Lisa Musielewicz *Legislative Service Commission*

Sub. H.B. 197

126th General Assembly
(As Passed by the General Assembly)

Reps. **Raussen, Gibbs, McGregor, J., Carmichael, Evans, C., Flowers, Evans, D., Faber, Ujvagi, Koziura, Schaffer, Blasdel, Martin, Beatty, Blessing, Cassell, Collier, DeBose, Distel, Dolan, Domenick, Fessler, Hagan, Hughes, Key, Law, Mason, Miller, Patton, S., Smith, S., Stewart, D., Sykes, Wagoner, White, Williams, Woodard, Yuko**

Sens. **Clancy, Coughlin, Gardner, Hottinger, Kearney, Miller, D., Mumper, Niehaus, Padgett, Schuler, Stivers, Harris, Zurz, Dann, Fedor, Miller, R., Spada, Fingerhut, Hagan, Prentiss**

Effective date: *

ACT SUMMARY

Advisory council and groups

- Creates the Hospital Measures Advisory Council.
- Requires the Director of Health to convene the Data Collection and Analysis Group: a group of experts in data collection and analysis or a related field, each member of which is appointed by a member of the Advisory Council.
- Requires the Advisory Council to convene, as needed, a group of health care consumers, nurses, and experts in infection control.

Performance measure information

- Requires each hospital to submit, on a semi-annual basis, information to the Director of Health that shows the hospital's record in meeting inpatient and outpatient service measures specified in rules to be adopted

* *The Legislative Service Commission had not received formal notification of the effective date at the time this analysis was prepared. Additionally, the analysis may not reflect action taken by the Governor.*

by the Director and identifies this information as "performance measure information."

- Requires the Director to adopt rules that include the measures developed or endorsed by specified national organizations, and permits the Director to adopt rules that include other measures recommended by the Advisory Council.

- Permits the Director to audit any performance measure information submitted by hospitals, including information adjusted for risk.

Price and volume information

- Repeals law authorizing the Department of Health to obtain information about Medicare and Medicaid patients from the U.S. Department of Health and Human Services and the Ohio Department of Job and Family Services, respectively.

- Modifies the laws requiring each hospital to make annual reports on prices and volume of patients by requiring the reports to be made with respect to all patients (not only nongovernmental patients) in each of the 60 (as opposed to 100) diagnosis related groups most frequently treated on an inpatient basis.

- Requires each hospital to make similar annual reports on price and volume relative to the 60 categories of outpatient services most frequently provided by the hospital.

Quality-of-care data reporting requirements

- Eliminates the annual quality-of-care data reporting requirements that apply to providers of specified types of health care services, including organ and bone marrow transplantation, stem cell harvesting, cardiac catheterization, open-heart surgery, obstetric and newborn care, pediatric intensive care, operation of linear accelerators, operation of cobalt radiation therapy units, and operation of gamma knives.

Public availability of information

- Requires the Director to make the information submitted by hospitals available to the public on an Internet web site, but only to the extent that

appropriations are made by the General Assembly to make performance of the Director's web site duties possible.

- Requires that the Director, subject to the General Assembly's appropriations, enter into a contract with a person selected by the Director to perform the Director's duties in establishing and administering the web site.

- Specifies organizational requirements and design features of any web site established.

- Requires the Director to make the information submitted by hospitals available for sale to any interested person or government entity for a reasonable fee.

Price information lists

- Requires the price information list that hospitals are required to maintain under continuing law to be compiled in a format that complies with the electronic transaction standards and code sets adopted under the federal Health Insurance Portability and Accountability Act (HIPAA).

- Requires the price information list to include, in addition to the items required by law in place prior to the act's effective date, the hospital's billing policies, including whether the hospital charges interest on an amount not paid in full by any person or governmental entity and the interest rate charged.

- Requires a hospital to make its price information list available free of charge on the hospital's web site.

Confidentiality of information

- Prohibits a hospital from submitting performance measure information or price and volume information to the Director that includes the name or social security number of a patient, physician, or dentist.

Verification of accuracy of information

- Requires the Director to permit a hospital to verify the accuracy of all performance measure information and price and volume information

submitted to the Director and to provide corrections of the information in a timely manner.

