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BILL SUMMARY

Advisory council and groups

- Creates the Hospital Performance Measures Advisory Council and establishes the responsibilities of the Council.
- Permits the Director of Health to consider, but does not require the Director to follow, the recommendations and on-going advice provided to the Director by the Council.
- Requires the Director of Health to convene a group of experts in data collection and analysis or a related field, each member of which is appointed by a member of the Hospital Performance Measures Advisory Council, and establishes the responsibilities of this group.
- Permits the Director of Health to convene a group of health care consumers, nurses, and experts in infection control, each member of which is appointed by the Director of Health, and establishes the responsibility of the group.

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 each of the performance measures for hospital inpatient and outpatient services established by certain national organizations ("performance measure information").
- Establishes requirements regarding how hospitals must submit performance measure information to the Director of Health.

- Permits hospitals to contract with third parties to determine whether any performance measure information submitted to the Director of Health should be adjusted for risk.
- Permits the Director of Health to audit any performance measure information submitted by hospitals to the Director, including information adjusted for risk.

Price, admission, and discharge data

- Repeals current law that permits 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, and instead, requires each hospital to disclose to the Director of Health price, admission, and discharge data regarding all patients (not just nongovernmental patients) in each of the 60 (as opposed to 100) diagnosis related groups most frequently treated on an inpatient basis and in each of the 60 diagnosis related groups most frequently treated on an outpatient basis as represented by inpatient and outpatient discharges, respectively, in the previous calendar year.

Confidentiality of information and data

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

Verification of accuracy of information and data

- Requires the Director of Health to permit a hospital to verify the accuracy of all performance measure information and price, admission, and discharge data submitted by a hospital to the Director of Health and to provide corrections of the information in a timely manner.

Liability for misused or improperly released information or data

- Provides that a hospital that submits performance measure information or discloses price, admission, and discharge data is not liable for the misuse or improper release of any of this information or data by the Department of Health, a person with whom the Department may contract, or a person whose misuse or improper release of information is not done on behalf of the hospital.

Standard of care; admissibility as evidence

- Prohibits performance measure information submitted, and price, admission, and discharge data disclosed, by a hospital to the Director of Health to be used to establish or alter any professional standard of care or be admissible as evidence in any civil, criminal, or administrative proceeding.

Public availability of information and data

- Requires the Director of Health to make performance measure information submitted, and price, admission, and discharge data disclosed, by hospitals to the Director of Health available to the public on an Internet web site.
- Establishes organizational requirements and design features of the web site the Director of Health must maintain.

Price information lists

- Maintains the requirement in current law that all hospitals compile, make available for inspection by the public, and update a price information list, but adds a requirement that the list be compiled and made available in a format that complies with the electronic transactions standards and code sets adopted by the U.S. Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act (HIPAA).
- Adds a requirement that in addition to the items that must be on a hospital's price information list under current law, the list must also 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.
- Requires a hospital to make its price information list available free of charge on the hospital's web site to any person and to post an announcement of the list's availability in each of the hospital's billing offices and admission, patient waiting, and reception areas.

Director of Health's rulemaking authority

- Requires the Director of Health to adopt rules governing hospitals' submission of performance measure information and price, admission, and discharge data.
- Permits the Director of Health to adopt rules to carry out the purposes of the price information list requirement and current law that permits a beneficiary, on notifying a hospital or provider of an overcharge exceeding \$500, to receive a refund of 15% of the amount overcharged.

Outsourcing of Director of Health's duties

- Permits the Director of Health to contract with a person for the person to perform all duties the Director must perform under the bill, except for rulemaking.

Director of Health's authority to seek injunctions

- Permits the Director of Health 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 failing to comply with the following requirements in the bill: (1) the submission of performance measure information, (2) the disclosure of price, admission, and discharge data, and (3) the compilation and public availability of price information on a price information list.

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CONTENT AND OPERATION

Advisory council and groups

Hospital Performance Measures Advisory Council

(R.C. 3727.30, 3727.301, 3727.302, 3727.303, 3727.304, and 3727.305)

Council membership. The bill creates the Hospital Performance Measures Advisory Council consisting of the following 16 members:

- The Director of Health (serves as chair of the Council).
- The Superintendent of Insurance.

- Two members of the Ohio House of Representatives, from different political parties, appointed by the Speaker of the House.
- Two members of the Ohio 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 bill specifies that members of the Council 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 bill also provides that Council members are not reimbursed for expenses incurred in performing Council duties.

