RCW 43.371.020 Statewide all-payer health care claims database—Selection and duties of lead organization—Certification as qualified entity pursuant to 42 C.F.R. Sec. 401.703(a)—Contract with data vendor. (1) The office shall establish a statewide all-payer health care claims database. On January 1, 2020, the office must transfer authority and oversight for the database to the authority. The office and authority must develop a transition plan that sustains operations by July 1, 2019. The database shall 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. The database must systematically collect all medical claims and pharmacy claims from private and public payers, with data from all settings of care that permit the systematic analysis of health care delivery.

(2) The authority shall use a competitive procurement process, in accordance with chapter 39.26 RCW, to select a lead organization from among the best potential bidders to coordinate and manage the database.

(a)(i) In conducting the competitive procurement, the authority must ensure that no state officer or state employee participating in the procurement process:

(A) Has a current relationship or had a relationship within the last three years with any organization that bids on the procurement that would constitute a conflict with the proper discharge of official duties under chapter 42.52 RCW; or

(B) Is a compensated or uncompensated member of a bidding organization's board of directors, advisory committee, or has held such a position in the past three years.

(ii) If any relationship or interest described in (a)(i) of this subsection is discovered during the procurement process, the officer or employee with the prohibited relationship must withdraw from involvement in the procurement process.

(b) Due to the complexities of the all-payer claims database and the unique privacy, quality, and financial objectives, the authority must give strong consideration to the following elements in determining the appropriate lead organization contractor: (i) The organization's degree of experience in health care data collection, analysis, analytics, and security; (ii) whether the organization has a long-term self-sustainable financial model; (iii) the organization's experience in convening and effectively engaging stakeholders to develop reports, especially among groups of health providers, carriers, and self-insured purchasers; (iv) the organization's experience in meeting budget and timelines for report generations; and (v) the organization's ability to combine cost and quality data to assess total cost of care.

(c) The successful lead organization must apply to be certified as a qualified entity pursuant to 42 C.F.R. Sec. 401.703(a) by the centers for medicare and medicaid services.

(d) The authority may not select a lead organization that:

(i) Is a health plan as defined by and consistent with the definitions in RCW 48.43.005;

(ii) Is a hospital as defined in RCW 70.41.020;

(iii) Is a provider regulated under Title 18 RCW;

(iv) Is a third-party administrator as defined in RCW 70.290.010; or

(v) Is an entity with a controlling interest in any entity covered in (d)(i) through (iv) of this subsection.

(3) As part of the competitive procurement process referenced in subsection (2) of this section, the lead organization shall enter into a contract with a data vendor or multiple data vendors to perform data collection, processing, aggregation, extracts, and analytics. A data vendor must:

(a) Establish a secure data submission process with data suppliers;

(b) Review data submitters' files according to standards established by the authority;

(c) Assess each record's alignment with established format, frequency, and consistency criteria;

(d) Maintain responsibility for quality assurance, including, but not limited to: (i) The accuracy and validity of data suppliers' data; (ii) accuracy of dates of service spans; (iii) maintaining consistency of record layout and counts; and (iv) identifying duplicate records;

(e) Assign unique identifiers, as defined in RCW 43.371.010, to individuals represented in the database;

(f) Ensure that direct patient identifiers, indirect patient identifiers, and proprietary financial information are released only in compliance with the terms of this chapter;

(g) Demonstrate internal controls and affiliations with separate organizations as appropriate to ensure safe data collection, security of the data with state of the art encryption methods, actuarial support, and data review for accuracy and quality assurance;

(h) Store data on secure servers that are compliant with the federal health insurance portability and accountability act and regulations, with access to the data strictly controlled and limited to staff with appropriate training, clearance, and background checks; and

(i) Maintain state of the art security standards for transferring data to approved data requestors.

(4) The lead organization and data vendor must submit detailed descriptions to the office of the chief information officer to ensure robust security methods are in place. The office of the chief information officer must report its findings to the authority and the appropriate committees of the legislature.

