SUBCHAPTER X. Evaluation of Network Physicians and Providers
28 TAC §21.3202

1. INTRODUCTION. The Texas Department of Insurance adopts new §21.3202, concerning requirements for health benefit plan issuers that utilize rankings, tiers, ratings or other comparisons of a physician's performance against standards, measures or other physicians. The new section is adopted with changes to the proposed text published in the November 27, 2009 issue of the *Texas Register* (34 TexReg 8455).

2. REASONED JUSTIFICATION. The new section is necessary to implement House Bill (HB) 1888, 81st Legislature, Regular Session. HB 1888 amends the Insurance Code, Subtitle F, Title 8, by adding Chapter 1460 to address standards required for certain rankings of physicians by health plans.

The legislative history of HB 1888 provides significant insight into the purpose and intent of the newly added Chapter 1460. In April 2008, the Consumer-Purchaser Disclosure Project (CPDP), a coalition of business organizations and consumer advocates formed to develop a fair and comprehensive measurement system, released the "Patient Charter for Physician Performance Measurement, Reporting, and Tiering Programs" (Patient Charter) to address the issue of determining a process for ranking and tiering physicians. One criterion of the Patient Charter states "[p]erformance reporting for consumers should include both quality and cost-efficiency information. While quality information may be reported in the absence of cost-efficiency, cost-efficiency information should not be reported without accompanying quality information."

To this criterion, a footnote provides “these criteria do not apply to pure cost comparison or shopping tools that estimate costs for specific procedures or treatments, so long as it is made clear to the public that such tools and information are based solely on cost or price.” The legislative history for HB 1888 also includes a Legislative Budget Board report submitted to the 81st Texas Legislature recommending an amendment to the Texas Insurance Code to require all insurers adopting physician ranking systems to meet the standards detailed in the CPDP for Physician Performance Measurement, Reporting, and Tiering Programs. (Texas Legislative Budget Board Staff, “Texas State Government Effectiveness and Efficiency” at 307 (January 2009)). Consequently, the enrolled version of HB 1888 adds the Insurance Code §1460.005 to require the Commissioner to consider the standards, guidelines, and measures prescribed by nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care for rules adopted under the Insurance Code §1460.005.

The Insurance Code §1460.003(a)(1) and (2) provides that a health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician’s performance against standards, measures, or other physicians, unless: (i) the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines adopted by the Commissioner; (ii) the standards and measurements to be used by the health benefit plan issuer are disclosed to each affected physician before any evaluation

period used by the benefit plan issuer; and (iii) each affected physician is afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that, at a minimum, includes due process protections that conform to the protections specified in the Insurance Code §1460.003(a)(3)(A) - (D).

The Insurance Code §1460.001(1) defines “health benefit plan issuer” to mean an entity authorized under the Insurance Code or another insurance law of this state that provides health insurance or health benefits in this state, including: (i) an insurance company; (ii) a group hospital service corporation operating under Chapter 842; (iii) a health maintenance organization operating under Chapter 843; and (iv) a stipulated premium company operating under Chapter 884. The Insurance Code §1460.002 provides that Chapter 1460 does not apply to: (i) a Medicaid managed care program operated under Chapter 533, Government Code; (ii) a Medicaid program operated under Chapter 32, Human Resources Code; (iii) the child health plan program under Chapter 62, Health and Safety Code or the health benefits plan for children under Chapter 63, Health and Safety Code; or (iv) a Medicare supplement benefit plan, as defined by Chapter 1652. New §21.3202(b)(2)(B) further provides that this section does not apply to a Medicare plan offered pursuant to Title XVIII, Part C and D of the Social Security Act. This adopted exemption is necessary to clarify the inapplicability of this new section to Medicare plans. It is adopted as an additional exemption to those specified in the Insurance Code §1460.002 pursuant to the Commissioner’s authority in the Insurance Code §1460.005 to adopt rules as necessary to implement this chapter.

Medicare plans under Parts C and D of Title XVIII of the Social Security Act are regulated pursuant to federal law and are not subject to state law regulation as provided in 42 U.S.C. §1395w-26(b)(3) and 42 U.S.C. §1395w-112(g). This exemption is necessary for the proper and unambiguous implementation of Chapter 1460 of the Insurance Code.