Liability for information; standard of care and admissibility as evidence

- Prohibits a hospital that submits performance measure information or price and volume information to the Director from being held liable for the misuse or improper release of any of this information by the Department of Health or other specified persons.

- Prohibits performance measure information and price and volume information submitted to the Director from being used to establish or alter any professional standard of care and from being admitted as evidence in any civil, criminal, or administrative proceeding.

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CONTENT AND OPERATION

Hospital Measures Advisory Council

(R.C. 3727.31, 3727.311, and 3727.313)

The act creates the Hospital Measures Advisory Council consisting of the following 17 members:

- The Director of Health (serves as chair of the Council).
- The Superintendent of Insurance.
- The executive director of the Commission on Minority Health or the executive director's designee.
- Two members of the House of Representatives, from different political parties, appointed by the Speaker of the House.
- Two members of the Senate, from different political parties, appointed by the President of the Senate.

- One representative of each of the following groups appointed by the Speaker of the House: health insurers, small employers,[1] organized labor, physicians in general practice, and childrens' hospitals.

- One representative of each of the following groups appointed by the President of the Senate: physicians specializing in public health, hospitals, health services researchers, health care consumers, and large employers.[2]

The members of the Council are to serve at the pleasure of their appointing authority and without remuneration, except to the extent that serving on the Council is considered a part of their regular employment duties. The members are not to be reimbursed for expenses.

The act requires the Department of Health to provide meeting space and staff and other administrative support for the Council.

Council responsibilities

(R.C. 3727.312)

The Council is required to do all of the following under the act:

(1) Study the issue of hospitals reporting information regarding their performance in meeting measures for hospital inpatient and outpatient services, including how such reports are made in other states.

(2) Issue a report to the Director of Health, not later than one year after the date the last of the initial Council members is appointed, that makes recommendations for all of the following:

--Collecting information under the act from hospitals that shows their performance in meeting measures for hospital inpatient and outpatient services;

--The audits the act permits the Director to conduct on the information;

--Dissemination information about the performance of hospitals in meeting the measures, including effective methods of displaying information on any Internet web site established under the act;

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[1] *The term, "small employer," is not defined in the act.*

[2] *The term, "large employer," is not defined in the act.*

--Explaining to the public how to use the information, including explanations about the limitations of the information.

(3) Provide the Director with ongoing advice on the issue of hospitals reporting information regarding their performance in meeting measures for hospital inpatient and outpatient services, disseminating the information, making improvements to the reports and dissemination of information, and making changes to the information collection requirements and dissemination methods.

Infection control group

(R.C. 3727.312(D) and 3727.313)

The act requires the Advisory Council to convene a group of health care consumers, nurses, and experts in infection control to provide information about infection issues to the Council as needed for the Council to perform its duties. The members of the group are to be appointed by the Council according to a method it selects.

The members of the group are to serve at the pleasure of their appointing authority, and without remuneration, except to the extent that serving in the group is considered a part of their regular employment duties. The members are not to be reimbursed for expenses.

Data Collection and Analysis Group

(R.C. 3727.32)

The act requires the Director of Health to convene the Data Collection and Analysis Group: a group of experts in data collection and analysis or a related field. Each member of the Hospital Measures Advisory Council is to appoint an individual to serve on the group. A Council member who is an expert in data collection and analysis or a related field may serve as a member rather than appoint another individual. The Director must ensure the group's membership includes at least one representative of small and rural hospitals.

The group members are to serve without remuneration, except to the extent that serving in the group is considered a part of their regular employment duties. The members are not to be reimbursed for expenses.

Recommendations on hospital service measures

(R.C. 3727.32(A)(1) and 3727.321)

The Data Collection and Analysis Group is required by the act to develop, on an ongoing basis, recommendations regarding measures for hospital inpatient and outpatient services. The recommendations are to be submitted to the Director for consideration when rules are adopted specifying the measures to be used by hospitals in submitting information under the act. The Group may recommend that the rules include some or all of the following measures (see **COMMENT** 1):

(1) Hospital quality measures publicly reported by the Centers for Medicare and Medicaid Services (see **COMMENT** 2);

(2) Hospital quality measures publicly reported by the Joint Commission on Accreditation of Healthcare Organizations (see **COMMENT** 2);

(3) Measures included in the patient safety indicators and inpatient quality indicators developed by the Agency for Health Care Research and Quality;

(4) Measures included in the "national voluntary consensus standards for hospital care" endorsed by the National Quality Forum.