(5) The lead organization is responsible for internal governance, management, funding, and operations of the database. At the direction of the authority, the lead organization shall work with the data vendor to:

(a) Collect claims data from data suppliers as provided in RCW 43.371.030;

(b) Design data collection mechanisms with consideration for the time and cost incurred by data suppliers and others in submission and collection and the benefits that measurement would achieve, ensuring the data submitted meet quality standards and are reviewed for quality assurance;

(c) Ensure protection of collected data and store and use any data in a manner that protects patient privacy and complies with this section. All patient-specific information must be deidentified with an up-to-date industry standard encryption algorithm;

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

(e) Report performance on cost and quality pursuant to RCW 43.371.060 using, but not limited to, the performance measures developed under RCW 41.05.690;

(f) Develop protocols and policies, including prerelease peer review by data suppliers, to ensure the quality of data releases and reports;

(g) Develop a plan for the financial sustainability of the database as may be reasonable and customary as compared to other states' databases and charge fees for reports and data files as needed to fund the database. Any fees must be approved by the authority and should be comparable, accounting for relevant differences across data requests and uses. The lead organization may not charge providers or data suppliers fees other than fees directly related to requested reports and data files; and

(h) Convene advisory committees with the approval and participation of the authority, including: (i) A committee on data policy development; and (ii) a committee to establish a data release process consistent with the requirements of this chapter and to provide advice regarding formal data release requests. The advisory committees must include in-state representation from key provider, hospital, public health, health maintenance organization, large and small private purchasers, consumer organizations, and the two largest carriers supplying claims data to the database.

(6) The lead organization governance structure and advisory committees for this database must include representation of the third-party administrator of the uniform medical plan. A payer, health maintenance organization, or third-party administrator must be a data supplier to the all-payer health care claims database to be represented on the lead organization governance structure or advisory committees. [2019 c 319 § 3; 2015 c 246 § 2; 2014 c 223 § 10.]

Transfer of powers, duties, and functions from the office of financial management to the health care authority—2019 c 319: "(1) The powers, duties, and functions of the office of financial management provided in chapter 43.371 RCW, except as otherwise specified in this act, are transferred to the health care authority.

(2)(a) All reports, documents, surveys, books, records, files, papers, or written material necessary for the health care authority to carry out the powers, duties, and functions in chapter 43.371 RCW being transferred from the office of financial management to the health care authority and that are in the possession of the office of financial management must be delivered to the custody of the health care authority. All funds or credits of the office of financial management that are solely for the purposes of fulfilling the powers, duties, and functions in chapter 43.371 RCW shall be assigned to the health care authority.

(b) Any specific appropriations made to the office of financial management for the sole purpose of fulfilling the duties, powers, and functions in chapter 43.371 RCW must, on May 8, 2019, be transferred and credited to the health care authority.

(c) If any question arises as to the transfer of any funds, books, documents, records, papers, files, equipment, or other tangible

property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management must make a determination as to the proper allocation and certify the same to the state agencies concerned.

(3) All rules and pending business before the office of financial management specifically related to its powers, duties, and functions in chapter 43.371 RCW that are being transferred to the health care authority shall be continued and acted upon by the health care authority. All existing contracts and obligations remain in full force and must be performed by the health care authority.

(4) The transfer of the powers, duties, and functions of the office of financial management does not affect the validity of any act performed before May 8, 2019.

(5) If apportionments of budgeted funds are required because of the transfers directed by this section, the director of financial management shall certify the apportionments to the agencies affected, the state auditor, and the state treasurer. Each of these must make the appropriate transfer and adjustments in funds and appropriation accounts and equipment records in accordance with the certification." [2019 c 319 § 11.]

Effective date—2019 c 319: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 8, 2019]." [2019 c 319 § 13.]

Finding—2014 c 223: See note following RCW 41.05.690.