The Insurance Code §1460.005(a) requires the Commissioner to adopt rules as necessary for compliance by a health benefit plan issuer that uses a physician ranking system. The Commissioner, in adopting these rules, is required to consider guidelines, standards and measures prescribed by nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care, including the National Quality Forum (NQF) and the AQA Alliance. If neither the NQF nor the AQA Alliance has established standards or guidelines regarding an issue, the Commissioner is required to consider the standards, guidelines, and measures prescribed by the National Committee on Quality Assurance (NCQA) and other similar national organizations. If the NQF, AQA Alliance or other national organizations do not have established standards or guidelines for an issue, the Commissioner is required to consider standards, guidelines, and measures based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship. Section 1460.006 requires health benefit plan issuers to ensure that physicians currently in clinical practice are actively involved in the development of the standards used under Chapter 1460. Section 1460.006 further requires that the measures and methodology

used in the comparison programs described by the Insurance Code §1460.003 are transparent and valid.

On September 30, 2009, the Department posted a draft rule for informal comment, concerning requirements for health benefit plan issuers that utilize rankings, tiers, ratings or other comparisons of a physician's performance against standards, measures or other physicians. The Department held a meeting on October 8, 2009, for stakeholder comments. The informal comment period ended on October 9, 2009. On November 16, 2009, the Department filed a proposed rule for comment, which was published in the November 27, 2009, issue of the *Texas Register* (34 TexReg 8455). The proposal comment period ended on December 28, 2009. In response to written comments received from interested parties, the Department has changed some of the proposed language in the text of the rule as adopted. However, none of the changes to the proposed text materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

The following changes are made to the proposed text. The Department made a nonsubstantive change to new §21.3202(b)(2), adding a colon after *to*. New §21.3202(c) is added in response to comment to clarify that a health benefit plan issuer may not rank, tier, or publish physician-specific information as described in the Insurance Code §1460.003 unless the standards used by the issuer meet the requirements of new §21.3202. The addition of new §21.3202(c) is necessary to reduce ambiguity as to the scope of the section. Section 21.3202(c) – (f) as proposed are redesignated as new §21.3202(d) – (g) in this adoption as a result of this addition.

Section 21.3202(e), proposed as §21.3202(d), is changed in response to comment. If a standard regarding an issue has not been endorsed by the NQF or AQA Alliance, the Insurance Code §1460.005(c) requires the Commissioner to consider both the standards prescribed by the NCQA and the standards of other similar national organizations in adopting rules under §1460.005. To increase consistency between the subsection and the Insurance Code §1460.005(c), new §21.3202(e) is, therefore, changed to include the standards of national organizations similar to the NCQA among the standards that a health benefit plan issuer using a physician ranking system must use in the absence of an applicable standard as endorsed by the NQF or the AQA Alliance. Section 21.3202(f), proposed as §21.3202(e), is changed in response to comment, for consistency with new §21.3202(e), and for consistency with the Insurance Code §1460.003 and §1460.005. If a standard or guideline regarding an issue has not been established by the NQF, the AQA Alliance, or other national organizations, the Insurance Code §1460.005(c) requires the Commissioner to consider standards, guidelines, and measures based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship in adopting rules under §1460.005. Additionally, the Insurance Code §1460.003(a)(1) provides that a health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparison’s of a physician’s performance against standards, measures, or other physicians unless the standards used by the health benefit plan

issuer conforms to nationally recognized standards and guidelines as required by rules adopted under Section 1460.005 of the Insurance Code. New §21.3202(f) clarifies that a health benefit plan issuer using a physician ranking system is required to use measures, guidelines, and standards based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship standards adopted by the Commissioner only if the NQF, AQA Alliance, or other national organizations, including NCQA, have not established applicable standards or guidelines regarding an issue. Therefore, any interested person that wants a health benefit plan issuer to use measures, guidelines, and standards based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship to rank physicians regarding an issue not addressed by NQF, AQA Alliance, or other national guidelines, may file a petition for rule making with the Department pursuant to the Government Code §2001.021 to request that the Commissioner consider the adoption of other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship standards for use in a health benefit plan issuer's physician ranking system. Section 21.3202(g)(1) - (2), proposed as §21.3202(f)(1) – (2), are changed in response to comment to clarify the scope of a health benefit plan issuer's duties under the subsection. New §21.3202(g) clarifies that the issuer's duties with respect to the transparency and validity of comparison programs and physician participation in the development of standards apply to the issuer's comparison program that is based upon

the nationally recognized standards, as described in the Insurance Code §1460.003. The Department has made a nonsubstantive change to new §21.3202(g)(1), proposed as subsection (f)(1), by changing “practices” to “practice” for consistency with the term as provided in the Insurance Code §1460.006(1). The Department has also made a nonsubstantive change to §21.3202(g)(1), proposed as subsection (f)(1), by adding a semicolon before *and*. The Department also made a nonsubstantive change to new §21.3202(g)(2), proposed as subsection (f)(2), by changing “programs” to “program” to clarify that the subsection applies to the health benefit plan issuer’s comparison program.

