

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:
<i>Ronald Mariano</i>	<i>3rd Norfolk</i>	<i>1/20/2017</i>
<i>Denise Provost</i>	<i>27th Middlesex</i>	

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:

1 SECTION 1. Section 2 of Chapter 32A of the General laws, as appearing in the 2014
2 Official Edition, is hereby amended by inserting the following

3 new definitions:

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

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

9 (1) “Physician performance evaluation”, a system designed to measure the quality, and
10 cost efficiency of a physician’s delivery of care and shall include quality improvement programs,
11 pay for performance programs, public reporting on physician performance or ratings’ and the use
12 of tiering networks.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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