SENATE DOCKET, NO. 59 FILED ON: 1/13/2015

# SENATE . . . . . No. 486

## The Commonwealth of Massachusetts

PRESENTED BY:

***Cynthia S. Creem***

*To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:*

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act relative to insurance companies and quality measures.

PETITION OF:

| NAME: | DISTRICT/ADDRESS: |
|---|---|
| *Cynthia S. Creem* | *First Middlesex and Norfolk* |

SENATE DOCKET, NO. 59 FILED ON: 1/13/2015

# SENATE . . . . . No. 486

By Ms. Creem, a petition (accompanied by bill, Senate, No. 486) of Cynthia S. Creem for legislation relative to insurance companies and quality measures. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *510* OF 2013-2014.]

## The Commonwealth of Massachusetts

**In the One Hundred and Eighty-Ninth General Court**
**(2015-2016)**

An Act relative to insurance companies and quality measures.

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

SECTION 1. Section 2 of Chapter 32A is hereby amended by inserting the following new definitions:

(j) "Quality", the degree to which health services for individuals and populations increase the likelihood of the desired health outcomes and are consistent with current professional knowledge.

(k) "Cost efficiency", the degree to which health services are utilized to achieve a given outcome or given level of quality.

(l) "Physician performance evaluation", a system designed to measure the quality, and cost efficiency of a physician's delivery of care and shall include quality improvement programs,

10 pay for performance programs, public reporting on physician performance or ratings' and the use
11 of tiering networks.

12 SECTION 2. Section 21 of Chapter 32A of the General Laws, as appearing the 2010
13 Official Edition, is hereby amended by inserting at the end thereof, the following:-

14 The commission shall not implement or contract with a carrier as defined in section 1 of
15 Chapter 1760 for the implementation of a physician performance evaluation program as defined
16 in section one unless the program has the following minimum attributes:

17 (1) Public disclosure regarding the methodologies, criteria and algorithms under
18 consideration, 180 days before any performance evaluations of physicians are applied;

19 (2) Meaningful input by independent practicing physicians and biostatisticians in a timely
20 fashion that will ensure the measures being used are clinically important and understandable to
21 patients and physicians and the tools used for performance evaluations are fair and appropriate;

22 (3) A mechanism to ensure data accuracy and validity that includes a feedback cycle of
23 not less than 120 days prior to the public reporting of the data, which accepts corrections to
24 errors from multiple sources, including the physician being evaluated, assesses the causes of the
25 error(s) and improves the overall evaluation system;

26 (4) A mechanism to provide the physician being evaluated with patient level drill downed
27 information on any cost efficiency measures used in the evaluation and patient lists for any
28 quality measures that are used in the evaluation that includes a list of patients counted towards
29 each quality measure, as well as the interventions for each patient that counted towards that
30 measure.

31 (5) Each quality measure shall have a reasonable target set for each measure and shall not
32 allow the target level to be open-ended.

33 (6) If a quality measure is to be constructed across multiple conditions then the measure
34 shall be case mix adjusted.

35 (7) A consensus process shall be in place to provide proper weighting of more important
36 quality measures at a higher weight and the equal weighting of all measure shall not be used as a
37 default.

38 (8) Sample sizes used in the development of quality measures should not be increased by
39 adding the number of interventions and number of opportunities across multiple health condition
40 to create an adherence ratio, without appropriate statistical adjustment of such a process.
41 Adherence must be assessed at a physician group practice level rather than at the individual
42 physician level.

43 (9) Sample sizes used in the development of cost efficiency measures must be large
44 enough to provide valid information.

45 (10) Information physicians are rated on must be current to reflect physicians' current
46 practices of care for their patients, be appropriately risk adjusted and include appropriate
47 attribution, definition of specialty and adjustments for unusual medical situations. Physicians
48 should be measured only on conditions appropriate to their specialties.

49 (11) Use of preventive care and under-use measures should not be considered as part of
50 cost efficiency measurements.

51 (12) Recommendations by which the physician can improve the results of the evaluation
52 reporting.

53 (13) An evaluation plan that uses assignment by tiering shall include a uniform tier
54 assignment protocol and shall have a statistically significant difference in rating calculations in
55 order to shift a physician from one tier to another. Separate categories shall be created for
56 physicians for who cannot be evaluated in a statistically reliable manner. Said categorization
57 shall not result in higher co-payments for patients being treated by physicians in these separate
58 categories. Said plans shall also employ a data driven process to determine which medical
59 specialties to tier.

60 (14) Uniform tiering should be assigned to group practices so as not to add additional
61 administrative burdens to physicians' practices.

62 (15) Accuracy regarding tiering is critical to avoid the unintended consequences of
63 limiting access to care and introducing risk adversity. Information should be disseminated in
64 such as fashion that results are is both understandable and comprehensive enough to promote
65 education and quality improvement.

66 (16) Increasing data accuracy must be approached as a continuous quality improvement
67 (CQI) project aimed at improving the evaluation system itself.