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

Council responsibilities

The bill establishes the responsibilities of the Council, the Council is required to do all of the following:

(1) Study the issue of hospitals reporting information regarding performance 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 members of the Council is appointed to the Council, that makes recommendations for all of the following:

(a) The collection of information from hospitals that shows the hospitals' records in meeting the performance measures established by the Agency for Health Care Research and Quality (AHRQ), the National Quality Forum (NQF),

¹ The term, "small employer," is not defined in the bill.

² The term, "large employer," is not defined in the bill.

the U.S. Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (see **COMMENT 1**, below).

(b) The audits the Director of Health may perform on performance measure information hospitals submit to the Director;

(c) The dissemination of hospitals' records in meeting the performance measures established by the AHRQ, NQF, CMS, NCQA, and JCAHO;

(d) Explaining to the public how to use the information about hospitals' records in meeting the performance measures, including explanations about the limitations of the information.

(3) Provide the Director of Health with ongoing advice on the issue of hospitals reporting information regarding performance measures for hospital inpatient and outpatient services, disseminating the information so reported by hospitals, and making improvements to the reports and dissemination of information.

Council is purely advisory

The bill provides that the Director of Health may consider, but is not required to follow, the recommendations and on-going advice provided to the Director by the Council when implementing the sections of the bill governing performance measure information, price, admission, and discharge data, public availability of information and data, and outsourcing of the Director's duties or when adopting rules.

Data Collection and Analysis Group

(R.C. 3727.31)

Group membership. The bill requires the Director of Health to convene a group of experts in data collection and analysis or a related field, each member of which is appointed by a member of the Hospital Performance Measures Advisory Council. A member of the Council who is an expert in data collection and analysis or a related field may appoint himself or herself to the group rather than appoint another individual.

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

Group responsibilities. The bill prescribes the duties of the Data Analysis and Collection Group; the Group must do all of the following:

(1) Select, not later than 30 days after the date the last of the initial members of the Hospital Performance Measures Advisory Council is appointed to the Council, either the refined-diagnostic related group (R-DRG) or the all patient refined-diagnostic related group (APR-DRG) method by which a hospital may risk-adjust information submitted to the Director of Health for purposes of showing the hospital's record in meeting the performance measures established by the AHRQ, NQF, CMS, NCQA, and JCAHO (see **COMMENTS** 1 and 2, below).

(2) Issue, not later than one year after the date the last of the initial members of the Hospital Performance Measures Advisory Council is appointed to the Council, a report to the Director of Health that advises the Director on how to provide for the Internet web site that the Director must establish under the bill to include a report on each hospital's overall record in meeting the performance measures described above.

(3) Submit to the Director of Health guidelines to be used to determine whether a hospital's record in meeting a specific performance measure should be excluded from the web site because of an insufficient number of cases at the hospital.

In addition to convening the Group for the above purposes, the bill provides that the Director of Health may convene the Group at other times the Director determines necessary to assist the Hospital Performance Measures Advisory Council with its duties, including assistance regarding the following:

(1) Determining the validity of performance measures for hospital inpatient and outpatient services;

(2) Determining the reliability of performance measure information hospitals submit to the Director, including how the factor of caseloads affects reliability;

(3) Audits that the Director of Health may conduct on performance measure information.

Infection control group

(R.C. 3727.32)

Group membership; remuneration. The bill permits the Director of Health, at times the Director determines necessary, to convene a group of health

care consumers, nurses, and experts in infection control. The bill directs that each member of the "Infection Control Group" be appointed by the Director of Health.

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

Group's responsibility. The bill prescribes that the Infection Control Group's responsibility is to provide the Hospital Performance Measures Advisory Council information about the infection issues that the Council needs to be able to perform its duties.

Performance measure information

Submission of information by hospitals

(R.C. 3727.33, 3727.331, and 3727.41)

The bill requires each hospital to submit, on a semi-annual basis, information to the Director of Health that shows the hospital's record in meeting each of the performance measures for hospital inpatient and outpatient services established by the Agency for Health Care Research and Quality (AHRQ), the National Quality Forum (NQF), the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (see **COMMENT 1**, below). Hospitals must begin the submission of "performance measure information" not later than 30 days after the Hospital Performance Measures Advisory Council selects either the refined-diagnostic related group (R-DRG) or the all patient refined-diagnostic related group (APR-DRG) method by which hospitals are permitted to risk-adjust this information (see **COMMENT 2**, below).