3. HOW THE SECTION WILL FUNCTION.

§21.3202. Physician Ranking Requirements. Section 21.3202 states the standards, measures and guidelines that health benefit plan issuers are required to utilize for their physician ranking systems.

§21.3202(a). Purpose. Section 21.3202(a) states the purpose of the section, which is to specify the standards and guidelines that are necessary to ensure that a health benefit plan issuer, including a subsidiary or affiliate, that utilizes rankings, tiers, ratings or other comparisons of a physician’s performance against standards, measures, or other physicians, uses a nationally recognized physician ranking system that emphasizes quality of health care in accordance with the Insurance Code §1460.005.

§21.3202(b). Applicability. Section 21.3202(b) addresses the applicability of the new section, including exemptions.

§21.3202(c). Section 21.3202(c) provides that the health benefit plan issuer may not rank, tier, or publish physician-specific information unless the standards used by the health benefit plan issuer meet the requirements of the section.

§21.3202(d). National Quality Forum (NQF) or AQA Alliance. Section 21.3202(d) provides that if a health benefit plan issuer uses a physician ranking system, it is required to follow the endorsed measures, guidelines, and standards of either the National Quality Forum (NQF) or the endorsed measures, guidelines, and standards of the AQA Alliance. Under this provision, the health benefit plan issuer may utilize either the NQF or AQA endorsed measures, guidelines, and standards regarding an issue involved in the physician ranking process.

§21.3202(e). National Committee on Quality Assurance (NCQA) and Other Similar National Organizations. Section 21.3202(e) provides that if neither the NQF nor the AQA Alliance has an endorsed measure, guideline, and standard regarding an issue, the health benefit plan issuer is required to follow the endorsed measures, guidelines, and standards of the NCQA and other similar national organizations.

§21.3202(f). Other Guidelines, Quality Standards, and Clinical Evidence. Section 21.3202(f) provides that if the NQF, AQA Alliance, or other national organizations have not established standards or guidelines regarding an issue, the health benefit plan issuer is required to follow measures, guidelines, and standards based on other bona fide nationally recognized guidelines, expert-based physician

consensus quality standards, or leading objective clinical evidence and scholarship standards adopted by the Commissioner.

§21.3202(g). Duties of Health Benefit Plan Issuer. Section 21.3202(g)(1) and (2), requires a health benefit plan issuer to ensure that physicians currently in clinical practice are actively involved in the development of the standards used in the health benefit plan issuer's comparison program and that the measures and methodology used in the health benefit plan issuer's comparison program are transparent and valid.

The amended subchapter title, *Evaluation of Network Physicians and Providers,* reflects the additional content of the subchapter.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General comment.

Comment: A commenter agrees with the proposed rule published in the *Texas Register.*

Agency Response: The Department appreciates the supportive comment.

Notice and due process requirements.

Comment: One commenter states that the Insurance Code §1460.003(a)(3)(A) requires that the notice from the health benefit plan issuer to a provider of its proposed rating, ranking, tiering, or comparison include the methodologies, data, and all other information utilized by the health benefit plan issuer in its rating, tiering, ranking, or comparison decision. The commenter recommends that proposed §21.3202 provide

further clarification on the nature and extent of data that must be provided in the notice required by the Insurance Code §1460.003(a)(3)(A).

Agency Response: The Department does not agree that further clarification concerning the nature and extent of data that must be provided in the written notice to the physician of the proposed rating, ranking, tiering, or comparison is necessary at this time. The Insurance Code §1460.003 adequately states the nature and extent of data that health benefit plan issuers are required to provide to each affected physician before any publication or other public dissemination. In relevant part, the Insurance Code §1460.003(a)(3)(A) states that "the health benefit plan issuer provides at least 45 days' written notice to the physician of the proposed rating, ranking, tiering, or comparison, including the methodologies, data, and all other information utilized by the health benefit plan issuer in its rating, tiering, ranking or comparison decision." However, as a result of the concern expressed regarding the nature and extent of data that must be provided to each affected provider, the Department will continue to monitor compliance with the due process provisions in the Insurance Code §1460.003 to determine the necessity for future rulemaking.

