

**HOUSE . . . . . No. 495**

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**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:

*Daniel Cahill*

DISTRICT/ADDRESS:

*10th Essex*

**HOUSE . . . . . No. 495**

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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.

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**The Commonwealth of Massachusetts**

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

1           SECTION 1. Paragraph (c) of section 14 of chapter 12C of the General Laws, as  
2 appearing in the 2014 Official Edition, is hereby amended by striking out the fourth sentence and  
3 inserting in place thereof the following sentence:--

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

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

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

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

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

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

53 SECTION 4. Chapter 118E, as so appearing, is hereby amended by striking out section  
54 13B and inserting in place thereof the following section:--

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

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

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

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

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

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

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

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

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

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

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

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