SENATE BILL REPORT
ESSB 5741

As Amended by House, April 24, 2019

Title: An act relating to making changes to support future operations of the state all payer claims database by transferring the responsibility to the health care authority, partnering with a lead organization with broad data experience, including with self-insured employers, and other changes to improve and ensure successful and sustainable database operations for access to and use of the data to improve health care, providing consumers useful and consistent quality and cost measures, and assess total cost of care in Washington state.

Brief Description: Making changes to support future operations of the state all payer claims database by transferring the responsibility to the health care authority, partnering with a lead organization with broad data experience, including with self-insured employers, and other changes to improve and ensure successful and sustainable database operations for access to and use of the data to improve health care, providing consumers useful and consistent quality and cost measures, and assess total cost of care in Washington state.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Keiser, Rivers, Frockt and Mullet; by request of Office of Financial Management and Health Care Authority).

Brief History:

Committee Activity: Health & Long Term Care: 2/18/19, 2/19/19 [DPS-WM, DNP].
Ways & Means: 2/27/19, 3/01/19 [DPS (HLTC), DNP, w/oRec].

Floor Activity:

Passed Senate: 3/13/19, 47-1.
Passed House: 4/16/19, 91-5; 4/24/19, 91-3.

Brief Summary of Engrossed First Substitute Bill

- Transfers authority and oversight of the All Payer Claims Database (APCD) from the Office of Financial Management to the Health Care Authority.
- Permits the lead organization to enter into a contract with multiple data vendors.
- Permits tribal agencies and the Health Benefit Exchange to access and use data from the APCD not containing direct patient identifiers.
- Establishes a state agency coordinating structure.

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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5741 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Randall, Vice Chair; Conway, Dhingra, Frockt, Keiser, Rivers and Van De Wege.

Minority Report: Do not pass.

Signed by Senators O'Ban, Ranking Member; Bailey and Becker.

Staff: Evan Klein (786-7483)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Mullet, Capital Budget Cabinet; Billig, Carlyle, Conway, Darneille, Hasegawa, Hunt, Keiser, Liias, Palumbo, Pedersen, Rivers and Van De Wege.

Minority Report: Do not pass.

Signed by Senators Schoesler and Warnick.

Minority Report: That it be referred without recommendation.

Signed by Senators Braun, Ranking Member; Honeyford, Assistant Ranking Member, Capital; Becker, Wagoner and Wilson, L..

Staff: Sandy Stith (786-7710)

Background: The 2014 Legislature directed the Office of Financial Management (OFM) to establish a statewide all-payer health care claims database. The goals of the database are to improve transparency to:

- assist patients, providers, and hospitals to make informed choices about care;
- enable providers, hospitals, and communities to benchmark their performance;
- enable purchasers to identify value, build expectations into their purchasing strategies, and reward improvements over time; and
- promote competition based on quality and cost.

The director of the OFM is required to 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. At the direction of OFM, the lead organization must, among other things:

- design collection mechanisms with consideration for time, cost, and benefits;
- ensure protection of collected data;
- make information from the database available as a resource;
- develop policies to ensure quality of data releases;
- develop a plan for financial sustainability and charge fees; and
- appoint advisory committees on data policy and the data release process.

Data suppliers must submit claims data to the database within the time frames established by OFM and in accordance with procedures established by the lead organization. Claims data includes (1) data related to health care coverage and services funded in the operating budget for Medicaid programs and the Public Employees Benefits Board program; and (2) data voluntarily provided by other data suppliers, including carriers and self-funded employers. An entity that is not a data supplier but chooses to participate in the database must require any third-party administrator to release any claims data related to persons receiving health coverage from the entity's plan.

The lead organization must maintain the confidentiality of the data it collects including direct or indirect patient identifiers. Any person who receives data with patient identifiers must also maintain confidentiality and may not release the information. Data with direct or indirect patient identifiers may be released to (1) federal, state, and local government agencies upon receipt of a signed data use agreement and (2) researchers with approval of an institutional review board upon receipt of a signed confidentiality agreement. Data with indirect patient identifiers may be released to an agency, researcher, and other person upon receipt of a signed data use agreement. Data not containing direct or indirect patient identifiers may be released upon request.

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

Under the supervision of OFM, the lead organization must use statewide performance measures and the database to prepare health care data reports. Prior to releasing reports using claims data, the lead organization must submit the reports to OFM for review and approval. Comparisons of costs among systems must account for differences, including acuity of patients.

Summary of Engrossed First Substitute Bill: The authority and oversight of the APCD are moved from OFM to the Health Care Authority (HCA). By July 1, 2019, OFM and HCA must develop a transition plan to sustain operations.

When determining the appropriate lead organization contractor, the HCA must consider:

- the organization's degree of experience in health care data collection;
- whether the organization has a long-term self-sustaining model;
- the organizations experience convening stakeholders, especially among groups of health providers, carriers, and self-insured purchasers;
- the organizations experience in meeting budget and timelines for reports; and
- the organization's ability to combine cost and quality data, especially among groups of health providers, carriers, and self-insured purchasers.

In conducting the procurement, HCA must ensure that no officer or employee participating in the procurement process has a conflict with the proper discharge of their duties, or is a member of a bidding organization's board of directors, advisory committee, or similar group.

