purchasing and set benchmarks;

(c) Supporting the initiatives of regional collaboratives to achieve healthy communities and populations, improve health care quality, and lower costs;

(d) Disseminating evidence-based training, tools, and other resources to providers and hospitals; and

(e) Supporting integration of services for physical health, behavioral health, and substance use by restructuring medicaid procurement.

NEW SECTION. **Sec. 2.** (1) The health care authority is responsible for coordination, implementation, and administration of interagency efforts and local collaborations of public and private organizations to implement the state health care innovation plan.

(2) By January 1, 2015, and January 1st of each year through January 1, 2019, the health care authority shall coordinate and submit a status report to the appropriate committees of the legislature regarding implementation of the innovation plan. The report must summarize any actions taken to implement the innovation plan, progress toward achieving the aims of the innovation plan, and anticipated future implementation efforts. In addition, the health care authority shall submit any recommendations for legislation necessary to implement the innovation plan.

NEW SECTION. **Sec. 3.** (1) An accountable collaborative for health is a regionally based collaborative designated by the authority, the purpose of which is to align actions and initiatives of a diverse coalition of members to achieve healthy communities and populations, improve health care quality, and lower costs.

(2) By September 1, 2014, the authority shall establish boundaries for up to nine regions for accountable collaboratives for health as provided in this subsection. Counties, through the Washington state association of counties, must be given the opportunity to propose the boundaries of the regions. If counties do not submit proposed boundaries for the regions by July 1, 2014, the task force on the adult behavioral health system created by section 1, chapter 338, Laws of 2013 shall submit proposed boundaries to the authority by August 1, 2014. The boundaries must be based on county borders and must be consistent with medicaid procurement regions.

(3) The authority shall develop a process for designating an entity as an accountable collaborative for health. An entity seeking designation is eligible if it:

(a) Is a nonprofit or public-private partnership;

(b) Incorporates broad membership from the health care delivery system, public health, social supports and services, and consumers, with no single entity or organizational cohort serving in a majority capacity; and

(c) Demonstrates an ongoing capacity to:

(i) Convene key stakeholders including: Primary care and specialty practices; ambulatory, hospital, and long-term services and supports; behavioral health; health plans; employers; and social service and public health agencies;

(ii) Lead health improvement activities within the region with other local systems to improve health outcomes and the overall health of the community, improve health care quality, and lower costs;

(iii) Distribute tools and resources from the health extension program created in section 5 of this act; and

(iv) Act in alignment with statewide health care initiatives by using the statewide all-payer health care claims database created in section 8 of this act, the statewide health performance and quality measures developed pursuant to section 11 of this act, and outcome measures reflecting local health needs as identified by the accountable collaborative for health.

(4) The authority may designate more than one accountable collaborative for health in a region, but an accountable collaborative for health may not cross the regional boundaries defined by the authority and may not overlap with another accountable collaborative for health.

(5) An entity designated by the authority as an accountable collaborative for health must convene key stakeholders to:

(a) Review existing data, including data collected through the community health assessment process;

(b) Evaluate the region's progress toward the objectives of the national healthy people 2020 initiative and the priorities identified in community health assessments and community health improvement plans;

(c) Assess the region's capacity to address chronic care needs, including the needs of persons with co-occurring disorders;

(d) Review available funding and resources; and

(e) Identify and prioritize regional health care needs and develop a plan to address those needs.

(6) For purposes of this section and section 4 of this act, the authority may only adopt rules that are necessary to implement this section and section 4 of this act.

NEW SECTION. **Sec. 4.** (1) The authority shall, subject to available funds, award grants to support the development and operation of accountable collaboratives for health. The authority may not award more than one grant per region.

(2) An entity may be eligible for a grant under this section if it has been designated as an accountable collaborative for health under section 3 of this act. A grant application must, at a minimum:

(a) Identify the geographic region served by the applicant;

(b) Demonstrate how the applicant's structure and operation reflect the interests of and are accountable to the region and the state for health improvement; and

(c) Indicate the size of the grant being requested and describe how the money will be spent.

(3) In awarding grants under this section, the authority shall consider the extent to which the applicant will:

(a) Further the purposes of the state health care innovation plan and section 3 of this act;

(b) Base decisions on public input and an active collaboration among key community partners, including, but not limited to, local governments, school districts, early learning regional coalitions, large and small businesses, labor organizations, health and human service organizations, tribal governments, health carriers, providers, hospitals, public health agencies, and consumers;

(c) Match the grant funding with funds from other sources; and

(d) Demonstrate capability for sustainability.