Under the bill, the Director of Health must adopt rules governing the submission of this information by hospitals. Beginning with the first submission of information made after the Director of Health adopts the initial form of these rules, hospitals must follow these rules.

In addition to following the rules the Director adopts, each hospital must also do the following in connection with submitting performance measure information to the Director of Health:

(1) Submit the information for the hospital's inpatient and outpatient services, regardless of who pays the charges incurred for the services.

(2) Use the diagnosis and procedure codes for either (a) the version of the international classification of diseases, clinical modification, that is current at the time the information is submitted, or (b) the version of the current procedural terminology (CPT) published by the American Medical Association that is current at the time the information is submitted.

(3) Include data about (a) the hospital's caseloads, (b) adjusted length of stays, (c) complication rates, and (d) mortality rates.

(4) Adjust the information to reflect the risk factors in accordance with the method selected by the Data Collection and Analysis Group if the hospital determines that any of the information is misleading unless adjusted for risk.

(5) Provide for the information to reflect the performance measures in effect on the date the information is submitted.

Outsourcing risk-adjustment of information

(R.C. 3727.331)

The bill permits a hospital to provide for a third party to determine whether any performance measure information submitted to the Director of Health should be adjusted for risk.

Auditing of information by the Director of Health

(R.C. 3727.332)

The bill permits the Director of Health to audit any performance measure information submitted by hospitals to the Director, including information adjusted for risk.

Price, admission, and discharge data

Information Department of Health can obtain about governmental patients

(R.C. 3727.13 (repealed))

Current law. Under current law, the Department of Health is 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. At least 30 days before releasing the information about Medicaid patients, the Department of Job and Family Services is required to provide each hospital that has provided information to it with a copy of the

information in a form that makes it possible for the hospital to review and verify the information's accuracy. After receiving comments from a hospital, the Department of Job and Family Services must correct any information it agrees is in error.

The data base of the information about Medicare and Medicaid patients that the Department of Health obtains and any analysis of the information must be maintained as a public record. However, the data cannot be released to the public except on an aggregate basis by geographic area, institution, or other aggregation.

The bill. The bill repeals the provision authorizing the Department of Health to obtain information about Medicaid patients from the Department of Job and Family Services and about Medicare patients from the U.S. Department of Health and Human Services. In place of this repealed law, the bill, as discussed below (see "**Disclosure of data by hospitals**"), 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.*

Disclosure of data by hospitals to the Director of Health

(R.C. 3727.11 (current law); R.C. 3727.34 (the bill))

Current law. Under current law, every hospital is required to disclose annually to the Department of Health certain data for nongovernmental patients³ in each of the 100 diagnosis related groups⁴ most frequently treated on an inpatient basis as represented by discharges during the previous calendar year. The disclosures are due on or before the first day of each March. The Department must maintain the disclosures as a public record.

The data that a hospital must disclose are (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 is not required to

³ *Current law defines "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. (R.C. 3727.11(A).)*

⁴ *"Diagnosis related group" is a term used in federal Medicare regulations governing the Medicare's prospective payment system for inpatient hospital services.*

disclose data for any diagnosis related group for which the hospital treated fewer than ten nongovernmental patients during the year.

A hospital is permitted to include with the data commentary concerning reasons for major deviations in the range of data for any diagnosis related group. A hospital's commentary must be included in all reports and other releases of information identifying the hospital that the Department makes.

A hospital is required make the data disclosures available for inspection by any person at any reasonable time. On request, the hospital must make copies available for a reasonable fee. The hospital must also advise the requesting person that the information is available from the Department. If a hospital has information available on the average prices of diagnosis related groups or specific procedures not required to be disclosed to the Department, the hospital must make that information available at the request of any person.

The bill. The bill amends current law to require hospitals to disclose the price, admission, and discharge data described above to the *Director of Health*, rather than the Department of Health. In addition, the bill makes the following changes with respect to the data disclosure requirements:

- Expands the population of patients for which hospitals must disclose price, admission, and discharge data to the Director to include *all* patients, regardless of who pays the charges incurred (therefore, not only nongovernmental patients).
- Reduces the number of diagnosis related groups (from 100 to 60) for which hospitals must disclose data to the Director about inpatient services rendered.
- Adds a new requirement that hospitals disclose to the Director price, admission, and discharge data for all patients in each of the 60 diagnosis related groups most frequently treated on an *outpatient basis* in the hospital as represented by *outpatient discharges* during the previous calendar year.

