SENATE BILL REPORT

SB 5625

As of February 24, 1997

Title: An act relating to health care quality protection.

Brief Description: Providing mechanisms to ensure the delivery of quality health care services.

Sponsors: Senators Franklin, Deccio, Fairley, Winsley, Wood and Patterson.

Brief History:
Committee Activity: Health & Long-Term Care: 2/27/97.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Don Sloma (786-7319)

Background: As health insurers and public purchasers of health coverage have increased their use of managed care strategies in recent years, certain health care provider groups and health care consumer groups have become concerned that managed care strategies may be undermining clinical decision making. Concern exists with managed care practices such as utilization review, treatment guidelines, gag rules– placed on providers who wish to report substandard practices to patients or to regulatory entities, incentive payments to providers to discourage unnecessary treatment and more.

Some have responded to these concerns by participating in the development of national managed care standards setting organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Utilization Review Accreditation Commission (URAC). These organizations, composed of insurers, purchasers, health care professionals, consumer group representatives, labor groups and others, assess a managed care plan a fee to examine their operations, and report the results of their review to the plan, to prospective managed care plan purchasers and to other entities.

However, some health provider and consumer groups observe that adherence to the standards of such organizations is voluntary. As a result, they are not universally applied to all managed care organizations. In addition, these groups suggest that these standards may not be adequate in all cases to ensure the quality of patient care. These provider and consumer groups suggest a stronger government role in establishing particular standards to ensure that health care providers control the course of clinical care, that information on managed care organization operations and performance be made available to consumers in a consistent format, and that the rights of consumers and providers to complain about dangerous or substandard care be protected.

Summary of Bill: All health care facilities as defined in RCW 48.43.005 and all health carriers, as defined in the act, must permit the treating health care provider, as defined in the act, to make all decisions regarding patient care. Covered services, including follow-up

care may not be denied as ordered by the treating provider. These clinical care decisions must be based on accepted medical practice.

No health carrier or health care facility may provide financial disincentives to a health care provider for complying with the terms of the act. However, financial incentives, such as capitated payment or case rate payment schemes may be employed.

Hospital licensing requirements are expanded to include the filing with the state Department of Health of specified information regarding facility operations, payments, and outcomes. This must include staffing information, quality indicators, morbidity and mortality rates, average length and cost of treatment, financial information, salary and other staff compensation data, information on corporate structure, state and federal financial reports, incidence of adverse patient outcomes, patient satisfaction, information on lawsuits and other complaints, the results of accreditation surveys and other evaluations by public and private entities and more.

The Department of Health must publish an annual, audited report summarizing this information, including a ranking of hospitals based upon it.

Licensing requirements for health carriers and their plans as defined in RCW 48.43.005 are expanded to include the filing of specified information with the state Insurance Commissioner regarding plan operations, payments, and outcomes. This report must include similar information to that required of hospitals plus information on claims denials, experimental procedure coverage decisions, prenatal care and postnatal lengths of stay and outcomes, and health promotion and disease prevention activities.

The Insurance Commissioner must publish an annual, audited report summarizing this information, including a ranking of carriers and plans based upon it.

Existing law which protects the confidentiality of a whistler blower– who complains about the quality of care by a health care provider or facility is extended to protect those complaining about a health carrier. Complaints about care in boarding homes, nursing homes, adult family homes, health departments or in any other setting regulated by the departments of Health, Social and Health Services, Labor and Industries, the Health Care Authority, the Insurance Commissioner or the state Board of Health are also protected. The Insurance Commissioner must adopt rules to integrate these complaint procedures with those established for health carrier complaints under Title 48 RCW.

Administration of nursing services in any health care facility may only be performed by a registered nurse whose scope of practice includes the care being supervised.

Any health carrier or hospital planning to merge with or acquire another health facility or plan must file a report with the state Department of Health which details the impact of the transaction on health services. The report must include impacts on 11 areas listed in the act, including services to mothers, children, the elderly, and other named groups; employment within the community; the status of collective bargaining agreements and other factors to be specified by the Health Care Policy Board. The Department of Health must conduct public hearings on the transaction, review the transaction, and determine if the transaction has a negative impact on the health and safety of patients and the community. If a transaction

determined to have such a negative impact is completed, the resulting entity is deemed not to be in compliance with the conditions of participation with state purchased health programs.

If the Department of Health determines that such transactions, having occurred, pose an immediate jeopardy or irreparable harm to patient health, safety and welfare, they must suspend the license of the hospital or health carrier involved.

An employee, contractor or volunteer in a public hospital or public hospital district may serve as a hospital commissioner.

Appropriation: None.

Fiscal Note: Requested on February 19, 1997.

Effective Date: Ninety days after adjournment of session in which bill is passed.