SENATE DOCKET, NO. 278 FILED ON: 1/15/2013

SENATE . . . . . No. 510

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:	DISTRICT/ADDRESS:
Cynthia S. Creem	*First Middlesex and Norfolk*

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SENATE . . . . . No. 510

By Ms. Creem, a petition (accompanied by bill, Senate, No. 510) of Cynthia S. Creem for legislation relative to insurance companies and quality measures. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *494* OF 2011-2012.]

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

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:

Purpose: Increasingly insurers and health plans have developed insurance and managed care products that include performance evaluations of health care providers. Physician performance evaluation is used for a number of purposes, which range from quality improvement to pay for performance to public reporting to tiering of networks. The consequence of inaccuracies varies in severity according to the purpose for using the information. Inaccurate information that may be used to select physicians may have significant unintended consequences for all healthcare stake holders, but especially for physicians and their patients. Inaccuracy interferes with the process of promoting change, as well and may also misdirect attention to costs or interventions that were mistakenly reported at a higher or lower than actual rate. Consequently each purpose requires a rigor in the development of mechanisms to evaluate physician performance in order to generate accurate, valid and meaningful results and to prevent damage to the patient physician relationship.

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

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

18 (k) "Cost efficiency", the degree to which health services are utilized to achieve a given
19 outcome or given level of quality.

20 (l) "Physician performance evaluation", a system designed to measure the quality, and
21 cost efficiency of a physician's delivery of care and shall include quality improvement programs,
22 pay for performance programs, public reporting on physician performance or ratings' and the use
23 of tiering networks.

24 SECTION 2. Section 21 of Chapter 32A of the General Laws, as appearing the 2010
25 Official Edition, is hereby amended by inserting at the end thereof, the following:-

26 "The commission shall not implement or contract with a carrier as defined in section 1 of
27 Chapter 1760 for the implementation of a physician performance evaluation program as defined
28 in section one unless the program has the following minimum attributes:

29 (1) Public disclosure regarding the methodologies, criteria and algorithms under
30 consideration, 180 days before any performance evaluations of physicians are applied;

31 (2) Meaningful input by independent practicing physicians and biostatisticians in a timely
32 fashion that will ensure the measures being used are clinically important and understandable to
33 patients and physicians and the tools used for performance evaluations are fair and appropriate;

34 (3) A mechanism to ensure data accuracy and validity that includes a feedback cycle of
35 not less than 120 days prior to the public reporting of the data, which accepts corrections to
36 errors from multiple sources, including the physician being evaluated, assesses the causes of the
37 error(s) and improves the overall evaluation system;

38 (4) A mechanism to provide the physician being evaluated with patient level drill downed
39 information on any cost efficiency measures used in the evaluation and patient lists for any
40 quality measures that are used in the evaluation that includes a list of patients counted towards
41 each quality measure, as well as the interventions for each patient that counted towards that
42 measure.

43 (5) Each quality measure shall have a reasonable target set for each measure and shall not
44 allow the target level to be open-ended.

45 (6) If a quality measure is to be constructed across multiple conditions then the measure
46 shall be case mix adjusted.

47 (7) A consensus process shall be in place to provide proper weighting of more important
48 quality measures at a higher weight and the equal weighting of all measure shall not be used as a
49 default.

50 (8) Sample sizes used in the development of quality measures should not be increased by
51 adding the number of interventions and number of opportunities across multiple health condition

52 to create an adherence ratio, without appropriate statistical adjustment of such a process.
53 Adherence must be assessed at a physician group practice level rather than at the individual
54 physician level.

55 (9) Sample sizes used in the development of cost efficiency measures must be large
56 enough to provide valid information.

57 (10) Information physicians are rated on must be current to reflect physicians' current
58 practices of care for their patients, be appropriately risk adjusted and include appropriate
59 attribution, definition of specialty and adjustments for unusual medical situations. Physicians
60 should be measured only on conditions appropriate to their specialties.

61 (11) Use of preventive care and under-use measures should not be considered as part of
62 cost efficiency measurements.

63 (12) Recommendations by which the physician can improve the results of the evaluation
64 reporting.

65 (13) An evaluation plan that uses assignment by tiering shall include a uniform tier
66 assignment protocol and shall have a statistically significant difference in rating calculations in
67 order to shift a physician from one tier to another. Separate categories shall be created for
68 physicians for who cannot be evaluated in a statistically reliable manner. Said categorization
69 shall not result in higher co-payments for patients being treated by physicians in these separate
70 categories. Said plans shall also employ a data driven process to determine which medical
71 specialties to tier.

72 (14) Uniform tiering should be assigned to group practices so as not to add additional
73 administrative burdens to physicians' practices.

74 (15) Accuracy regarding tiering is critical to avoid the unintended consequences of
75 limiting access to care and introducing risk adversity. Information should be disseminated in
76 such as fashion that results are is both understandable and comprehensive enough to promote
77 education and quality improvement.

78 (16) Increasing data accuracy must be approached as a continuous quality improvement
79 (CQI) project aimed at improving the evaluation system itself.

80 SECTION 3. No carrier as defined in Section 1 of Chapter 1760 of the general laws shall
81 establish a physician performance evaluation program unless the program has the following
82 minimum attributes:

83 (1) Public disclosure regarding the methodologies, criteria and algorithms under
84 consideration, 180 days before any performance evaluations of physicians are applied;

85 (2) Meaningful input by independent practicing physicians and biostatisticians in a timely
86 fashion that will ensure the measures being used are clinically important and understandable to
87 patients and physicians and the tools used for performance evaluations are fair and appropriate;

88 (3) A mechanism to ensure data accuracy and validity that includes a feedback cycle of
89 not less than 120 days prior to the public reporting of the data, which accepts corrections to
90 errors from multiple sources, including the physician being evaluated, assesses the causes of the
91 error(s) and improve the overall evaluation system; and

92 (4) A mechanism to provide the physician being evaluated with patient level drill downed
93 information on any efficiency measures used in the evaluation and patient lists for any quality
94 measures that are used in the evaluation.

95 (5) Each quality measure shall have a reasonable target set for each measure and shall not
96 allow the target level to be open-ended.

97 (6) If a quality measure is to be constructed across multiple conditions then the measure
98 shall be case mix adjusted.

99 (7) A consensus process shall be in place to provide proper weighting of more important
100 quality measures at a higher weight and the equal weighting of all measure shall not be used as a
101 default.

102 (8) Sample sizes used in the development of quality measures should not be increased by
103 adding the number of interventions and number or opportunities across multiple health condition
104 to create an adherence ratio. Adherence must be assessed at a physician group practice level
105 rather than at the individual physician level.

106 (9) Recommendations by which the physician can improve the results of the evaluation
107 reporting.

108 (10) An evaluation plan that uses assignment by tiering shall include a uniform tier
109 assignment protocol and shall have a statistically significant difference in rating calculations in
110 order to shift a physician from one tier to another. Separate categories shall be created for
111 physicians for who cannot be evaluated in a statistically reliable manner. Said categorization
112 shall not result in higher co-payments for patients being treated by physicians in these separate
113 categories. Said plans shall also employ a data driven process to determine which medical
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115 (11) Uniform tiering should be assigned to group practices so as not to add additional
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122 (CQI) project aimed at improving the evaluation system itself.