

CERTIFICATION OF ENROLLMENT

SENATE BILL 5144

64th Legislature
2015 Regular Session

Passed by the Senate March 10, 2015
Yeas 45 Nays 4

President of the Senate

Passed by the House April 8, 2015
Yeas 97 Nays 0

Speaker of the House of Representatives

Approved

Governor of the State of Washington

CERTIFICATE

I, Hunter G. Goodman, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SENATE BILL 5144** as passed by Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

**Secretary of State
State of Washington**

SENATE BILL 5144

Passed Legislature - 2015 Regular Session

State of Washington

64th Legislature

2015 Regular Session

By Senators Dammeier, Becker, Bailey, Rivers, Brown, Parlette, and O'Ban

Read first time 01/14/15. Referred to Committee on Health Care.

1 AN ACT Relating to making the Bree collaborative more accessible
2 to the public and promoting transparency; and amending RCW
3 70.250.050.

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

5 **Sec. 1.** RCW 70.250.050 and 2011 c 313 s 3 are each amended to
6 read as follows:

7 (1) Consistent with the authority granted in RCW 41.05.013, the
8 authority shall convene a collaborative, to be known as the Robert
9 Bree collaborative. The collaborative shall identify health care
10 services for which there are substantial variation in practice
11 patterns or high utilization trends in Washington state, without
12 producing better care outcomes for patients, that are indicators of
13 poor quality and potential waste in the health care system. On an
14 annual basis, the collaborative shall identify up to three health
15 care services it will address.

16 (2) For each health care service identified, the collaborative
17 shall:

18 (a) Analyze and identify evidence-based best practice approaches
19 to improve quality and reduce variation in use of the service,
20 including identification of guidelines or protocols applicable to the
21 health care service. In evaluating guidelines, the collaborative

1 should identify the highest quality guidelines based upon the most
2 rigorous and transparent methods for identification, rating, and
3 translation of evidence into practice recommendations.

4 (b) Identify data collection and reporting necessary to develop
5 baseline health service utilization rates and to measure the impact
6 of strategies adopted under this section. Methods for data collection
7 and reporting should strive to minimize cost and administrative
8 effort related to data collection and reporting wherever possible,
9 including the use of existing data resources and nonfee-based tools
10 for reporting.

11 (c) Identify strategies to increase use of the evidence-based
12 best practice approaches identified under (a) of this subsection in
13 both state purchased and privately purchased health care plans.
14 Strategies considered should include, but are not limited to:
15 Identifying goals for appropriate utilization rates and reduction in
16 practice variation among providers; peer-to-peer consultation or
17 second opinions; provider feedback reports; use of patient decision
18 aids; incentives for appropriate use of health care services; centers
19 of excellence or other provider qualification standards; quality
20 improvement systems; and service utilization and outcomes reporting,
21 including public reporting. In developing strategies, the
22 collaborative should strongly consider related efforts of
23 organizations such as the Puget Sound health alliance, the Washington
24 state hospital association, the national quality forum, the joint
25 commission on accreditation of health care organizations, the
26 national committee for quality assurance, the foundation for health
27 care quality, and, where appropriate, more focused quality
28 improvement efforts, such as the Washington state perinatal advisory
29 committee and the Washington state surgical care and outcomes
30 assessment program. The collaborative shall provide an opportunity
31 for public comment on the strategies chosen before finalizing their
32 recommendations.

33 (3) If the collaborative chooses a health care service for which
34 there is substantial variation in practice patterns or a high or low
35 utilization trend in Washington state, and a lack of evidence-based
36 best practice approaches, it should consider strategies that will
37 promote improved care outcomes, such as patient decision aids,
38 provider feedback reports, centers of excellence or other provider
39 qualification standards, and research to improve care quality and
40 outcomes.

1 (4) The governor shall appoint twenty members of the
2 collaborative, who must include:

3 (a) Two members, selected from health carriers or third-party
4 administrators that have the most fully insured and self-funded
5 covered lives in Washington state. The count of total covered lives
6 includes enrollment in all companies included in their holding
7 company system. Each health carrier or third-party administrator is
8 entitled to no more than a single position on the collaborative to
9 represent all entities under common ownership or control;

10 (b) One member, selected from the health maintenance organization
11 having the most fully insured and self-insured covered lives in
12 Washington state. The count of total lives includes enrollment in all
13 companies included in its holding company system. Each health
14 maintenance organization is entitled to no more than a single
15 position on the collaborative to represent all entities under common
16 ownership or control;

17 (c) One member, chosen from among three nominees submitted by the
18 association of Washington health plans, representing national health
19 carriers that operate in multiple states outside of the Pacific
20 Northwest;

