FIRST REGULAR SESSION

SENATE BILL NO. 149

95TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR DEMPSEY.

Pre-filed January 5, 2009, and ordered printed.

TERRY L. SPIELER, Secretary.

0809S.01I

AN ACT

To amend chapter 191, RSMo, by adding thereto nine new sections relating to health care technology, with penalty provisions.

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

Section A. Chapter 191, RSMo, is amended by adding thereto nine new sections, to be known as sections 191.1005, 191.1008, 191.1010, 191.1200, 191.1250, 191.1256, 191.1259, 191.1265, and 191.1271, to read as follows:

191.1005. 1. For purposes of this section, "insurer" includes the state of Missouri for purposes of the rendering of health care services by providers under a medical assistance program of the state.

2. Programs of insurers that publicly assess and compare the quality and cost efficiency of health care providers shall conform to the following criteria:

(1) The insurers shall retain, at their own expense, the services of a nationally-recognized independent health care quality standard-setting organization to review the plan's programs for consumers that measure, report, and tier providers based on their performance. Such review shall include a comparison to national standards and a report detailing the measures and methodologies used by the health plan. The scope of the review shall encompass all elements described in this section and section 191.1008;

(2) The program measures shall provide performance information that reflects consumers' health needs. Programs shall clearly describe the extent to which they encompass particular areas of care, including primary care and other areas of specialty care;

(3) Performance reporting for consumers shall include both quality and cost efficiency information. While quality information may

be reported in the absence of cost-efficiency, cost-efficiency information shall not be reported without accompanying quality information;

(4) When any individual measures or groups of measures are combined, the individual scores, proportionate weighting, and any other formula used to develop composite scores shall be disclosed. Such disclosure shall be done both when quality measures are combined and when quality and cost efficiency are combined;

(5) Consumers or consumer organizations shall be solicited to provide input on the program, including methods used to determine performance strata;

(6) A clearly defined process for receiving and resolving consumer complaints shall be a component of any program;

(7) Performance information presented to consumers shall include context, discussion of data limitations, and guidance on how to consider other factors in choosing a provider;

(8) Relevant providers and provider organizations shall be solicited to provide input on the program, including the methods used to determine performance strata;

(9) Providers shall be given reasonable prior notice before their individual performance information is publicly released;

(10) A clearly defined process for providers to request review of their own performance results and the opportunity to present information that supports what they believe to be inaccurate results, within a reasonable time frame, shall be a component of any program. Results determined to be inaccurate after the reconsideration process shall be corrected;

(11) Information about the comparative performance of providers shall be accessible and understandable to consumers and providers;

(12) Information about factors that might limit the usefulness of results shall be publicly disclosed;

(13) Measures used to assess provider performance and the methodology used to calculate scores or determine rankings shall be published and made readily available to the public. Some elements shall be assessed against national standards. Examples of measurement elements that shall be assessed against national standards include: risk

and severity adjustment, minimum observations, and statistical standards utilized. Examples of other measurement elements that shall be fully disclosed include: data used, how providers' patients are identified, measure specifications and methodologies, known limitations of the data, and how episodes are defined;

(14) The rationale and methodologies supporting the unit of analysis reported shall be clearly articulated, including a group practice model versus the individual provider;

(15) Sponsors of provider measurement and reporting shall work collaboratively to aggregate data whenever feasible to enhance its consistency, accuracy, and use. Sponsors of provider measurement and reporting shall also work collaboratively to align and harmonize measures used to promote consistency and reduce the burden of collection. The nature and scope of such efforts shall be publicly reported;

(16) The program shall be regularly evaluated to assess its effectiveness and any unintended consequences;

(17) Measures shall be based on national standards. The primary source shall be measures endorsed by the National Quality Forum (NQF). When non-NQF measures are used because NQF measures do not exist or are unduly burdensome, it shall be with the understanding that they will be replaced by comparable NQF-endorsed measures when available;

(18) Where NQF-endorsed measures do not exist, the next level of measures to be considered, to the extent practical, shall be those endorsed by the Ambulatory Care Quality Alliance, national accrediting organizations such as the National Committee for Quality Assurance, or the Joint Commission on the Accreditation of Healthcare Organizations and federal agencies;

(19) Supplemental measures are permitted if they address areas of measurement for which national standards do not yet exist or for which existing national standard measure requirements are unreasonably burdensome on providers or program sponsors. Supplemental measures may be used if they are part of a pilot program to assess the extent to which the measures could fill national gaps in measurement. When supplemental measures are used they shall reasonably adhere to the NQF measure criteria, including

importance, scientific acceptability, feasibility and usability, and may include sources such as provider specialty society guidelines. The director of the department of insurance, financial institutions and professional registration shall be authorized to adopt by administrative rule any updates or modifications to the most recent version of the Patient Charter for Physician Performance, Measurement, Reporting and Tiering Programs.

3. The use by insurers of programs to publicly assess and compare the quality and cost efficiency of health care providers under subsection 2 of this section shall not be a basis for a provider to decline to enter into a provider contract with an insurer. A provider shall not withhold or otherwise obstruct an insurer from using data collected from medical claims or other sources generated by the provider and in possession of the insurer for the purpose of providing plan enrollees, providers, or the public information on the quality and cost efficiency differences in treatments and providers as long as the data is not used in a manner that violates any provisions of the federal Health Insurance Portability and Accountability Act or antitrust law.