Provisions applicable to the submission of performance measure information and price, admission, and discharge data

Confidentiality of information and data

(R.C. 3727.14 (current law); R.C. 3727.36 (the bill))

Current law. Under current law, hospitals are prohibited from disclosing the names and social security numbers of non-governmental patients to the Department of Health in connection with the price, admission, and discharge data requirements currently in place (see "**Disclosure of data by hospitals,**" above). Current law also prohibits the Department of Job and Family Services (ODJFS) and the U.S. Department of Health and Human Services (HHS) from disclosing names and social security numbers of governmental patients and their physicians to the Department of Health in connection with the information the Department of Health may obtain from ODJFS and HHS under current law (see "**Information Department of Health can obtain about governmental patients,**" above).

The Department of Health is also prohibited from releasing the data, described above, to the public except on an aggregate basis by geographic area, institution, or other aggregation.

The bill. Consistent with the new information and data submission requirements of the bill, the bill prohibits a hospital from submitting performance measure information *or* price, admission, or discharge data to the Director that includes the name or social security number of a patient, physician, or dentist.

Verification of accuracy of information and data

(R.C. 3727.15 (current law); R.C. 3727.35 (the bill))

Current law. Existing law permits the Department of Health to issue reports concerning the data about nongovernmental patients that hospitals disclose to the Department and information about Medicare and Medicaid patients the Department is authorized to obtain from ODJFS and HHS. Prior to releasing a report that identifies a hospital, the Department must allow the hospital 30 days to verify the accuracy of any hospital-specific data that has not previously been provided for hospital review. After receiving comments from a hospital, the Department is required to correct any information the Department agrees is in error. The Department must 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 is reported.

The bill. Under the bill, the Director of Health is required to permit a hospital to verify the accuracy of all performance measure information and price,

admission, and discharge data submitted by a hospital to the Director of Health and to provide corrections of the information in a timely manner.⁵

Liability for misused or improperly released information and data

(R.C. 3727.14 (current law); R.C. 3727.37 (the bill))

Current law. Under current law, no hospital that discloses price, admission, or discharge data concerning non-governmental patients or data for purposes of the information the Department of Health may obtain regarding governmental patients is liable for the misuse or improper release of this data by the Department of Health or any other person.

The bill. The bill repeals the law described above and provides, instead, that a hospital that submits performance measure information or price, admission, and discharge data is not liable for the misuse or improper release of any of this information or data by the Department of Health, a person with whom the Department may contract, or a person whose misuse or improper release of information is not done on behalf of the hospital.

Standard of care; admissibility as evidence

(R.C. 3727.38)

The bill prohibits performance measure information and price, admission, and discharge data submitted by a hospital to the Director of Health to be used to establish or alter any professional standard of care or be admissible as evidence in any civil, criminal, or administrative proceeding.

Public availability of data

Internet web site

(R.C. 3727.39(A))

The bill requires the Director of Health to make both (1) the performance measure information submitted, and (2) the price, admission, and discharge data disclosed, to the Director of Health, as described above, available to the public on an Internet web site.

⁵ The bill does not specify what is meant by "a timely manner."

Design of the Internet web site

(R.C. 3727.39(A))

The bill requires the Director of Health to do all of the following with respect to the information submitted and data disclosed for purposes of the web site described above:

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

(2) Exclude from the web site any information that compromises patient privacy.

(3) Include links to the hospitals' web sites to enable the public to obtain additional information about hospitals, including hospitals' programs designed to enhance quality and safety.

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

(5) Update the web site as hospitals submit new information and disclose new data, and as needed to correct errors.

