

HOUSE No. 968

The Commonwealth of Massachusetts

In the Year Two Thousand Nine

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:

1 SECTION 1. Section 2, chapter 32A, of the General Laws, as appearing in the 2006
2 Official Edition, is hereby amended by adding the following definitions:

3 “Quality”, the degree to which health services for individuals and populations increase
4 the likelihood of the desired health outcomes and are consistent with current professional
5 knowledge.

6 “Cost efficiency”, the degree to which health services are utilized to achieve a given
7 outcome or given level of quality.

8 “Physician performance evaluation”, a system designed to measure the quality and cost
9 efficiency of a physician’s delivery of care and which shall include quality improvement
10 programs, pay for performance programs, public reporting on physician performance or ratings
11 and the use of tiering networks.

12 SECTION 2. Section 21, chapter 32A of the General Laws is hereby amended by adding
13 after the last sentence, the following:

14 The commission shall not implement or contract with a carrier as defined in section 2 of
15 chapter 176O for the implementation of a physician performance evaluation program as defined
16 in section 1 unless the program has the following minimum attributes:

17 Public disclosure regarding the methodologies, criteria and algorithms under
18 consideration 180 days before any performance evaluations of physicians are applied.

19 Meaningful input by independent practicing physicians and biostatisticians in a timely
20 fashion that will ensure that the measures being used are clinically important and understandable
21 to patients and physicians and that the tools used for performance evaluations are fair and
22 appropriate;

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

27 A mechanism to provide the physician being evaluated with patient level drill down
28 information on any cost efficiency measures used in the evaluation and patient lists for any
29 quality measures that are used in the evaluation that includes a list of patients counted towards
30 each quality measure, as well as the interventions for each patient that counted towards that
31 measure.

32 Each quality measure shall have a reasonable target set for each measure and shall not
33 allow the target level to be open-ended.

34 If a quality measure is to be constructed across multiple conditions then the measure shall
35 be case mix adjusted.

36 A consensus process shall be in place to provide proper weighting of more important
37 quality measures at a higher weight and the equal weighting of all measures shall not be used as
38 a default.

39 Sample sizes used in the development of quality measures should not be increased by
40 adding the number of interventions and the number of opportunities across multiple health
41 conditions to create an adherence ratio, without appropriate statistical adjustment of such a
42 process. Adherence must be assessed at a physician group practice level rather than at the
43 individual physician level.

44 Sample sizes used in the development of cost efficiency measures must be large enough
45 to provide valid information.

46 Information physicians are rated on must be current to reflect physicians' current
47 practices of care for their patients, be appropriately risk adjusted and include appropriate
48 attribution, definition of specialty and adjustments for unusual medical situations. Physicians
49 should be measured only on conditions appropriate to their specialties.

50 Use of preventive care and under-use measures should not be considered as part of cost
51 efficiency measurements.

52 Recommendations by which the physician can improve the results of the evaluation
53 reporting.

54 An evaluation plan that uses assignment by tiering shall include a uniform tier
55 assignment protocol and shall have a statistically significant difference in rating calculations in
56 order to shift a physician from one tier to another. Separate categories shall be created for
57 physicians for who cannot be evaluated in a statistically reliable manner. Said categorization
58 shall not result in higher co-payments for patients being treated by physicians in these separate
59 categories. Said plans shall also employ a data driven process to determine which medical
60 specialties to tier.

61 Uniform tiering should be assigned to group practices so as not to add additional
62 administrative burdens to physicians' practices.

63 Accuracy regarding tiering is critical to avoid the unintended consequences of limiting
64 access to care and introducing risk adversity. Information should be disseminated in such a
65 fashion that results are both understandable and comprehensive enough to promote education and
66 quality improvement.

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

69 SECTION 3. No carrier as defined in section 2 chapter 176O of the General Laws shall
70 establish a physician performance evaluation program unless the program has the following
71 minimum attributes:

72 Public disclosure regarding the methodologies, criteria and algorithms under
73 consideration 180 days before any performance evaluations of physicians are applied.

74 Meaningful input by independent practicing physicians and biostatisticians in a timely
75 fashion that will ensure the measures being used are clinically important and understandable to
76 patients and physicians and the tools used for performance evaluations are fair and appropriate;

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

81 A mechanism to provide the physician being evaluated with patient level drill down
82 information on any efficiency measures used in the evaluation and patient lists for any quality
83 measures that are used in the evaluation.

84 Each quality measure shall have a reasonable target set for each measure and shall not
85 allow the target level to be open-ended.

86 If a quality measure is to be constructed across multiple conditions then the measure shall
87 be case mix adjusted.

88 A consensus process shall be in place to provide proper weighting of more important
89 quality measures at a higher weight and the equal weighting of all measure shall not be used as a
90 default.

91 Sample sizes used in the development of quality measures should not be increased by
92 adding the number of interventions and number of opportunities across multiple health
93 conditions to create an adherence ratio. Adherence must be assessed at a physician group
94 practice level rather than at the individual physician level.

95 Recommendations by which the physician can improve the results of the evaluation
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99 order to shift a physician from one tier to another. Separate categories shall be created for
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101 not result in higher co-payments for patients being treated by physicians in these separate
102 categories. Said plans shall also employ a data driven process to determine which medical
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