SECOND REGULAR SESSION

SENATE BILL NO. 956

97TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SCHAAF.

Read 1st time February 27, 2014, and ordered printed.

TERRY L. SPIELER, Secretary.

6285S.01I

AN ACT

To amend chapter 191, RSMo, by adding thereto three 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. Chapter 191, RSMo, is amended by adding thereto three new sections, to be known as sections 191.1005, 191.1008, and 191.1010, to read as follows:

191.1005. 1. For purposes of this section, the following terms shall mean:

(1) "Estimate of cost", an estimate given prior to the provision of medical services which is based on specific patient information or general assumptions about typical utilization and costs for medical services. Upon written request by a patient, a provider or insurer shall be required to provide the patient a timely estimate of cost for any elective or nonemergent health care service. Such requirement shall not apply to emergency health care services or any provider documenting to consumers the cost of the provider's twenty most common charges electronically or in paper format, or to any referral services that the provider does not provide directly to a patient. Any estimate of cost may include a disclaimer noting the actual amount billed may be different from the estimate of cost. An estimate of cost shall not be deemed an authorization for the provision of services;

(2) "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.

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. Elements shall be assessed against national standards as defined in subdivisions (17) and (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;

(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, accuracy, reliability, validity, and any unintended consequences, including any effect on access to health care;

(17) Measures shall be based on national standards. The primary source shall be measures endorsed by the National Quality Forum (NQF). When nonNQF 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, Healthcare Effectiveness and Data Information Set (HEDIS), other national provider specialty organizations, or federal agencies;

(19) The public, including consumers and employers, has a right to obtain reliable and valid information to assist them in comparing the cost and quality of health care services and health care providers. For such purpose, health carriers shall have the ability to use reliable data which is collected from medical claims, health care providers, medical records review or other sources, including the federal Centers for Medicare and Medicaid Services (CMS) and other entities for such purpose. Health carriers and health care providers are prohibited from entering into new contracts or amending existing contracts that limit the use of medical claims data to payment of claims or otherwise preclude health carriers from responding to the public's need for comparative cost, quality, and efficiency information, or other performance information, on health care services and health care providers. Health carriers may use claims and contracted rate data to report on cost, quality, and efficiency consistent with the patient charter or other nationally recognized standards, such as those issued by the National Committee for Quality Assurance. No health carrier or any other entity shall use such information in a manner that violates any state or federal law, including antitrust law; and

(20) A health plan shall be deemed compliant with this section if the health plan receives certification from the National Committee for Quality Assurance (NCQA) on programs that evaluate the quality of physicians and hospitals. The health plan is deemed to be in compliance for the length of time the NCQA certification has been granted or awarded.

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, 2014, 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.

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