Comment: A commenter recommends that the Department add a new section regarding the new notice and due process requirements under the Insurance Code §1460.003 that health benefit plan issuers are required to follow when ranking physicians. The commenter states that the notice requirements are critical to ensuring fairness of the rankings to physicians and should be reflected in the adopted rules as well as the statute in order to provide appropriate guidance to health benefit plan

issuers choosing to rank physicians. The commenter recommends the addition of a new section incorporating language included in the Department's informal draft to specifically address: (i) a requirement of written notice to a participating physician describing the comparison program to be used prior to any evaluation period as required by the Insurance Code 1460.003; (ii) a requirement that the participating physician be afforded opportunity for a written, telephonic, or in person fair reconsideration process as required by the Insurance Code 1460.003; and (iii) a requirement that the health benefit plan issuer provide notice of a proposed rating, ranking, tiering, or comparison to the physician no less than 45 days prior to publication, including the methodologies, data, and all other information used by the issuer in its decision.

The commenter states uncertainty as to the reason for the removal of the language in the proposed rule. The commenter further opines that some carriers intend to use old data to rank physicians in contravention of the statutory requirements under the Insurance Code §1460.003(a)(2). The commenter requests the Department's assurance that the statute's requirements that data be used prospectively and with proper notice will be enforced. The commenter states that inclusion of this requirement in the rules would demonstrate the Department's commitment to holding plans to the requirements under the law and ensure a fair review process, including due process rights, for physicians. The commenter explains that a physician must have the relevant information used by the plan to challenge an inappropriate ranking. The commenter also states that the recommended language closely tracks the statutory language in the

Insurance Code §1406.003(a)(3)(A) which provides that the physician is entitled to "at least 45 days' written notice ... of the proposed rating, ranking, tiering, or comparison, including the methodologies, data, and all other information utilized by the health benefit plan issuer in its rating, tiering, ranking, or comparison decision…"

Agency Response: The Department disagrees that it is necessary to restate the due process provisions of the Insurance Code §1460.003 in this adopted rule. The Insurance Code §1460.003 provides the due process requirements with which health benefit plan issuers must comply before ranking or classifying physicians into tiers based on performance, or publishing physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians. Furthermore, the Department does not agree that restating the Insurance Code §1460.003 in the adopted rule is necessary to subject health benefit plan issuers to its requirements. The Insurance Code §1460.007(a) sufficiently informs a health benefit plan issuer that a violation of the Insurance Code, Chapter 1460 or a rule adopted under the Insurance Code Chapter 1460 would subject the health benefit plan issuer to sanctions and disciplinary actions under the Insurance Code Chapters 82 and 84. However, as a result of the concern expressed regarding the due process protections that must be provided to each affected provider, the Department will continue to monitor compliance with the due process provisions in the Insurance Code §1460.003 to determine the necessity for future rulemaking.

Scope of §21.3202.

Comment: A commenter states its support of the proposed language in §21.3202(a) providing that the purpose of the section is to specify the standards and guidelines necessary to ensure the use of to use of a nationally recognized physician ranking system that emphasizes quality of health care by those health benefit plan issuers that use rankings, tiers, ratings or other comparisons of a physician's performance against standards, measures, or other physicians. The commenter asserts that proposed §21.3202(a) is consistent with the Insurance Code §1460.005. The commenter further requests that the Department clarify that the phrase "emphasizes quality of health care" as used in this subsection indicates the Department's intent that: (i) the requirements of the section apply to any standard, measure, or guideline used to rank physicians whether quality, cost, or efficiency-based; and (ii) the source of the guidelines must emphasize quality of care and not solely or primarily focus on cost, efficiency, or other concerns. The commenter explains that under HB 1888, a physician ranking system may not be solely or primarily based on cost or efficiency because the Insurance Code §1460.005(c) requires any nationally recognized physician ranking system used to emphasize quality of health care. The commenter further requests clarification concerning the same issue based upon the Public Benefit/Cost Note portion of the proposal. Specifically, the proposal provides that "[t]he public benefits anticipated as a result of the proposed new sections will be a fair, consistent, efficient, and transparent system of physician ranking that is based on nationally recognized *quality* measures and that emphasizes quality of health care. (emphasis added)." The commenter states

