QUALITY ASSESSMENT AND IMPROVEMENT MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the Quality Assessment and Improvement Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose and Intent

This Act establishes criteria for the quality assessment activities of all health carriers that offer managed care plans and for the quality improvement activities of health carriers issuing closed plans or combination plans that have a closed component. The purpose of the criteria is to enable health carriers to evaluate, maintain and improve the quality of health care services provided to covered persons.

Section 3. Definitions

A. "Closed plan" means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan.

B. "Commissioner" means the commissioner of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If jurisdiction of managed care organizations lies with some other state agency, or if dual regulation occurs, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

C. "Consumer" means someone in the general public who may or may not be a covered person or a purchaser of health care, including employers.

D. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

E. "Facility" means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

F. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

G. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate "persons."

H. "Health care provider" or "provider" means a health care professional or a facility.

I. "Health care services" or "health services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

J. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

K. "Health indemnity plan" means a health benefit plan that is not a managed care plan.

L. "Managed care plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

M. "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

N. "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.

O. "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups or populations.

P. "Quality improvement" means the effort to improve the processes and outcomes related to the provision of care within the health plan.

Section 4. Applicability and Scope

Except as otherwise specified, this Act shall apply to all health carriers that offer managed care plans.

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity shall make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a managed care plan has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist.

Section 5. Quality Assessment Standards

A health carrier that provides managed care plans shall develop and maintain the infrastructure and disclosure systems necessary to measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by the health carrier. A health carrier shall:

A. Establish a system designed to assess the quality of health care provided to covered persons and appropriate to the types of plans offered by the health carrier. The system shall include systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements;

Drafting Note: The level of quality assessment activities undertaken by a health plan will vary based on the plan's structure. For example, PPO plans and HMOs will have different quality assessment programs and techniques.

B. Communicate findings in a timely manner to applicable regulatory agencies, providers and consumers as provided in Section 8;

C. Report to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider. A health carrier acting in good faith shall be granted immunity from any cause of action under state law in making the report; and

D. File a written description of the quality assessment program with the commissioner in the prescribed format, which shall include a signed certification by a corporate officer of the health carrier that the filing meets the requirements of this Act.

Section 6. Quality Improvement Standards for Closed Plans

A health carrier that issues a closed plan, or a combination plan having a closed component, shall, in addition to complying with the requirements of Section 5, develop and maintain the internal structures and activities necessary to improve quality as required by this section. A health carrier subject to the requirements of this section shall:

A. Establish an internal system capable of identifying opportunities to improve care. This system shall be structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement;

B. Use the findings generated by the system to work, on a continuing basis, with participating providers and other staff within the closed plan or closed component to improve the health care delivered to covered persons;

C. Develop and maintain an organizational program for designing, measuring, assessing and improving the processes and outcomes of health care as identified in the health carrier's quality improvement program filed with the commissioner and consistent with the provisions of this Act. This program shall be under the direction of the Chief Medical Officer or Clinical Director. The organizational program shall include:

(1) A written statement of the objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, performance improvement activities and an annual effectiveness review of the quality improvement program;

(2) A written quality improvement plan that describes how the health carrier intends to:

(a) Analyze both processes and outcomes of care, including focused review of individual cases as appropriate, to discern the causes of variation;

(b) Identify the targeted diagnoses and treatments to be reviewed by the quality improvement program each year. In determining which diagnoses and treatments to target for review, the health carrier shall consider practices and diagnoses that affect a substantial number of the plan's covered persons, or that could place covered persons at serious risk. This section shall not be construed to require a health carrier to review every disease, illness and condition that may affect a member of a managed care plan offered by the health carrier;

Drafting Note: This paragraph seeks to ensure that the diagnoses and patterns of care that a health carrier monitors in any given year are chosen because of their importance and appropriateness to the population served by the closed plan.

(c) Use a range of appropriate methods to analyze quality, including:

(i) Collection and analysis of information on over-utilization and under-utilization of services;

(ii) Evaluation of courses of treatment and outcomes of health care, including health status measures, consistent with reference data bases such as current medical research, knowledge, standards and practice guidelines; and

(iii) Collection and analysis of information specific to a covered person or persons or provider or providers, gathered from multiple sources such as utilization management, claims processing, and documentation of both the satisfaction and grievances of covered persons;

(d) Compare program findings with past performance, as appropriate, and with internal goals and external standards, where available, adopted by the health carrier;

(e) Measure the performance of participating providers and conduct peer review activities, such as:

(i) Identifying practices that do not meet the health carrier's standards;

(ii) Taking appropriate action to correct deficiencies;

(iii) Monitoring participating providers to determine whether they have implemented corrective action; and

(iv) Taking appropriate action when the participating provider has not implemented corrective action;

(f) Utilize treatment protocols and practice parameters developed with appropriate clinical input and using the evaluations described in Paragraphs (2)(a) and (2)(b) above, or utilize acquired treatment protocols developed with appropriate clinical input; and provide participating providers with sufficient information about the protocols to enable participating providers to meet the standards established by these protocols;

(g) Evaluate access to care for covered persons according to standards established by statute, regulation or the commissioner. The quality improvement plan shall describe the health carrier's strategy for integrating public health goals with health services offered to covered persons under the managed care plans of the health carrier, including a description of the health carrier's good faith efforts to initiate or maintain communication with public health agencies;