Presentation of performance measure information on the web site

(R.C. 3727.39(B))

The bill requires the Director of Health to present hospitals' performance measure information in a manner that enables the public to compare hospitals' records in meeting the performance measures for hospital inpatient and outpatient services established by the Agency for Health Care Research and Quality (AHRQ), the National Quality Forum (NQF), the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (see **COMMENT 1**, below). In making this information available on the web site described above, the Director must do all of the following:

(1) Enable the public to compare hospitals' records in meeting the performance 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 to the Director of Health by the Data Collection and Analysis Group (see "*Data Analysis and Collection Group*," above), include a report of each hospital's overall record in meeting the performance measures;

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

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

(6) Exclude from the web site a hospital's record in meeting a specific performance measure if the hospital's caseload for the diagnosis or procedure that the performance measure concerns is insufficient, as determined in accordance with the guidelines issued by the Data Analysis and Collection Group (see "*Data Analysis and Collection Group*," above), to make the hospital's record 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 data used in the web site and explain the analytical methods used in determining hospitals' records in meeting performance measures.

Price information lists

Compilation and public inspection of list; compliance with HIPAA

(R.C. 3727.12 (current law); R.C. 3727.42(A) (the bill))

Current law. Current 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 bill. The bill maintains the price information list requirement, but adds a requirement that the list be compiled and made available in a format that complies with the electronic transactions standards and code sets adopted by the U.S. Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act (HIPAA).

Hospital billing policies

(R.C. 3727.42(B))

The bill adds a requirement that in addition to the information that must be on a hospital's price information list under current law, the list must 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.

Availability of list on hospitals' web site

(R.C. 3727.42(C))

The bill requires each hospital to make its price information list available free of charge on the hospital's web site to any person and to post an announcement of the list's availability in each of the hospital's billing offices and admission, patient waiting, and reception areas.

Rulemaking regarding price information lists and identification of billing errors

(R.C. 3727.44)

The bill permits the Director of Health to adopt rules in accordance with the Ohio Administrative Procedure Act (R.C. Chapter 119.) to carry out the purposes of the price information list requirement and current law that permits a beneficiary, on notifying a hospital or provider of an overcharge exceeding \$500, to receive a refund of 15% of the amount overcharged.

Outsourcing of Director of Health's duties

(R.C. 3727.40)

The bill permits the Director of Health to contract with a person for the person to perform all duties the Director must perform under the bill, except for rulemaking.

Injunctions

(R.C. 3727.45)

Current law. Under current law, the Director of Health is permitted 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 price, admission, and discharge data disclosure requirement in current law (R.C. 3727.11).

The bill. The bill expands the Director's authority by permitting the Director to also seek an injunction for failure to comply with the requirements regarding the submission of performance measure information and the compilation and public availability of price information on a price information list.

COMMENT

1. Performance measures

Agency for Health Care Research and Quality (AHRQ)

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. In its second annual report made in 2004 (the last one accessible on the agency's web site), the AHRQ analyzed 179 performance measures.⁶

The AHRQ sponsors the National Quality Measures Clearinghouse (NQMC), a public repository for evidence-based quality measures and measure sets.⁷

National Quality Forum (NQF)

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.⁸ According to a report published by the NQF in November 2005, this organization has endorsed 68 voluntary consensus-based

⁶ Agency for Health Care Research and Quality (AHRQ). "Key Themes and Highlights from the National Healthcare Quality Report," accessible at <<http://www.qualitytools.ahrq.gov/qualityreport/browse/browse.aspx?id=4996>> (visited Dec. 19, 2005).

⁷ Agency for Health Care Research and Quality (AHRQ). "National Quality Measures Clearinghouse, Welcome Page," accessible at <<http://www.qualitymeasures.ahrq.gov/>> (visited Dec. 19, 2005).

⁸ National Quality Forum (NQF). "Welcome Page," accessible at <<http://www.qualityforum.org/>> (visited Dec. 19, 2005).

standards to measure various aspects of hospital performance including the direct measure of patient perception of care.⁹

Centers for Medicare & Medicaid Services (CMS)

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.¹⁰

CMS uses quality measures in several activities of its "Hospital Quality Initiative," most notably for the Hospital Compare web site that the agency maintains.¹¹ According to the Hospital Compare web site, the agency 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.¹²

National Committee for Quality Assurance (NCQA)

The National Committee for Quality Assurance (NCQA) is an independent not-for-profit organization. Its mission "is to improve health care quality everywhere."¹³

The NCQA has developed "HEDIS measures." According to the NCQA, HEDIS is a tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care and service. HEDIS measures address a broad range of health issues, including asthma, blood pressure, cancer,

⁹ National Quality Forum (NQF). "Standardizing a Measure of Patient Perspectives of Hospital Care," (Nov. 2005), accessible at <<http://www.qualityforum.org/txHCAHPSFinalforWebPublic.pdf>>.

