HOUSE . . . . . No. 5181

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, June 26, 1995.

The committee on Health Care, to whom were referred the petition (accompanied by bill, Senate, No. 502) of Louis P. Bertonazzi and Marc R. Pacheco for legislation to increase public access to data concerning physicians and to create a clinical quality improvement unit at the Board of Registration in Medicine, the petition (accompanied by bill, House, No. 719) of Carmen H. Buell, Edward B. Teague III and Lida E. Harkins relative to physicians in the establishment of a clinical quality improvement unit within the Board of Registration in Medicine, the petition (accompanied by bill, House, No. 1305) of Steven Angelo and others for legislation to establish a central records registry within the Board of Registration in Medicine, the petition (accompanied by bill, House, No. 1306) of Steven Angelo and others that the Board of Registration in Medicine be directed to establish regulations for medical malpractice complaints, and the petition (accompanied by bill, House, No. 3908) of Patricia D. Jehlen and Benjamin Swan for legislation to require the disclosure of certain information by physicians, reports recommending that the accompanying bill (House, No. 5181) ought to pass.

For the committee,

CARMEN H. BUELL.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Ninety-Five.

AN ACT TO INCREASE PUBLIC ACCESS TO DATA CONCERNING PHYSICIANS AND CREATE A CLINICAL QUALITY IMPROVEMENT UNIT AT THE BOARD OF REGISTRATION IN MEDICINE.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 53B of chapter 111 of the General Laws, as it appears in the 1992 Official Edition, is hereby amended by inserting before the words "All information" in line 13, the following: — Except as provided in section 5 of chapter 112,.

SECTION 2. Section 5 of chapter 112 of the General Laws, as it appears in the 1992 Official Edition, is hereby amended by inserting after line 11, the following:—

There shall also be established within the board of registration in medicine a clinical quality improvement unit. The purpose of the clinical quality improvement unit is to (1) develop and implement a plan to identify cases that appear to involve substandard care and develop procedures for referral, investigation and possible disciplinary action, and (2) develop and implement a plan for a remediation program designed to improve physicians' clinical and communication skills. Participation in the remediation program shall be offered to physicians, on a voluntary basis, as an alternative to disciplinary action in appropriate cases. Cases selected for remediation shall be based on a criteria determined by the board.

SECTION 3. Section 5 of chapter 112 of the General Laws, as appearing in the 1992 Official Edition, is hereby amended by inserting after line 27, the following:—

There shall also be established within the board of registration in medicine a consumer information unit. Notwithstanding any other provision of law, the consumer information unit shall collect

the following information to create individual profiles on licensees, in a format created by the board, that shall be available for dissemination to the public:

(a) description of any criminal convictions for felonies, and for serious misdemeanors as determined by the board, within the most recent ten years. For the purposes of this subsection, a person shall be deemed convicted of a crime if he pleaded guilty or nolo contendere, or if he was found or adjudged guilty by a court of competent jurisdiction, or if sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction.

(b) description of any final board disciplinary actions;

(c) description of any final disciplinary actions by licensing boards in other states;

(d) description of revocation or involuntary restriction of hospital privileges for reasons related to competence or character that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded, or the resignation from or nonrenewal of medical staff membership or the restriction of privileges at a hospital taken in lieu of or in settlement of a pending disciplinary case related to competence or character at that hospital. Only cases which have occurred within the most recent ten years shall be disclosed by the board to the public;

(e) all medical malpractice court judgments in which a payment is awarded to a plaintiff during the most recent 10 years; all medical malpractice arbitration awards in favor of a patient during the most recent 10 years; and all settlements of medical malpractice claims in which a payment is made to a patient within the most recent 10 years. Dispositions of paid claims should be reported in a minimum of three graduated categories indicating the level of significance of the award or settlement. Information concerning paid medical malpractice claims shall be put in context by comparing an individual licensee's medical malpractice judgment awards and settlements to the experience of other physicians within the same specialty. Pending malpractice claims shall not be disclosed by the board to the public. Nothing herein shall be construed to prevent the board from investigating and disciplining any licensee on the basis of medical malpractice claims that are pending.

