ENGROSSED SECOND SUBSTITUTE HOUSE BILL 2572

State of Washington 63rd Legislature 2014 Regular Session

By House Appropriations (originally sponsored by Representative Cody; by request of Governor Inslee)

READ FIRST TIME 02/11/14.

1 AN ACT Relating to improving the effectiveness of health care
2 purchasing and transforming the health care delivery system by
3 advancing value-based purchasing, promoting community health, and
4 providing greater integration of chronic illness care and needed social
5 supports; amending RCW 42.56.360 and 70.02.045; adding new sections to
6 chapter 41.05 RCW; adding a new section to chapter 43.70 RCW; adding a
7 new section to chapter 48.02 RCW; adding a new section to chapter 74.09
8 RCW; adding a new chapter to Title 43 RCW; creating new sections; and
9 providing an expiration date.

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

11 NEW SECTION. **Sec. 1.** (1) The legislature finds that the state of
12 Washington has an opportunity to transform its health care delivery
13 system through multipayer payment reform, the development of a
14 statewide comprehensive prevention framework, and other state-led
15 initiatives in line with the state health care innovation plan.
16 (2) The state health care innovation plan establishes the following
17 primary drivers of health transformation, each with individual key
18 actions that are necessary to achieve the objective:

1 (a) Improve health overall by building healthy communities and
2 people through prevention and early mitigation of disease throughout
3 the lifespan;
4 (b) Improve chronic illness care through better integration and
5 strengthening of linkages between the health care delivery system and
6 community, particularly for individuals with physical and behavioral
7 comorbidities; and
8 (c) Advance value-based purchasing across the community, and lead
9 by example in transforming how the state purchases health care
10 services.
11 (3) The legislature intends to facilitate the implementation of
12 these improvements by:
13 (a) Establishing an all-payer claims database that improves
14 transparency for patients, providers, hospitals, and purchasers;
15 (b) Developing standard statewide performance and quality measures
16 to inform purchasing and set benchmarks;
17 (c) Supporting the initiatives of regional collaboratives to
18 achieve healthy communities and populations, improve health care
19 quality, and lower costs;
20 (d) Disseminating evidence-based training, tools, and other
21 resources to providers and hospitals; and
22 (e) Supporting integration of services for physical health,
23 behavioral health, and chemical dependency by restructuring medicaid
24 procurement.

25 NEW SECTION. **Sec. 2.** (1) The health care authority is responsible
26 for coordination, implementation, and administration of interagency
27 efforts and local collaborations of public and private organizations to
28 implement the state health care innovation plan.
29 (2) By January 1, 2015, and January 1st of each year through
30 January 1, 2019, the health care authority shall coordinate and submit
31 a status report to the appropriate committees of the legislature
32 regarding implementation of the innovation plan. The report must
33 summarize any actions taken to implement the innovation plan, progress
34 toward achieving the aims of the innovation plan, and anticipated
35 future implementation efforts. In addition, the health care authority
36 shall submit any recommendations for legislation necessary to implement
37 the innovation plan.

NEW SECTION. **Sec. 3.** A new section is added to chapter 41.05 RCW to read as follows:

(1) An accountable collaborative for health is a regionally based, voluntary collaborative designated by the authority, the purpose of which is to align actions and initiatives of a diverse coalition of members to achieve healthy communities and populations, improve health care quality, and lower costs. "Accountable collaborative for health" is a term used to recognize entities that are currently active and those that may become active that perform the functions described in this section. This term is used only to assist in directing funding or other support that may be available to these local entities. The designation of an entity as an accountable collaborative for health is not intended to create an additional government entity.