191.1008. 1. Any person who sells or otherwise distributes to the public health care quality and cost efficiency data for disclosure in comparative format to the public shall identify the measure source or evidence-based science behind the measure and the national consensus, multi-stakeholder, or other peer review process, if any, used to confirm the validity of the data and its analysis as an objective indicator of health care quality.

2. Articles or research studies on the topic of health care quality or cost efficiency that are published in peer-reviewed academic journals that do not receive funding from or is affiliated with a health care insurer or by state or local government shall be exempt from the requirements of subsection 1 of this section.

3. (1) Upon receipt of a complaint of an alleged violation 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, 2009, shall be invalid and void.

191.1010. All alleged violations of sections 191.1005 to 191.1008 by a health insurer 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.

191.1200. 1. The general assembly shall appropriate four hundred thousand dollars from the health care technology fund created in section 208.975, RSMo, to the department of social services for the purpose of awarding a grant to implement an Internet web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. The grantee shall establish a program that diverts patients presenting at an emergency room for nonemergency care to more appropriate outpatient settings as is consistent with federal law and regulations. The program shall refer the patient to an appropriate health care professional based on the patient's health care needs and situation. The program shall provide the patient with a scheduled appointment that is timely, with an appropriate provider who is conveniently located. If the patient is uninsured and potentially eligible for MO HealthNet, the program shall connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process. The program shall also ensure that discharged patients are connected with a community-based primary care provider and assist in scheduling any

necessary follow-up visits before the patient is discharged.

2. The program shall not require a provider to pay a fee for accepting charity care patients in a Missouri public health care program.

3. The grantee shall report to the director on a quarterly basis the following information:

(1) The total number of appointments available for scheduling by specialty;

(2) The average length of time between scheduling and actual appointment;

(3) The total number of patients referred and whether the patient was insured or uninsured; and

(4) The total number of appointments resulting in visits completed and number of patients continuing services with the referring clinic.

4. The director, in consultation with the Missouri Hospital Association, or a successor organization, shall conduct an evaluation of the emergency room diversion pilot project and submit the results to the general assembly by January 15, 2009. The evaluation shall compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and an estimate of the costs saved from any documented reductions.

191.1250. As used in sections 191.1250 to 191.1277, the following terms shall mean:

(1) "Chronic condition", any regularly recurring, potentially life-threatening medical condition that requires regular supervision by a primary care physician and/or medical specialist;

(2) "Department", the department of health and senior services;

(3) "EMR" or "electronic medical record", refers to a patient's medical history that is stored in real-time using information technology and which can be amended, updated, or supplemented by the patient or the physician using the electronic medical record;

(4) "HIPAA", the federal Health Insurance Portability and Accountability Act of 1996;

(5) "Originating site", a place where a patient may receive health care via telehealth. An originating site may include:

(a) A licensed inpatient center;

(b) An ambulatory surgical center;

(c) Any practice location, office, or clinic of a licensed health care professional;

(d) A skilled nursing facility;

(e) A residential treatment facility;

(f) A home health agency;

(g) A diagnostic laboratory or imaging center;

(h) An assisted living facility;

(i) A school-based health program;

(j) A mobile clinic;

(k) A mental health clinic;

(l) A rehabilitation or other therapeutic health setting;

(m) The patient's residence;

(n) The patient's place of employment; or

(o) The patient's then-current location if the patient is away from the patient's residence or place of employment;

(6) "Telehealth", the use of telephonic and other electronic means of communications to provide and support health care delivery, diagnosis, consultation, and treatment when distance separates the patient and the health care provider;

(7) "Telehealth practitioner", a person who is a licensed health care professional and who utilizes telehealth to diagnose, consult with, or treat patients without having conducted an in-person consultation with a particular patient.

191.1256. Sections 191.1250 to 191.1277 do not:

(1) Alter the scope of practice of any health care practitioner; or

(2) Limit a patient's right to choose in-person contact with a health care professional for the delivery of health care services for which telehealth is available.

191.1259. The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in this state. No health care provider or operator of an originating site shall be disciplined for or discouraged from participating in sections 191.1250 to 191.1277. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines and shall follow established federal and state rules

regarding security, confidentiality and privacy protections for health care information.

191.1265. Only telehealth practitioners qualified under sections 191.1250 to 191.1277 may practice telehealth care in this state. Telehealth practitioners may reside outside this state but shall be licensed by an appropriate board within the division of professional registration. Beginning July 1, 2010, all health carriers, as defined under section 376.1350, RSMo, shall reimburse services provided through telehealth in the same manner they would reimburse a standard office visit or consultation by the provider or specialist. The department of social services shall promulgate rules for the MO HealthNet program consistent with the provisions of this section.

191.1271. By January 1, 2010, the department shall promulgate quality control rules and regulations to be used in removing and improving the services of telehealth practitioners. 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, 2009, shall be invalid and void.

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