

E2SHB 2572 - S COMM AMD

By Committee on Ways & Means

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** (1) The legislature finds that the state of
4 Washington has an opportunity to transform its health care delivery
5 system.

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

9 (a) Improve health overall by stressing prevention and early
10 detection of disease and integration of behavioral health;

11 (b) Developing linkages between the health care delivery system and
12 community; and

13 (c) Supporting regional collaboratives for communities and
14 populations, improve health care quality, and lower costs.

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

19 (2) Prior to the authority submitting a grant application for
20 innovation plan funding, the authority must consult a neutral actuarial
21 firm not currently contracted with the agency to review the estimated
22 savings with the innovation plan prior to application submission. The
23 plan and the actuarial information must be presented to the joint
24 select committee on health care oversight, including the scope and
25 details of the grant application and any request for proposal, prior to
26 an application submission. The joint committee must review the
27 application in a timely fashion that enables the grant application, if
28 approved, to be submitted within the required time frame.

29 (3) The grant application cannot commit the state to any financial

1 obligations beyond the actual grant award amount.

2 (4) All required federal reporting related to a grant award must be
3 shared with the joint committee at the same time it is submitted to the
4 federal government.

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

14 NEW SECTION. **Sec. 3.** (1) The joint select committee on health
15 care oversight is established in statute, continuing the committee
16 created in Engrossed Substitute Senate Concurrent Resolution No. 8401
17 passed in 2013.

18 (2) The membership of the joint select committee on health care
19 oversight must consist of the following: (a) The chairs of the health
20 care committees of the senate and the house of representatives, who
21 must serve as cochairs; (b) four additional members of the senate, two
22 each appointed by the leadership of the two largest political parties
23 in the senate; and (c) four additional members of the house of
24 representatives, two each appointed by the leadership of the two
25 largest political parties in the house of representatives. The
26 governor must be invited to appoint, as a liaison to the joint select
27 committee, a person who must be a nonvoting member.

28 (3) The joint select committee on health care oversight must
29 provide oversight between the health care authority, health benefit
30 exchange, the office of the insurance commissioner, the department of
31 health, and the department of social and health services. The goal
32 must be to ensure that these entities are not duplicating their efforts
33 and are working toward a goal of increased quality of services which
34 will lead to reduced costs to the health care consumer.

35 (4) The joint select committee on health care oversight must, as
36 necessary, propose legislation to the health care committees and budget

1 recommendations to the ways and means committees of the legislature
2 that aids in their coordination of activities and that leads to better
3 quality and cost savings.

4 (5) The joint select committee on health care oversight expires on
5 December 31, 2022.

6 NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05 RCW
7 to read as follows:

8 (1) The authority shall, subject to the availability of amounts
9 appropriated or grants received for this specific purpose, award grants
10 to support the development of two pilot projects for a community of
11 health. A community of health is a regionally based, voluntary
12 collaborative. The purpose of the collaborative is to align actions to
13 achieve healthy communities and populations, improve health care
14 quality, and lower costs. Grants may only be used for start-up costs.

15 (2) The authority shall develop a process for designating an entity
16 as a community of health. An entity seeking designation is eligible
17 if:

18 (a) It is a nonprofit or public-private partnership, including
19 those led by local public health agencies;

20 (b) Its membership is broad and incorporates key stakeholders, such
21 as the long-term care system, the health care delivery system,
22 behavioral health, social supports and services, primary care and
23 specialty providers, hospitals, consumers, small and large employers,
24 health plans, and public health, with no single entity or
25 organizational cohort serving in a majority capacity; and

26 (c) It demonstrates an ongoing capacity to:

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

30 (ii) Distribute tools and resources from the health extension
31 program created in section 5 of this act.

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

34 (a) Base decisions on public input and an active collaboration
35 among key community partners, which can include, but are not limited
36 to, local governments, housing providers, school districts, early
37 learning regional coalitions, large and small businesses, labor

1 organizations, health and human service organizations, tribal
2 governments, health carriers, providers, hospitals, public health
3 agencies, and consumers;

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

5 (c) Demonstrate capability for sustainability without reliance on
6 state general fund appropriations.