¹⁰ Centers for Medicare & Medicaid Services. "Quality Measures," accessible at <http://www.cms.hhs.gov/HospitalQualityInits/10_HospitalQualityMeasures.asp#TopOfPage> (visited Dec. 19, 2005).

¹¹ *Id.*

¹² Centers for Medicare & Medicaid Services (CMS). "Quality Measures," accessible at <http://www.hospitalcompare.hhs.gov/Hospital/Static/About-HospQuality.asp?dest=NAV/Home/About/QualityMeasures#TabTop> (visited Dec. 19, 2005).

¹³ National Committee for Quality Assurance (NCQA). "About NCQA," accessible at <<http://www.ncqa.org/about/about.htm>> (visited Dec. 19, 2005).

childhood immunizations, diabetes, cardiovascular disease, depression, and smoking. It appears that there are currently 43 HEDIS measures.¹⁴

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent, not-for-profit organization that is, according to the JCAHO, "the oldest and largest 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 more than 8,200 hospitals and home care organizations and more than 6,800 other health care organizations that provide long term care, assisted living, behavioral health care, and laboratory and ambulatory services.¹⁵

At present, the JCAHO's accreditation standards number more than 250. These standards address everything from patient rights and education, infection control, medication management, and preventing medical errors, to how the hospital verifies that its staff is competent and qualified, how it prepares for emergencies, and how it collects data on performance and uses that data to improve itself.¹⁶

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.¹⁷

2. Background--Diagnostic Related Group (DRG) Classification Scheme

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

¹⁴ National Committee for Quality Assurance (NCQA). "The State of Health Care Quality 2005," accessible at <http://www.ncqa.org/Docs/SOHCQ_2005.pdf> (visited Dec. 19, 2005), pp. 4, 21.

¹⁵ Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "Frequently Asked Questions about the Joint Commission," accessible at <<http://www.jcaho.org/news+room/faqs/index.htm#1>> (visited Dec. 19, 2005).

¹⁶ *Id.*

¹⁷ *Id.* The Quality Check website is accessible at <<http://www.jcaho.org/quality+check/index.htm>>.

on similar diagnoses, treatments, and use of hospital resources. DRGs allow comparisons of resource use across hospitals with varying mixes of patients.¹⁸

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.¹⁹

Refined-Diagnostic Related Group (R-DRG) Scheme

The Refined-Diagnostic Related Group (R-DRG) scheme is a refined version of the DRG scheme that classifies cases into levels of severity and complexity based on the impact they are likely to have on the use of hospital resources.²⁰

All-Patient Refined Diagnosis Related Group (APR-DRG) Scheme

As the health care industry evolved, there was an increased demand for a patient classification scheme that would be used for applications beyond resource use, cost, and payment. Consequently, the All-Patient Refined Diagnosis Related Group (APR-DRG) scheme was developed to expand the basic DRG structure by adding four subclasses to each DRG. The addition of the four subclasses addresses patient differences relating to severity of illness and risk of mortality. The four severity of illness subclasses and the four risk of mortality subclasses are numbered sequentially from 1 to 4 to indicate, respectively, minor, moderate, major, or extreme severity of illness or risk of mortality.²¹

¹⁸ Wickpedia. Definition of "Diagnosis-related Group," accessible at <http://en.wikipedia.org/wiki/Diagnosis-related_group> (visited Dec. 15, 2005); California Public Employees Retirement System. Memo to Members of the California Health Benefits Committee Regarding Senate Bill 917 (May 17, 2005), accessible at <<http://www.calpers.ca.gov/eip-docs/about/board-cal-agenda/agendas/hbc/200505/item04-f.doc>> (visited Dec. 15, 2005).

¹⁹ *Id.*

²⁰ University of Manitoba, Centre for Health Policy. "Diagnostic Related Groupings, Glossary of Terms," accessible at <http://www.umanitoba.ca/centres/mchp/concept/thesaurus/thesaurus_R.html#RDRG> (visited Dec. 15, 2005).

²¹ 3M Health Information Systems et al. "All Patient Refined Diagnosis Related Groups (APR-DRGs): Methodology Overview," accessible at <<http://www.hcup-us.ahrq.gov/db/nation/nis/APR-DRGsV20MethodologyOverviewandBibliography.pdf>> (visited Dec. 15, 2005).

HISTORY

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