

**SENATE . . . . . No. 510**

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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 passage of the accompanying:

An Act relative to insurance companies and quality measures..

PETITION OF:

NAME:

*Cynthia S. Creem*

DISTRICT/ADDRESS:

*First Middlesex and Norfolk*

**SENATE . . . . . No. 510**

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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.

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

**The Commonwealth of Massachusetts**

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

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

15 (j) "Quality", the degree to which health services for individuals and populations increase  
16 the likelihood of the desired health outcomes and are consistent with current professional  
17 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 down  
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 a fashion that results are 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 down  
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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120 education and quality improvement.

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