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

10 (5) Before grant funds are disbursed, the authority and the
11 applicant must agree on performance requirements.

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

14 (1) Subject to the availability of amounts appropriated for this
15 specific purpose, the department shall establish a health extension
16 program to provide training, tools, and technical assistance to primary
17 care, behavioral health, and other providers. The program must
18 emphasize high quality preventive, chronic disease, and behavioral
19 health care that is comprehensive and evidence-based.

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

22 (a) Integration of physical and behavioral health;

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

24 (c) Reports of the Robert Bree collaborative created by RCW
25 70.250.050 and findings of health technology assessments under RCW
26 70.14.080 through 70.14.130;

27 (d) Methods of formal assessment;

28 (e) Support for patients managing their own conditions;

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

32 (g) Identification of evidence-based models to effectively treat
33 depression and other conditions in primary care settings, such as the
34 program advancing integrated mental health solutions, and others.

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

1 NEW SECTION. **Sec. 6.** A new section is added to chapter 41.05 RCW
2 to read as follows:

3 (1) There is created a performance measures committee, the purpose
4 of which is to identify and recommend standard statewide measures of
5 health performance to inform public and private health care purchasers
6 and to propose benchmarks to track costs and improvements in health
7 outcomes.

8 (2) Members of the committee must include representation from state
9 agencies, small and large employers, health plans, patient groups,
10 federally recognized tribes, consumers, academic experts on health care
11 measurement, hospitals, physicians, and other providers. The governor
12 shall appoint the members of the committee, except that a statewide
13 association representing hospitals may appoint a member representing
14 hospitals, and a statewide association representing physicians may
15 appoint a member representing physicians. The governor shall ensure
16 that members represent diverse geographic locations and both rural and
17 urban communities. The chief executive officer of the lead
18 organization must also serve on the committee. The committee must be
19 chaired by the director of the authority.

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

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

- 25 (a) Prevention and screening;
- 26 (b) Effective management of chronic conditions;
- 27 (c) Key health outcomes;
- 28 (d) Care coordination and patient safety; and
- 29 (e) Use of the lowest cost, highest quality care for preventive
30 care and acute and chronic conditions.

31 (5) The committee shall develop a measure set that:

- 32 (a) Is of manageable size;
- 33 (b) Is based on readily available claims and clinical data;
- 34 (c) Gives preference to nationally reported measures and, where
35 nationally reported measures may not be appropriate, measures used by
36 state agencies that purchase health care or commercial health plans;
- 37 (d) Focuses on the overall performance of the system, including
38 outcomes and total cost;

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

4 (f) Considers the needs of different stakeholders and the
5 populations served; and

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

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

12 (7) The committee shall establish a public process to periodically
13 evaluate the measure set and make additions or changes to the measure
14 set as needed.

15 NEW SECTION. **Sec. 7.** A new section is added to chapter 74.09 RCW
16 to read as follows:

17 (1) The authority and the department may restructure medicaid
18 procurement of health care services and agreements with managed care
19 systems on a phased basis to better support integrated physical health,
20 mental health, and chemical dependency treatment. By January 1, 2019,
21 medicaid services provided under this chapter and chapters 71.24,
22 71.36, and 70.96A RCW may be fully integrated in a managed health care
23 system that provides mental health, chemical dependency, and medical
24 care services to medicaid clients. The authority and the department
25 may develop and utilize innovative mechanisms to promote and sustain
26 integrated clinical models of physical and behavioral health care.

