FIRST REGULAR SESSION

SENATE BILL NO. 517

95TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR LEMBKE.

Read 1st time February 25, 2009, and ordered printed.

TERRY L. SPIELER, Secretary.

2186L.01I

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AN ACT

To repeal sections 192.068 and 374.426, RSMo, and to enact in lieu thereof four new sections relating to health care transparency, with a penalty provision.

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

Section A. Sections 192.068 and 374.426, RSMo, are repealed and four
2 new sections enacted in lieu thereof, to be known as sections 192.068, 374.426, 1,
3 and 2, to read as follows:

192.068. 1. Any entity subject to the provisions of sections 354.400 to
2 354.636, RSMo, shall provide data regarding quality of care, access to care,
3 member satisfaction and member health status to the director of the department
4 of health and senior services. **Data submitted to the department under**
5 **section 374.426, RSMo, and transferred to the department of health and**
6 **senior services shall not be required to be submitted under this**
7 **section.** Failure to provide such data shall be reported to the director of the
8 department of insurance, financial institutions and professional registration and
9 shall be subject to the penalties provided in section 354.444, RSMo. Any entity
10 subject to the provisions of sections 354.400 to 354.636, RSMo, which continually
11 or substantially fails to comply with the provisions of this section may be
12 prohibited by the director of the department of insurance, financial institutions
13 and professional registration from participating in any health program
14 administered by the state. The department of health and senior services shall
15 promulgate rules defining continual or substantial failure to comply with the
16 provisions of this section.

17 2. The department of health and senior services shall specify by rule the
18 types of data which shall be submitted and the methods of collection and

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EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

19 submission. In defining data standards for the measurement of the quality of
20 care, access to care, member satisfaction and member health status, the director
21 of the department of health and senior services may:
22 (1) Use as the data set the Health Plan Employer Data and Information
23 Set (HEDIS) or an equivalent data set as determined by the department of health
24 and senior services;
25 (2) Consider published standards developed by nationally recognized
26 accreditation organizations including, but not limited to, the National Committee
27 for Quality Assurance and the Joint Committee on Accreditation of Health Care
28 Organizations;
29 (3) Consult with other state agencies and interested parties responsible
30 for delivering, financing and purchasing health care in the state; and
31 (4) Use available department of health and senior services data and other
32 agency data wherever appropriate.
33 3. Data or other information obtained by the department of health and
34 senior services pursuant to the provisions of this section shall not be public
35 information. Reports and studies prepared by the department based upon such
36 information shall be public information and may identify individual entities in
37 the business of delivering or financing health care. The department of health and
38 senior services may authorize the use of the data for other research pursuant to
39 the provisions of section 192.067. The department shall not release data in a
40 form which could be used to identify a patient.
41 4. The department may choose to perform studies and shall publish
42 information, including at least an annual consumer guide, based upon the
43 information obtained pursuant to the provisions of this section. The department
44 shall allow health care financing entities or health care providers who have
45 submitted data which will be used in any report to review and comment on the
46 report prior to its publication or release for public use. With the permission of
47 the entity or the health care provider, the department may include any comments
48 of a health care financing entity or health care provider in the publication. The
49 reports shall be made available to the public. The department may charge a
50 reasonable fee to any entity in the business of delivering or financing health care
51 for specialized reports or services requested by such entity. The fees shall be
52 credited to the public health services fund established in section 192.900.

374.426. 1. **A health carrier as defined in section 376.1350, RSMo,**
2 **and to the extent allowable under federal law,** any **other** entity in the

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3 business of [delivering or financing] **offering** health care **coverage** shall provide
4 data regarding quality of patient care**, access to care, enrollee health status,**
5 and patient satisfaction to the director of the department of insurance, financial
6 institutions and professional registration. **The data submission requirements**
7 **under this subsection shall be consistent with, but may be more**
8 **expansive than, the requirements established for health maintenance**
9 **organizations under section 192.068, RSMo.** Failure to provide such data
10 as required by the director of the department of insurance, financial institutions
11 and professional registration shall constitute grounds for violation of the unfair
12 trade practices act, sections 375.930 to 375.948, RSMo.

