HOUSE DOCKET, NO. 2681 FILED ON: 1/20/2017

HOUSE . . . . . No. 2183

The Commonwealth of Massachusetts

PRESENTED BY:

Ronald Mariano

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:	DATE ADDED:
Ronald Mariano	*3rd Norfolk*	*1/20/2017*
Denise Provost	*27th Middlesex*	

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HOUSE . . . . . No. 2183

By Mr. Mariano of Quincy, a petition (accompanied by bill, House, No. 2183) of Ronald Mariano and Denise Provost relative to the establishment of physician evaluation programs by insurance companies. Financial Services.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE HOUSE, NO. *906* OF 2015-2016.]

The Commonwealth of Massachusetts

In the One Hundred and Ninetieth General Court
(2017-2018)

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 of the General laws, as appearing in the 2014 Official Edition, 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, pay for performance programs, public reporting on physician performance or ratings’ and the use of tiering networks.

SECTION 2. Section 21 of said Chapter 32A, as so appearing, is hereby amended by inserting at the end thereof, the following:-

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

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

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

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

(4) A mechanism to provide the physician being evaluated with patient level drill downed information on any cost efficiency measures used in the evaluation and patient lists for any quality measures that are used in the evaluation that includes a list of patients counted towards

each quality measure, as well as the interventions for each patient that counted towards that measure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) Sample sizes used in the development of quality measures should not be increased by adding the number of interventions and number or opportunities across multiple health condition to create an adherence ratio. Adherence must be assessed at a physician group practice level rather than at the individual physician level.

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

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

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

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

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

SECTION 4. Subsection (b) of section 11 of chapter 176J of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by striking out the second sentence and inserting in place thereof the following sentences:-

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

SECTION 5. Section 11 of said chapter 176J, as so appearing, is hereby amended by striking out subsection (c) and inserting in place thereof the following subsection:–

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

SECTION 6. Section 11 of said chapter 176J, as so appearing, is hereby amended by striking out subsection (f) and inserting in place thereof the following subsection:–

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

selective network plan web sites and telephone response services, and shall issue guidelines for best practices.