HOUSE DOCKET, NO. 02030 FILED ON: 01/20/2011

HOUSE . . . . . No. 02081

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 bill:

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*

HOUSE . . . . . No. 02081

By Mr. Conroy of Wayland, a petition (accompanied by bill, House, No. 2081) of Sullivan and Conroy 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.
 Joint Committee on Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

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:

SECTION 1.

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

Section 6. (a). There shall be established a reviewing committee to govern the administration of the division's all-payer claims data base. The reviewing committee shall be comprised of representatives from the hospital, health plan and provider communities, and shall include, but not be limited to the following: a representative of the Massachusetts Hospital Association, a representative of Blue Cross and Blue Shield of Massachusetts, a representative of the Massachusetts Association of Health Plans, and a representative of the Massachusetts Medical

Society. The reviewing committee shall be responsible for advising the division on the standards for release and use of the data submitted, and shall ensure that such standards protect patient privacy, and guard against utilization of the data for the purpose of anti-competitive behavior.

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

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

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

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

The division shall require the submission of data and other information from each private health care payer offering small or large group health plans including, but not limited to: (i) average annual individual and family plan premiums for each payer's most popular plans for a representative range of group sizes, as further determined in regulations and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology, and collected under section 21 of chapter 176O; (v) information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels; (vii) health status adjusted total medical expenses by provider group and local

practice group and zip code calculated according to a uniform methodology; (viii) relative prices paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider and calculated according to a uniform methodology; and (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16A. Health Care Claims Data

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