13 2. In defining data standards for quality of care**, access to care,**
14 **enrollee health status,** and patient satisfaction, the director of the department
15 of insurance, financial institutions and professional registration shall:

16 (1) Use as the initial data set the HMO Employer Data and Information
17 Set developed by the National Committee for Quality Assurance;

18 (2) Consult with nationally recognized accreditation organizations,
19 including but not limited to the National Committee for Quality Assurance and
20 the Joint Committee on Accreditation of Health Care Organizations; and

21 (3) Consult with [a state committee of a national committee] **entities**
22 convened to develop standards regarding uniform billing of health care claims.

23 **3. The department shall collect or compile and make publicly**
24 **available data on each entity's:**

25 **(1) Medical loss ratios for each of the previous three years;**

26 **(2) Administrative costs as a percentage of total premium for**
27 **each of the previous three years; and**

28 **(3) Incidence of grievances, as defined in section 376.1350, RSMo,**
29 **filed with the department in each of the previous three years and the**
30 **subsequent disposition, by outcome, of such grievances or adverse**
31 **determinations under chapter 376, RSMo.**

32 **4. Data obtained by the department under subsection 1 of this**
33 **section shall not be public information but may be disclosed to the**
34 **department of health and senior services. Reports and studies**
35 **prepared by the department or the department of health and senior**
36 **services based upon such information shall be public information and**
37 **may identify individual health care or coverage providers. The**
38 **departments shall not use or release any information provided under**

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39 **this section which would enable any person to determine any health**
40 **care provider's negotiated discounts with specific health carriers. The**
41 **departments shall not release data in a form which could be used to**
42 **identify a patient. Any violation of this subsection is a class B**
43 **misdemeanor.**

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

2 **(1) "Health care provider", the same meaning as such term is**
3 **defined in section 376.1350, RSMo;**
4 **(2) "Health carrier", the same meaning as such term is defined in**
5 **section 376.1350, RSMo;**
6 **(3) "Quality of care data", data intended to measure the quality**
7 **of health care services delivered by a specific health care provider.**
8 **2. A contract between a health carrier and a health care provider**
9 **shall not require the provider to submit quality of care data to the**
10 **health carrier as a condition of payment for medical services rendered,**
11 **unless such data is included in the set of quality of care indicators**
12 **selected by the federal Centers for Medicare and Medicaid Services for**
13 **disclosure in comparative format to the public. The provisions of this**
14 **section shall not be construed to limit the health carrier's ability to:**
15 **(1) Abstract quality of care data from billing data submitted by**
16 **the provider; or**
17 **(2) Collect data necessary to comply with federal or state law,**
18 **regulation, or accreditation standards; or**
19 **(3) Collect data from health care providers for whom the federal**
20 **Centers for Medicare and Medicaid Services has not implemented**
21 **quality of care indicators for disclosure in comparative format.**
22 **3. Any person who sells or otherwise distributes to the public**
23 **quality of care data shall, if the product includes data that is not**
24 **included in the set of quality of care indicators selected by the federal**
25 **Centers for Medicare and Medicaid Services for disclosure in**
26 **comparative format to the public:**
27 **(1) Include the following disclaimer on the information**
28 **distributed: "These data includes quality of care indicators other than**
29 **those used by the federal Centers for Medicare and Medicaid Services**
30 **and as such may be based on research methodologies that deviate from**
31 **those used by that agency."; and**

