The Massachusetts Medical Society (MMS) is a professional association of over 25,000 physicians and medical students and advocates on behalf of patients for a better health care system, and on behalf of physicians, to help them to provide the best care possible. To that end, the MMS wishes to be recorded in strong support for H.1218, An Act Relative to Insurance Companies and Quality Measures. Rising health care costs and further attention to the quality of health care delivered in the Commonwealth have driven payers, employers, and providers to seek out new ways to measure costs and value with regard to the provision of health care. This bill puts forth provisions to address those goals.

To assist in the successful development and implementation of performance measurement, reporting and rewards programs, the MMS has done research with national experts to develop recommendations and guidelines to help ensure that methodologies used to develop these programs are carefully and thoughtfully researched, developed, and validated with the goal of protecting patients from exposure to potential inaccuracies and unintended consequences. We believe that particular attention must be paid to transparency regarding all aspects of the methodologies and criteria used to judge physicians. We equally believe that physician involvement is needed to define both valid and meaningful quality and cost measures as well as an appropriate methodology to use quality and cost information. In addition, physician involvement is necessary in determining a process to correct inaccuracies in the data. To these ends we offer the following comments:

Consumer directed programs that include “preferred networks” should:

- **Support the Patient/Provider Relationship:** Quality and cost efficiency measurement programs should be directed at supporting and improving patient-physician relationships. They should not create obstacles for providers treating patients regardless of their health condition, ethnicity, economic circumstance, demographics, or treatment compliance pattern.

- **Support Sound Performance Measures:** Quality, efficiency and cost performance measures should be evidence-based, valid, reliable, broadly accepted, and clinically meaningful. Measures should be consistent with those collected by national or regional organizations such as the AMA’s Physician Performance Consortium, Ambulatory Care Quality Alliance (Better Quality Initiative), National Quality Foundation, JCAHO, Massachusetts Health Quality Partners (MHQP), and the Centers for Medicare and Medicaid Services thus facilitating an alignment of measurement goals in the marketplace.
  
  - Evidence-based quality and cost measures should be evaluated in relation to each other. Measures should result in no unintended harmful consequences.

- **Support Methodology/Data Transparency:** Complete descriptions of all criteria, algorithms, methodologies and data sources used in such programs should be made readily available to plan members and participating physicians, as should all of the underlying individual
physician quality, cost, efficiency and patient satisfaction data.

- There should be a statistically valid reason for judging any data used and arbitrary cut-offs must be avoided; and physicians whose practices are too new, too small to measure, or different from their peers should be handled separately from others.

**Support Data Accuracy:** Measurements should be accurate and timely. Physicians should be given patient-level drilldowns for the efficiency measure, and patient lists for the quality measures. There should be a formal feedback and correction mechanism so that errors uncovered by physicians, plans, and other analysts can contribute to improving the evaluation system.

- Data should be adjusted for such items as sample size and case-mix composition, outliers when appropriate, socio-economic differences when possible, appropriate use of preventive care and other under-utilized interventions; reasonable targets should be set for each measure; and adjusted to account for variations in the cost of delivering care which are outside the providers' control (e.g., variations in payor mix, area wage index, and state mandated requirements).

- Data should not be attributed to an individual physician unless limited to the results of the diagnoses the individual physician has made and the care he/she has provided. If the data reflects the results of all of the care received by a cohort of patients (rather than just the care provided/ordered by an individual physician), the results should be attributed to a physician practice or network only - with no individual physician attribution.

- Measurements should be at a group level until data accuracy is improved and the methodology is further validated.

**Support Data Sharing at Individual Level for Quality Improvement:** At this time, because of limitations to the current system and issues surrounding attribution, and appropriate volume it is inappropriate to judge physician performance at a level finer than the large group level. This would include integrated health care systems and Independent Physician Associations (IPAs). It is, however, appropriate and desirable to provide data to medical groups and physicians that can be drilled down to the individual physician and individual patient for purposes of providing best care and improving the process of measurement.

**Support Physician Involvement in the Process:** Practicing physicians, hospitals, and their professional organizations should be involved in the design and ongoing modification of programs such as these that judge physicians in order to be fair to physicians and physician patient relationships. Results must be shared with physicians well in advance of any final judgments about their performance. Criteria used to judge physicians’ performance should be circulated well in advance of any final opinions about their performance. There should not be any introduction of unnecessary administrative complications to practices. Physicians should be provided with specific behaviors (action items) by which they can improve their results. A uniform approach to measurements should be adopted.

**Support a Uniform Format for Reporting:** In order for physicians and patients to better understand and make use of the information available, information about physicians should be provided in a common format.

The legislation before you is an attempt to codify these recommendations to more effectively promote quality improvement and appropriate cost control while not adversely impacting the patient physician relation or the physician practice environment in Massachusetts.

For the reasons above, the MMS urges the Committee on Financial Services to act favorably on H.1218.