that the preamble would be more accurate if it stated that "[t]he public benefits anticipated as a result of the proposed new sections will be a fair, consistent, efficient and transparent system of physician ranking that is based on nationally recognized measures and that emphasize quality of care." The commenter states that all physician ranking measures based on cost, efficiency, or quality must satisfy the standards imposed by HB 1888. Another commenter states that the Insurance Code Chapter 1460 does not prohibit a health benefit plan issuer comparison program from including a rating, ranking, or tiering based on cost. The commenter recommends that proposed §21.3202 clarify that rating, ranking, or tiering a physician by a health benefit plan issuer based on cost is permissible provided there is compliance with the other requirements of the Insurance Code Chapter 1460 and the adopted rule.

Agency Response: The Department appreciates the support regarding the adopted language in §21.3202(a). The Department agrees that there is no prohibition in the Insurance Code Chapter 1460 or new §21.3202 against rating, ranking, or tiering based on cost by a health benefit plan issuer. The Department also agrees, however, that a health benefit plan issuer is required to follow the endorsed measures, guidelines, and standards of nationally recognized ranking systems that emphasize quality of health care in the order specified under new §21.3202 to determine how to assess a physician's performance using quality measures in conjunction with other measures, including cost and efficiency. The purpose of the rule, as explained in §21.3202(a), is to specify the standards and guidelines that are necessary to ensure that a health benefit plan issuer, including a subsidiary or affiliate, that utilizes rankings, tiers, ratings or other

comparisons of a physician's performance against standards, measures, or other physicians, uses a nationally recognized physician ranking system that emphasizes quality of health care, in accordance with the Insurance Code §1460.005. The phrase "emphasizes quality of health care," is consistent with the Insurance Code §1460.005(c), which requires the Department to consider the standards, guidelines, and measures prescribed by certain nationally recognized organizations that establish or promote guidelines and performance measures emphasizing quality of health care. The phrase "emphasizing quality of health care" as used in the Insurance Code §1460.005(c) evidences a legislative intent that a health benefit plan issuer that ranks physicians according to the nationally recognized standards and guidelines required by rule may evaluate a physician's performance using other measures in conjunction with the assessment of the quality of the health care. New §21.3202 provides the framework within which a health benefit plan issuer must incorporate such measures when used. In response to these and related comments, new §21.3202(c) is added to clarify that a health benefit plan issuer may not rank, tier, or publish physician-specific information as described in the Insurance Code §1460.003 unless the standards used by the issuer meet the requirements of §21.3202. The Department also agrees that the public benefit anticipated as a result of the proposed new section will be a fair, consistent, efficient, and transparent system of physician ranking as described in the Insurance Code §1460.003.

Comment: A commenter recommends inclusion of an additional subsection to reflect the general application of HB 1888 to all rankings of physicians in Texas, regardless of

the use of efficiency, quality, or cost measures, for three reasons. The first reason cited by the commenter in support of a statement of general application is that such a statement is supported by legislative history. The commenter states that both the House Committee Report and the Senate Committee Report indicate that HB 1888 is intended to apply to all standards used in physician ranking systems. The commenter explains that both reports state that "[i]n recent years, many health insurance companies have developed ranking systems to measure the quality and efficiency of physicians. The goal of these systems is to allow health plans and consumers to choose higher-quality and more efficient providers." The commenter states that the House and Senate reports mention the Consumer-Purchaser Disclosure Project and its "Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs." The commenter further asserts that the Patient Charter contains the following statement: "Performance reporting for consumers should include both quality and cost-efficiency information. While quality information may be reported in the absence of cost-efficiency, cost-efficiency information should not be reported without accompanying quality information." The commenter asserts that these statements of legislative intent are evidence that the terms of HB 1888 are intended to regulate cost-efficiency measures as well as quality measures. The second reason cited by the commenter is that the Insurance Code §1460.003(a) requirements for a health benefit plan issuer to conform to nationally recognized standards and guidelines and disclose the standards and measurements to be used by the issuer have no words of limitation supporting application of those requirements to quality measures alone. The third

reason cited by the commenter in support of a statement of general application is that the National Quality Forum is in the process of adopting several efficiency standards, and clarification concerning the scope of application of the Insurance Code §§1460.003, 1460.005, and 1460.006 is necessary to ensure the provisions are properly applied. The commenter specifically recommends the addition of language stating that the health benefit plan issuer may not rank, tier or publish physician-specific information unless the standards used by the health benefit plan issuer meet the requirements of the regulation.