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

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

34 (b) Accountability for the client outcomes established in RCW
35 43.20A.895 and 71.36.025 and performance measures linked to those
36 outcomes;

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

4 (d) Evidence-based care interventions and continuous quality
5 improvement must be enforced through contract specifications and
6 performance measures that provide meaningful integration at the patient
7 care level with broadly distributed accountability for results;

8 (e) Active purchasing and oversight of medicaid managed care
9 contracts is a state responsibility;

10 (f) A deliberate and flexible system change plan with identified
11 benchmarks to promote system stability, provide continuity of treatment
12 for patients, and protect essential existing behavioral health system
13 infrastructure and capacity; and

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

16 (3) The principles identified in subsection (2) of this section are
17 not intended to create an individual entitlement to services.

18 (4) The authority shall increase the use of value based
19 contracting, alternative quality contracting, and other payment
20 incentives that promote quality, efficiency, cost savings, and health
21 improvement, for medicaid and public employee purchasing. The
22 authority shall also implement additional chronic disease management
23 techniques that reduce the subsequent need for hospitalization or
24 readmissions. It is the intent of the legislature that the reforms the
25 authority implements under this subsection are anticipated to reduce
26 extraneous medical costs, across all medical programs, when fully
27 phased in by fiscal year 2017 to generate budget savings identified in
28 the omnibus appropriations act.

29 NEW SECTION. **Sec. 8.** The definitions in this section apply
30 throughout this chapter unless the context clearly requires otherwise.

31 (1) "Authority" means the health care authority.

32 (2) "Carrier" and "health carrier" have the same meaning as in RCW
33 48.43.005.

34 (3) "Claims data" means the data required by section 11 of this act
35 to be submitted to the database, as defined by the director in rule.
36 "Claims data" includes, but is not limited to, claims data related to
37 health care coverage and services funded, in whole or in part, in the

1 omnibus appropriations act, including coverage and services funded by
2 appropriated and nonappropriated state and federal moneys, for medicaid
3 programs and the public employees benefits board program.

4 (4) "Database" means the statewide all-payer health care claims
5 database established in section 10 of this act.

6 (5) "Director" means the director of financial management.

7 (6) "Lead organization" means the organization selected under
8 section 10 of this act.

9 (7) "Office" means the office of financial management.

10 NEW SECTION. **Sec. 9.** The legislature finds that:

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

18 (2) The benefits of collaboration, together with active state
19 supervision, outweigh potential adverse impacts. Therefore, the
20 legislature intends to exempt from state antitrust laws, and provide
21 immunity through the state action doctrine from federal antitrust laws,
22 activities that are undertaken, reviewed, and approved by the office
23 pursuant to this chapter that might otherwise be constrained by such
24 laws. The legislature does not intend and does not authorize any
25 person or entity to engage in activities not provided for by this
26 chapter, and the legislature neither exempts nor provides immunity for
27 such activities including, but not limited to, agreements among
28 competing providers or carriers to set prices or specific levels of
29 reimbursement for health care services.

30 NEW SECTION. **Sec. 10.** (1) The office shall establish a statewide
31 all-payer health care claims database to support transparent public
32 reporting of health care information. The database must improve
33 transparency to: Assist patients, providers, and hospitals to make
34 informed choices about care; enable providers, hospitals, and
35 communities to improve by benchmarking their performance against that
36 of others by focusing on best practices; enable purchasers to identify

1 value, build expectations into their purchasing strategy, and reward
2 improvements over time; and promote competition based on quality and
3 cost.

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

8 (a) Collect claims data from data suppliers as provided in section
9 11 of this act;

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

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

16 (d) Consistent with the requirements of this chapter, make
17 information from the database available as a resource for public and
18 private entities, including carriers, employers, providers, hospitals,
19 and purchasers of health care;

20 (e) Report performance on cost and quality pursuant to section 14
21 of this act using, but not limited to, the performance measures
22 developed under section 6 of this act;

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

25 (g) Develop a plan for the financial sustainability of the database
26 and charge fees not to exceed five thousand dollars for reports and
27 data files as needed to fund the database. Any fees must be approved
28 by the office and must be comparable across data requesters and users;
29 and

30 (h) Convene advisory committees with the approval and participation
31 of the office, including: (i) A committee on data policy development;
32 and (ii) a committee to establish a data release process consistent
33 with the requirements of this chapter and to provide advice regarding
34 formal data release requests. The advisory committees must include
35 representation from key provider, hospital, payer, public health,
36 health maintenance organization, purchaser, and consumer organizations.

