Z-0735.1

HOUSE BILL 2572

State of Washington 63rd Legislature 2014 Regular Session

By Representative Cody; by request of Governor Inslee

Read first time 01/21/14. Referred to Committee on Health Care & Wellness.

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; amending RCW 41.05.650, 41.05.660, and 43.70.533; adding new sections to chapter 41.05 RCW; adding new sections to chapter 43.41 RCW; adding a new section to chapter 48.43 RCW; adding a new section to chapter 74.09 RCW; and creating a new section.

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

NEW SECTION. **Sec. 1.** The legislature declares that collaboration among state purchased health care programs, private health carriers, third-party purchasers, and health care providers to identify appropriate strategies that will increase the quality and effectiveness of health care delivered in Washington state is in the best interest of the public. The legislature therefore exempts from state antitrust laws, and intends to provide immunity from federal antitrust laws through the state action doctrine, those activities convened and supervised by the director of the health care authority or the director's designee pursuant to this act or by the director of the

office of financial management pursuant to sections 8 and 9 of this act that might otherwise be constrained by such laws. The legislature does not intend and does not authorize any person or entity to engage in activities or to 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 health carriers as to the price or specific level of reimbursement for health care services.

NEW SECTION. **Sec. 2.** (1) 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 Washington state's strategy to transform its health care delivery system through multipayer payment reform and other state-led initiatives, including exploration of health innovation funding options.

(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) Through strategic leadership and collaborative partnership, Washington will advance value-based purchasing across the community, and lead by example in transforming how it purchases health care services.

(3) Implementation of the plan must address barriers in Washington which impede the progress of health care delivery system transformation, including:

(a) Costly and inefficient systems resulting in fragmentation, inefficient delivery and payment models, and silos within the public and private sectors;

(b) A health care market influenced by diverse, misaligned payment methods, priorities, and performance measures;

(c) A lack of comparable information regarding the price and quality of health care;

(d) Significant gaps in coordination between primary care and specialty practices; ambulatory, hospital settings, long-term services and supports; and primary care and behavioral health;

(e) Health care delivery and data systems that have not consistently addressed the impacts of the social determinants of health or embraced population health strategies such as nutrition, early childhood interventions, education, and housing.

NEW SECTION. **Sec. 3.** (1) The authority is responsible for coordinating, planning, 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 authority shall coordinate and issue a report to the legislature summarizing the status of the progress made and actions taken towards implementing the innovation plan, including the reporting provisions in sections 11 and 12 of this act and agency recommendations for legislation necessary to implement the innovation plan.

(3) The authority may adopt policies, procedures, standards, and rules, as necessary to implement and enforce sections 2 through 4, 10, 12, and 13 of this act and RCW 41.05.650 and 41.05.660.

NEW SECTION. **Sec. 4.** (1) The authority shall develop certification criteria for the establishment of accountable collaboratives for health, in close collaboration with state and local partners. The authority shall certify each accountable collaborative for health, as a regional organization responsible for aligning community actions and initiatives within the region for the purpose of achieving healthy communities and populations, improving health care quality, and lowering costs. Each accountable collaborative for health shall align their mutual activities to achieve local public health services improvement and assessment goals consistent with RCW 43.70.520 and health improvement innovations consistent with the state health

care innovation plan. The authority shall provide for a phased implementation approach to address variations in regional, community, and local organizational readiness.

(2) By September 1, 2014, after consultation with counties and other interested entities, no more than nine regional boundaries for accountable collaboratives for health must be established, consistent with medicaid procurement established by the authority and the department of social and health services under chapters 71.24, 70.96A, and 74.09 RCW. The boundaries for each region must be contiguous and distinct based on county borders, with population sufficient to support risk-based contracting for medicaid services.

(3) Entities seeking certification may be nonprofit or quasi-governmental in orientation and must incorporate membership from across the health care delivery system, public health, social supports and services, and consumers with no single entity or organizational cohort serving in majority capacity.