21 (d) Four physicians, selected from lists of nominees submitted by
22 the Washington state medical association, as follows:

23 (i) Two physicians, one of whom must be a practicing primary care
24 physician, representing large multispecialty clinics with fifty or
25 more physicians, selected from a list of five nominees. The primary
26 care physician must be either a family physician, an internal
27 medicine physician, or a general pediatrician; and

28 (ii) Two physicians, one of whom must be a practicing primary
29 care physician, representing clinics with less than fifty physicians,
30 selected from a list of five nominees. The primary care physician
31 must be either a family physician, an internal medicine physician, or
32 a general pediatrician;

33 (e) One osteopathic physician, selected from a list of five
34 nominees submitted by the Washington state osteopathic medical
35 association;

36 (f) Two physicians representing the largest hospital-based
37 physician systems in the state, selected from a list of five nominees
38 submitted jointly by the Washington state medical association and the
39 Washington state hospital association;

1 (g) Three members representing hospital systems, at least one of
2 whom is responsible for quality, submitted from a list of six
3 nominees from the Washington state hospital association;

4 (h) Three members, representing self-funded purchasers of health
5 care services for employees;

6 (i) Two members, representing state purchased health care
7 programs; and

8 (j) One member, representing the Puget Sound health alliance.

9 (5) The governor shall appoint the chair of the collaborative.

10 (6) The collaborative shall add members to its membership or
11 establish clinical committees for each therapy under review by the
12 collaborative for the purpose of acquiring clinical expertise needed
13 to accomplish its responsibilities under this section and RCW
14 70.250.010 and 70.250.030. Membership of clinical committees should
15 reflect clinical expertise in the area of health care services being
16 addressed by the collaborative, including clinicians involved in
17 related quality improvement or comparative effectiveness efforts, as
18 well as nonphysician practitioners. Each clinical committee shall
19 include at least two members of the specialty or subspecialty society
20 most experienced with the health service identified for review.

21 (7) Permanent and ad hoc members of the collaborative or any of
22 its committees may not have personal financial conflicts of interest
23 that could substantially influence or bias their participation. If a
24 collaborative or committee member has a personal financial conflict
25 of interest with respect to a particular health care service being
26 addressed by the collaborative, he or she shall disclose such an
27 interest. The collaborative must determine whether the member should
28 be recused from any deliberations or decisions related to that
29 service.

30 (8) A person serving on the collaborative or any of its clinical
31 committees shall be immune from civil liability, whether direct or
32 derivative, for any decisions made in good faith while pursuing
33 activities associated with the work of collaborative or any of its
34 clinical committees.

35 (9) The guidelines or protocols identified under this section
36 shall not be construed to establish the standard of care or duty of
37 care owed by health care providers in any cause of action occurring
38 as a result of health care.

39 (10) The collaborative shall actively solicit federal or private
40 funds and in-kind contributions necessary to complete its work in a

1 timely fashion. The collaborative shall not accept private funds if
2 receipt of such funding could present a potential conflict of
3 interest or bias in the collaborative's deliberations. Available
4 state funds may be used to support the work of the collaborative when
5 the collaborative has selected a health care service that is a high
6 utilization or high-cost service in state purchased health care
7 programs or the health care service is undergoing evaluation in one
8 or more state purchased health care programs and coordination will
9 reduce duplication of efforts. The collaborative shall not begin the
10 work described in this section unless sufficient funds are received
11 from private or federal resources, or available state funds.

12 (11) No member of the collaborative or its committees may be
13 compensated for his or her service.

14 (12) The proceedings of the collaborative shall be open to the
15 public and notice of meetings shall be provided at least twenty days
16 prior to a meeting.

17 (13) All meetings of the collaborative, including those of a
18 subcommittee, are subject to the open public meetings act.

19 (14) The collaborative shall report to the administrator of the
20 authority regarding the health services areas it has chosen and
21 strategies proposed. The administrator shall review the strategies
22 recommended in the report, giving strong consideration to the
23 direction provided in section 1, chapter 313, Laws of 2011 and this
24 section. The administrator's review shall describe the outcomes of
25 the review and any decisions related to adoption of the recommended
26 strategies by state purchased health care programs. Following the
27 administrator's review, the collaborative shall report to the
28 legislature and the governor regarding chosen health services,
29 proposed strategies, the results of the administrator's review, and
30 available information related to the impact of strategies adopted in
31 the previous three years on the cost and quality of care provided in
32 Washington state. The initial report must be submitted by November
33 15, 2011, with annual reports thereafter.

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