1 NEW SECTION. **Sec. 11.** (1) Data suppliers must submit claims data
2 to the database within the time frames established by the director in
3 rule and in accordance with procedures established by the lead
4 organization.

5 (2) An entity that is not a data supplier but that chooses to
6 participate in the database shall require any third-party administrator
7 utilized by the entity's plan to release, at no additional cost, any
8 claims data related to persons receiving health coverage from the plan.

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

13 NEW SECTION. **Sec. 12.** (1) The claims data provided to the
14 database, the database itself, including the data compilation, and any
15 raw data received from the database are not public records and are
16 exempt from public disclosure under chapter 42.56 RCW.

17 (2) Claims data obtained in the course of activities undertaken
18 pursuant to or supported under this chapter are not subject to subpoena
19 or similar compulsory process in any civil or criminal, judicial, or
20 administrative proceeding, nor may any individual or organization with
21 lawful access to data under this chapter be compelled to testify with
22 regard to such data, except that data pertaining to a party in
23 litigation may be subject to subpoena or similar compulsory process in
24 an action brought by or on behalf of such individual to enforce any
25 liability arising under this chapter.

26 NEW SECTION. **Sec. 13.** (1) Except as otherwise required by law,
27 claims or other data from the database shall only be available for
28 retrieval in original or processed form to public and private
29 requesters pursuant to this section and shall be made available within
30 a reasonable time after the request.

31 (2) Except as otherwise required by law, the office shall direct
32 the lead organization to maintain the confidentiality of claims or
33 other data it collects for the database that include direct and
34 indirect patient identifiers. Any agency, researcher, or other person
35 that receives claims or other data under this section containing direct
36 or indirect patient identifiers must also maintain confidentiality and

1 may not release such claims or other data except as consistent with
2 this section. The office shall oversee the lead organization's release
3 of data as follows:

4 (a) Claims or other data that include direct or indirect patient
5 identifiers, as specifically defined in rule, may be released to:

6 (i) Federal, state, and local government agencies upon receipt of
7 a signed data use agreement with the office and the lead organization;
8 and

9 (ii) Researchers with approval of an institutional review board
10 upon receipt of a signed confidentiality agreement with the office and
11 the lead organization.

12 (b) Claims or other data that do not contain direct patient
13 identifiers but that may contain indirect patient identifiers may be
14 released to agencies, researchers, and other persons upon receipt of a
15 signed data use agreement with the lead organization.

16 (c) Claims or other data that do not contain direct or indirect
17 patient identifiers may be released upon request.

18 (3) Recipients of claims or other data under subsection (2)(a) or
19 (b) of this section must agree in a data use agreement or a
20 confidentiality agreement to, at a minimum:

21 (a) Take steps to protect direct and indirect patient identifying
22 information as described in the agreement; and

23 (b) Not redisclose the data except as authorized in the agreement
24 consistent with the purpose of the agreement or as otherwise required
25 by law.

26 (4) Recipients of the claims or other data under subsection (2)(b)
27 of this section must not attempt to determine the identity of persons
28 whose information is included in the data set or use the claims or
29 other data in any manner that identifies the individuals or their
30 families.

31 (5) For purposes of this section, the following definitions apply
32 unless the context clearly requires otherwise.

33 (a) "Direct patient identifier" means information that identifies
34 a patient.

35 (b) "Indirect patient identifier" means information that may
36 identify a patient when combined with other information.

1 NEW SECTION. **Sec. 14.** (1) Under the supervision of the office,
2 the lead organization shall prepare health care data reports using the
3 database and the statewide health performance and quality measure set,
4 including only those measures that can be completed with readily
5 available claims data. Prior to releasing any health care data reports
6 that use claims data, the lead organization must submit the reports to
7 the office for review and approval.