In considering whether to recommend a particular measure, the Group must consider whether there are any excessive administrative or financial implications associated with the reporting of information by hospitals regarding their performance in meeting the measure.

Additional duties

(R.C. 3727.32(A)(2) to (4))

In addition to making recommendations regarding measures of hospital services, the Data Collection and Analysis Group is required by the act to do the following:

(1) Issue a report to the Director providing advice on how to provide for any Internet web site established under the act to include a report on each hospital's overall performance in meeting the measures specified in the rules. The report must be issued not later than one year after the date the last of the initial members of the Advisory Council is appointed.

(2) Submit to the Director guidelines to be used in determining whether a hospital's performance in meeting a particular measure should be excluded from the web site because the hospital's caseload for the diagnosis or procedure that the

measure concerns is insufficient to make the hospital's performance a reliable indicator of its ability to treat the diagnosis or perform the procedure in a quality manner;

(3) Assist the Advisory Council with the part of its report that includes recommendations on the Director's authority under the act to audit the information submitted by hospitals regarding their performance in meeting the act's measures for hospital services.

Submission of information on hospital performance measures

(R.C. 3727.33)

Semiannually, the act requires each hospital to submit information to the Director of Health that shows the hospital's performance in meeting each of the inpatient and outpatient service measures specified in rules adopted under the act. The reports must be submitted not later than the first day of each April and October. The reporting requirement begins in 2007.

Rules for submitting information

(R.C. 3727.41)

The act requires the Director of Health to adopt rules governing hospitals in their submission of the information. The rules must be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.).

The rules must specify the inpatient and outpatient service measures to be used by hospitals in submitting the information. The act permits the rules to include any of the measures recommended by the Data Analysis and Collection Group. It also requires the rules to include measures from the following:

(1) Hospital quality measures publicly reported by the Centers for Medicare and Medicaid Services;

(2) Hospital quality measures publicly reported by the Joint Commission on Accreditation of Healthcare Organizations;

(3) Measures that examine volume of cases, adjusted length of stay, complications, infections, or mortality rates and are developed by the Agency for Health Care Research and Quality;

(4) Measures included in the "national voluntary consensus standards for hospital care" endorsed by the National Quality Forum.

In adopting the rules, the act requires the Director to consider both of the following: (a) whether hospitals have a sufficient caseload to make a particular measure a reliable indicator of their ability to treat a diagnosis or perform a procedure in a quality manner, and (b) whether there are any excessive administrative or financial implications associated with the reporting of information by hospitals regarding their performance in meeting a particular measure.

Procedures for submitting information

(R.C. 3727.33(A) to (D))

In submitting performance measure information, the act requires each hospital to do the following:

(1) Submit the information regardless of who pays the charges incurred for the services;

(2) For each measure for which the information is submitted, use the form and specifications for the measure that the entity that developed or endorsed the measure recommends be used for the measure;

(3) Adjust for risk, as needed, the information for a particular measure in accordance with the risk adjustment methodology that the entity that developed or endorsed the measure recommends be used for the measure;

(4) Provide for the information to reflect the hospital's performance in meeting the measures over a 12-month period;

(5) Follow the Director's rules governing submission of the information.

Auditing of information

(R.C. 3727.331)

The act permits the Director to audit any performance measure information submitted by hospitals under the act, including information adjusted for risk.

Injunctions

(R.C. 3727.45)

The act authorizes the Director to apply to the court of common pleas of the county in which a hospital is located for a temporary or permanent injunction

restraining the hospital from failure to comply with the act's requirement to submit performance measure information to the Director.

Quality-of-care data reports on health services

(R.C. 111.15, 3702.11, 3702.16, and 3702.18)

Under Am. Sub. S.B. 50 of the 121st General Assembly, the requirements of the Certificate of Need (CON) program were terminated for most health services other than long-term care. As the program was phased-out, S.B. 50 required the Director of Health to implement a licensing program for certain types of freestanding health care facilities and to adopt rules establishing quality standards for providers of nine types of health services. The quality rules for health services must include safety standards, quality-of-care standards, and annual quality-of-care data reporting requirements for the following:

(1) Solid organ and bone marrow transplantation;

(2) Stem cell harvesting and reinfusion;

(3) Cardiac catheterization;

(4) Open-heart surgery;

(5) Obstetric and newborn care;

(6) Pediatric intensive care;

(7) Operation of linear accelerators;

(8) Operation of cobalt radiation therapy units;

(9) Operation of gamma knives.

