HOUSE DOCKET, NO. 2030 FILED ON: 1/20/2011

HOUSE . . . . . No. 2081

The Commonwealth of Massachusetts

PRESENTED BY:

Thomas P. Conroy

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 passage of the accompanying:

An Act creating an all-payer claims database review committee and designating DHCFP as sole repository of health care claims data.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Thomas P. Conroy	*13th Middlesex*
David B. Sullivan	*6th Bristol*

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HOUSE . . . . . No. 2081

By Mr. Conroy of Wayland, a petition (accompanied by bill, House, No. 2081) of Thomas P. Conroy and David B. Sullivan creating an all-payer claims database review committee and designating the Division of Health Care Finance and Policy as sole repository of health care claims data. Health Care Financing.

The Commonwealth of Massachusetts

An Act creating an all-payer claims database review committee and designating DHCFP as sole repository of health care claims data.

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.

2 Chapter 118G of the General Laws is hereby amended by inserting after section 5 the
3 following new section:

4 Section 6. (a). There shall be established a reviewing committee to govern the
5 administration of the division's all-payer claims data base. The reviewing committee shall be
6 comprised of representatives from the hospital, health plan and provider communities, and shall
7 include, but not be limited to the following: a representative of the Massachusetts Hospital
8 Association, a representative of Blue Cross and Blue Shield of Massachusetts, a representative of
9 the Massachusetts Association of Health Plans, and a representative of the Massachusetts
10 Medical Society. The reviewing committee shall be responsible for advising the division on the
11 standards for release and use of the data submitted, and shall ensure that such standards protect
12 patient privacy, and guard against utilization of the data for the purpose of anti-competitive
13 behavior.

14 (b) The division shall promulgate such regulations as may be necessary to ensure the
15 uniform reporting of revenues, charges, costs and utilization of health care services delivered by
16 institutional and non-institutional providers. Such uniform reporting shall enable the division to
17 identify, on a patient-centered and provider-specific basis, statewide and regional trends in the
18 cost, availability and utilization of medical, surgical, diagnostic and ancillary services provided
19 by acute hospitals, nursing homes, chronic care and rehabilitation hospitals, other specialty
20 hospitals, clinics, including mental health clinics, and such ambulatory care providers as the
21 division may specify.

22 In addition, such uniform reporting shall provide the name and address and such other
23 identifying information as may be needed relative to the employer of any patient for whom
24 health care services were rendered under this chapter and for whom reimbursement from the
25 uncompensated care pool or the Health Safety Net Trust Fund has been requested.

26 The division may promulgate regulations necessary to ensure the uniform reporting of
27 information from private and public health care payers that enables the division to analyze: (i)
28 changes over time in health insurance premium levels; (ii) changes in the benefit and cost-
29 sharing design of plans offered by these payers; and (iii) changes in measures of plan cost and
30 utilization; provided that this analysis shall facilitate comparison among plans and between
31 public and private payers.

32 The division shall ensure the timely reporting of information required under this section.
33 The division shall notify payers of any applicable reporting deadlines. The division may assess
34 penalties against any private health care payer that fails to meet a reporting deadline. The
35 division shall notify, in writing, a private health care payer that it has failed to meet a reporting
36 deadline and that failure to respond within 2 weeks of the receipt of the notice may result in
37 penalties. A payer that fails, without just cause, to provide the requested information within 2
38 weeks following receipt of the written notice required under this paragraph may be assessed a
39 penalty of up to $1,000 per week for each week of delay after the 2 week period following the
40 payer's receipt of the written notice; provided, however, that the maximum annual penalty
41 against a private payer under this section shall be $50,000. Amounts collected pursuant to this
42 section shall be deposited in the General Fund.

43 The division shall require the submission of data and other information from each private
44 health care payer offering small or large group health plans including, but not limited to: (i)
45 average annual individual and family plan premiums for each payer's most popular plans for a
46 representative range of group sizes, as further determined in regulations and average annual
47 individual and family plan premiums for the lowest cost plan in each group size that meets the
48 minimum standards and guidelines established by the division of insurance under section 8H of
49 chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for
50 each plan; (iii) summaries of the plan designs for each plan; (iv) information concerning the
51 medical and administrative expenses, including medical loss ratios for each plan, using a uniform
52 methodology, and collected under section 21 of chapter 176O; (v) information concerning the
53 payer's current level of reserves and surpluses; (vi) information on provider payment methods
54 and levels; (vii) health status adjusted total medical expenses by provider group and local
55 practice group and zip code calculated according to a uniform methodology; (viii) relative prices
56 paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center,
57 mental health facility, rehabilitation facility, skilled nursing facility and home health provider in
58 the payer's network, by type of provider and calculated according to a uniform methodology; and
59 (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a
60 uniform methodology.

61 The division shall require the submission of data and other information from public
62 health care payers including, but not limited to: (i) average premium rates for health insurance
63 plans offered by public payers and information concerning the actuarial assumptions that
64 underlie these premiums; (ii) average annual per-member per-month payments for enrollees in
65 MassHealth primary care clinician and fee for service programs; (iii) summaries of plan designs
66 for each plan or program; (iv) information concerning the medical and administrative expenses,
67 including medical loss ratios for each plan or program; (v) where appropriate, information
68 concerning the payer's current level of reserves and surpluses; (vi) information on provider
69 payment methods and levels, including information concerning payment levels to each hospital
70 for the 25 most common medical procedures provided to enrollees in these programs, in a form
71 that allows payment comparisons between Medicaid programs and managed care organizations
72 under contract to the office of Medicaid; (vii) health status adjusted total medical expenses by
73 provider group and local practice group and zip code calculated according to a uniform
74 methodology; (viii) relative prices paid to every hospital, physician group, ambulatory surgical
75 center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing
76 facility and home health provider in the payer's network, by type of provider and calculated
77 according to a uniform methodology.