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

12 (i) Whether providers and health systems deliver efficient, high
13 quality care; and

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

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

20 (c) Comparisons of costs among providers and health care systems
21 must account for differences in acuity of patients, as appropriate and
22 feasible, and must take into consideration the cost impact of
23 subsidization for uninsured and governmental patients, as well as
24 teaching expenses, when feasible with available data.

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

27 (a) Directly or indirectly identify patients; or

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

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

33 (a) Allows the data supplier, the hospital, or the provider to
34 verify the accuracy of the information submitted to the lead
35 organization and submit to the lead organization any corrections of
36 errors with supporting evidence and comments within forty-five days of
37 receipt of the report; and

1 (b) Corrects data found to be in error within a reasonable amount
2 of time.

3 (5) The office and the lead organization may use claims data to
4 identify and make available information on payers, providers, and
5 facilities, but may not use claims data to recommend or incentivize
6 direct contracting between providers and employers.

7 (6) The lead organization shall ensure that no individual data
8 supplier comprises more than twenty-five percent of the claims data
9 used in any report or other analysis generated from the database. For
10 purposes of this subsection, a "data supplier" means a carrier and any
11 self-insured employer that uses the carrier's provider contracts.

12 NEW SECTION. **Sec. 15.** (1) The director shall adopt any rules
13 necessary to implement this chapter, including:

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

18 (b) Deadlines for submission of claim files;

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

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

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

25 (2) The director may not adopt rules, policies, or procedures
26 beyond the authority granted in this chapter.

27 NEW SECTION. **Sec. 16.** A new section is added to chapter 48.02 RCW
28 to read as follows:

29 (1) The commissioner may not use data acquired from the statewide
30 all-payer health care claims database created in section 10 of this act
31 for purposes of reviewing rates pursuant to this title.

32 (2) The commissioner's authority to access data from any other
33 source for rate review pursuant to this title is not otherwise
34 curtailed, even if that data may have been separately submitted to the
35 statewide all-payer health care claims database.

1 **Sec. 17.** RCW 42.56.360 and 2013 c 19 s 47 are each amended to read
2 as follows:

3 (1) The following health care information is exempt from disclosure
4 under this chapter:

5 (a) Information obtained by the pharmacy quality assurance
6 commission as provided in RCW 69.45.090;

7 (b) Information obtained by the pharmacy quality assurance
8 commission or the department of health and its representatives as
9 provided in RCW 69.41.044, 69.41.280, and 18.64.420;

10 (c) Information and documents created specifically for, and
11 collected and maintained by a quality improvement committee under RCW
12 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee
13 under RCW 4.24.250, or by a quality assurance committee pursuant to RCW
14 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056,
15 for reporting of health care-associated infections under RCW 43.70.056,
16 a notification of an incident under RCW 70.56.040(5), and reports
17 regarding adverse events under RCW 70.56.020(2)(b), regardless of which
18 agency is in possession of the information and documents;

19 (d)(i) Proprietary financial and commercial information that the
20 submitting entity, with review by the department of health,
21 specifically identifies at the time it is submitted and that is
22 provided to or obtained by the department of health in connection with
23 an application for, or the supervision of, an antitrust exemption
24 sought by the submitting entity under RCW 43.72.310;

25 (ii) If a request for such information is received, the submitting
26 entity must be notified of the request. Within ten business days of
27 receipt of the notice, the submitting entity shall provide a written
28 statement of the continuing need for confidentiality, which shall be
29 provided to the requester. Upon receipt of such notice, the department
30 of health shall continue to treat information designated under this
31 subsection (1)(d) as exempt from disclosure;

32 (iii) If the requester initiates an action to compel disclosure
33 under this chapter, the submitting entity must be joined as a party to
34 demonstrate the continuing need for confidentiality;