Agency Response: The Department agrees that the legislative history provides background information for the purpose and intent of HB 1888. The Department further agrees that the reference to the CPDP provides insight into the background of HB 1888 and that a health benefit plan issuer ranking system based solely on cost would not be compliant with the adopted rule. The phrase “emphasizing quality of health care” as used in the Insurance Code §1460.005(c) evidences a legislative intent that a health benefit plan issuer that ranks physicians according to the nationally recognized standards and guidelines required by rule may evaluate a physician’s performance using other measures in conjunction with the assessment of the quality of the health care. New §21.3202 provides the framework within which a health benefit plan issuer must incorporate such measures when used. Therefore, the Department agrees that when a health benefit plan issuer ranks physicians using quality of health care measures and other measures allowed by the nationally recognized standards and guidelines adopted under §21.3202, the provisions of the Insurance Code §1460.003

pertaining to the physician ranking requirements, §1460.005 pertaining to the rules and standards, and §1460.006 pertaining to the health benefit plan issuer requirements apply to the other measures used by the issuer in conjunction with the assessment of the quality of the health care. In response to these and related comments, new §21.3202(c) is added to clarify that a health benefit plan issuer may not rank, tier, or publish physician-specific information as described in the Insurance Code §1460.003 unless the standards used by the issuer meet the requirements of §21.3202. This language is consistent with the Insurance Code §1460.003(a) which provides that a health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians unless there is compliance with statutory due process provisions afforded to affected physicians and the rules adopted by the Commissioner under §1460.005. This added language is also consistent with §1460.007(a), which provides that a health benefit plan issuer that violates Chapter 1460 or a rule adopted under this chapter is subject to sanctions and disciplinary actions under Chapters 82 and 84.

§21.3202(c) - (e) As Proposed Are Redesignated As §21.3202(d) - (f). Hierarchy of Nationally Recognized Measures, Guidelines and Standards.

Comment: A commenter states that the language regarding the hierarchy of standards contained in subsection (c) as proposed reflects that a health benefit plan issuer must first either use the endorsed measures, guidelines and standards of the NQF or the

AQA Alliance if either of these organizations have a standard on the particular issue. The commenter agrees that this subsection as proposed is consistent with Insurance Code, Section 1460.005(c). The commenter opines that the Insurance Code §1460.005(c) does not permit automatic approval of the NCQA measures if the NQF and AQA Alliance do not have an endorsed measure regarding a particular issue. Rather, the commenter states that the Insurance Code §1460.005(c) requires the Commissioner to consider both the NCQA's standards and the standards of "other similar national organizations", if a standard has not been endorsed by the NQF or AQA Alliance. The commenter, therefore, recommends that §21.3202(d) as proposed be revised for consistency with §1460.005(c).

A commenter states that subsection (e) as proposed is not consistent with the Insurance Code §1460.005(c), which provides that "[i]f neither the National Quality Forum, nor the AQA Alliance, nor other national organizations have established standards or guidelines regarding an issue, the Commissioner shall consider standards, guidelines and measures based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship." The commenter asserts that §1460.005(c) relates to "other national organizations" and not just to NCQA to address the use of measures that are not organizationally-tied when there are no measures developed by the NQF, AQA Alliance, or other national organizations (including the NCQA). The commenter recommends a revision of subsection (e) for consistency with §1460.005(c).

Agency Response: The Department appreciates the supportive comment concerning subsection (c) as proposed which the Department has redesignated as new subsection (d). Further, the Department agrees that the Insurance Code §1460.005(c) requires the Commissioner to consider the standards of both the NCQA and the standards of other similar national organizations if neither the NQF nor AQA Alliance has established standards or guidelines regarding an issue. Therefore, the Department has changed §21.3202(d) as proposed, redesignated as §21.3202(e), for consistency with the Insurance Code §1460.005(c) to read "[i]f neither the NQF nor the AQA Alliance has an endorsed measure, guideline, and standard regarding an issue, the health benefit plan issuer is required to follow the endorsed measures, guidelines, and standards of the NCQA and other similar national organizations." The Department further agrees that the use of "national organizations" includes, but is not limited to NCQA. Accordingly, §21.3202(e) as proposed, redesignated as new §21.3202(f), is changed to read, "If the NQF, AQA Alliance, or other national organizations have not established standards or guidelines regarding an issue, the health benefit plan issuer is required to follow measures, guidelines, and standards based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship standards adopted by the Commissioner." This added language to new §21.3202(f) clarifies that a health benefit issuer using a physician ranking system may use measures, guidelines, and standards based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship standards adopted by the