(4) To qualify as an accountable collaborative for health, an organization must demonstrate ongoing capacity to:

(a) Convene key stakeholders to link, align, and achieve regional and state health care innovation plan goals;

(b) Lead health improvement activities within the region with other local systems, including primary care and specialty practices; ambulatory, hospital, long-term services and supports; behavioral health; and social service and public health agencies, to improve health outcomes and the overall health of the community, improve health care quality, and lower costs;

(c) Develop a partnership with the state and local jurisdictions to provide shared leadership and involvement in developing medicaid procurement criteria and conducting performance evaluation related to the health care services provided within the region;

(d) Act as a regional host for the health regional extension program under RCW 43.70.533;

(e) Act in alignment with statewide health care initiatives, including the statewide all payer health care claims database under sections 8 and 9 of this act and the statewide health performance and quality measures under section 10 of this act;

(f) Incorporate the following collective impact principles to successfully act as a catalyst for change:

(i) All accountable collaborative for health participants have a shared vision for change including a common understanding and joint approach to solving problems through agreed upon actions;

(ii) Data collection and results measurements are consistent across the community and participants to ensure efforts remain aligned and participants hold each other accountable;

(iii) Participant activities are coordinated with the activities of others through a plan of action;

(iv) Maintain consistent and open communication across participants to build trust, assure mutual objectives, and create common motivation;

(v) Create, manage, and coordinate the collective work of multiple organizations each with staff and a specific set of skills to provide the resources to implement initiatives and coordinate participating organizations and agencies.

Sec. 5. RCW 41.05.650 and 2009 c 299 s 1 are each amended to read as follows:

(1) The community health care collaborative grant program is established to ((~~further the efforts~~)) support the design, development, and sustainability of community-based ((~~coalitions to increase access to appropriate, affordable health care for Washington residents, particularly employed low-income persons and children in school who are uninsured and underinsured, through local programs addressing one or more of the following: (a) Access to medical treatment; (b) the efficient use of health care resources; and (c) quality of care~~)) accountable collaboratives for health.

(2) ((~~Consistent with funds appropriated for community health care collaborative grants specifically for this purpose, two-year~~)) Subject to available funds:

(a) Community health care collaborative grants may be awarded pursuant to RCW 41.05.660 by the ((~~administrator~~)) director of the health care authority.

((~~(3)~~)) (b) The health care authority shall provide administrative support and technical assistance for the program. ((~~Administrative support activities~~)) This may include health care authority facilitation of statewide discussions regarding best practices and standardized performance measures among grantees, or subcontracting for such discussions.

((~~(4)~~)) (3) Eligibility for community health care collaborative grants related to the design and development of an accountable collaborative for health shall be limited to nonprofit or quasi-governmental organizations ((~~established to serve a defined geographic region or organizations with public agency status under the jurisdiction of a local, county, or tribal government. To be eligible, such entities must have a formal collaborative governance structure and decision-making process that includes representation by the following health care providers: Hospitals, public health, behavioral health, community health centers, rural health clinics, and private practitioners that serve low-income persons in the region, unless there are no such providers within the region, or providers decline or refuse to participate or place unreasonable conditions on their participation~~)). The ((~~nature and~~)) format of the application, and the application procedure, shall be determined by the ((~~administrator~~)) director of the health care authority. At a minimum, each application shall: (a) Identify the geographic region served by the organization; (b) show how the structure and operation of the organization reflects the interests of, and is accountable to, this region and ((~~members providing care within this region~~)) the state; (c) indicate the size of the grant being requested, and how the money will be spent; ((~~and~~)) (d) include sufficient information for an evaluation of the application based on the criteria established ((~~in~~)) under RCW 41.05.660; and (e) identify any other needs or expectations the organization has of the state in order to be successful.

Sec. 6. RCW 41.05.660 and 2009 c 299 s 2 are each amended to read as follows:

(1) ((~~The~~)) No more than one community health care collaborative grant((~~s~~)) shall be awarded ((~~on a competitive basis based on a determination of which applicant organization will best serve the purposes of the grant program established in RCW 41.05.650. In making this determination, priority for funding shall be given to the applicants that demonstrate:~~

~~(a) The initiatives to be supported by the community health care collaborative grant are likely to address, in a measurable fashion, documented health care access and quality improvement goals aligned~~

~~with state health policy priorities and needs within the region to be served;~~

~~(b) The applicant organization must document~~)) at a time within each region established under section 4 of this act. In deciding whether and to which organization to award a grant, the health care authority shall consider, but is not limited to, the following factors:

(a) Whether and to what extent the organization will be able to further the purposes of sections 2 through 13 of this act, help achieve for all Washington residents better health, better care, and lower costs, and serve as a sustainable foundation for an accountable collaborative for health under section 4 of this act;

(b) Whether and to what extent the decisions of the organization will be based on public input and the formal, active collaboration among key community partners ((~~that includes~~)) including but not limited to, local governments, school districts, early learning regional coalitions, large and small businesses, labor organizations, nonprofit health and human service organizations, tribal governments, carriers, ((~~private~~)) health care providers, and public health agencies((~~, and community public health and safety networks, as defined in RCW 70.190.010~~));

(c) Whether and to what extent the applicant organization will match the community health care collaborative grant with funds from other sources.

(2) The health care authority may ((~~award grants solely to~~)) prioritize grant awards for those organizations providing at least ((~~two dollars~~)) one dollar in matching funds for each community health care collaborative grant dollar awarded((~~;~~

~~(d) The community health care collaborative grant will enhance the long-term capacity of the applicant organization and its members to serve the region's documented health care access needs, including the sustainability of the programs to be supported by the community health care collaborative grant;~~

~~(e) The initiatives to be supported by the community health care collaborative grant reflect creative, innovative approaches which complement and enhance existing efforts to address the needs of the uninsured and underinsured and, if successful, could be replicated in other areas of the state; and~~

~~(f) The programs to be supported by the community health care collaborative grant make efficient and cost-effective use of available funds through administrative simplification and improvements in the structure and operation of the health care delivery system.~~

~~(2) The administrator of the health care authority shall endeavor to disburse community health care collaborative grant funds throughout the state, supporting collaborative initiatives of differing sizes and scales, serving at-risk populations~~)).

(3) Grants shall be disbursed ((~~over a two-year cycle, provided the grant recipient consistently provides timely reports that demonstrate the program~~)) in a way that assures the organization or agency is satisfactorily meeting the purposes of the grant and the objectives identified in ((~~the organization's~~)) its application. ((~~The requirements for the performance reports shall be determined by the health care authority administrator.~~)) Before any grant funds are disbursed to an organization or agency, the health care authority and the organization shall agree on performance requirements and the consequence if the organization meets or fails to meet those requirements. The performance ((~~measures~~)) requirements shall be aligned with the ((~~community health care collaborative grant program goals and, where possible, shall be consistent with statewide policy trends and outcome measures required by other public and private grant funders~~)) purposes of sections 2 through 13 of this act.

Sec. 7. RCW 43.70.533 and 2011 c 316 s 3 are each amended to read as follows:

(1) ((~~The department shall conduct a program of training and technical assistance regarding care of people with chronic conditions for providers of primary care. The program shall emphasize evidence-based high quality preventive and chronic disease care and shall collaborate with the health care authority to promote the adoption of primary care health homes established under chapter 316, Laws of 2011. The department may designate one or more chronic conditions to be the subject of the program.~~

~~(2) The training and technical assistance program shall include the following elements:~~

~~(a)~~)) Subject to available funds, the department shall establish a health regional extension program. The department shall establish a

program hub with agencies that conduct state purchased health care and other appropriate entities. The program must provide training and technical assistance to primary care, behavioral health, and other providers. The program must emphasize comprehensive, evidence-based, high-quality preventive, chronic disease and behavioral health care.

(2) The health regional extension program hub shall coordinate training, technical assistance, and distribution of tools and resources through local regional extensions that promote the following elements:

(a) Physical and behavioral health integration;

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

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

((~~(c) Clinical delivery system design;~~))

(d) Support for patients managing their own conditions; ((~~and~~))

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

(f) 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) ((~~In selecting primary care providers to participate in the program, the department shall consider the number and type of patients with chronic conditions the provider serves, and the provider's participation in the medicaid program, the basic health plan, and health plans offered through the public employees' benefits board.~~

~~(4)~~)) For the purposes of this section, "health home" and "primary care provider" have the same meaning as in RCW 74.09.010.

(4) The department will continue to collaborate with the health care authority to promote the adoption of primary care health homes established under chapter 316, Laws of 2011.

