QUALITY ASSESSMENT AND IMPROVEMENT MODEL ACT

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Section 1. Title

This Act shall be known and may be

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.

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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 overutilization and underutilization of services;

(ii)

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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.

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Section 12. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid,

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