The act eliminates the Director's duty to adopt rules establishing annual quality-of-care *reporting* requirements for the nine health services specified above, while retaining the duty to adopt rules establishing safety and quality-of-care standards for the services. The act provides for the ongoing confidentiality of the following information reported to the Director prior to the act's effective date: (1) information that identifies or would tend to identify specific patients, and (2) reports on specific adverse events, bodily injuries, or complaints.

Information about governmental patients

(R.C. 3727.13 (repealed))

Under former law, the Department of Health was authorized to obtain information about Medicaid patients from the Department of Job and Family Services and about Medicare patients from the United States Department of Health and Human Services. The act eliminates this authority. In its place, the act, as discussed below, requires every hospital in Ohio to disclose to the Director of Health data regarding prices, patient discharges, patient admissions, and related factors for *all* patients, regardless of who pays the charges incurred.

Submission of information on hospital prices and number of patients

Background--former law

(R.C. 3727.11 (former law))

Under former law, every hospital was required to disclose annually to the Department of Health certain data for nongovernmental patients[3] in each of the 100 diagnosis related groups[4] most frequently treated on an inpatient basis as represented by discharges during the previous calendar year. The disclosures were due on or before the first day of each May. The Department was required to maintain the disclosures as public records.

The data that a hospital had to disclose were (1) the total number of patients discharged, (2) the mean, median, and range of total hospital charges, (3) the mean, median, and range of length of stay, (4) the number of admissions, and (5) the number of nongovernmental patients falling within certain diagnosis related group numbers used in federal Medicare regulations. A hospital was not required to disclose data for any diagnosis related group for which the hospital treated fewer than ten nongovernmental patients during the year.

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[3] *Former law defined "nongovernmental patient" as any patient other than a patient for whom primary charges are paid under the Medicare or Medicaid program or by the Bureau for Children with Medical Handicaps in the Department of Health. (Former R.C. 3727.11(A).)*

[4] *See* ***COMMENT*** *3.*

Inpatient information

(R.C. 3727.34(A) and 3727.41(A))

The act requires hospitals to submit, on or before the first day of May each year, the price and volume information described above to the Director of Health, rather than the Department of Health and makes a number of changes, including the following:

- Expands the population of patients for which hospitals must submit the information by including *all* patients, regardless of who pays the charges incurred (not only nongovernmental patients).

- Reduces the number of diagnosis related groups (from 100 to 60) for which hospitals must disclose the information.

- Requires the Director to make the information available to the public through an Internet web site or by selling it to any interested person or government entity.

- Eliminates a requirement that hospitals report prices for diagnosis related groups by using a severity of illness classification system.

- Eliminates the authority of the Public Health Council to adopt rules governing the submission of inpatient service information, and instead, requires the Director to adopt the rules.

Outpatient information

(R.C. 3727.16 (former law) and R.C. 3727.34(B) to (E), 3727.41(A), and 3727.45)

The act similarly requires each hospital to submit price and volume information to the Director pertaining to the hospital's outpatient services. The information must be submitted, regardless of who pays the charges incurred for the services, for patients in each of the 60 categories of outpatient services most frequently provided by the hospital. The 60 categories are to be determined from outpatient discharges during the previous calendar year.

Specifically, the act requires the following outpatient service information to be reported on or before the first day of May each year:

(1) The mean and median of total hospital charges for the services;

(2) For each of the 60 categories of services, the number of patients for whom the hospital provided the services.

In the same manner that information on inpatient prices and volume must be made publicly available, the Director and the hospital must make the information on outpatient prices and volume publicly available. The Director's authority to adopt rules governing the submission of inpatient service information is extended to the submission of outpatient service information. The Director's authority to seek injunctions for failure to comply with the reporting requirements is also extended to the duty to submit outpatient service information.