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

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

(a) It is a nonprofit or public-private partnership;

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

(c) It demonstrates an ongoing capacity to:

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

1 (ii) Distribute tools and resources from the health extension
2 program created in section 6 of this act; and
3 (iii) Act in alignment with statewide health care initiatives by
4 using the statewide all-payer health care claims database created in
5 section 9 of this act, the statewide health performance and quality
6 measures developed pursuant to section 13 of this act, and outcome
7 measures reflecting local health needs as identified by the accountable
8 collaborative for health.
9 (4) The authority may designate more than one accountable
10 collaborative for health in any region that consists of more than one
11 county, but an accountable collaborative for health may not cross the
12 regional boundaries defined by the authority or overlap with another
13 accountable collaborative for health.
14 (5) An entity designated by the authority as an accountable
15 collaborative for health must convene key stakeholders to:
16 (a) Review existing data, including data collected through the
17 community health assessment process;
18 (b) Evaluate the region's progress toward the objectives of the
19 national healthy people 2020 initiative and the priorities identified
20 in community health assessments and community health improvement plans;
21 (c) Assess the region's capacity to address chronic care needs,
22 including the needs of persons with co-occurring disorders;
23 (d) Review available funding and resources; and
24 (e) Identify and prioritize or reaffirm regional health care needs
25 and prevention strategies and develop a plan or use an existing plan to
26 address those needs.
27 (6) For purposes of this section and section 4 of this act, the
28 authority may only adopt rules that are necessary to implement this
29 section and section 4 of this act.

30 NEW SECTION. **Sec. 4.** A new section is added to chapter 41.05 RCW
31 to read as follows:
32 (1) The authority shall, subject to the availability of amounts
33 appropriated or grants received for this specific purpose, award grants
34 to support the development of accountable collaboratives for health.
35 Grants may only be used for start-up costs.
36 (2) An entity may be eligible for a grant under this section if it

1 has been designated as an accountable collaborative for health under
2 section 3 of this act. A grant application must, at a minimum:
3 (a) Identify the geographic region served by the applicant;
4 (b) Demonstrate how the applicant's structure and operation reflect
5 the interests of and are accountable to the region and the state for
6 health improvement; and
7 (c) Indicate the size of the grant being requested and describe how
8 the money will be spent.
9 (3) In awarding grants under this section, the authority shall
10 consider the extent to which the applicant will:
11 (a) Further the purposes of state health care purchasing as
12 described in sections 1 and 17 of this act;
13 (b) Base decisions on public input and an active collaboration
14 among key community partners, including, but not limited to, local
15 governments, housing providers, school districts, early learning
16 regional coalitions, large and small businesses, labor organizations,
17 health and human service organizations, tribal governments, health
18 carriers, providers, hospitals, public health agencies, and consumers;
19 (c) Match the grant funding with funds from other sources; and
20 (d) Demonstrate capability for sustainability without reliance on
21 state general fund appropriations.
22 (4) The authority may prioritize applications that commit to
23 providing at least one dollar in matching funds for each grant dollar
24 awarded.
25 (5) Before grant funds are disbursed, the authority and the
26 applicant must agree on performance requirements and the consequences
27 for failing to meet those requirements. The performance requirements
28 must be aligned with the purposes of state health care purchasing as
29 described in sections 1 and 17 of this act.

30 NEW SECTION. **Sec. 5.** A new section is added to chapter 41.05 RCW
31 to read as follows:
32 Any entity designated as an accountable collaborative for health
33 pursuant to section 3 of this act shall submit a report to the
34 appropriate committees of the legislature and the authority beginning
35 December 1, 2015, and December 1st of each year through December 1,
36 2019. The report must:

1 (1) Describe the regional health care needs identified by the entity and key stakeholders to date, the plan developed to address those needs, any actions taken by the entity and other stakeholders pursuant to the plan, and any measurable progress toward meeting those needs;

(2) Identify any grant funds received by the entity pursuant to section 4 of this act; and

(3) For the final report, demonstrate the entity's capability for sustainability without reliance on state general fund appropriations.

NEW SECTION. **Sec. 6.** A new section is added to chapter 43.70 RCW to read as follows:

(1) Subject to the availability of amounts appropriated for this specific purpose, the department shall establish a health extension program to provide training, tools, and technical assistance to primary care, behavioral health, and other providers. The program must emphasize high quality preventive, chronic disease, and behavioral health care that is comprehensive and evidence-based. If the department contracts for services under this section, it may only contract with an organization that has demonstrated the ability to provide educational services to providers, clinics, and hospitals on the topics listed in subsection (2) of this section.

