Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 10-0916.01 Thomas Morris **SENATE BILL 10-178**

SENATE SPONSORSHIP

Hodge and Mitchell,

HOUSE SPONSORSHIP

Gerou and Miklosi,

Senate Committees
Judiciary

House Committees

A BILL FOR AN ACT

CONCERNING FAIRNESS IN WORKERS' COMPENSATION HEALTH CARE PROVIDER REVIEW PROCESSES, AND, IN CONNECTION THEREWITH, REQUIRING CREDENTIALING, QUALITY, AND SERVICE REVIEW AND PERFORMANCE INITIATIVE PROGRAMS TO BE TRANSPARENT, INCLUDE OBJECTIVE AND STANDARDIZED CRITERIA THAT ARE APPLIED CONSISTENTLY, AND PROVIDE MINIMUM DUE PROCESS TO PROVIDERS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at

http://www.leg.state.co.us/billsummaries.)

The bill creates the "Provider Review and Disclosure Act". The act requires workers' compensation insurers to include quality and patient data in performance initiatives. The act also requires such initiatives to be based on objective data that is available to affected providers. The act requires credentialing, quality, and service reviews to be based on objective criteria that are applied consistently. The act provides due process for health care providers, including disclosure of the processes followed, the provider's rights, and an appeal process to challenge results and decisions relating to performance initiatives.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 43 of title 8, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART 6

PROVIDER REVIEW AND DISCLOSURE

8-43-601. Short title. THIS PART 6 SHALL BE KNOWN AND MAY BE CITED AS THE "PROVIDER REVIEW AND DISCLOSURE ACT".

8-43-602. Legislative declaration. (1) THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES THAT INSURER PERFORMANCE INITIATIVES ARE USED IN MARKETING, SALES, AND OTHER EFFORTS, AND, AS SUCH, MAY IMPACT AN EMPLOYER'S SELECTION OF AN AUTHORIZED HEALTH CARE PROVIDER. TO PROTECT PATIENTS, EMPLOYERS, AND PROVIDERS, AND TO AVOID IMPROPER PROFILING, ALL PERFORMANCE INITIATIVES MUST BE FAIR, OBJECTIVE, CONSISTENTLY APPLIED, AND ACCORD PROVIDERS DUE PROCESS. CONSISTENT WITH THESE GOALS, PERFORMANCE INITIATIVES SHOULD ALIGN INCENTIVES NOT ONLY WITH EFFICIENT OPERATIONS, BUT ALSO WITH COST-EFFECTIVE, HIGH-QUALITY CARE. ACCORDINGLY, THE GENERAL ASSEMBLY FINDS THAT REQUIRING MINIMUM STANDARDS AND FULL DISCLOSURE OF PERFORMANCE INITIATIVE

DATA AND METHODOLOGIES WILL HELP IMPROVE THE QUALITY AND EFFICIENCY OF HEALTH CARE DELIVERED TO COLORADO WORKERS.

(2) THE GENERAL ASSEMBLY FURTHER FINDS, DETERMINES, AND DECLARES THAT CREDENTIALING, QUALITY, AND SERVICE REVIEW PROCESSES AFFECT FUNDAMENTAL PROVIDER RIGHTS AND PATIENT CARE. CONSEQUENTLY, ENSURING THAT SUCH PROCESSES ARE FAIR, OBJECTIVE, CONSISTENTLY APPLIED, AND ACCORD PROVIDERS DUE PROCESS IS VITAL TO ENSURING THAT PROVIDER-PATIENT RELATIONSHIPS ARE FREE FROM INAPPROPRIATE OUTSIDE PRESSURE.

8-43-603. Definitions. AS USED IN THIS PART 6, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ADVERSE ACTION" MEANS ANY QUALIFICATION, CONDITION, OR RESTRICTION ON A PROVIDER'S STATUS AS AN AUTHORIZED PROVIDER OR NETWORK PARTICIPANT, INCLUDING ANY REPRESENTATION THAT MAY IMPLY ANYTHING OTHER THAN UNQUALIFIED STATUS. "ADVERSE ACTION" DOES NOT INCLUDE A CONFIDENTIAL LETTER OF CONCERN DISCLOSED ONLY TO THE PROVIDER.

