

**SENATE . . . . . No. 486**

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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:

*Cynthia S. Creem*

DISTRICT/ADDRESS:

*First Middlesex and Norfolk*

**SENATE . . . . . No. 486**

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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.

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

The Commonwealth of Massachusetts

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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:*

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

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

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

8 (l) “Physician performance evaluation”, a system designed to measure the quality, and  
9 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 down  
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 down  
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 through 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.