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

(a) Integration of physical and behavioral health;

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

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

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

(e) Methods of formal assessment;

(f) Support for patients managing their own conditions;

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

(h) Practice transformation, including, but not limited to, team-

based care, shared decision making, use of population level health data and management, and quality improvement linked to common statewide performance measures.

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

NEW SECTION. **Sec. 7.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

(3) "Claims data" means the data required by section 10 of this act to be submitted to the database, as defined by the director in rule. "Claims data" includes, but is not limited to:

(a) Claims data for fully insured plans; and

(b) Claims data related to health care coverage and services funded, in whole or in part, in the omnibus appropriations act, including coverage and services funded by appropriated and nonappropriated state and federal moneys.

(4) "Data supplier" means a health carrier or an employer that provides health insurance to its employees. It does not include any entity, other than a state or local governmental entity, that is self-insured.

(5) "Database" means the statewide all-payer health care claims database established in section 9 of this act.

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

(7) "Lead organization" means the organization selected under section 9 of this act.

(8) "Office" means the office of financial management.

NEW SECTION. **Sec. 8.** The legislature finds that:

(1) The activities authorized by this chapter will require collaboration among state agencies and local governments that purchase health care, private health carriers, third-party purchasers, health care providers, and hospitals. These activities will identify strategies to increase the quality and effectiveness of health care

delivered in Washington state and are therefore in the best interest of the public.

(2) The benefits of collaboration, together with active state supervision, outweigh potential adverse impacts. Therefore, the legislature intends to exempt from state antitrust laws, and provide immunity through the state action doctrine from federal antitrust laws, activities that are undertaken, reviewed, and approved by the office pursuant to this chapter 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 not provided for by this chapter, and the legislature neither exempts nor provides immunity for such activities including, but not limited to, agreements among competing providers or carriers to set prices or specific levels of reimbursement for health care services.

NEW SECTION. **Sec. 9.** (1) The office shall establish a statewide all-payer health care claims database to support transparent public reporting of health care information. The database must improve transparency to: Assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practices; enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost.

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

(a) Collect claims data from data suppliers as provided in section 10 of this act;

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

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

1 (d) Consistent with the requirements of this chapter, make
2 information from the database available as a resource for public and
3 private entities, including carriers, employers, providers, hospitals,
4 and purchasers of health care;
5 (e) Report performance on cost and quality pursuant to section 14
6 of this act using, but not limited to, the performance measures
7 developed under section 13 of this act;
8 (f) Develop protocols and policies to ensure the quality of data
9 releases;
10 (g) Develop a plan for the financial sustainability of the database
11 and charge fees not to exceed five thousand dollars for reports and
12 data files as needed to fund the database. Any fees must be approved
13 by the office and must be comparable across data requesters and users;
14 and
15 (h) Convene advisory committees with the approval and participation
16 of the office, including: (i) A committee on data policy development;
17 and (ii) a committee to establish a data release process consistent
18 with the requirements of this chapter and to provide advice regarding
19 formal data release requests. The advisory committees must include
20 representation from key provider, hospital, payer, public health,
21 health maintenance organization, purchaser, and consumer organizations.

22 NEW SECTION. **Sec. 10.** (1) Data suppliers must submit claims data
23 to the database within the time frames established by the director in
24 rule and in accordance with procedures established by the lead
25 organization.
26 (2) An entity that is not a data supplier but that chooses to
27 participate in the database shall require any third-party administrator
28 utilized by the entity's plan to release, at no additional cost, any
29 claims data related to persons receiving health coverage from the plan.
30 (3) Each data supplier shall submit an annual status report to the
31 office regarding its compliance with this section. The report to the
32 legislature required by section 2 of this act must include a summary of
33 these status reports.

34 NEW SECTION. **Sec. 11.** (1) The claims data provided to the
35 database, the database itself, including the data compilation, and any

raw data received from the database are not public records and are exempt from public disclosure under chapter 42.56 RCW.