(2) "INSURER" MEANS AN ENTITY THAT PROVIDES WORKERS' COMPENSATION INSURANCE COVERAGE REQUIRED BY ARTICLE 44 OF THIS TITLE, INCLUDING ANY THIRD-PARTY INSURER OR SELF-INSURED EMPLOYER.

(3) "METHODOLOGY" MEANS THE METHOD BY WHICH AN ASSESSMENT OR MEASUREMENT IS DETERMINED, INCLUDING ALGORITHMS OR STUDIES, EVALUATION OF DATA, APPLICATION OF GUIDELINES, OR PERFORMANCE MEASURES.

(4) "PATIENT" MEANS A PERSON WHO QUALIFIES FOR HEALTH CARE BENEFITS UNDER ARTICLES 40 TO 47 OF THIS TITLE.

(5) "PERFORMANCE INITIATIVE" MEANS ANY PROGRAM, SYSTEM, OR PROCESS THROUGH WHICH AN INSURER RATES OR RECOGNIZES THE COST, EFFICIENCY, QUALITY, OR OTHER ASSESSMENT OR MEASUREMENT OF A PROVIDER'S CARE, WHETHER THROUGH AWARDS, PAYMENTS, ASSIGNMENT, CHARACTERIZATION, OR REPRESENTATION.

(6) "PROVIDER" MEANS A PHYSICIAN LICENSED UNDER THE "COLORADO MEDICAL PRACTICE ACT", ARTICLE 36 OF TITLE 12, C.R.S., OR A CLINIC THAT PROVIDES HEALTH CARE PURSUANT TO ARTICLES 40 TO 47 OF THIS TITLE.

8-43-604. Performance initiatives. (1) ALL PERFORMANCE INITIATIVES SHALL INCLUDE, AT A MINIMUM:

(a) A QUALITY OF CARE COMPONENT THAT IS SATISFIED BY USING STANDARD TREATMENT GUIDELINES PROMULGATED BY THE DIRECTOR PURSUANT TO SECTION 8-42-101 OR EVIDENCED-BASED ADMINISTRATIVE, OPERATIONAL, OR CLINICAL PERFORMANCE MEASURES THAT IMPROVE CARE;

(b) A CLEAR REPRESENTATION OF THE WEIGHT GIVEN TO THE QUALITY OF CARE COMPONENT IN COMPARISON WITH OTHER FACTORS, WHICH WEIGHT SHALL BE EQUAL TO OR GREATER THAN ANY OTHER FACTOR;

(c) IF A PERFORMANCE INITIATIVE INCLUDES AN EMPLOYER SATISFACTION ELEMENT, A CLAIMANT SATISFACTION ELEMENT, WHICH SHALL BE WEIGHTED EQUAL TO OR GREATER THAN THE EMPLOYER SATISFACTION ELEMENT;

(d) STATISTICAL ANALYSES THAT ARE OBJECTIVE, ACCURATE, VALID, RELIABLE, AND VERIFIABLE;

(e) A PERIOD OF ASSESSMENT OF DATA, PERTINENT TO THE

PERFORMANCE INITIATIVE, WHICH SHALL BE UPDATED AT APPROPRIATE INTERVALS;

(f) IF CLAIMS DATA ARE USED, ACCURATE CLAIMS DATA APPROPRIATELY ATTRIBUTED TO THE PROVIDER. WHEN REASONABLY AVAILABLE, THE INSURER SHALL USE AGGREGATED DATA FROM OTHER INSURERS TO SUPPLEMENT ITS OWN CLAIMS DATA.

(g) THE PROVIDER'S RESPONSIBILITY FOR HEALTH CARE DECISIONS AND THE FINANCIAL CONSEQUENCES OF THOSE DECISIONS, WHICH SHALL BE FAIRLY AND ACCURATELY ATTRIBUTED TO THE PROVIDER.

(2) PERFORMANCE INITIATIVE RESULTS SHALL BE REPORTED TO EACH PROVIDER REVIEWED IN THE INITIATIVE AND SHALL INCLUDE COMPARISON OF THE PROVIDER'S RESULTS TO THE RESULTS OF THE PROVIDER'S PEERS.