Confidentiality of information submitted by hospitals

(R.C. 3727.14 (former law) and 3727.36)

Former law prohibited hospitals from disclosing the name or social security number of a patient or physician in connection with the data that they were required to disclose under former law. Former law also prohibited this data from being released to the public, except on an aggregate basis, and required that the "health care information data base" collected by the Department under former law and any analysis of this information be maintained as a public record.

Consistent with the new information submission requirements under the act, the act prohibits a hospital from submitting performance measure information *or* price and volume information that includes the name or social security number not only of patients and physicians, but dentists as well. The act also repeals the requirement regarding the "health care information data base" collected by the Department because the law requiring the Department to maintain this database is repealed by the act (see "***Information about governmental patients***," above).

Verification of accuracy of information and data

(R.C. 3727.15 (repealed) and R.C. 3727.35)

Prior law permitted the Department of Health to issue reports concerning the data about nongovernmental patients that hospitals disclosed to the Department and information about Medicare and Medicaid patients the Department was authorized to obtain from ODJFS and the U.S. Department of Health and Human Services. Prior to releasing a report that identified a hospital, the Department of Health had to allow the hospital 30 days to verify the accuracy of any hospital-specific data that had not previously been provided for hospital review. After receiving comments from a hospital, the Department was required to correct any information the Department agreed was in error. The Department had to include

in the reports commentary from hospitals concerning major deviations in the range of data for any of the diagnosis related groups for which information was reported.

Under the act, the Director of Health is required to permit a hospital to verify the accuracy of all performance measure information, submitted by a hospital to the Director, as well as the hospital's price and volume information on inpatient and outpatient services. The hospital must be permitted to provide corrections of the information in a timely manner.[5]

Liability for misused or improperly released information and data

(R.C. 3727.14 (former law) and R.C. 3727.37)

Under former law, a hospital that disclosed price and volume information concerning non-governmental patients, or data for purposes of the information the Department of Health was permitted to obtain regarding governmental patients, was not liable for the misuse or improper release of the information by the Department or any other person.

The act provides that a hospital that submits performance measure information or price and volume information on its inpatient and outpatient services is not liable for the misuse or improper release of any of this information by the Department of Health, a person with whom the Director of Health contracts under the act to disseminate hospital information on an Internet web site, or a person whose misuse or improper release of the information is not done on behalf of the hospital.

Standard of care; admissibility as evidence

(R.C. 3727.38)

The act prohibits performance measure information and price and volume information submitted by a hospital to the Director of Health from being used to establish or alter any professional standard of care. The act also prohibits the information from being admissible as evidence in any civil, criminal, or administrative proceeding.

[5] *The act does not specify what is meant by "a timely manner."*

Internet web site

(R.C. 3727.39(A) and (B))

Subject to the funding and contracting provisions described below, the act requires the Director of Health to make both the performance measure information and the price and volume information submitted by hospitals to the Director available on an Internet web site. The information must be made available on the web site not later than 90 days after the information is submitted.

The act requires the Director to do all of the following with respect to the web site:

(1) Make the web site available to the public without charge;

(2) Provide for it to be organized in a manner that enables the public to use it easily;

(3) Exclude any information that compromises patient privacy;

(4) Include links to hospital web sites to enable the public to obtain additional information about hospitals, including hospital programs designed to enhance quality and safety;

(5) Allow other web sites to link to the web site for purposes of increasing the web site's availability and encouraging ongoing improvement;

(6) Update the web site as needed to include new information and to correct errors.

Presentation of performance measure information

(R.C. 3727.39(B))

The act requires the Director to present performance measure information on the web site in a manner that enables the public to compare the performance of hospitals in meeting the measures. In making this information available on a web site, the Director must do all of the following:

(1) Enable the public to compare the performance of hospitals in meeting the measures for specific diagnoses and procedures;

(2) Enable the public to make the comparisons by different geographic regions, such as by county or zip code;

(3) Based on the report issued by the Data Collection and Analysis Group discussed above, include a report of each hospital's overall performance in meeting the measures;

(4) To the extent possible, include state and federal benchmarks for the measures;

(5) Include contextual information and explanations that the public can easily understand, including contextual information that explains why differences in the performance of hospitals in meeting the measures may be misleading;

(6) Exclude from the web site a hospital's performance in meeting a particular measure if the hospital's caseload for the diagnosis or procedure that the measure concerns is insufficient, as determined in accordance with the guidelines submitted by the Data Collection and Analysis Group, to make the hospital's performance for the diagnosis or procedure a reliable indicator of its ability to treat the diagnosis or provide the procedure in a quality manner;

(7) Clearly identify the sources of information used in the web site and explain both (a) the analytical methods used in determining the performance of hospitals in meeting the measures and (b) the risk adjustment methodologies used by hospitals when submitting performance measure information under the act.