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

NEW SECTION. **Sec. 12.** (1) Except as otherwise required by law, claims or other data from the database shall only be available for retrieval in original or processed form to public and private requesters pursuant to this section and shall be made available within a reasonable time after the request.

(2) Except as otherwise required by law, the office shall direct the lead organization to maintain the confidentiality of claims or other data it collects for the database that include direct and indirect patient identifiers. Any agency, researcher, or other person that receives claims or other data under this section containing direct or indirect patient identifiers must also maintain confidentiality and may not release such claims or other data except as consistent with this section. The office shall oversee the lead organization's release of data as follows:

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

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

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

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

1 (c) Claims or other data that do not contain direct or indirect
2 patient identifiers may be released upon request.
3 (3) Recipients of claims or other data under subsection (2)(a) or
4 (b) of this section must agree in a data use agreement or a
5 confidentiality agreement to, at a minimum:
6 (a) Take steps to protect direct and indirect patient identifying
7 information as described in the agreement; and
8 (b) Not redisclose the data except as authorized in the agreement
9 consistent with the purpose of the agreement or as otherwise required
10 by law.
11 (4) Recipients of the claims or other data under subsection (2)(b)
12 of this section must not attempt to determine the identity of persons
13 whose information is included in the data set or use the claims or
14 other data in any manner that identifies the individuals or their
15 families.
16 (5) For purposes of this section, the following definitions apply
17 unless the context clearly requires otherwise.
18 (a) "Direct patient identifier" means information that identifies
19 a patient.
20 (b) "Indirect patient identifier" means information that may
21 identify a patient when combined with other information.

22 NEW SECTION. **Sec. 13.** (1) There is created a performance measures
23 committee, the purpose of which is to identify and recommend standard
24 statewide measures of health performance to inform public and private
25 health care purchasers and set benchmarks to track costs and
26 improvements in health outcomes. The committee shall coordinate its
27 activities and recommendations with the lead organization selected
28 under section 9 of this act.
29 (2) Members of the committee must include representation from state
30 agencies, small and large employers, health plans, patient groups,
31 consumers, academic experts on health care measurement, hospitals,
32 physicians, and other providers. The governor shall appoint the
33 members of the committee, except that a statewide association
34 representing hospitals may appoint a member representing hospitals and
35 a statewide association representing physicians may appoint a member
36 representing physicians. The governor shall ensure that members
37 represent diverse geographic locations and both rural and urban

1 communities. The chief executive officer of the lead organization must
2 also serve on the committee. The committee must be chaired by the
3 director of the authority.
4 (3) The committee shall develop a transparent process for selecting
5 performance measures, and the process must include opportunities for
6 public comment.
7 (4) By January 1, 2015, the committee shall submit the performance
8 measures to the authority. The measures must include dimensions of:
9 (a) Prevention and screening;
10 (b) Effective management of chronic conditions;
11 (c) Key health outcomes;
12 (d) Care coordination and patient safety; and
13 (e) Use of the lowest cost, highest quality care for acute
14 conditions.
15 (5) The committee shall develop a measure set that:
16 (a) Is of manageable size;
17 (b) Is based on readily available claims and clinical data;
18 (c) Gives preference to nationally reported measures and, where
19 nationally reported measures may not be appropriate, measures used by
20 the health benefit exchange and state agencies that purchase health
21 care;
22 (d) Focuses on the overall performance of the system, including
23 outcomes and total cost;
24 (e) Is aligned with the governor's performance management system
25 measures and common measure requirements specific to medicaid delivery
26 systems under RCW 70.320.020 and 43.20A.895;
27 (f) Considers the needs of different stakeholders and the
28 populations served; and
29 (g) Is usable by multiple payers, providers, hospitals, purchasers,
30 public health, and communities as part of health improvement, care
31 improvement, provider payment systems, benefit design, and
32 administrative simplification for providers and hospitals.
33 (6) State agencies shall use the measure set developed under this
34 section to inform purchasing decisions and set benchmarks.
35 (7) The committee shall establish a public process to periodically
36 evaluate the measure set and make additions or changes to the measure
37 set as needed.