78 The division shall require the submission of data and other such information from each
79 acute care hospital on hospital inpatient and outpatient costs, including direct and indirect costs,
80 according to a uniform methodology.

81 The division shall publicly report and place on its website information on health status
82 adjusted total medical expenses, relative prices and hospital inpatient and outpatient costs,
83 including direct and indirect costs under this section on an annual basis; provided, however, that
84 at least 10 days prior to the public posting or reporting of provider specific information the
85 affected provider shall be provided the information for review. The division shall request from
86 the federal Centers for Medicare and Medicaid Services the health status adjusted total medical
87 expenses of provider groups that serve Medicare patients.

88 The division shall, before adopting regulations under this section, consult with other
89 agencies of the commonwealth and the federal government, affected providers, and affected
90 payers, as applicable, to ensure that the reporting requirements imposed under the regulations are
91 not duplicative or excessive. If reporting requirements imposed by the division result in
92 additional costs for the reporting providers, these costs may be included in any rates promulgated
93 by the division for these providers. The division may specify categories of information which
94 may be furnished under an assurance of confidentiality to the provider; provided that such
95 assurance shall only be furnished if the information is not to be used for setting rates.

96 With respect to any acute or non-acute hospital, the division shall, by regulation,
97 designate information necessary to effect the purposes of this chapter including, but not be
98 limited to, the filing of a charge book, the filing of cost data and audited financial statements and

99 the submission of merged billing and discharge data. The division shall, by regulation, designate
100 standard systems for determining, reporting and auditing volume, case-mix, proportion of low
101 income patients and any other information necessary to effectuate the purposes of this chapter
102 and to prepare reports comparing acute and non-acute care hospitals by cost, utilization and
103 outcome. Such regulations may require such hospitals to file required information and data by
104 electronic means; provided, however, that the division shall allow reasonable waivers from such
105 requirement. The division shall, at least annually, publish a report analyzing such comparative
106 information for the purpose of assisting third-party payers and other purchasers of health services
107 in making informed decisions. Such report shall include comparative price and service
108 information relative to outpatient mental health services.

109 When collecting information or compiling reports intended to compare individual health
110 care providers, the commission shall require that:

111 (a) provider organizations which are representative of the target group for profiling shall
112 be meaningfully involved in the development of all aspects of the profile methodology, including
113 collection methods, formatting and methods and means for release and dissemination;

114 (b) the entire methodology for collecting and analyzing the data shall be disclosed to all
115 relevant provider organizations and to all providers under review;

116 (c) data collection and analytical methodologies shall be used that meet accepted
117 standards of validity and reliability;

118 (d) the limitations of the data sources and analytic methodologies used to develop
119 provider profiles shall be clearly identified and acknowledged, including, but not limited to, the
120 appropriate and inappropriate uses of the data;

121 (e) to the greatest extent possible, provider profiling initiatives shall use standard-based
122 norms derived from widely accepted, provider-developed practice guidelines;

123 (f) provider profiles and other information that have been compiled regarding provider
124 performance shall be shared with providers under review prior to dissemination; provided,
125 however, that opportunity for corrections and additions of helpful explanatory comments shall be
126 provided prior to publication; and, provided, further, that such profiles shall only include data
127 which reflect care under the control of the provider for whom such profile is prepared;

128 (g) comparisons among provider profiles shall adjust for patient case-mix and other
129 relevant risk factors and control for provider peer groups, when appropriate;

130 (h) effective safeguards to protect against the unauthorized use or disclosure of provider
131 profiles shall be developed and implemented;

132 (i) effective safeguards to protect against the dissemination of inconsistent, incomplete,
133 invalid, inaccurate or subjective profile data shall be developed and implemented;

134 (j) the quality and accuracy of provider profiles, data sources and methodologies shall
135 be evaluated regularly;

136 (k) providers shall be reimbursed for the reasonable costs that are required for
137 assembling, formatting and transmitting data and information to organizations that develop or
138 disseminate provider profiles; and

139 (l) the benefits of provider profiling shall outweigh the costs of developing and
140 disseminating the profiles.

141 Except as specifically provided otherwise by the division, insurer data collected by the
142 division under this section shall not be a public record under clause Twenty-sixth of section 7 of
143 chapter 4 or under chapter 66.

144 The division shall ensure that health care providers and payors that supply the data are
145 not charged any administrative fees for access to the data in accordance with the division's
146 requirements for protecting patient privacy, and guarding against utilization of the data for the
147 purpose of anti-competitive behavior.

148 SECTION 2. Chapter 6A of the General Laws is hereby amended by adding after section
149 16, the following new language:

150 16A. Health Care Claims Data

151 The division of health care finance and policy shall be the sole repository for health care
152 data collected pursuant to Section 6 of Chapter 118G. All other agencies, authorities, councils,
153 boards, and commissions of the commonwealth seeking health care data that is collected by the
154 division shall utilize such data prior to requesting any data from health care providers and payers.
155 The division may enter into interagency services agreements for transfer and use of the data.