(3) ANY DISCLOSURE OF THE RESULTS OF A PERFORMANCE INITIATIVE SHALL BE ACCOMPANIED BY A CONSPICUOUS DISCLAIMER WRITTEN IN BOLD-FACED TYPE STATING THAT THE INFORMATION IS INTENDED ONLY AS A GUIDE, SHOULD NOT BE THE SOLE FACTOR IN SELECTING A PROVIDER, HAS A RISK OF ERROR, AND SHOULD BE DISCUSSED WITH THE PROVIDER.

(4) NO PROGRAM SHALL CONTAIN INCENTIVES THAT LIMIT AN INJURED WORKER'S ABILITY TO OBTAIN APPROPRIATE MEDICAL TREATMENT FOR HIS OR HER CLAIM-RELATED INJURIES.

8-43-605. Credentialing, quality, and service review. (1) ALL CREDENTIALING, QUALITY, AND SERVICE REVIEWS SHALL BE INITIATED AND PERFORMED CONSISTENTLY AMONG PROVIDERS ACCORDING TO WRITTEN POLICIES AND PROCEDURES THAT ARE BASED ON OBJECTIVE CRITERIA. OBJECTIVE CRITERIA MAY INCORPORATE THE MEDICAL

TREATMENT GUIDELINES PROMULGATED BY THE DIRECTOR PURSUANT TO SECTION 8-42-101.

(2) CREDENTIALING, QUALITY, AND SERVICE REVIEW RESULTS SHALL, WHEN PRACTICAL, INCLUDE COMPARISON OF THE PROVIDER'S RESULTS TO THE RESULTS OF THE PROVIDER'S PEERS.

8-43-606. Due process. (1) AT LEAST FORTY-FIVE DAYS BEFORE FINALIZING OR PUBLICLY DISCLOSING THE RESULTS OF A PERFORMANCE INITIATIVE OR ACTING UPON RESULTS OF A CREDENTIALING, QUALITY, OR SERVICE REVIEW, UNLESS PATIENT SAFETY REQUIRES EMERGENCY ACTION, AN INSURER SHALL GIVE A PROVIDER WRITTEN NOTICE OF THE PROVIDER'S INDIVIDUAL RESULT AND A DESCRIPTION OF THE IMPLICATIONS TO THE PROVIDER. THE WRITTEN NOTICE SHALL DESCRIBE THE PROCEDURES BY WHICH THE PROVIDER MAY REQUEST:

(a) THE INFORMATION REQUIRED TO BE DISCLOSED UNDER SUBSECTION (2) OF THIS SECTION; AND

(b) AN APPEAL OF THE RESULT PURSUANT TO SUBSECTION (3) OF THIS SECTION.

(2) (a) WITHIN SEVEN DAYS AFTER RECEIVING A REQUEST BY OR ON BEHALF OF A PROVIDER, AN INSURER SHALL DISCLOSE, IN A MANNER THAT IS REASONABLY UNDERSTANDABLE AND THAT ALLOWS THE PROVIDER TO VERIFY THE DATA AGAINST HIS OR HER RECORDS:

(I) THE METHODOLOGY AND ALL DATA UPON WHICH A PROVIDER'S PERFORMANCE INITIATIVE RESULT WAS CALCULATED, WITH SUFFICIENT DETAIL TO ALLOW THE PROVIDER TO DETERMINE THE EFFECT OF THE METHODOLOGY ON THE DATA REVIEWED; AND

(II) THE CREDENTIALING, QUALITY, OR SERVICE REVIEW PROCESS USED AND A DESCRIPTION OF HOW SUCH PROCESS WAS APPLIED TO THE

PROVIDER, WITH SUFFICIENT DETAIL TO ALLOW THE PROVIDER TO DETERMINE WHETHER AN OBJECTIVE AND CONSISTENT PROCESS WAS USED. THE INSURER SHALL ALSO INCLUDE IN THE DISCLOSURE A DETAILED EXPLANATION OF THE FINDINGS OF THE REVIEW ALONG WITH ANY DATA OR INFORMATION SPECIFIC TO THE PROVIDER THAT WAS CONSIDERED IN THE REVIEW.