Commissioner, when the NQF, AQA Alliance, or other national organizations, including NCQA, have not established applicable standards or guidelines regarding an issue. Therefore, any interested person that wants a health benefit plan issuer to use measures, guidelines, and standards based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship to rank physicians regarding an issue not addressed by the NQF, AQA Alliance, or other national guidelines may file a petition for rule making with the Department pursuant to the Government Code §2001.021 to request that the Commissioner consider the adoption of other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship standards for use in a health benefit plan issuer's physician ranking system.

§21.3202(g)(1) and (g)(2).

Comment: A commenter requests clarification of language in the Statutory Authority portion of the proposal that "Section 1460.006 requires health benefit plan issuers to ensure that quality guidelines are developed with the input of currently practicing physicians and are transparent and valid." The commenter asserts that this statement from the proposal does not accurately reflect the Insurance Code §1460.006 and incorrectly implies that only quality guidelines (and not efficiency or cost guidelines) must be developed with the input of practicing physicians and be transparent and valid. The commenter states that the Insurance Code §1460.006 imposes the duty on health plans to ensure that any guidelines used to rank physicians, and not only quality

guidelines: (i) are developed with the input of currently practicing physicians; and (ii) are transparent and valid (as well as satisfying the hierarchy requirements of §1460.003 and proposed rule subsections §21.3202(c) - (e) as proposed). Another commenter states that the requirement in the Insurance Code §1460.006 for the active involvement of physicians in clinical practice in the development of the comparison program standards utilized by a health benefit plan issuer refers to each issuer's unique program standards and not the nationally recognized standards, such as NQF, AQA Alliance, NCQA, etc., on which those programs must be based. The commenter believes a health benefit plan issuer has no control over whether physicians in clinical practice are involved in the development of such national standards. However, the commenter states that the issuers can ensure that physicians in clinical practice are involved in the development of the issuer's program standards which must be based on those national standards. The commenter recommends a revision of §21.3202(f)(1) as proposed to state that "physicians currently in clinical practice are actively involved in the development of the standards used in the health plan issuer's comparison program." Another commenter requests clarification of language at 34 TexReg 8458 (2009) which states that "Section 1460.006 requires health benefit plan issuers to ensure that quality guidelines are developed with the input of currently practicing physicians and are transparent and valid." The commenter states that the language does not accurately reflect the Insurance Code §1460.006. The commenter states that the Insurance Code §1460.006 imposes the duty on health plans to ensure that any guidelines used to rank physicians are developed with the input of currently practicing physicians, are

transparent and valid (as well as satisfying the hierarchy requirements of §1460.003 and subsections (c), (d), and (e) as proposed. The preamble incorrectly implies that only quality guidelines (and not efficiency or cost guidelines) must be developed with the input of practicing physicians and be transparent and valid. This limitation of the health plan's duties to only quality guidelines is not supported by the language of the statute.

Agency Response: The Department agrees that a health benefit plan issuer is required to ensure that physicians currently in clinical practice are actively involved in the development of the comparison program standards created by the health benefit plan issuer. The description of statutory authority in the proposal concerning the Insurance Code §1460.006 does not indicate a Department position that physician input is only necessary as to quality guidelines. The Department clarifies that §21.3202(f) as proposed, redesignated as §21.3202(g), requires that a health benefit plan issuer ensure that physicians currently in clinical practice are actively involved in the development of the comparison program standards created by the health benefit plan issuer and that the measures and methodologies used in the health benefit plan issuer comparison program described by the Insurance Code §1460.003 are transparent and valid as provided in the Insurance Code §1460.006. The Insurance Code §1460.003(a)(1) provides that a health benefit plan issuer may not rank physicians, classify physicians into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians, unless the standards

used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted under the Insurance Code §1460.005. Therefore, the comparison program standards used by the health benefit plan issuer are required to conform to the nationally recognized standards and guidelines as required by the adoption of new §21.3202. The Department has redesignated §21.3202(f)(1) as proposed to subsection (g)(1), to read, "physicians currently in clinical practice are actively involved in the development of the standards used in the health plan issuer's comparison program." As a result of this clarification, it is further necessary to redesignate subsection (f)(2) as proposed, to subsection (g)(2), and delete the reference to "subsections (c) - (e)," which in the proposal of this rule pertained to the nationally recognized physician ranking systems adopted by the Commissioner. New §21.3202(g)(2) is accordingly changed to read "the measures and methodology used in the health benefit plan issuer's comparison program are transparent and valid."

