Alan Van Dyne *Legislative Service Commission*

Bill Analysis

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

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BILL SUMMARY

Advisory council and groups

- Creates the Hospital Measures Advisory 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 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 by the Director.
- 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 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.

- 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

- Maintains the current requirement that all hospitals make a price information list available for public inspection, but adds a requirement that the list 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).

- Provides that in addition to the items currently required to be on a hospital's price information list, 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.

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

TABLE OF CONTENTS

Hospital Measures Advisory Council 4
Council responsibilities 5
Infection control group 6
Data Collection and Analysis Group 6
Recommendations on hospital service measures 7
Additional duties 7
Submission of information on hospital performance measures 8
Rules for submitting information 8
Procedures for submitting information 9
Auditing of information 9
Injunctions 9
Quality-of-care data reports on health services 10
Information about governmental patients 11
Submission of information on hospital prices and number of patients 11
Background 11
Inpatient information 12
Outpatient information 13
Confidentiality of information submitted by hospitals 13
Verification of accuracy of information and data 14

Liability for misused or improperly released information and data.....14
Standard of care; admissibility as evidence 15
Internet web site.....15
Presentation of performance measure information 16
Funding and contracting for the web site 17
Sale of submitted hospital information.....17
Price information lists.....17
Format 17
Hospital billing policies.....18
Availability of list on hospital's web site 18
Rules governing price information lists and identification of billing errors.....18

COMMENT 1 18
Performance measures 18
Agency for Health Care Research and Quality 18
National Quality Forum.....19
Centers for Medicare & Medicaid Services.....19
Joint Commission on Accreditation of Healthcare Organizations 20

COMMENT 2 21
Diagnostic Related Groups 21

CONTENT AND OPERATION

Hospital Measures Advisory Council

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

The bill 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 bill 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:

(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 bill from hospitals that shows their performance in meeting measures for hospital inpatient and outpatient services;

--The audits the bill 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 bill;

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

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

--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 bill 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 bill requires the Director of Health to convene 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 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 bill. 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;

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

(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 bill 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 bill 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 bill to audit the information submitted by hospitals regarding their performance in meeting the bill's measures for hospital services.

Submission of information on hospital performance measures

(R.C. 3727.33)

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

Injunctions

(R.C. 3727.45)

The bill 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 bill'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 bill 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 bill provides for the ongoing confidentiality of the following information reported to the Director prior to the bill'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 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 repeals the provision authorizing the Department of Health to obtain information about Medicaid and Medicare patients. In place of this repealed law, the bill, 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

(R.C. 3727.11)

Under current law, every hospital is 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 are due on or before the first day of each May. The Department must maintain the disclosures as a public record.

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[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] *See* ***COMMENT*** *2.*

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 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.

Inpatient information

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

The bill requires hospitals to submit the price and volume information described above to the *Director of Health*, rather than the Department of Health. In addition, the bill makes the following changes:

- Expands the population of patients for which hospitals must submit the information by including *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 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, 3727.34(B) to (E), 3727.41(A), and 3727.45)

The bill 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 bill 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 and 3727.36)

With regard to hospital information submitted or obtained under current law, all of the following apply:

(1) Hospitals cannot disclose the names and social security numbers of non-governmental patients to the Department of Health in connection with the price and volume data disclosed to the Department.

(2) The Department of Job and Family Services (ODJFS) cannot disclose the names and social security numbers of governmental patients and their

physicians to the Department of Health in connection with the information the Department may obtain from ODJFS.

(3) The Department of Health cannot release data received from hospitals, ODJFS, and the U.S. Department of Health and Human Services to the public except on an aggregate basis by geographic area, institution, or other aggregation.

Consistent with its information submission requirements, the bill prohibits a hospital from submitting performance measure information *or* price and volume information 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 (repealed) and R.C. 3727.35)

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 the U.S. Department of Health and Human Services. Prior to releasing a report that identifies a hospital, the Department of Health 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.

Under the bill, 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 and to provide corrections of the information in a timely manner.[5]

Liability for misused or improperly released information and data

(R.C. 3727.37)

Under current law, a hospital that discloses price and volume information concerning non-governmental patients, or data for purposes of the information the Department of Health may obtain regarding governmental patients, is not liable for

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

the misuse or improper release of the information by the Department or any other person.

The bill 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 bill 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 bill provides that performance measure information and price and volume information submitted by a hospital to the Director of Health cannot be used to establish or alter any professional standard of care. The bill also provides that the information is not admissible as evidence in any civil, criminal, or administrative proceeding.

Internet web site

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

Subject to the funding and contracting provisions described below, the bill 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 bill 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 bill 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 bill.

Funding and contracting for the web site

(R.C. 3727.391)

The bill specifies that the duties of the Director to make the information submitted by hospitals under the bill 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 bill 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 bill 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 bill, 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)

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.

Format

(R.C. 3727.42(A))

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 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).

Hospital billing policies

(R.C. 3727.42(B))

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

Availability of list on hospital's 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 Internet web site.

Rules governing price information lists and identification of billing errors

(R.C. 3727.121, 3727.43, and 3727.44)

Current law authorizes the Public Health Council to adopt rules to carry out the purposes of the price information list requirement and current law that 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 bill permits the 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.).

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.

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

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

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.[10]

CMS uses quality measures in several activities of its "Hospital Quality Initiative," most notably for the Hospital Compare web site that the agency

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[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).*

[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).*

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]

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 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.[13]

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.[14]

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.[15]

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[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] *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).*

[14] *Id.*

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

COMMENT 2

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 on similar diagnoses, treatments, and use of hospital resources. DRGs allow comparisons of resource use across hospitals with varying mixes of patients.[16]

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.[17]

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

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[16] *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).*

[17] *Id.*