Drafting Note: Health carriers are not expected to duplicate the services provided by public health agencies, but health carriers should ensure that their plans facilitate the achievement of local public health goals and initiatives. Examples of these initiatives include immunization goals, goals to increase the use of preventive diagnostic services such as Pap smears and mammograms, and efforts to increase the use of seat belts and bicycle helmets. Most states support or maintain health care facilities designed to meet the needs of special populations. These facilities may include migrant worker clinics, community health centers in metropolitan areas, and public health hospitals. States should consider methods of assisting these facilities in developing the capacity to meet health carrier standards for participation in health care networks to preserve this public health infrastructure and avoid conflicting requirements between insurance regulation and public managed care programs. Health carriers should evaluate the compliance of their access provisions with standards set forth in [insert reference to state law similar to the NAIC s Provider Network Adequacy and Contracting Model Act].

(h) Implement improvement strategies related to program findings; and

(i) Evaluate periodically, but not less than annually, the effectiveness of the strategies implemented in Subparagraph (h);

D. Assure that participating providers have the opportunity to participate in developing, implementing and evaluating the quality improvement system; and

E. Provide covered persons the opportunity to comment on the quality improvement process.

Section 7. Corporate Oversight

The Chief Medical Officer or Clinical Director of the health carrier shall have primary responsibility for the quality assessment and quality improvement activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of this Act are met. The Chief Medical Officer or Clinical Director shall approve the written quality assessment and quality improvement programs, as applicable, implemented in compliance with this Act, and shall periodically review and revise the program document and act to assure ongoing appropriateness. Not less than semi-annually, the Chief Medical Officer or Clinical Director shall review reports of quality assessment and quality improvement activities. The commissioner shall hold the health carrier responsible for the actions of the Chief Medical Officer or Clinical Director carried out on behalf of the health carrier and shall hold the health carrier responsible for ensuring that all requirements of this Act are met.

Section 8. Reporting and Disclosure Requirements

A. A health carrier shall document and communicate information, as specified below, about its quality assessment program and its quality improvement program, if it has one, and shall:

(1) Include a summary of its quality assessment and quality improvement programs in marketing materials;

(2) Include a description of its quality assessment and quality improvement programs and a statement of patient rights and responsibilities with respect to those programs in the certificate of coverage or handbook provided to newly enrolled covered persons; and

(3) Make available annually to providers and covered persons findings from its quality assessment and quality improvement programs and information about its progress in meeting internal goals and external standards, where available. The reports shall include a description of the methods used to assess each specific area and an explanation of how any assumptions affect the findings.

Drafting Note: A state should review its applicable state law addressing data reporting requirements and confidentiality issues to ensure that the requirements of this section are consistent with those laws. The NAIC is developing models to address data reporting and confidentiality.

B. (1) A health carrier shall certify to the commissioner annually that its quality assessment program and its quality improvement program, if it has one, along with the materials provided to providers and consumers in accordance with Subsection A, meet the requirements of this Act.

(2) A health carrier shall make available for review by the public upon request, subject to a reasonable fee, the materials certified in Paragraph (1), except for the materials subject to the confidentiality requirements of Section 9, and materials that are proprietary to the health plan. A health carrier shall retain all certified materials for at least three (3) years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

Section 9. Confidentiality

A. Data or information pertaining to the diagnosis, treatment or health of a covered person obtained from the person or from a provider by a health carrier is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this Act and as allowed by state law; or upon the express consent of the covered person; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of a claim or litigation between the covered person and the health carrier where the data or information is pertinent, regardless of whether the information is in the form of paper, is preserved on microfilm or is stored in computer retrievable form. If any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant is disclosed pursuant to the provisions of this subsection, the health carrier making this required disclosure shall not be liable for the disclosure or any subsequent use or misuse of the data. A health carrier shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the health carrier is entitled to claim.

B. A person who, in good faith and without malice, takes an action or makes a decision or recommendation as a member, agent or employee of a health carrier's quality committee in furtherance of and consistent with the quality assessment or quality improvement activities of the health carrier, or who furnishes any records, information or assistance to a quality committee in furtherance of and consistent with the quality assessment or quality improvement activities of the health carrier, shall not be subject to liability for civil damages or any legal action in consequence of his or her action, nor shall the health carrier that established the quality committee or the officers, directors, employees or agents of the health carrier be liable for the activities of the person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

C. (1) The information considered by a quality committee and the records of its actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the quality committee's findings or recommendations. No member of a quality committee, or officer, director or other member of a health carrier or its staff engaged in assisting the quality committee, or engaged in the health carrier's quality assessment or quality improvement activities, or any person assisting or furnishing information to the quality committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on these activities.

(2) Information considered by a quality committee and the records of its actions and proceedings that are used pursuant to Subsection C(1) by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of a quality committee.

D. To fulfill its obligations under this section, the health carrier shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any covered person.

Section 10. Contracting

Whenever a health carrier contracts to have another entity perform the quality assessment or quality improvement functions required by this Act or applicable regulations, the commissioner shall hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of this Act and applicable regulations are met.

Section 11. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 12. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 13. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1996 Proc. 1st Quarter 29-30, 123, 626, 640, 656, 667-671 (adopted).