

SENATE No. 494

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:

Cynthia S. Creem

DISTRICT/ADDRESS:

SENATE No. 494

By Ms. Creem, a petition (accompanied by bill, Senate, No. 494) 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. 528 OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

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

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

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

8 Physician performance evaluation shall mean a system designed to measure the quality,
9 and cost efficiency of a physician’s delivery of care and 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 of Chapter 32 A of the General laws as appearing the 2004
13 Official Edition is hereby amended by adding after the last sentence, the following: The
14 commission shall not implement or contract with a carrier as defined in section 2 of Chapter
15 176O for the implementation of a physician performance evaluation program as defined in
16 section one unless the program has the following minimum attributes:

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

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

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

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

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

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

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

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

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

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

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

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

53 (13)An evaluation plan that uses assignment by tiering shall include a uniform tier
54 assignment protocol and shall have a statistically significant difference in rating calculations in
55 order to shift a physician from one tier to another. Separate categories shall be created for
56 physicians for who cannot be evaluated in a statistically reliable manner. Said plans shall also
57 employ a data driven process to determine which medical specialties to tier.

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

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

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

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

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

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

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

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

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

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

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

93 (9)Recommendations by which the physician can improve the results of the evaluation
94 reporting.

95 (10)An evaluation plan that uses assignment by tiering shall include a uniform tier
96 assignment protocol and shall have a statistically significant difference in rating calculations in
97 order to shift a physician from one tier to another. Separate categories shall be created for
98 physicians for who cannot be evaluated in a statistically reliable manner. Said plans shall also
99 employ a data driven process to determine which medical specialties to tier.

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

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

106 (13)Increasing data accuracy must be approached as a continuous quality improvement
107 (CQI) project aimed at improving the evaluation system itself. Individual public reporting and
108 tiering must be implemented in a phased in approach over three years after enactment.