(b) AN INSURER SHALL NOT USE THE "UNIFORM TRADE SECRETS ACT", ARTICLE 74 OF TITLE 7, C.R.S., TO AVOID COMPLIANCE WITH THIS SECTION.

(3) INSURERS SHALL ESTABLISH PROCEDURES FOR PROVIDERS TO APPEAL THE RESULTS OF A REVIEW OR PERFORMANCE INITIATIVE. SUCH PROCEDURES, IN ADDITION TO THE DISCLOSURES AND THE WRITTEN NOTICE FURNISHED, SHALL PROVIDE:

(a) A REASONABLE METHOD BY WHICH THE PROVIDER MAY SUBMIT NOTICE OF THE DESIRE TO APPEAL;

(b) THE NAME, TITLE, QUALIFICATIONS, AND RELATIONSHIP TO THE INSURER OF ANY PERSON RESPONSIBLE FOR DECIDING THE APPEAL, WHO SHALL BE AUTHORIZED TO UPHOLD, MODIFY, OR REJECT RESULTS OR REQUIRE ADDITIONAL ACTION TO ENSURE THAT RESULTS ARE FAIR, REASONABLE, ACCURATE, AND COMPLY WITH THE REQUIREMENTS OF THIS ARTICLE;

(c) AN OPPORTUNITY FOR A PROVIDER TO SUBMIT OR HAVE CONSIDERED CORRECTED DATA OR OTHER INFORMATION RELEVANT TO THE RESULTS OR THE APPROPRIATENESS OF THE METHODOLOGY USED. IF REQUESTED BY A PROVIDER, SUCH OPPORTUNITY MAY BE IN A FACE-TO-FACE MEETING WITH THOSE RESPONSIBLE FOR THE APPEAL DECISION AT A LOCATION REASONABLY CONVENIENT TO THE PROVIDER OR

BY TELECONFERENCE.

(d) IF A REVIEW RESULTS IN A RECOMMENDATION FOR ANY ADVERSE ACTION, THE PROVIDER IS ENTITLED TO A HEARING PURSUANT TO SECTION 8-43-207;

(e) A PRESUMPTION THAT ALL DATA SUBMITTED BY A PROVIDER IS VALID AND ACCURATE. THIS PRESUMPTION DOES NOT PERMIT AN INSURER TO UNREASONABLY WITHHOLD CONSIDERATION OF CORRECTED OR SUPPLEMENTED DATA.

(f) THE PROVIDER'S RIGHT TO BE ASSISTED BY A REPRESENTATIVE, INCLUDING AN ATTORNEY;

(g) A DETAILED WRITTEN DECISION REGARDING THE APPEAL THAT STATES THE REASONS FOR UPHOLDING, MODIFYING, OR REJECTING THE APPEAL;

(h) RESOLUTION OF THE APPEAL WITHIN FORTY-FIVE DAYS AFTER THE DATE UPON WHICH THE DATA AND METHODOLOGY ARE DISCLOSED UNLESS OTHERWISE AGREED TO BY THE PARTIES TO THE APPEAL; AND

(i) A STAY ON THE IMPLEMENTATION, USE, AND DISCLOSURE OF AND ACTION UPON THE RESULTS OF THE REVIEW OR PERFORMANCE INITIATIVE UNTIL THE APPEAL, INCLUDING ANY HEARING REQUESTED PURSUANT TO SECTION 8-43-207, HAS BECOME FINAL.

8-43-607. Enforcement. (1) AN INSURER SHALL NOT LIMIT, BY CONTRACT OR OTHER MEANS, THE RIGHT OF A PROVIDER TO ENFORCE THIS PART 6.

(2) THIS PART 6 MAY BE ENFORCED IN A CIVIL ACTION, AND ANY REMEDIES AT LAW AND IN EQUITY ARE AVAILABLE.

(3) A VIOLATION OF THIS PART 6 CONSTITUTES AN UNFAIR OR DECEPTIVE ACT OR PRACTICE UNDER PART 11 OF ARTICLE 3 OF TITLE 10,

C.R.S.

SECTION 2. Specified effective date - applicability. This act shall take effect July 1, 2010, and shall apply to performance initiatives and reviews conducted on or after said date.

SECTION 3. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.