Senate Bill 425

By: Senator McKoon of the 29th

A BILL TO BE ENTITLED

AN ACT

To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to provide for a physician profiling program; to provide definitions; to provide profiling program standards; to establish criteria for programs that evaluate a physician's cost of care; to provide for certain disclosure information to patients; to provide that the Commissioner shall contract with an independent oversight entity; to provide for violations and penalties; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

**SECTION 1.**

Title 33 of the Official Code of Georgia Annotated, relating to insurance, is amended by adding a new chapter to read as follows:

"CHAPTER 20C

33-20C-1.

As used in this chapter, the term:

(1) 'Economic criteria' means measures used to determine physician resource utilization or costs of care for health care services.

(2) 'Profiling program' means a system that compares, rates, ranks, measures, tiers, or classifies a physician's or physician group's performance, quality, or cost of care against objective or subjective standards or the practice of other physicians, include without limitation quality improvement programs, pay-for-performance programs, public reporting on physician performance or ratings, and the use of tiered or narrowed networks.

(3) 'Quality criteria' are measures used to determine the degree to which health services for individuals and populations increase the likelihood of the desired health outcomes, consistent with current professional knowledge.

33-20C-2.

(a) No profiling results of any profiling program may be disclosed to the public or used for network or reimbursement purposes unless such program has been approved as provided for by this chapter.

(b) Profiling programs shall not be based on cost of services alone. Any such program shall:

(1) Use evaluation criteria developed in collaboration with practicing physicians and their professional organizations;

(2) Use standardized quality and cost measures;

(3) Reduce the administrative burden on physician practices; and

(4) Consider quality measures, including professional standards of care, and the resulting mortality, morbidity, productivity, and quality of life.

(c) In evaluating quality of care, a profiling program shall:

(1) Use measures based on specialty-appropriate, nationally recognized, evidence-based medical guidelines or nationally recognized, consensus-based guidelines; endorsed by the National Quality Forum or the AQA alliance, or their successors; and developed by the Physician Consortium for Performance Improvement or other entities whose work in the area of physician quality performance is generally accepted within the health care industry;

(2) Use a statistically valid number of disease state or specialty specific cases, subject to review and approval by the department, to produce accurate and reliable measurements and profiling information;

(3) Ensure that statistically valid risk adjustment is used to account for the characteristics of the physician's or physician group's patient population, including case mix, severity of patients' conditions, comorbidities, outlier episodes, and other factors, subject to review and approval by the department. With respect to process measures, these factors shall be considered in evaluating patient compliance rates and whether compliance with a measure is not indicated, contraindicated, or rejected by the patient;

(4) Determine which physicians shall be held reasonably accountable for a patient's care, subject to review and approval by the department;

(5) Ensure that patient preferences are respected, and that physician ratings are not adversely affected by patient noncompliance with a physician's referral, treatment recommendation, or plan of care;

(6) Ensure that the quality measurement system in no way discourages physicians from providing preventive care or from treating sicker, economically underprivileged or minority patients; and

(7) Publicly report or otherwise use quality rankings at the physician group practice level rather than at the individual physician level where the individual physician is practicing as part of a medical group, and clearly identify such ranking as a group score.

(d) Professional certification or accreditation may be used in determining physician quality of care, but shall not be solely relied upon as the determinant of physician quality.

33-20C-3.

(a) Physician profiling programs that evaluate a physician's cost of care shall:

(1) Compare physicians within the same specialty within the same geographical market;

(2) Utilize a statistically valid number of patient episodes of care, subject to review and approval by the independent oversight entity;

(3) Ensure that statistically valid risk adjustment is used to account for the characteristics of a physician's patient population, including case mix, severity of patients' conditions, comorbidities, outlier episodes, and other factors, subject to review and approval by the independent oversight entity;

(4) Determine appropriate rules for attribution for cost-efficiency, subject to review and approval of the independent oversight entity;

(5) Ensure that patient preferences are respected and that physician ratings are not adversely affected by patient noncompliance with a physician's referral, treatment recommendation, or plan of care;

(6) Ensure that the cost-efficiency measurement system in no way discourages physicians from providing preventive care, or from treating sicker, economically underprivileged or minority patients; and

(7) Publicly report or otherwise use cost-efficiency rankings at the physician group practice level rather than at the individual physician level where the individual physician is practicing as part of a medical group, and clearly identify such ranking as a group score.

(b) Physician profiling programs shall ensure that data relied upon is:

(1) Accurate, including consideration of whether medical record verification is appropriate and necessary; and

(2) The most current, considering the necessity to attain adequate sample size, subject to the review and approval of the independent oversight authority.

(c) To the extent available, physician profiling programs shall use aggregated data rather than the data specific to a particular health insurer or other payer.

33-20C-4.

(a) Physician profiling programs shall conspicuously disclose to patients the following information on the Internet and in other relevant materials:

(1) Information explaining the physician rating system, including the basis upon which physician performance is measured and the statistical likelihood the rating is accurate;

(2) Limitations of the data used to measure physician performance;

(3) How the ratings affect the physician, including but not limited to a physician's inclusion into or exclusion from a network;

(4) The quality and economic criteria used in the rating system, including the measurements for each criterion and its relative weight in the overall evaluation;

(5) A conspicuous written disclaimer stating the following:

'Physician performance ratings should only be used as a guide to choosing a physician. You should talk to your doctor before making a health care decision based on the rating. Ratings may be wrong and should not be used as the sole basis for selecting a doctor.'; and

(6) Information explaining how the patient may contact the independent oversight entity to register complaints about the system.

