SECOND REGULAR SESSION

HOUSE BILL NO. 2418

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE ONDER.

Read 1st time March 12, 2008 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

5313L.01I

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to standardization of quality of care data for health insurance, with a penalty provision.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Chapter 376, RSMo, is amended by adding thereto one new section, to be known as section 376.412, to read as follows:

376.412. 1. As used in this section, the following terms shall mean:

(1) "Health carrier", the same meaning as such term is defined in section 376.1350;

(2) "Health care provider", the same meaning as such term is defined in section 376.1350;

(3) "Quality of care data", data intended to measure the quality of health care services delivered by a specific health care provider.

2. A contract between a health carrier and a health care provider shall not require the provider to submit quality of care data to the health carrier as a condition of payment for medical services rendered, unless such data is included in the set of quality of care indicators selected by the federal Centers for Medicare and Medicaid Services for disclosure in comparative format to the public. The provisions of this section shall not be construed to limit the health carrier's ability to:

(1) Abstract quality of care data from billing data submitted by the provider;

(2) Collect data necessary to comply with federal or state law or regulation or accreditation standards; or

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(3) Collect data from health care providers for whom the federal Centers for Medicare and Medicaid Services has not implemented quality of care indicators for disclosure in comparative format.

3. Any person who sells or otherwise distributes to the public quality of care data shall, if the product includes data that is not included in the set of quality of care indicators selected by the federal Centers for Medicare and Medicaid Services for disclosure in comparative format to the public:

(1) Include the following disclaimer on the information distributed: "This data includes quality of care indicators other than those used by the federal Centers for Medicare and Medicaid Services and as such may be based on research methodologies that deviate from those used by such agency.";

(2) Identify what peer review process, if any, was used to confirm the validity of the data and its analysis as an objective indicator of health care quality;

(3) Indicate whether health care providers identified in the information were consulted regarding its development and data analysis standards;

(4) Provide such health care providers with the opportunity to comment on data made available to the public;

(5) At the option of the provider, include such provider comments with the publicly disclosed information if the seller or distributor of the information declines to make changes based on such comments; and

(6) Post on their web site the methodology, including all formulas sufficient to replicate data produced by quality of care indicators not used by the federal Centers for Medicare and Medicaid Services.

4. Articles or research studies on the topic of quality of care assessment that are published in peer-reviewed academic journals shall be exempt from the requirements of subsection 3 of this section.

5. Programs of health carriers to assess and compare the performance and efficiency of health care providers shall conform to the following requirements:

(1) If a consolidated provider performance indicator includes measures of both quality of performance and cost-efficiency, the weight given to each type of measure shall be disclosed;

(2) The relative weight of each quality of performance indicator to the overall rating shall be disclosed;

(3) Providers shall be notified at least forty-five days prior to the implementation of a quality of performance or cost-efficiency measure. The notification shall include a

description of the process for using the quality of performance or cost-efficiency measure or measures;

(4) Quality of performance or cost-efficiency data shall reflect appropriate risk adjustment to account for the characteristics of the patients treated by the health care provider. Such risk adjustment shall include, but not be limited to, case mix, severity of the medical condition, co-morbidities, and outlier episodes;

(5) When multiple providers are involved in a patient's treatment, quality of performance indicators shall disclose the methodology for determining which health care provider will be held accountable for a patient's care;

(6) In disclosing comparative data, health carriers shall prominently state that performance rankings are only a guide in choosing a health care provider and that such rankings are based on statistical analysis and as such have a risk of error;

(7) Health care providers shall have the right to review quality of performance and cost-efficiency data prior to its disclosure. If a health care provider files a timely appeal following such review, the health carrier shall not post the quality of performance or cost-efficiency data until the appeal is completed; and

(8) Quality of performance and cost-efficiency data shall be designed to compare like types of health care providers within the appropriate geographic market.

6. All alleged violations of subsections 1 to 5 of this section by a health carrier shall be investigated and enforced by the department of insurance, financial institutions and professional registration under the department's powers and responsibilities to enforce the insurance laws of this state in accordance with chapter 374, RSMo.

7. (1) Upon receipt of a complaint of an alleged violation of subsection 3 of this section by a person or entity other than a health carrier, the department of health and senior services shall investigate the complaint and, upon finding that a violation has occurred, shall be authorized to impose a penalty in an amount not to exceed one thousand dollars. The department shall promulgate rules governing its processes for conducting such investigations and levying fines authorized by law.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

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