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

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

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

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

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

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

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

(a) Directly or indirectly identify patients; or

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

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

(a) Allows the data supplier, the hospital, or the provider to verify the accuracy of the information submitted to the lead organization and submit to the lead organization any corrections of errors with supporting evidence and comments within forty-five days of 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 9 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.

NEW SECTION. **Sec. 17.** A new section is added to chapter 74.09 RCW to read as follows:

(1) Consistent with the implementation of the state health care innovation plan and the provisions of RCW 70.320.020, the authority and the department shall restructure medicaid procurement of health care services and agreements with managed care systems on a phased basis to better support integrated physical health, mental health, and chemical dependency treatment. By January 1, 2019, medicaid services provided under this chapter and chapters 71.24, 71.36, and 70.96A RCW must be fully integrated in a managed health care system that provides mental health, chemical dependency, and medical care services to medicaid clients. The authority and the department shall develop and utilize innovative mechanisms to promote and sustain integrated clinical models of physical and behavioral health care such as: Practice transformation support and resources; workforce capacity and flexibility; shared clinical information sharing, tools, resources, and training; and outcome-based payments to providers and hospitals.

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

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

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

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

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

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

1 (f) Evidence-based care interventions and continuous quality
2 improvement must be enforced through contract specifications and
3 performance measures, including the statewide measure set under section
4 13 of this act, that provide meaningful integration at the patient care
5 level with broadly distributed accountability for results;
6 (g) Active purchasing and oversight of medicaid managed care
7 contracts is a state responsibility;
8 (h) A deliberate and flexible system change plan with identified
9 benchmarks and periodic readiness reviews will promote system
10 stability, provide continuity of treatment for patients, and protect
11 essential existing behavioral health system infrastructure and
12 capacity; and
13 (i) Community and organizational readiness are key determinants of
14 implementation timing; a phased approach is therefore desirable.
15 (3) The principles identified in subsection (2) of this section are
16 not intended to create an individual entitlement to services.

17 **Sec. 18.** RCW 42.56.360 and 2013 c 19 s 47 are each amended to read
18 as follows:
19 (1) The following health care information is exempt from disclosure
20 under this chapter:
21 (a) Information obtained by the pharmacy quality assurance
22 commission as provided in RCW 69.45.090;
23 (b) Information obtained by the pharmacy quality assurance
24 commission or the department of health and its representatives as
25 provided in RCW 69.41.044, 69.41.280, and 18.64.420;
26 (c) Information and documents created specifically for, and
27 collected and maintained by a quality improvement committee under RCW
28 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee
29 under RCW 4.24.250, or by a quality assurance committee pursuant to RCW
30 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056,
31 for reporting of health care-associated infections under RCW 43.70.056,
32 a notification of an incident under RCW 70.56.040(5), and reports
33 regarding adverse events under RCW 70.56.020(2)(b), regardless of which
34 agency is in possession of the information and documents;
35 (d)(i) Proprietary financial and commercial information that the
36 submitting entity, with review by the department of health,
37 specifically identifies at the time it is submitted and that is

provided to or obtained by the department of health in connection with an application for, or the supervision of, an antitrust exemption sought by the submitting entity under RCW 43.72.310;

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

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

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

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

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

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

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

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

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

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

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

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

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

6 **Sec. 19.** RCW 70.02.045 and 2000 c 5 s 2 are each amended to read
7 as follows:

8 Third-party payors shall not release health care information
9 disclosed under this chapter, except as required by chapter 43.--- RCW
10 (the new chapter created in section 21 of this act) and to the extent
11 that health care providers are authorized to do so under RCW 70.02.050.

12 NEW SECTION. **Sec. 20.** If any provision of this act or its
13 application to any person or circumstance is held invalid, the
14 remainder of the act or the application of the provision to other
15 persons or circumstances is not affected.

16 NEW SECTION. **Sec. 21.** Sections 7 through 15 of this act
17 constitute a new chapter in Title 43 RCW.

18 NEW SECTION. **Sec. 22.** Sections 3 through 5 of this act expire
19 July 1, 2020.

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