

SENATE NO. 653

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 following meanings:

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

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

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

10 SECTION 2. Section 21 of Chapter 32 A of the General laws as appearing the 2004 Official Edition is hereby
11 amended by adding after the last sentence, the following: The commission shall not implement or contract with
12 a carrier as defined in section 2 of Chapter 176O for the implementation of a physician performance evaluation
13 program as defined in section one unless the program has the following minimum attributes:

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

17

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

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

25

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

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

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

36

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

39

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

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

47

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

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

55

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

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

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

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

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70 (16)Increasing data accuracy must be approached as a continuous quality improvement (CQI) project aimed at
71 improving the evaluation system itself. Individual public reporting and tiering should be implemented in a
72 phased in approach over three years from enactment.

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

76

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

79

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

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84

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

88

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

92

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

95

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

98

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

101

102 (8)Sample sizes used in the development of quality measures should not be increased by adding the number of
103 interventions and number or opportunities across multiple health condition to create an adherence ratio.

104 Adherence must be assessed at a physician group practice level rather than at the individual physician level.

105

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

107

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

113

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

116

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

120

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