FINAL BILL REPORT
ESHB 1311

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Synopsis as Enacted

Brief Description: Creating a collaborative to improve health care quality, cost-effectiveness, and outcomes.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Bailey, Green, Clibborn, Appleton, Moeller, Frockt, Seaquist and Dickerson).

House Committee on Health Care & Wellness
House Committee on Health & Human Services Appropriations & Oversight
Senate Committee on Health & Long-Term Care

Background:

The Health Care Authority (Authority) administers state employee health benefit programs through the Public Employees Benefits Board, as well as health care programs targeted at low-income individuals, such as the Basic Health Plan and the Community Health Services Grants. In addition, the Authority coordinates initiatives related to state-purchased health care, such as the Prescription Drug Program and the Health Technology Assessment Program. Through the Prescription Drug Program, the state contracts for independent reviews of prescription drugs to compare the safety, efficacy, and effectiveness of drug classes from which recommendations are made by a clinical committee for the development of a preferred drug list. The Health Technology Assessment program reviews scientific, evidence-based reports about the safety and effectiveness of medical devices, procedures, and tests, and a clinical committee determines whether or not the state should pay for them.

Chapter 258, Laws of 2009 (Engrossed Substitute House Bill 2105) established a work group to be appointed by the Authority. The work group included physicians and private and public health care purchasers. The work group was responsible for identifying evidence-based best practice guidelines and decision support tools related to advanced diagnostic imaging services. All state-purchased health care programs that purchase services directly were required to implement the guidelines by September 1, 2009. The work group expired on July 1, 2010.

Summary:

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.

Legislative findings are established related to the need for public and private health care purchasers to work together to improve the quality and cost-effectiveness of health care services and the existence of substantial variations in practice patterns or high utilization trends as indicators of poor quality and potential waste. Legislative declarations are made regarding the need for state and private health care purchasers to collaborate to identify strategies to increase the effectiveness of health care and to provide immunity from state and federal antitrust laws. It is stated that it is not the Legislature's intent to mandate payment or coverage decisions by private health carriers or purchasers.

The Robert Bree Collaborative (Collaborative) is established. The Collaborative consists of 20 members appointed by the Governor. The members include:

- two representatives of health carriers or third party administrators;
- one representative of a health maintenance organization;
- one representative of a national health carrier;
- two physicians, one of whom is a primary care provider, representing large multispecialty clinics with 50 or more physicians;
- two physicians, one of whom is a primary care provider, representing clinics with fewer than 50 physicians;
- one osteopathic physician;
- two physicians representing the largest hospital-physician groups in the state;
- three representatives of hospital systems, at least one of whom is responsible for quality;
- three representatives of self-funded purchasers;
- two representatives of state-purchased health care programs; and
- one representative of the Puget Sound Health Alliance.

The Collaborative is required to add members or establish clinical committees to acquire clinical expertise in particular health care service areas under review. Clinical committees must include at least two members who are associated with the most experienced specialty or subspecialty society for the health services under consideration. No member may be compensated for his or her service. Members of the Collaborative and clinical committees are immune from civil liability for any decisions made in good faith while conducting work related to the Collaborative or its clinical committees. The Collaborative's proceedings must be open to the public and notice of meetings must be provided at least 20 days in advance. The Collaborative may not begin its work unless there are sufficient federal funds, private funds, or state funds available through other ongoing health care service review efforts. Private funds may not be accepted if their receipt could present a potential conflict of interest in the Collaborative's deliberations.

The Collaborative must annually identify up to three health care services for which there are substantial variations in practice patterns or high utilization trends in Washington. In addition, the services must not produce better care outcomes and be indicators of poor quality and potential waste in the health care system.

Upon the identification of such health care services, the Collaborative is required to identify evidence-based best practices to improve quality and reduce variation in the use of the service. The Collaborative must also identify data collection and reporting for the development of baseline utilization rates and ways to measure the impact of strategies to

promote the use of the best practices. To the extent possible, the reporting must minimize cost and administrative effort and use existing data resources.

Lastly, the Collaborative must identify strategies to increase the use of the evidence-based practices. The strategies may include: goals for appropriate utilization rates; peer-to-peer consultation; provider feedback reports; use of patient decision aids; incentives for the appropriate use of health services; centers of excellence or other provider qualification standards; quality improvement systems; and service utilization and outcome reporting. In the event that the Collaborative selects a health care service that lacks evidence-based best practices, the Collaborative must consider strategies that promote improved care outcomes, including patient decision aids and provider feedback reports. The Collaborative must strongly consider the efforts of other organizations when developing strategies.

The Collaborative is required to report to the Administrator of the Health Care Authority (Administrator) on the selected health services and the proposed strategies. The Administrator must review the recommended strategies and inform the Collaborative of any decisions to adopt the strategies. Following the Administrator's review, the Collaborative must report to Governor and Legislature. The reports must be submitted annually and describe the selected services, proposed strategies, and results of the Administrator's review.

Upon receiving the endorsement of the Administrator, all state-purchased health care programs, including health carriers and third party administrators that contract with state programs, must implement the evidence-based practice guidelines and strategies by January 1, 2012, and every subsequent year. If the Collaborative does not reach consensus, state purchased health care programs may implement evidence-based strategies on their own initiative.

The Health Care Authority work group, established to identify evidence-based practices related to advanced diagnostic imaging services that would apply to all state-purchased health care programs, and its duties are repealed.

Votes on Final Passage:

House	62	35	
Senate	38	11	(Senate amended)
House	58	38	(House concurred)

Effective: July 22, 2011