(4) The authority may prioritize applications that commit to providing at least one dollar in matching funds for each grant dollar awarded.

(5) Before grant funds are disbursed, the authority and the applicant must agree on performance requirements and the consequences for failing to meet those requirements. The performance requirements must be aligned with the purposes of the state health care innovation plan.

NEW SECTION. **Sec. 5.** A new section is added to chapter 43.70 RCW to read as follows:

(1) Subject to available funds, the department shall establish a health extension program to provide training, tools, and technical assistance to primary care, behavioral health, and other providers. The program must emphasize high quality preventive, chronic disease, and behavioral health care that is comprehensive and evidence-based.

(2) The health extension program must coordinate dissemination of evidence-based tools and resources that promote:

(a) Integration of physical and behavioral health;

(b) Clinical information systems with sharing and organization of patient data;

(c) Clinical decision support to promote evidence-based care;

(d) Reports of the Robert Bree collaborative created by RCW 70.250.050 and findings of health technology assessments under RCW 70.14.080 through 70.14.130;

(e) Methods of formal assessment;

(f) Support for patients managing their own conditions;

(g) Identification and use of resources that are available in the community for patients and their families, including community health workers; and

(h) Practice transformation, including, but not limited to, team-based care, shared decision making, use of population level health data and management, and quality improvement linked to common statewide performance measures.

(3) The department may adopt rules necessary to implement this section, but may not adopt rules, policies, or procedures beyond the scope of authority granted in this section.

NEW SECTION. **Sec. 6.** The legislature finds that:

(1) The activities authorized by sections 7 through 13 of this act will require collaboration among state agencies and local governments that purchase health care, private health carriers, third-party purchasers, health care providers, and hospitals. These activities will identify strategies to increase the quality and effectiveness of health care delivered in Washington state and are therefore in the best interest of the public.

(2) The benefits of collaboration, together with active state supervision, outweigh potential adverse impacts. Therefore, the legislature, through the state action doctrine, intends to exempt and provide immunity from state and federal antitrust laws for activities undertaken pursuant to sections 7 through 13 of this act that might otherwise be constrained by such laws when the activities are reviewed and approved by the health care authority. The legislature does not intend and does not authorize any person or entity to engage in activities or conspire to engage in activities that would constitute per se violations of state and federal antitrust laws including, but not limited to, agreements among competing health care providers or private health carriers regarding the price or specific level of reimbursement for health care services.

NEW SECTION. **Sec. 7.** The definitions in this section apply throughout sections 8 through 13 of this act unless the context clearly requires otherwise.

(1) "Data supplier" means an entity required to submit data to the database pursuant to section 9 of this act.

(2) "Database" means the statewide all-payer health care claims database established in section 8 of this act.

(3) "Health care information" has the same meaning as in RCW 70.02.010.

(4) "Lead organization" means the organization selected under section 8 of this act.

NEW SECTION. **Sec. 8.** (1) The authority shall establish a statewide all-payer health care claims database to support transparent public reporting of health care information. The database must improve transparency to: Assist patients, providers, and hospitals to make informed choices about care; enable providers and communities to improve by benchmarking their performance against that of others by focusing on best practices; enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost.

(2) The director shall select a lead organization to coordinate and manage the database. The lead organization is responsible for internal governance, management, funding, and operations of the database. The lead organization shall:

(a) Collect claims data from data suppliers, as provided in section 9 of this act;

(b) Design data collection mechanisms with consideration for the time and cost involved in collection and the benefits that measurement would achieve;

(c) Ensure protection of collected data and store and use any data with patient-specific information in a manner that protects patient privacy;

(d) Make the database available as a resource for public and private entities, including insurers, employers, providers, hospitals, and purchasers of health care;

(e) Report performance on cost and quality pursuant to section 12 of this act using the performance measures developed under section 11 of this act;

(f) Develop protocols and policies to ensure the quality of data releases;

(g) Develop a plan for the financial sustainability of the database and charge reasonable fees for reports and data files as needed to fund the database. Any fees must be comparable across data requesters and users; and

(h) Appoint advisory committees, including:

(i) A data policy development committee to maximize the commitment and participation of key provider, hospital, payer, health maintenance organization, purchaser, and consumer organizations; and

(ii) A committee to establish a data release process consistent with requirements under state and federal privacy laws, including the federal health insurance portability and accountability act, and to provide advice regarding formal data release requests.

