SECOND REGULAR SESSION

SENATE BILL NO. 1062

95TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCHMITT.

Read 1st time March 1, 2010, and ordered printed.

TERRY L. SPIELER, Secretary.

5309S.01I

AN ACT

To amend chapter 191, RSMo, by adding thereto three new sections relating to health care data standardization and transparency, 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 three new sections, to be known as sections 191.1005, 191.1008, and 191.1011, to read as follows:

191.1005. 1. For purposes of sections 191.1005 to 191.1011, the following terms shall mean:

(1) "Insurer", the same meaning as the term "health carrier" is defined in section 376.1350, and includes the state of Missouri for purposes of the rendering of health care services by providers under a medical assistance program of the state and, to the extent authorized by federal law, any plan of coverage provided under the Employee Retirement Income Security Act of 1974, 29 D.S.C. 1001, *et seq.*;

(2) "Provider", the same meaning as such term is defined in section 376.1350.

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) The program measures shall provide the market costs of high-volume, routine services including, but not limited to, the most common routine tests, office visits, outpatient and inpatient procedures;

(4) 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;

(5) 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;

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

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

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

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

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

(11) 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;

(12) Information about the comparative performance of providers shall be accessible and understandable to consumers and providers and shall recognize cost factors associated with medical education and research, patient characteristics, and specialized services;

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

(14) 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. Elements shall be assessed against national standards as defined in subdivision (18) of this subsection. 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;

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

(16) 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;

(17) The program shall be regularly evaluated to assess its effectiveness, accuracy, reliability, validity, and any unintended consequences, including any effect on access to health care;

(18) All quality measures shall be endorsed by the National Quality Forum (NQF), or its successor organization. Where NQF-endorsed measures do not exist, the next level of measures to be considered, until such measures are endorsed by the National Quality Forum (NQF), or its successor organization, shall be those endorsed by

the Ambulatory Care Quality Alliance, the National Committee for Quality Assurance, or the Joint Commission on the Accreditation of Healthcare Organizations, Healthcare Effectiveness and Data Information Set (HEDIS).

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 neither receive funding from nor are 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 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, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, 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, 2010, shall be invalid and void.

191.1011. 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.

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