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: Texas Association of Health Plans

For with changes: Blue Cross Blue Shield of Texas; Texas Medical Association

6. STATUTORY AUTHORITY. The sections are adopted pursuant to the Insurance Code §§1460.003, 1460.005, 1460.006 and 36.001. Section 1460.003 prohibits health benefit plan issuers from engaging in physician ranking unless the issuer utilizes standards adopted by the Commissioner and prescribes the notice and process

requirements to be followed by health benefit plan issuers in performing their physician ranking procedures. Section 1460.005 authorizes the Commissioner to adopt rules to ensure that a health benefit plan issuer that uses a physician ranking system utilizes nationally recognized standards, guidelines and measures that emphasize quality of health care. The Commissioner, in adopting these rules, is required to consider the guidelines, standards and measures of nationally recognized organizations, including the National Quality Forum (NQF) and the AQA Alliance. If neither the NQF nor the AQA Alliance has established standards or guidelines regarding an issue, the Commissioner shall consider the standards, guidelines, and measures prescribed by the National Committee on Quality Assurance (NCQA) and other similar national organizations. If the NQF, AQA Alliance, NCQA, or other national organizations do not have established standards or guidelines regarding an issue, the Commissioner is required to consider standards, guidelines, and measures based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship. Section 1460.006 provides that a health benefit plan issuer shall ensure that physicians currently in clinical practice are actively involved in the development of the standards used under the Insurance Code Chapter 1460, and that the measures and methodology used in the comparison programs described by the Insurance Code Section 1460.003 are transparent and valid. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

SUBCHAPTER X. Evaluation of Network Physicians and Providers

§21.3202. Physician Ranking Requirements.

(a) Purpose. In accordance with the Insurance Code §1460.005, this section specifies the standards and guidelines that are necessary to ensure that a health benefit plan issuer, including a subsidiary or affiliate, that utilizes rankings, tiers, ratings or other comparisons of a physician's performance against standards, measures, or other physicians, uses a nationally recognized physician ranking system that emphasizes quality of health care.

(b) Applicability.

(1) This section applies to a health benefit plan issuer as defined in the Insurance Code §1460.001.

(2) This section does not apply to:

(A) a plan specified in the Insurance Code §1460.002; or

(B) a Medicare plan offered pursuant to Title XVIII, Part C and D of the Social Security Act.

(c) General Prohibition. A health benefit plan issuer may not rank, tier or publish physician-specific information unless the standards used by the health benefit plan issuer meet the requirements of this section.

(d) National Quality Forum (NQF) or AQA Alliance. A health benefit plan issuer that uses a physician ranking system is required to follow the endorsed measures,

guidelines, and standards of the NQF or the endorsed measures, guidelines, and standards of the AQA Alliance.

(e) National Committee on Quality Assurance (NCQA) and Other Similar National Organizations. If neither the NQF nor the AQA Alliance has an endorsed measure, guideline, and standard regarding an issue, the health benefit plan issuer is required to follow the endorsed measures, guidelines, and standards of the NCQA and other similar national organizations.

(f) Other Guidelines, Quality Standards, and Clinical Evidence. If the NQF, AQA Alliance, or other national organizations have not established standards or guidelines regarding an issue, the health benefit plan issuer is required to follow measures, guidelines, and standards based on other bona fide nationally recognized guidelines, expert-based physician consensus quality standards, or leading objective clinical evidence and scholarship standards adopted by the Commissioner.

(g) Duties of Health Benefit Plan Issuer. In accordance with the Insurance Code §1460.006, a health benefit plan issuer using a comparison program as described in the Insurance Code §1460.003 shall ensure that:

(1) physicians currently in clinical practice are actively involved in the development of the standards used in the health benefit plan issuer’s comparison program; and

(2) the measures and methodology used in the health benefit plan issuer’s comparison program are transparent and valid.