Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Innovation, Technology & Economic Development Committee

HB 1776

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: Representatives Cody, Harris, Macri, Caldier, Robinson, Jinkins, Tarleton, Ormsby and Slatter; by request of Office of Financial Management and Health Care Authority.

Brief Summary of Bill

- Transfers authority and oversight of the statewide, all-payer health care claims database from the Office of Financial Management (OFM) to Washington State Health Care Authority (HCA) on January 1, 2020.
- Requires the HCA to convene a state agency coordinating structure, with oversight from the OFM, to assess and improve database performance by state agencies.
- Modifies the procurement process for selecting a lead organization to coordinate and manage the database.
- Changes certain release of claims data and database management requirements.

Hearing Date: 2/13/19

Staff: Kyle Raymond (786-7190).

Background:

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.

In 2014, the Legislature directed the Office of Financial Management (OFM) to establish a statewide all-payer health care claims database (hereafter 'database') to support transparent public reporting of health care information.

Lead Organization.
The OFM Director is required to 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 OFM, the lead organization will work with the data vendor to collect claims data, design data collection mechanisms, ensure protection of the data, provide reports from the database, develop protocols and policies, develop a plan for financial sustainability, charge fees for reports and data files, and convene advisory committees.

The OFM must initiate a competitive procurement process to select a lead organization, and the lead organization's proposal must be awarded additional scoring evaluation points for the organization's:

- degree of relevant experience in health care data collection, analysis, analytics, and security;
- long-term self-sustainable financial model;
- experience convening and effectively engaging stakeholders to develop reports;
- experience in meeting budget and timelines for report generations; and
- ability to combine cost and quality data.

The lead organization must enter into a contract with a data vendor to perform data collection, processing, aggregation, extracts, and analytics.

In July 2016, the OFM Director selected the Center for Health Systems Effectiveness (CHSE) at Oregon Health & Science University as the lead organization and Onpoint Health as the data vendor to coordinate and manage the database.

Submissions to the Database.
Data suppliers must submit claims data to the database within an established time frame. The state Medicaid program, the Public Employees' Benefits Board program, state health carriers, third-party administrators, and the Department of Labor and Industries must submit their claims data to the database, and the CHSE must submit an annual status report to the OFM regarding their compliance. Claims data includes all data required to be submitted to the database, including billed, allowed and paid amounts, and additional information defined in rule.

Release of Claims Data.
Requests for claims data must include information about the: requestor's identity; the purpose for the request; the proposed methodology with specific variables intended for use; the requestor intended data handling practices and safety measures; the data privacy and confidentiality protection; and consent to penalties for inappropriate disclosures or uses of direct patient identifiers and proprietary financial information. The requestors must also include in the data request a description of the method by which the data will be stored, destroyed, or returned to the CHSE at the conclusion of the data agreement.

The CHSE may deny a request for data if the request does not include the required information or meet established criteria. In conjunction with the OFM and the data vendor, the CHSE must

develop a process to govern levels of access to and use of data. Data that include proprietary financial information, direct patient identifiers, or indirect patient identifiers may be released only to researchers to the extent necessary to achieve the goals of the database. The OFM is required to adopt procedures for data release, penalties associated with inappropriate disclosures, and uses of patient identifiers and proprietary financial information.

Confidentiality.
The CHSE and the data vendor must maintain confidentiality of proprietary financial information, in addition to direct or indirect patient identifiers. Any entity that receives data must also maintain confidentiality and may only release the data if it does not contain proprietary financial information, direct patient identifiers, or indirect patient identifiers and the release is approved as part of the data request. Recipients of data must agree to the conditions in a data use or confidentiality agreement.

Periodic Reporting Requirements.
Under the supervision of and through the contract with the OFM, the CHSE is required to prepare data reports using the database and the Statewide Health Performance and Quality Measure to promote awareness and transparency in the health care market. The CHSE must submit a list of reports it anticipates producing during the following year to the OFM, who must submit the report to the Legislature with public comment.