NEW SECTION. **Sec. 8.** A new section is added to chapter 43.41 RCW to read as follows:

(1) The office of financial management shall establish a statewide all payer health care claims database as provided in this section and

section 9 of this act. The statewide all payer health care claims database must support transparent public reporting of health care information to facilitate:

(a) A comprehensive view of the variation in the cost and quality of health care services;

(b) Advanced web-enabled analytic capabilities to provide health quality and cost transparency and access for consumers, health care providers and purchasers, insurers, and researchers;

(c) Integrated cost, quality, and outcome information available for public purposes to improve health, cost, and efficiency.

(2) The statewide database shall comply with all federal and state privacy requirements. The office shall ensure that data received from reporting entities is securely collected, compiled, and stored in compliance with state and federal law. Federally protected confidential patient-protected data or data protected by the health information portability and accountability act provided by an entity to the statewide database is confidential and exempt from public inspection and copying under chapter 42.56 RCW. The statewide database, including the data compilation and the unified data management platform database is exempt from public disclosure, inspection, copying, and review as a public record.

(3) Paid claims data related to health care coverage and services funded, in whole or in part, by state or federal moneys appropriated in the state omnibus budget or nonappropriated funds otherwise used for this purpose must be included in the statewide database pursuant to the data terms and rules adopted by the office and provide documentation of compliance to the office.

(4) Local government and private employers are encouraged to actively support the inclusion of their employee claims data in the statewide all payer health care claims database. Claims data related to health care coverage and services funded through self-insured employers or trusts are exempt from participating. However, to the extent they wish to participate, their third-party administrators must provide claims data pursuant to this section and section 11 of this act.

(5) The statewide database must be available as a resource for public agencies and private entities, including insurers, employers,

providers, and purchasers of health care, to continuously review health utilization, expenditures, and performance.

(6) The office may adopt policies, procedures, standards, timelines, and rules, as necessary to implement and enforce this section and section 9 of this act including, but not limited to, definition of claims data submission and data files for all covered medical services; pharmacy claims and dental claims; member eligibility and enrollment data; and provider data with necessary identifiers. To the extent fees are levied, the fees must be comparable across data requesters and users.

NEW SECTION. **Sec. 9.** A new section is added to chapter 43.41 RCW to read as follows:

(1) The director shall select a lead organization and enter into an agreement with the selected organization to coordinate and manage the statewide all payer health care claims database. The organization is responsible for the collection of claims data from public and private payers for reporting performance on cost and quality using the statewide health performance and quality measures developed under section 10 of this act. Efforts must be designed to provide transparency that:

(a) Assists patients and providers to make informed choices about care;

(b) Enables providers and communities to improve by benchmarking their performance against that of others and by focusing on best practices;

(c) Enables purchasers to identify value, build expectations into their purchasing strategy and reward improvements over time;

(d) Promotes competition based on quality and cost.

(2) The director may appoint an interagency steering committee to provide oversight, direction, and assistance to the lead organization of the statewide database. The committee may advise the lead organization on the composition of the lead organization's advisory committees for the statewide database under subsection (3)(b) of this section.

(3) The lead organization of the statewide database shall:

(a) Be responsible for internal governance, management, funding, and operations of a statewide all payer health care claims database in

a manner that improves transparency, and the quality, value, and efficiency of health care in Washington state; provides data to stakeholders for measurement and analysis of the status and progress on performance goals and objectives; and supports continuous improvement and elimination of unwarranted variation. Data collection mechanisms must be chosen with consideration for the time and cost involved in collection and the benefits to be achieved from measurement;

(b) Appoint advisory committees including, but not limited to: A data policy development committee on the statewide database that maximizes the commitment and participation of key provider, payer, health maintenance organization, purchaser, and consumer organizations; and a data release review committee to establish a data release process consistent with state and federal privacy requirements, including the health insurance portability and accountability act privacy requirements and to provide advice and counsel regarding formal data release requests. The lead organization shall end the data policy development committees when it deems appropriate with the approval of the director;

(c) Ensure protection of collected data. All data with patient-specific information will be stored and used in a manner that protects patient privacy. Data and reports derived from requested data may be used in conjunction with other data sets to achieve the purposes of sections 2 through 13 of this act, consistent with state and federal law, including the health insurance portability and accountability act privacy rules;

(d) Develop a plan for the financial sustainability of the statewide database and charge reasonable fees for reports and data files, as needed to fund the statewide database.