68 SECTION 3. No carrier as defined in Section 1 of Chapter 1760 of the general laws shall
69 establish a physician performance evaluation program unless the program has the following
70 minimum attributes:

71 (1) Public disclosure regarding the methodologies, criteria and algorithms under
72 consideration, 180 days before any performance evaluations of physicians are applied;

73 (2) Meaningful input by independent practicing physicians and biostatisticians in a timely
74 fashion that will ensure the measures being used are clinically important and understandable to
75 patients and physicians and the tools used for performance evaluations are fair and appropriate;

76 (3) A mechanism to ensure data accuracy and validity that includes a feedback cycle of
77 not less than 120 days prior to the public reporting of the data, which accepts corrections to
78 errors from multiple sources, including the physician being evaluated, assesses the causes of the
79 error(s) and improve the overall evaluation system; and

80 (4) A mechanism to provide the physician being evaluated with patient level drill downed
81 information on any efficiency measures used in the evaluation and patient lists for any quality
82 measures that are used in the evaluation.

83 (5) Each quality measure shall have a reasonable target set for each measure and shall not
84 allow the target level to be open-ended.

85 (6) If a quality measure is to be constructed across multiple conditions then the measure
86 shall be case mix adjusted.

87 (7) A consensus process shall be in place to provide proper weighting of more important
88 quality measures at a higher weight and the equal weighting of all measure shall not be used as a
89 default.

90 (8) Sample sizes used in the development of quality measures should not be increased by
91 adding the number of interventions and number or opportunities across multiple health condition

92 to create an adherence ratio. Adherence must be assessed at a physician group practice level
93 rather than at the individual physician level.

94 (9) Recommendations by which the physician can improve the results of the evaluation
95 reporting.

96 (10) An evaluation plan that uses assignment by tiering shall include a uniform tier
97 assignment protocol and shall have a statistically significant difference in rating calculations in
98 order to shift a physician from one tier to another. Separate categories shall be created for
99 physicians for who cannot be evaluated in a statistically reliable manner. Said categorization
100 shall not result in higher co-payments for patients being treated by physicians in these separate
101 categories. Said plans shall also employ a data driven process to determine which medical
102 specialties to tier.

103 (11) Uniform tiering should be assigned to group practices so as not to add additional
104 administrative burdens to physicians' practices.

105 (12) Accuracy regarding tiering is critical to avoid the unintended consequences of
106 limiting access to care and introducing risk adversity. Information should be disseminated in
107 such as fashion that results are is both understandable and comprehensive enough to promote
108 education and quality improvement.

109 (13) Increasing data accuracy must be approached as a continuous quality improvement
110 (CQI) project aimed at improving the evaluation system itself.

111 SECTION 4. Subsection (b) of section 11 of chapter 176J of the General Laws is hereby
112 amended by striking out the second sentence and inserting in place thereof the following
113 sentences:-

114 The commissioner shall determine by regulation standard tiering criteria to be used by all
115 carriers based on health outcomes, quality performance as measured by the standard quality
116 measure set and by cost performance as measured by health status adjusted total medical
117 expenses and relative prices. The criteria shall require that all providers of the same type who are
118 participants in a particular Accountable Care Organization or Patient Centered Medical Home, as
119 defined in section 1 of chapter 6D, shall be classified in the same tier.

120 SECTION 5. Section 11 of chapter 176J of the General Laws is hereby amended by
121 striking out subsection (c) and inserting in place thereof the following subsection:–

122 (c) The commissioner shall promulgate by regulation uniform criteria for determining
123 network adequacy for a tiered network plan based on the availability of sufficient network
124 providers in the carrier's overall network of providers, including standards for adequate
125 geographic proximity of providers to members, taking into account distance, travel time and
126 availability of public transportation. In determining network adequacy, the commissioner shall
127 require that carriers classify providers into tiers so that every member enrolled in a plan has
128 reasonable access to at least one provider in the lowest cost-sharing tier for every covered
129 service.

130 SECTION 6. Section 11 of chapter 176J of the General Laws is hereby amended by
131 striking out subsection (f) and inserting in place thereof the following subsection:–

132 (f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in
133 selective and tiered plans no more than once per calendar year except that carriers may reclassify
134 providers from a higher cost tier to a lower cost tier or add providers to a selective network at
135 any time. If the carrier reclassifies provider tiers or providers participating in a selective plan
136 during the course of an account year, the carrier shall provide affected members of the account
137 with information regarding the plan changes at least 30 days before the changes take effect. If a
138 member is in a course of treatment with a mental health provider who is reclassified to a higher
139 cost tier, the member shall be permitted to remain with the provider with cost sharing at the
140 previous lower cost tier for one year following the reclassification. Carriers shall provide
141 information understandable to an average consumer on their websites and though a toll-free
142 telephone number that includes an option of talking to a live person about any tiered or selective
143 network plan, including but not limited to, a searchable list of the providers participating in the
144 plan, the selection criteria for those providers and where applicable, the tier in which each
145 provider is classified. The information shall clearly distinguish among different facilities of a
146 provider if those facilities are in different tiers or are excluded from a selective plan. All
147 promotional materials for tiered and selective plans must include a readily understandable
148 general explanation of the cost sharing and tiering elements of the plan, and a prominent notice
149 of the web site and toll-free telephone number where a consumer may find more information
150 about the cost sharing and tiering elements. The commissioner shall monitor the web sites and
151 telephone response services for completeness, accuracy and understandability. The
152 commissioner may conduct consumer surveys and focus groups reviewing carrier tiered and
153 selective network plan web sites and telephone response services, and shall issue guidelines for
154 best practices.