HOUSE DOCKET, NO. 881 FILED ON: 1/17/2017

HOUSE . . . . . No. 495

The Commonwealth of Massachusetts

PRESENTED BY:

Daniel Cahill

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 to ensure focused quality improvement.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Daniel Cahill	*10th Essex*	*1/17/2017*

HOUSE DOCKET, NO. 881 FILED ON: 1/17/2017

HOUSE . . . . . No. 495

By Mr. Cahill of Lynn, a petition (accompanied by bill, House, No. 495) of Daniel Cahill relative to alternative contract payments based on health care provider quality performance. Financial Services.

The Commonwealth of Massachusetts

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

An Act to ensure focused quality improvement.

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. Paragraph (c) of section 14 of chapter 12C of the General Laws, as appearing in the 2014 Official Edition, is hereby amended by striking out the fourth sentence and inserting in place thereof the following sentence:--

The standard quality measure set may consist of the following quality measures: (1) the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention; (2) the Hospital Consumer Assessment of Healthcare Providers and Systems survey; (3) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group; and (4) the Ambulatory Care Experiences Survey.

SECTION 2. Section 20 of said chapter 12C, is hereby amended by striking out subsection (b) and inserting in place thereof the following section:--

(b) The website shall provide updated information on a regular basis, but no more than 90 days after data required to post such information has been reported to the center, and additional comparative quality, price and cost information shall be published as determined by the center. To the extent possible, the website shall include: (1) comparative price and cost information for the most common referral or prescribed services, as determined by the center, categorized by payer and listed by facility, provider, and provider organization or other groupings, as determined by the center; (2) comparative quality information from the standard quality measure set and verified by the center, available by facility, provider, provider organization or any other provider grouping, as determined by the center, for each such service or category of service for which comparative price and cost information is provided; (3) general information related to each service or category of service for which comparative information is provided; (4) comparative quality information from the standard quality measure set and verified by the center, available by facility, provider, provider organization or other groupings, as determined by the center, that is not service-specific, including information related to patient safety and satisfaction; (5) data concerning healthcare-associated infections and serious reportable events reported under section 51H of chapter 111; (6) definitions of common health insurance and medical terms, including, but not limited to, those determined under sections 2715(g) (2) and (3) of the Public Health Service Act, so that consumers may compare health coverage and understand the terms of their coverage; (7) a list of health care provider types, including but not limited to primary care physicians, nurse practitioners and physician assistants, and what types of services they are authorized to perform in the commonwealth under applicable state and federal scope of practice laws; (8) factors consumers should consider when choosing an insurance product or provider group, including, but not limited to, provider network, premium, cost-

sharing, covered services, and tiering; (9) patient decision aids, which are interactive, written or audio-visual tools that provide a balanced presentation of the condition and treatment or screening options, benefits and harms, with attention to the patient's preferences and values, and which may facilitate conversations between patients and their health care providers about preference-sensitive conditions or diseases such as chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, and cataracts; provided, however, that decision aids shall be made available on, but not be limited to, long-term care and supports and palliative care; (10) a list of provider services that are physically and programmatically accessible for people with disabilities; and (11) descriptions of standard quality measures, as determined by the statewide quality advisory committee and verified by the center.

SECTION 3. Chapter 32A, as so appearing, is hereby amended by adding the following section:--

Section 28. Carriers or third party administrators with whom the commission contracts that enter alternative payment contracts that make payments based on quality performance to providers, including accountable care organizations and risk bearing provider organizations, shall limit the use of quality measures to those that are part of the standard quality measure set pursuant to section 14 of chapter 12C of the General Laws.

SECTION 4. Chapter 118E, as so appearing, is hereby amended by striking out section 13B and inserting in place thereof the following section:--

Section 13B. Hospital rate increases shall be made contingent upon hospital adherence to quality standards and achievement of performance benchmarks, including the reduction of racial and ethnic disparities in the provision of health care. Such benchmarks shall be developed or

adopted by the executive office of health and human services so as to advance a common national framework for quality measurement and reporting, drawing on measures that are approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality, in addition to the Boston Public Health Commission Disparities Project Hospital Working Group Report Guidelines. To the greatest extent possible, the executive office of health and human services shall limit, or require its contracted health insurers, health plans, health maintenance organizations, behavioral health management firms, and third party administrators under contract to a Medicaid managed care organization or primary care clinical plan to limit, the number of measures to those in the statewide quality measure set in order to align and coordinate quality measures across all payers. The office of Medicaid shall consult with the MassHealth payment policy advisory board established under section 16M of said chapter 6A, during the process of developing these quality standards and performance benchmarks.

SECTION 5. Chapter 175, as so appearing, is hereby amended by adding the following section:--

Section 108N. Carriers that enter alternative payment contracts that make payments based on quality performance to providers, including accountable care organizations and risk bearing provider organizations, shall limit the use of quality measures to those that are part of the standard quality measure set pursuant to section 14 of chapter 12C of the General Laws.

SECTION 6. Chapter 176A, as so appearing, is hereby amended by adding the following section:--

Section 38. Every non-profit hospital service corporation that enters alternative payment contracts that make payments based on quality performance to providers, including accountable care organizations and risk bearing provider organizations, shall limit the use of quality measures to those that are part of the standard quality measure set pursuant to section 14 of chapter 12C of the General Laws.

SECTION 7. Chapter 176B, as so appearing, is hereby amended by adding the following section:--

Section 25. Every medical service corporation that enters alternative payment contracts that make payments based on quality performance to providers, including accountable care organizations and risk bearing provider organizations, shall limit the use of quality measures to those that are part of the standard quality measure set pursuant to section 14 of chapter 12C of the General Laws.

SECTION 8. Chapter 176G, as so appearing, is hereby amended by adding the following section:--

Section 33. Every health maintenance organization that enters alternative payment contracts that make payments based on quality performance to providers, including accountable care organizations and risk bearing provider organizations, shall limit the use of quality measures to those that are part of the standard quality measure set pursuant to section 14 of chapter 12C of the General Laws.

SECTION 9. Chapter 176J, as so appearing, is hereby amending by adding the following section:--

Section 18. Carriers that enter alternative payment contracts that make payments based on quality performance to providers, including accountable care organizations and risk bearing provider organizations, shall limit the use of quality measures to those that are part of the standard quality measure set pursuant to section 14 of chapter 12C of the General Laws.