NEW SECTION. **Sec. 9.** (1) Data suppliers must submit claims data to the database within the time frames established by the director in rule and in accordance with procedures established by the lead organization.

(2)(a) Health carriers, as defined in RCW 48.43.005, shall submit claims data to the database.

(b) Paid claims data related to health care coverage and services funded, in whole or in part, in the omnibus appropriations act must be included in the database. The submitted claims data must include coverage and services funded by appropriated or nonappropriated state or federal moneys.

(c) A local government, private employer, self-insured employer, or Taft-Hartley plan may choose to submit claims data to the database. A self-insured employer or Taft-Hartley plan that chooses to participate in the database shall require any third-party administrator utilized by the plan to release, at no additional cost, any claims data related to persons receiving health coverage from the plan.

(3) Each data supplier shall submit an annual status report to the authority regarding its compliance with this section. The report to the legislature required by section 2 of this act must include a summary of these status reports.

NEW SECTION. **Sec. 10.** (1) The data provided to the database, the database itself, including the data compilation, and any raw data received from the database are not public records under chapter 42.56 RCW.

(2) All information, reports, statements, memoranda, or other data received by the lead organization or the authority are strictly confidential. Any use, release, or publication of the information shall be done in such a way that no person is identifiable.

(3) Data obtained in the course of activities undertaken pursuant to or supported under sections 7 through 13 of this act are not subject to subpoena or similar compulsory process in any civil or criminal, judicial, or administrative proceeding, nor may any individual or organization with lawful access to data under sections 7 through 13 of this act be compelled to testify with regard to such data, except that data pertaining to a party in litigation may be subject to subpoena or similar compulsory process in an action brought by or on behalf of such individual to enforce any liability arising under sections 7 through 13 of this act.

NEW SECTION. **Sec. 11.** (1) There is created a performance measures committee, the purpose of which is to develop and recommend standard statewide measures of health performance to inform state purchasing of health care and set benchmarks to track costs and improvements in health outcomes. The governor shall terminate the committee on January 31, 2015.

(2) Members of the committee must include representation from state agencies, employers, health plans, patient groups, consumers, academic experts on health care measurement, hospitals, physicians, and other providers. The governor shall appoint the members of the committee, except that a statewide association representing hospitals may appoint a member representing hospitals and a statewide association representing physicians may appoint a member representing physicians. The governor shall ensure that members represent diverse geographic locations and both rural and urban communities. The chief executive officer of the lead organization must also serve on the committee.

(3) The committee shall develop a transparent process for selecting performance measures, and the process must include opportunities for public comment.

(4) By January 1, 2015, the committee shall submit the performance measures to the authority and the lead organization. The measures must include dimensions of:

(a) Prevention and screening;

(b) Effective management of chronic conditions;

(c) Key health outcomes;

(d) Care coordination and patient safety; and

(e) Use of the lowest cost, highest quality care for acute conditions.

(5) The lead organization shall develop a measure set based on the recommendations of the committee. The measure set must:

(a) Be of manageable size;

(b) Be based on readily available claims and clinical data;

(c) Give preference to nationally reported measures and measures used by the health benefit exchange and state agencies that purchase health care;

(d) Focus on the overall performance of the system, including outcomes and total cost;

(e) Be aligned with the governor's performance management system measures and common measure requirements specific to medicaid delivery systems under RCW 70.320.020 and 43.20A.895;

(f) Consider the needs of different stakeholders and the populations served; and

(g) Be usable by multiple payers, providers, hospitals, purchasers, and communities as part of health improvement, care improvement, provider payment systems, benefit design, and administrative simplification for providers and hospitals.

(6) States agencies shall use the measure set developed under this section to inform purchasing decisions and set benchmarks.

(7) The lead organization shall establish a public process to periodically evaluate the measure set and make necessary additions or changes to the measure set.

NEW SECTION. **Sec. 12.** (1) The lead organization shall prepare health care data reports using the statewide health performance and quality measure set and the database. The lead organization must submit the health care data reports to the authority for review and may release the reports only with the approval of the authority.