NEW SECTION. **Sec. 10.** The authority shall develop standard statewide measures of health performance and select a lead organization to complete the following tasks:

(1) By January 1, 2015, develop an initial statewide health performance and quality measures set that includes dimensions of prevention, effective management of chronic disease, and use of the lowest-cost, highest-quality care for acute conditions. The measure set must:

(a) Be of manageable size;

(b) Give preference to nationally endorsed measures;

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

(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) Be used by the state health benefit exchange and state purchased health care;

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

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

(2) The lead organization shall establish a process to periodically evaluate the measures set and make additions or changes to the measures set as needed.

(3) The lead organization must use the statewide health performance and quality measure set and statewide all payer health care claims database to provide health care data reports with transparent access to reliable and comparable information about variation in quality and price. Wherever possible, measures will be stratified by demography, income, language, health status, and geography to identify both disparities in care and successful efforts to reduce disparities. Analyses must be conducted and shared to:

(a) Identify and recognize providers and health systems delivering efficient, high-quality care, and enable purchasers and consumers to direct business to these systems;

(b) Identify unnecessary variation in care and other opportunities to improve quality of care and reduce cost.

NEW SECTION. **Sec. 11.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Health insurance issuers shall submit claims data to the statewide all payer health care claims database, in compliance with the timeline and criteria established under sections 8 and 9 of this act.

(2) Health insurance issuers shall annually submit a status report to the commissioner regarding compliance with the provisions of subsection (1) of this section. The commissioner shall provide a summary of this information to the health care authority for inclusion in the interagency report to the legislature under section 3 of this act.

(3) The commissioner may adopt rules necessary to implement and enforce this section and may impose penalties pursuant to RCW 48.05.185 for noncompliance with this section.

NEW SECTION. **Sec. 12.** (1) State purchased health care, in coordination with other private and public purchasers, shall develop common and aligned procurement methodologies, best practices to assure implementation of contractual provisions, common payer and delivery system organization expectations, and aligned utilization of the statewide measure set under section 10 of this act.

(2) State purchased health care initiatives and purchasing strategies must be consistent with the provisions of sections 2 through 13 of this act.

(3) State purchased health care must submit paid claims data to the statewide all payer health care claims database, in compliance with the timeline, criteria, and rules established under sections 8 and 9 of this act. State purchased health care contracts for the purchase or administration of health care services must require compliance with the reporting requirements in this subsection. The authority shall request state purchased health care agencies to provide a status report regarding compliance with the provisions of this subsection. The authority shall include a summary of the information, in the annual report to the legislature under section 3 of this act.

NEW SECTION. **Sec. 13.** 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 as provided in sections 2 through 13 of this act and the provisions of RCW 70.320.020, the health care authority and the department of social and health services 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 department shall develop and utilize innovative mechanisms to spread and sustain integrated clinical models of physical and behavioral health care including: Practice transformation support and resources; workforce capacity and flexibility; shared clinical information sharing, tools, resources, and training; and outcome-based payments to providers.

(2) The authority and department shall facilitate and utilize the accountable collaboratives for health and primary health regional extension services infrastructure established in sections 4 and 7 of this act and RCW 43.70.533 to support integration of services and transformation to a provider payment system based on cost, quality, and effectiveness. This must include the agencies engaging in a partnership with established accountable collaboratives for health to provide shared leadership and involvement in developing medicaid procurement criteria and local oversight of performance.

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

(a) Equitable access to effective behavioral health services for adults and children is an essential state priority;

(b) People with complex behavioral health conditions often do not receive comparable access to, and quality of, physical health care, resulting in increased rates of morbidity and mortality. Any new approach must address this core disparity for individuals with either common or complex behavioral health challenges;

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

(d) Behavioral health services and interventions are linked to local systems such as law enforcement and other first responders, courts, and jails. These community connections must be amplified through new levels of accountability supported by community governance and oversight;

(e) Medicaid benefit design must include adequate preventive care, crisis intervention, and support services that ensure 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 10 of this act, that ensure meaningful integration at the patient care level with broadly distributed accountability for results;

(g) Active purchasing and oversight of medicaid managed care contracts is a shared state and community responsibility, without which individuals with behavioral health needs will suffer;

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

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

NEW SECTION. **Sec. 14.** Sections 2 through 4, 10, and 12 of this act are each added to chapter 41.05 RCW.

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