35 (e) Records of the entity obtained in an action under RCW 18.71.300
36 through 18.71.340;

37 (f) Complaints filed under chapter 18.130 RCW after July 27, 1997,
38 to the extent provided in RCW 18.130.095(1);

1 (g) Information obtained by the department of health under chapter
2 70.225 RCW;

3 (h) Information collected by the department of health under chapter
4 70.245 RCW except as provided in RCW 70.245.150;

5 (i) Cardiac and stroke system performance data submitted to
6 national, state, or local data collection systems under RCW
7 70.168.150(2)(b); (~~and~~)

8 (j) All documents, including completed forms, received pursuant to
9 a wellness program under RCW 41.04.362, but not statistical reports
10 that do not identify an individual; and

11 (k) Data and information exempt from disclosure under section 12 of
12 this act.

13 (2) Chapter 70.02 RCW applies to public inspection and copying of
14 health care information of patients.

15 (3)(a) Documents related to infant mortality reviews conducted
16 pursuant to RCW 70.05.170 are exempt from disclosure as provided for in
17 RCW 70.05.170(3).

18 (b)(i) If an agency provides copies of public records to another
19 agency that are exempt from public disclosure under this subsection
20 (3), those records remain exempt to the same extent the records were
21 exempt in the possession of the originating entity.

22 (ii) For notice purposes only, agencies providing exempt records
23 under this subsection (3) to other agencies may mark any exempt records
24 as "exempt" so that the receiving agency is aware of the exemption,
25 however whether or not a record is marked exempt does not affect
26 whether the record is actually exempt from disclosure.

27 **Sec. 18.** RCW 70.02.045 and 2000 c 5 s 2 are each amended to read
28 as follows:

29 Third-party payors shall not release health care information
30 disclosed under this chapter, except as required by chapter 43.--- RCW
31 (the new chapter created in section 22 of this act) and to the extent
32 that health care providers are authorized to do so under RCW 70.02.050.

33 NEW SECTION. **Sec. 19.** If any provision of this act or its
34 application to any person or circumstance is held invalid, the
35 remainder of the act or the application of the provision to other
36 persons or circumstances is not affected.

1 NEW SECTION. **Sec. 20.** Section 3 of this act constitutes a new
2 chapter in Title 44 RCW.

3 NEW SECTION. **Sec. 21.** Section 4 of this act expires July 1, 2020.

4 NEW SECTION. **Sec. 22.** Sections 8 through 15 of this act
5 constitute a new chapter in Title 43 RCW."

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By Committee on Ways & Means

6 On page 1, line 5 of the title, after "supports;" strike the
7 remainder of the title and insert "amending RCW 42.56.360 and
8 70.02.045; adding new sections to chapter 41.05 RCW; adding a new
9 section to chapter 43.70 RCW; adding a new section to chapter 74.09
10 RCW; adding a new section to chapter 48.02 RCW; adding a new chapter to
11 Title 44 RCW; adding a new chapter to Title 43 RCW; creating new
12 sections; and providing an expiration date."

EFFECT: Modifies intent section.

HCA must have a neutral actuarial firm review the estimated savings in the innovation plan prior to application.

Before the 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 (from December 31, 2017, established in Engrossed Substitute Senate Concurrent Resolution No. 8401, in 2013).

Changes the "accountable collaborative for health" to "community of health", removes the establishment of regional boundaries, modifies the community of health grant criteria, and reduces 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 Health Technology Assessment program, and inserts information on evidence-based models to effectively treat depression and other conditions such as the AIMS program.

Restores and modifies the Performance Measures Committee to recommend statewide measures and benchmarks; adds a representative of the federally recognized tribes and the nurses association.

Modifies the Medicaid purchasing, changing the integration of behavioral health from shall to may, modifies guiding principles and makes them permissive.

Adds 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.

Restores the references to the all-payer claims database and related data protections, but modifies the reporting to include the state funded claims in the Medicaid programs and Public Employees' Benefits Board program.

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