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SENATE . . . . . No. 528

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:

SECTION 1. Definitions: As used in this chapter, the following words shall have the following meanings:

Quality is 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.

Cost efficiency is the degree to which health services are utilized to achieve a given outcome or given level of quality.

Physician performance evaluation shall mean a system designed to measure the quality, and cost efficiency of a physician's delivery of care and shall include quality improvement programs, pay for performance programs, public reporting on physician performance or ratings' and the use of tiering networks.

SECTION 2. Section 21 of Chapter 32 A of the General laws as appearing the 2004 Official Edition is hereby amended by adding after the last sentence, the following: The

commission shall not implement or contract with a carrier as defined in section 2 of Chapter 176O for the implementation of a physician performance evaluation program as defined in section one unless the program has the following minimum attributes:

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

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

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

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

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

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

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

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

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

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

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

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

(13)An evaluation plan that uses assignment by tiering shall include a uniform tier assignment protocol and shall have a statistically significant difference in rating calculations in order to shift a physician from one tier to another. Separate categories shall be created for

physicians for who cannot be evaluated in a statistically reliable manner. Said plans shall also employ a data driven process to determine which medical specialties to tier.

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

(15)Accuracy regarding tiering is critical to avoid the unintended consequences of limiting access to care and introducing risk adversity. Information should be disseminated in such as fashion that results are is both understandable and comprehensive enough to promote education and quality improvement.(16)Increasing data accuracy must be approached as a continuous quality improvement (CQI) project aimed at improving the evaluation system itself. Individual public reporting and tiering should be implemented in a phased in approach over three years from enactment.

SECTION 3. No carrier as defined in Section 2 of Chapter 176O of the general laws shall establish a physician performance evaluation program unless the program has the following minimum attributes:

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

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

(3)A mechanism to ensure data accuracy and validity that includes a feedback cycle of not less than 120 days prior to the public reporting of the data, which accepts corrections to

errors from multiple sources, including the physician being evaluated, assesses the causes of the error(s) and improve the overall evaluation system.

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

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

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

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

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

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