Funding and contracting for the web site

(R.C. 3727.391)

The act specifies that the duties of the Director to make the information submitted by hospitals under the act available on an Internet web site apply only to the extent that appropriations are made by the General Assembly to make performance of the duties possible.

Subject to these appropriations, the act requires the Director to enter into a contract with a person under which the person performs the Director's duties regarding the web site. The contract may be entered into with any person selected by the Director. The act permits the Department of Health to accept gifts, grants, donations, and awards for purposes of paying the fees or other costs incurred when a contract is entered into with a person to establish and administer the web site.

Sale of submitted hospital information

(R.C. 3727.40)

Not later than 90 days after a hospital submits information to the Director under the act, the Director must make the submitted information available for sale

to any interested person or government entity. When the Director sells the information, the fee charged must not exceed a reasonable amount.

Price information lists

(R.C. 3727.12 (former law) and R.C. 3727.42)

Continuing law requires every hospital to compile and make available for public inspection a list containing certain information regarding charges for services. The list must be updated periodically to maintain current information.

The act adds a requirement that the list be compiled and made available in a format that complies with the electronic transaction standards and code sets adopted by the U.S. Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act (HIPAA).[6]

The act also requires that the list include the hospital's billing policies, including whether the hospital charges interest on an amount not paid in full by any person or government entity, and the interest rate charged.

The act requires each hospital to make its price information list available free of charge on the hospital's Internet web site.

Rules governing price information lists and identification of billing errors

(R.C. 3727.121 (former law) and R.C. 3727.43 and 3727.44)

Former law authorized the Public Health Council to adopt rules to carry out the purposes of the price information list requirement and law unchanged by the act permits a health insurance beneficiary, on notifying a hospital or provider of an overcharge exceeding $500, to receive a refund of 15% of the amount overcharged.

The act permits these rules to be adopted by the Director of Health, rather than the Public Health Council. As when adopted by the Council, the rules adopted by the Director must be adopted in accordance with the Administrative Procedure Act (R.C. Chapter 119.).

[6] *These standards and code sets are in 45 Code of Federal Regulations Parts 160 and 162.*

COMMENT 1

Performance measures

Agency for Health Care Research and Quality

The Agency for Health Care Research and Quality (AHRQ) is an agency within the U.S. Department of Health and Human Services. In 1999, Congress mandated that this agency report annually to the Nation about health care quality. To comply with this mandate, the agency annually publishes the "National Healthcare Quality Report." The 2005 version of the Report includes 179 performance measures, 46 of which are considered "core measures" representing what the agency asserts are "the most important and scientifically sound measures of quality."[7]

The AHRQ also sponsors the National Quality Measures Clearinghouse (NQMC), a public repository for evidence-based quality measures and measure sets.[8]

National Quality Forum

The National Quality Forum (NQF) is a private, not-for-profit membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting.[9] According to a report published by the NQF in November 2005, this organization has endorsed 68 voluntary consensus-based standards to measure various aspects of hospital performance including the direct measure of patient perception of care.[10]

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[7] Agency for Health Care Research and Quality (AHRQ). "Welcome to the Web-Enabled 2005 National Health Care Quality Report (NHRQ)," accessible at <http://www.qualitytools.ahrq.gov/qualityreport/2005/browse/browse.aspx> (visited June 15, 2006).

[8] Agency for Health Care Research and Quality (AHRQ). "National Quality Measures Clearinghouse, Welcome Page," accessible at <http://www.qualitymeasures.ahrq.gov/> (visited June 15, 2006).

[9] National Quality Forum (NQF). "Welcome Page," accessible at <http://www.qualityforum.org/> (visited June 15, 2006).

[10] National Quality Forum (NQF). "Standardizing a Measure of Patient Perspectives of Hospital Care," (Nov. 2005), accessible at <http://www.qualityforum.org/txHCAHPSFinalforWebPublic.pdf> (visited June 15, 2006).