(b) Physician profiling programs shall:

(1) Disclose the methodologies, criteria, data, and analysis used to evaluate physicians' quality performance and cost-efficiency, including but not limited to the statistical difference between each rating and the statistical confidence level of each rating, at least 180 days before implementing or making any material change to any physician profiling program;

(2) Disclose a physician's profile to the physician, including the patient-specific data and analysis used to create the profile, and recommendations on how the physician can improve the physician's score, at least 90 days prior to its public disclosure or other use;

(3) Provide physicians with the opportunity to correct errors, submit additional information for consideration, and seek review of data and performance ratings;

(4) Provide physicians with the following rights to challenge a profiling determination at least 60 days prior to its public disclosure or other use:

(A) Opportunity to submit a written appeal;

(B) Suspension of the initial or modified quality and cost-efficiency rating when a timely appeal is made; and

(C) Opportunity for review by the independent oversight entity to assess the appeal decision;

(5) Ensure that the profiling program does not disparage in any way any physician who is not profiled because of insufficient data; and

(6) Provide the disclosures, correction opportunities, and appeal rights provided for by this subsection with respect to the initial and any subsequent profiling determination.

33-20C-5.

(a) The Commissioner shall contract with an independent oversight entity, which shall be an organization qualified to oversee physician profiling programs and exempt from taxation pursuant to Section 501(c)(3) of the Internal Revenue Code, to administer the provisions of this chapter, subject to the following criteria:

(1) The entity shall not be an affiliate or a subsidiary of, nor in whole or in part, directly or indirectly, be owned or controlled by any physician, employer of physicians, hospital, health plan, trade association of health plans, trade association of employers of physicians, trade association of hospitals, or trade association of physicians. No board member, director, officer, or employee of the entity shall serve as a board member, director, officer or employee of a hospital, health plan, trade association of health plans, trade association of employers of physicians, trade association of hospitals, or trade association of physicians; and

(2) The entity shall demonstrate that is has a quality assurance mechanism in place that ensures that:

(A) Experts retained are qualified in the areas of physician quality and efficiency measurement;

(B) Conflict-of-interest policies and prohibitions are in place to address the independence of experts retained to perform reviews;

(C) Reviews are timely, clear, credible, and monitored for quality on an ongoing basis; and

(D) Confidential or proprietary information submitted by the plan or the physician is not improperly disclosed.

(b) The independent oversight entity shall:

(1) Establish criteria necessary for assessment of compliance with the provisions of this chapter, including but not limited to the minimum statistical confidence level required before any profiling results may be used for network or reimbursement purposes or disclosed to the public;

(2) Monitor each physician profiling program's compliance with the provisions of this chapter;

(3) Approve the methodologies, data collection and analysis, and disclosure and appeal processes, consistent with the provisions of this chapter, of any new physician profiling program or material modification to any existing physician profiling program prior to its implementation. Profiling programs in existence on July 1, 2011, shall apply for review

and approval within 30 days after the selection of the independent oversight entity, and shall cease using for network or reimbursement purposes or publicly disclosing any profiling results of any program which has not been approved by the independent oversight entity within 90 days of its receipt of the application;

(4) Resolve patient and physician complaints;

(5) Oversee the physician appeals process;

(6) Post the results of its review of each physician profiling program on the Internet, including its findings with respect to each criteria it has established pursuant to subsection (a) of this Code section; and

(7) Report and make recommendations to the Commissioner relating to the implementation of the provisions of this chapter.

33-20C-6.

(a) Where the Commissioner determines that there has been a willful and knowing refusal by a physician profiling program to completely disclose the profiling data or methodology to a physician at least 90 days prior to the publication or other use for network or reimbursement purposes of any initial or subsequent profiling determination or to provide the appeal rights required by this chapter, or where it is established that a false or misleading designation has been published to a third party, the Commissioner shall impose a fine of $500.00 for each violation, and $500.00 for each day such violation continued. An Internet posting shall be deemed to be a disclosure to each person who has access to the physician network affected by the physician profiling program, and each such disclosure shall be deemed a separate violation of this Code section. Any profiling determinations published by a physician profiling program that is not approved pursuant to the terms of this chapter or awaiting approval pursuant to the provisions of paragraph (3) of subsection (b) of Code Section 33-20C-5 shall be a violation of the provisions of this Code section.

(b) Nothing in this chapter shall prohibit or limit any claim or private right of action for a claim that the claimant has against any person or entity for any act or omission constituting a violation of the provisions of this chapter.

(c) In addition to any other liability which may apply, any person who publicly discloses or otherwise uses for network or reimbursement purposes any profiling results in violation of this chapter shall be liable to the affected physician or physician group for treble damages, reasonable attorneys' fees, and any other appropriate relief, including injunctive relief.″

**SECTION 2.**

All laws and parts of laws in conflict with this Act are repealed.