Any officer or employee with a prohibited relationship must withdraw from the procurement process.

The lead organization is permitted to enter into a contract with multiple data vendors. Any claims data collected by the APCD is owned by the state, and ownership may not be transferred to the lead organization or data vendor through a contract.

Requiring the lead organization to develop a plan for the APCD to be self-sustaining is removed. The lead organization must develop a plan for the financial sustainability of the APCD, as may be reasonable and customary, compared to other states' databases.

Requiring each request for claims data to include the method by which the data will be stored or returned to the lead organization is removed.

Tribal agencies and the Washington Health Benefit Exchange, upon receipt of a signed data use agreement, are permitted to access and use data from the APCD not containing direct patient identifiers, but that may contain proprietary financial information, indirect patient identifiers, or unique identifiers.

Persons and entities with data use agreements in place on June 1, 2019, must be permitted to extend those agreements through June 30, 2020, with the same fee schedule, if the person or entity chooses.

Beginning July 1, 2020, the school employees' benefits board must submit claims data to the APCD.

The lead organization may not publish any Medicaid data that is in conflict with the biannual Medicaid forecast.

HCA is required to report on any grants received to the Legislature annually.

OFM is directed to convene a state agency coordinating structure, consisting of agencies with related data needs, to assess and improve performance of the APCD and the health benefit exchange. The coordinating structure must collaborate in a private or public manner with the lead organization and accountable communities of health, and consult with OFM in any development of database policies and rules. OFM must be a key part of the coordinating structure and evaluate progress towards meeting the goals of the APCD. OFM must annually assess:

- the list of approved agency use case projects;
- successful and unsuccessful data requests;
- on-line data portal access;
- adequacy of data security; and
- timeliness, adequacy, and responsiveness of the APCD regarding requests for access to data.

HCA and OFM, in consultation with the agency coordinating structure, lead organization, data vendor, and the performance management coordinating committee, must jointly develop an effectiveness review process for the state common measure set.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Staff Summary of Public Testimony on Original Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: The APCD took several years to establish, and OFM did a fantastic job setting it up. However, the APCD does not include a large swath of the market, because self-insured health plans are not currently reporting to the APCD. The hope is to establish a state agency coordinating structure that will help institutionalize the program. The Washington Health Alliance supports a single APCD in Washington, managed by the Alliance. A single database will save money and lead to efficiencies in reporting claims data in Washington. The Alliance represents purchasers, payers, and consumers. The trusted relationships developed by the Alliance can help unify the two all payer claims databases. There is concern about the sustainability of the APCD. Moving forward, the state should set reasonable expectations. The APCD is a tool that makes price and quality data transparent. A single sustainable APCD is more important now than ever, in order to move towards value based purchasing and affordable health care. The Health Benefit Exchange has been purchasing data from the APCD, and has found the data extremely helpful.

OTHER: The bill needs to clarify exactly how the data in the Alliance's current database is going to be used, and that the protections under the current APCD are maintained.

Persons Testifying (Health & Long Term Care): PRO: Fred Jarrett, Washington Health Alliance; Steve Mullin, Washington Roundtable; Sue Birch, HCA Director; Pam MacEwen, CEO, Washington HBE; Marc Baldwin, OFM.

OTHER: Meg Jones, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: This is an important bill and one the agencies have worked hard to present. This bill changes the APCD authorities from OFM to HCA. That takes effect January 1, 2020. The only reason OFM has a fiscal note is that we have to keep the lights on through December 31, 2019, and we have responsibilities through that time. We have not ever had state funds allocated to this project. This has been done through federal funds, some of which run out at the end of June. We collaborated extensively with OFM. This will allow us to take the state’s APCD to the next level with more data, potentially some of those more voluntary submissions from plans, more clinical information, and build on their previous work in helping us understand cost drivers and spending trends in making health care more affordable. APCDs cost money. Other states have tried to make them self-sustaining. This has largely been unsuccessful. Most have been sustained through SIM funding. This has run out. We think we may be able to get some Medicaid match for this work.

Persons Testifying (Ways & Means): PRO: Senator Karen Keiser, Prime Sponsor; Dr. Judy Zerzan, HCA, Chief Medical Officer; Marc Baldwin, OFM, Assistant Director.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.

EFFECT OF HOUSE AMENDMENT(S):

- Removes the provision that claims data in the APCD is owned by the state and may not be transferred to the lead organization or data vendor.
- Permits copies of the claims data information to be retained by the lead organization.
- Specifies that HCA must give strong consideration to a bidding organization's experience in convening stakeholders, especially among groups of health providers, carries and self-insured purchasers.
- Specifies that HCA must give strong consideration to a bidding organization's ability to combine cost and quality data, to assess total cost of care.
- Prohibits HCA from selecting a lead organization that is a health plan, hospital, provider, third-party administrator, or is an entity with a controlling interest in any of these entities.
- Transfers the authority for convening a state agency coordinating structure from OFM to HCA.
- Modifies the purpose of the state agency coordinating structure such that the structure is responsible for ensuring the database is meeting the needs of state agencies and other data users, rather than being responsible for assessing and improving database performance by state agencies.
- Requires the HCA to provide the OFM with the necessary information needed to complete the database progress evaluation report in an efficient and not overly burdensome manner.
- Adds a null and void clause.