(2)(a) Health care data reports prepared by the lead organization must assist the legislature and the public with awareness and promotion of transparency in the health care market by reporting on:

(i) Providers and health systems that deliver efficient, high quality care;

(ii) Geographic and other variations in medical care and costs as demonstrated by data available to the lead organization; and

(iii) Rate and price increases by health care providers that exceed the consumer price index - medical care as compiled by the bureau of labor statistics of the United States department of labor.

(b) Measures in the health care data reports should be stratified by demography, income, language, health status, and geography when feasible to identify disparities in care and successful efforts to reduce disparities.

(c) Comparisons of costs among health care systems must account for differences in acuity of patients, as appropriate and feasible, and must take into consideration the cost impact of subsidization for uninsured and governmental patients, as well as teaching expenses.

(3) The lead organization may not publish any data or health care data reports that:

(a) Directly or indirectly identify patients; or

(b) Disclose specific terms of contracts, discounts, or fixed reimbursement arrangements or other specific reimbursement arrangements between an individual provider and a specific payer.

(4) The lead organization may not release a report that compares and identifies providers or data suppliers unless it:

(a) Allows the data supplier or the provider to verify the accuracy of the information submitted to the lead organization and submit to the lead organization any corrections of errors with supporting evidence and comments within a reasonable period of time;

(b) Corrects data found to be in error; and

(c) Allows the data supplier a reasonable amount of time prior to publication to review the lead organization's interpretation of the data and prepare a response.

(5) The authority and the lead organization may not use the data provided to it 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.

NEW SECTION. **Sec. 13.** (1) The director shall adopt any rules necessary to implement sections 7 through 12 of this act, including:

(a) Definitions of claim and data files that data suppliers must submit to the database, including: Files for covered medical services, pharmacy claims, and dental claims; member eligibility and enrollment data; and provider data with necessary identifiers;

(b) Deadlines for submission of claim files;

(c) Penalties for failure to submit claim files as required;

(d) Procedures for ensuring that all data received from data suppliers are securely collected and stored in compliance with state and federal law; and

(e) Procedures for ensuring compliance with state and federal privacy laws.

(2) The director may not adopt rules, policies, or procedures beyond the authority granted in this section and sections 7 through 12 of this act.

NEW SECTION. **Sec. 14.** A new section is added to chapter 74.09 RCW to read as follows:

(1) Consistent with the implementation of the state health care innovation plan and the provisions of RCW 70.320.020, the authority and the department shall 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 authority and the department shall develop and utilize innovative mechanisms to promote and sustain integrated clinical models of physical and behavioral health care such as: Practice transformation support and resources; workforce capacity and flexibility; shared clinical information sharing, tools, resources, and training; and outcome-based payments to providers and hospitals.

(2) The authority and the department shall incorporate the following principles into future medicaid procurement efforts aimed at integrating the delivery of physical and behavioral health services:

(a) Facilitating equitable access to effective behavioral health services for adults and children is a state priority;

(b) Recognition that the delivery of better integrated, person-centered care to meet enrollees' physical and behavioral health care needs is a shared responsibility of contracted regional support networks, managed health care systems, service providers, hospitals, the state, and communities;

(c) Medicaid purchasing must support delivery of integrated, person-centered care that addresses the spectrum of individuals' health needs in the context of the communities in which they live and with the availability of care continuity as their health needs change;

(d) Accountability for the client outcomes established in RCW 43.20A.895 and 71.36.025 and performance measures linked to those outcomes;

(e) Medicaid benefit design must recognize that adequate preventive care, crisis intervention, and support services promote a recovery-focused approach;

(f) Evidence-based care interventions and continuous quality improvement must be enforced through contract specifications and performance measures, including the statewide measure set under section 11 of this act, that provide meaningful integration at the patient care level with broadly distributed accountability for results;

(g) A deliberate and flexible system change plan with identified benchmarks and periodic readiness reviews will promote system stability, provide continuity of treatment for patients, and protect essential existing behavioral health system infrastructure and capacity; and

(h) Community and organizational readiness are key determinants of implementation timing; a phased approach is therefore desirable.

NEW SECTION. **Sec. 15.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 16.** Sections 3, 4, and 7 through 13 of this act are each added to chapter 41.05 RCW.

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