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32 **(2) Identify what peer review, if any, was used to confirm the**
33 **validity of the data and its analysis as an objective indicator of health**
34 **care quality; and**
35 **(3) Indicate whether health care providers identified in the**
36 **information were consulted regarding its development and data**
37 **analysis standards; and**
38 **(4) Give such health care providers the opportunity to comment**
39 **on data made available to the public; and**
40 **(5) At the option of the provider, include such provider**
41 **comments with the publicly disclosed information if the seller or**
42 **distributor of the information declines to make changes based on such**
43 **comments; and**
44 **(6) Post on its web site the methodology, including all formulas**
45 **sufficient to replicate data produced by quality of care indicators not**
46 **used by the federal Centers for Medicare and Medicaid Services.**
47 **4. Articles or research studies on the topic of quality of care**
48 **assessment that are published in peer-reviewed academic journals shall**
49 **be exempt from the requirements of subsection 3 of this section.**
50 **5. Programs of health carriers to assess and compare the**
51 **performance and efficiency of health care providers shall conform to**
52 **the following requirements:**
53 **(1) If a consolidated provider performance indicator includes**
54 **measures of both quality of performance and cost efficiency, the weight**
55 **given to each type of measure shall be disclosed;**
56 **(2) The relative weight of each quality of performance indicator**
57 **to the overall rating shall be disclosed;**
58 **(3) Providers shall be notified at least forty-five days prior to the**
59 **implementation of a quality of performance or cost efficiency**
60 **measure. The notification shall include a description of the process for**
61 **using the quality of performance or cost efficiency measure or**
62 **measures;**
63 **(4) Quality of performance or cost efficiency data shall reflect**
64 **appropriate risk adjustment to account for the characteristics of the**
65 **patients treated by the health care provider. Such risk adjustment**
66 **shall include, but not be limited to, case mix, severity of the medical**
67 **condition, comorbidities, and outlier episodes;**
68 **(5) When multiple providers are involved in a patient's**

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69 **treatment, quality of performance indicators shall disclose the**
70 **methodology for determining which health care provider will be held**
71 **accountable for a patient's care;**
72 **(6) In disclosing comparative data, health carriers shall**
73 **prominently state that performance rankings are only a guide in**
74 **choosing a health care provider and such rankings are based on**
75 **statistical analysis and as such have a risk of error;**
76 **(7) Health care providers shall have the right to review quality**
77 **of performance and cost efficiency data prior to its disclosure. If a**
78 **health care provider files a timely appeal following such review, the**
79 **health carrier shall not post the quality of performance or cost**
80 **efficiency data until the appeal is completed; and**
81 **(8) Quality of performance and cost efficiency data shall be**
82 **designed to compare like types of health care providers within the**
83 **appropriate geographic market.**
84 **6. Alleged violations of subsection 1 of this section by a health**
85 **carrier shall be investigated and enforced by the department of**
86 **insurance, financial institutions and professional registration under the**
87 **department's powers and responsibilities to enforce the insurance laws**
88 **of this state in accordance with chapter 374, RSMo.**
89 **7. Upon receipt of a complaint of an alleged violation of this**
90 **section by a person or entity other than a health carrier, the**
91 **department of health and senior services shall investigate the**
92 **complaint and upon finding that a violation has occurred, shall be**
93 **authorized to impose a civil penalty in an amount not to exceed one**
94 **thousand dollars for each day of such violation. The department shall**
95 **promulgate rules governing its processes for conducting such**
96 **investigations and imposing penalties under law. Any rule or portion**
97 **of a rule, as that term is defined in section 536.010, RSMo, that is**
98 **created under the authority delegated in this section shall become**
99 **effective only if it complies with and is subject to all of the provisions**
100 **of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This**
101 **section and chapter 536, RSMo, are nonseverable and if any of the**
102 **powers vested with the general assembly pursuant to chapter 536,**
103 **RSMo, to review, to delay the effective date, or to disapprove and annul**
104 **a rule are subsequently held unconstitutional, then the grant of**
105 **rulemaking authority and any rule proposed or adopted after August**

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106 **28, 2009, shall be invalid and void.**