The OFM is required to submit a report to the Legislature every six months regarding any grants received or extended. The OFM must also report the cost, performance, and effectiveness of the database and the performance of the CHSE to the Legislature biennially. The report must use independent economic expertise to evaluate the lead organization's performance and whether the database has advanced its stated goals. The report must also make recommendations on: (1) how the database could be improved; (2) whether the contract with the lead organization should be modified, renewed, or terminated; and (3) the impact the database has had on competition.

Summary of Bill:

Statewide Health Care Database Transfer.
The Office of Financial Management (OFM) must transfer authority and oversight of the statewide, all-payer health care claims database to the Washington State Health Care Authority (HCA) on January 1, 2020. The OFM and HCA are required to develop a transition plan by July 1, 2019 that sustains operations.

The OFM must deliver all materials necessary for the HCA to transfer the database, including reports, documents, records, and other written materials. All OFM funds, credits, or specific appropriations that are solely for the purpose of coordinating or managing the database must be assigned to the HCA.

The HCA will continue to act on all OFM rules, pending business, and existing contracts and obligations. The transfer of the powers, duties, and functions to the HCA does not affect the validity of any OFM act performed.

The OFM Director must make final determination on any questions that arise related to the database transfer, and the Director must certify any budgeted fund allotments required as a result of the transfer to the agencies affected, the state auditor, and the state treasurer.

The HCA maintains the OFM's requirement to biennially report the cost, performance, and effectiveness of the database and the lead organization's performance under its contract with the HCA. The HCA's grant reporting requirement to the Legislature is extended from six months to one year.

Lead Organization Procurement.
The HCA's procurement process for selecting a lead organization to coordinate and manage the database is modified to:

- Remove the requirement that the HCA select from the best potential bidders;
- Authorizes the lead organization to contract with multiple data vendors; and
- Requires the HCA to give strong consideration to, rather than award extra evaluation points for, the lead organization's procurement criteria.

The HCA must also give preference to groups of health providers, carriers, and self-insured purchasers in the state when evaluating how potential lead organizations engage stakeholders and combine cost and quality data.

Database Management and Funding.
The financial sustainability plan, developed by the lead organization and data vendor, must be reasonable and customary as compared to other states' databases, and the requirement that the plan be self-sustaining is removed. The lead organization is also permitted to charge providers or other data suppliers fees directly related to data files.

Release of Claims Data.
Claims or data recipients are required to destroy the data they obtain at the conclusion of the data agreement. The release of claims requirement for requestors to identify the method by which data will be sorted and returned is removed.

Claims or other data that do not contain direct patient identifiers, but that may contain proprietary information, indirect patient identifiers, and unique identifiers may be released to the Washington Health Benefit Exchange upon receipt of a signed data use agreement with the HCA and the lead organization, as directed by HCA rules.

The HCA must adopt rules to establish a minimum threshold below which the data supplier is not required to submit data.

State Agency Coordinating Structure.
The HCA must convene a state agency coordinating structure to assess and improve database performance by state agencies. The structure must consist of state agencies with related data needs to ensure effectiveness of the database and the agencies' program. The coordinating structure must collaborate with the lead organization and other partners both publicly and privately, and the structure must consult with the HCA in developing database policies and rules, including ensuring agency access to the database.

The OFM must participate as a key part of the coordinating structure and evaluate progress towards meeting the database's goals. The OFM may recommend strategies for maintaining and promoting the progress of the database as needed and report its findings to the Legislature annually. The OFM must have all necessary access to database processes, procedures, methodologies, and outcomes to perform these functions. The annual review shall assess, at a minimum, the:

- list of approved agency use case projects and related data requirements;
- successful and unsuccessful data requests and outcomes related to health researchers;
- on-line data portal access and effectiveness related to research requests and data provider review and reconsideration;
- adequacy of data security and policy consistent with the policy of the Office of the Chief Information Officer;
- timeliness, adequacy, and responsiveness of the database requests; and
- for potential improvements in data sharing, data processing, and communication.

The OFM and the HCA must jointly develop an effectiveness review process for the HCA Statewide Common Measure Set, and the OFM may make recommendations for improvements, as needed.

Appropriation: None.

Fiscal Note: Requested on February 8, 2019.

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