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services, uses the term, "quality measure," as a synonym for the term, "performance measure." According to CMS, a quality measure converts medical information from patient records into a rate or percentage that allows facilities to assess their performance.[11]

CMS uses quality measures in several activities of its "Hospital Quality Initiative," most notably for the Hospital Compare web site that the agency maintains.[12] According to the Hospital Compare web site, the agency currently has 20 quality measures: eight measures related to heart attack care, four measures related to heart failure care, six measures related to pneumonia care, and two measures related to surgical infection prevention.[13]

Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent, not-for-profit organization that is, according to its web site, "the predominate standards-setting and accrediting body in health care." The JCAHO evaluates and accredits more than 15,000 health care organizations and programs in the U.S., including hospitals, home care organizations, and other health care organizations that provide long term care, assisted living, behavioral health care, and laboratory and ambulatory services.[14]

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[11] *Centers for Medicare & Medicaid Services. "Quality Measures," accessible at <http://www.cms.hhs.gov/HospitalQualityInits/10_HospitalQualityMeasures.asp#TopOfPage> (visited June 15, 2006).*

[12] *Id.*

[13] *Centers for Medicare & Medicaid Services (CMS). "Hospital Compare - Information for Professionals," accessible at http://www.hospitalcompare.hhs.gov/Hospital/Static/About-HospQuality.asp?dest=NAV|Home|DataDetails|ProfessionalInfo#measureset> (visited June. 15, 2006).*

[14] *Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "Facts About the Joint Commission on Accreditation of Healthcare Organizations," accessible at <http://www.jointcommission.org/AboutUs/joint_commission_facts.htm> (visited June 15, 2006).*

At present, the JCAHO has developed five "core measure" sets related to surgical infection prevention, heart failure, acute myocardial infarction, pneumonia, and pregnancy.[15]

The JCAHO makes information on the safety and quality of care at nearly 15,000 healthcare organizations available to the public via its Quality Check web site.[16]

COMMENT 2

Required performance measures

The act requires the Data Collection and Analysis Group the Director of Health must convene to recommend to the Director performance measures that the Director should require, through the Director's rulemaking authority, hospitals to use in submitting information under the act. The act permits (but does not require) the Group to recommend that the rules include hospital quality measures publicly reported by the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (see R.C. 3727.321).

While the Group is not required to recommend that the performance measures the Director adopts include measures publicly reported by CMS and the JCAHO, the act nonetheless *requires* the Director of Health to adopt these measures (see R.C. 3727.41). Thus, under the act, even if the Group does not recommend that the Director adopt these measures, the Director must adopt them.

COMMENT 3

Diagnostic related groups

Primarily used by CMS as a method of reimbursing hospitals for care provided to Medicare patients, the diagnostic related group (DRG) is a scheme to classify hospital cases into one of 503 groups, also referred to as "DRGs," based

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[15] *Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "Performance Measurement Initiatives," accessible at <http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/> (visited June 15, 2006).*

[16] *The Quality Check web site is accessible at <http://www.qualitycheck.org>.*

on similar diagnoses, treatments, and use of hospital resources. DRGs allow comparisons of resource use across hospitals with varying mixes of patients.[17]

DRGs were implemented in 1983 to contain costs for the Medicare Program. Instead of basing a hospital's Medicare reimbursement for a patient's care on retrospective charges, the reimbursement system changed to a prospective payment system, with hospitals compensated for a patient's care based on the qualifying DRG.[18]

HISTORY

ACTION	DATE
Introduced	04-24-05
Reported, H. Health	12-15-05
Passed House (95-1)	02-14-06
Reported, S. Health, Human Services & Aging	05-18-06
Passed Senate (33-0)	05-24-06
House concurred in Senate amendments (95-0)	05-25-06

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[17] *Wickpedia. Definition of "Diagnosis-Related Group," accessible at <http://en.wikipedia.org/wiki/Diagnosis-related_group> (visited June 15, 2006); Maryland Health Care Commission. "Maryland Hospital Performance Evaluation Guide: Diagnosis Related Groups," accessible at <http://hospital/guide.mhcc. state.md.us/Definitions/define_drgs.htm> (visited June 15, 2006).*

[18] *Id.*