Section 2. 1. As used in this section, the following terms shall
2 **mean:**
3 **(1) "Affiliate", any person or entity that has ownership or control**
4 **of a contracting entity, is owned or controlled by a contracting entity,**
5 **or is under common ownership or control with a contracting entity;**
6 **(2) "Contracting entity", any person who has a primary business**
7 **purpose of contracting with participating providers for the delivery of**
8 **health care services;**
9 **(3) "Electronic claims transport", accepting and digitizing claims**
10 **or accepting claims already digitized, placing such claims into a format**
11 **that complies with the electronic transaction standards issued by the**
12 **United States Department of Health and Human Services under the**
13 **federal Health Insurance Portability and Accountability Act of 1996, 42**
14 **U.S.C. Sections 1320d, et seq., as amended, as such electronic standards**
15 **are applicable to the parties and as such electronic standards are**
16 **updated from time to time, and electronically transmitting such claims**
17 **to the appropriate contracting entity, payer, or third-party**
18 **administrator;**
19 **(4) "Health care contract", a contract entered into, materially**
20 **amended, or renewed between a contracting entity and a participating**
21 **provider for the delivery of health care services to enrollees;**
22 **(5) "Participating provider", a provider who has a health care**
23 **contract with a contracting entity and is entitled to reimbursement for**
24 **health care services rendered to an enrollee under the health care**
25 **contract;**
26 **(6) "Payer", any person who assumes the financial risk for the**
27 **payment of claims under a health care contract or the reimbursement**
28 **for health care services provided to enrollees by participating**
29 **providers under a health care contract.**
30 **2. No contracting entity shall sell, rent, or give a third party the**
31 **contracting entity's rights to a participating provider's services under**
32 **the contracting entity's health care contract with the participating**
33 **provider unless one of the following applies:**
34 **(1) The third party accessing the participating provider's**
35 **services under the health care contract is an employer or other entity**
36 **providing coverage for health care services to its employees or**

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37 **members, and such employer or entity has a contract with the**
38 **contracting entity or its affiliate for the administration or processing**
39 **of claims for payment for services provided under the health care**
40 **contract with the participating provider;**
41 **(2) The third party accessing the participating provider's**
42 **services under the health care contract either is an affiliate or**
43 **subsidiary of the contracting entity or is providing administrative**
44 **services to or receiving administrative services from the contracting**
45 **entity or an affiliate or subsidiary of the contracting entity;**
46 **(3) The health care contract specifically provides that it applies**
47 **to network rental arrangements and states that one purpose of the**
48 **contract is selling, renting, or giving the contracting entity's rights to**
49 **the services of the participating provider, including other preferred**
50 **provider organizations, and the third party accessing the participating**
51 **provider's services is any one of the following:**
52 **(a) A payer or third-party administrator or other entity**
53 **responsible for administering claims on behalf of the payer;**
54 **(b) A preferred provider organization or preferred provider**
55 **network that receives access to the participating provider's services**
56 **under an arrangement with the preferred provider organization or**
57 **preferred provider network in a contract with the participating**
58 **provider that is in compliance with this subdivision and is required to**
59 **comply with all of the terms, conditions, and affirmative obligations to**
60 **which the originally contracted primary participating provider**
61 **network is bound under its contract with the participating provider,**
62 **including but not limited to obligations concerning patient steerage**
63 **and the timeliness and manner of reimbursement; or**
64 **(c) An entity that is engaged in the business of providing**
65 **electronic claims transport between the contracting entity and the**
66 **payer or third-party administrator and complies with all of the**
67 **applicable terms, conditions, and affirmative obligations of the**
68 **contracting entity's contract with the participating provider, including**
69 **but not limited to obligations concerning patient steerage and the**
70 **timeliness and manner of reimbursement.**
71 **3. The contracting entity that sells, rents, or gives the**
72 **contracting entity's rights to a participating provider's services under**
73 **the contracting entity's health care contract with the participating**

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74 **provider as provided in subsection 2 of this section shall do both of the**
75 **following:**
76 **(1) Maintain a web site that contains a listing of third parties**
77 **described in subdivisions (2) and (3) of subsection 2 of this section with**
78 **whom a contracting entity contracts for the purpose of selling, renting,**
79 **or giving the contracting entity's rights to the services of participating**
80 **providers, or maintain a toll-free telephone number accessible to all**
81 **participating providers by means of which participating provider may**
82 **access the same listing of third parties; and**
83 **(2) Require that the third party accessing the participating**
84 **provider's services through the participating provider's health care**
85 **contract is obligated to comply with all of the applicable terms and**
86 **conditions of the contract, including but not limited to the products for**
87 **which the participating provider has agreed to provide services; except**
88 **that, a payer receiving administrative services from the contracting**
89 **entity or its affiliate shall be solely responsible for payment to the**
90 **participating provider.**
91 **4. Except as provided in subsection 2 of this section, no entity**
92 **shall sell, rent, or give a contracting entity's rights to a participating**
93 **provider's services under a health care contract.**

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