(f) names of medical schools, and date of graduation;
(g) graduate medical education;
(h) specialty board certification, recertification or whether the licensee is qualified or eligible for certification or recertification;
(i) number of years in practice;
(j) names of the hospitals where the licensee has privileges;
(k) appointments to medical school faculties and indication as to whether licensee has any responsibility for graduate medical education within the most recent ten years;
(l) information regarding publications in peer-reviewed medical literature within the most recent ten years;
(m) description of the licensee's involvement in clinical research within the most recent ten years;
(n) information regarding professional or community service activities and awards;
(o) the location of the licensee's primary practice setting;
(p) identification of any translating services that may be available at the licensee' s primary practice location;
(q) indication of whether the licensee participates in Medicaid.

The board shall provide individual licensees with a copy of their profiles prior to release to the public. The licensees shall be provided with a reasonable amount of time in which to correct any factual inaccuracies that appear in the profile.

SECTION 4. The secretary of consumer affairs and business regulation and the board of registration in medicine shall submit to the house committee on ways and means and the senate committee on ways and means by March 1, 1996 a proposed spending plan for the board for fiscal years 1997, 1998 and 1999.

The plan shall contain an assessment of the board's disciplinary unit, including standards for measuring its effectiveness, and identify any additional staff positions or any personnel reclassifications necessary to increase the unit's effectiveness. The plan also shall describe the staff positions or other resources necessary to establish and maintain a clinical quality improvement unit, provide a detailed budget for such unit, and provide standards for measuring the effectiveness of that unit. The plan shall contain an assessment of the board's information management systems and recommendations for any necessary improvements in those

systems. The plan also shall identify any law, regulation or executive order governing the commonwealth's personnel or information systems which hampers the operations of the board and from which the board should be exempted.

The plan further shall contain estimates of the cost of the foregoing and identify potential sources of revenue to defray such costs. In considering fee increases as potential sources of revenue, the plan shall include existing and projected fee structures and compare those to fee structures in use by other states for medical licensing boards. The board shall include in its recommendations provisions for a transition, commencing January 1, 1997, to a license renewal cycle in which physicians licensed pursuant to section two of chapter one hundred twelve who are born in an even-numbered year renew their licenses on their birthdays in even-numbered years, and physicians born in an odd-numbered year renew their licenses on their birthdays in odd-numbered years.

In addition, the board shall submit to the house and senate ways and means committee within thirty days of enactment of this bill a proposed spending plan for the balance of the 1996 fiscal year for staff positions and other resources necessary to establish and maintain a consumer information unit.

SECTION 5. Section 10 of chapter 6B of the General Laws, as appearing in the 1992 Official Edition, is hereby amended by adding the following paragraph:—

Whenever collecting information or compiling reports intended to compare individual health care providers, the commission shall comply with the following:—

(a) provider organizations which are representative of the target group for profiling shall be meaningfully involved in the development of all aspects of the profile methodology including collection methods, formatting and methods and means for release and dissemination;

(b) the entire methodology for collecting and analyzing the data shall be disclosed to all relevant provider organizations and to all providers under review;

(c) data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability;

(d) the limitations of the data sources and analytic methodologies used to develop provider profiles shall be clearly identified and acknowledged, as well as the appropriate and inappropriate uses of the data

(e) to the greatest extent possible, provider profiling initiatives shall use standard-based norms derived from widely accepted, provider-developed practice guidelines;

(f) provider profiles and any other information that have been compiled regarding provider performance shall be shared with providers under review prior to dissemination; opportunity for corrections and additions of helpful explanatory comments shall be provided prior to publication; the profiles shall only include data which reflects care under the control of the provider for whom the profile is prepared;

(g) comparisons among provider profiles shall adjust for patient case-mix and other relevant risk factors, and control for provider peer group when appropriate;

(h) elective safeguards to protect against the unauthorized use or disclosure of provider profiles shall be developed and implemented;

(i) elective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate or subjective profile data shall be developed and implemented;

(j) the quality and accuracy of provider profiles, data sources, and methodologies shall be evaluated regularly;

(k) providers should be reimbursed for the reasonable costs that are required for assembling, formatting, and transmitting data and information to organizations that develop and/or disseminate provider profiles; and

(l) the benefits of provider profiling should outweigh the costs of developing and disseminating the profiles.

SECTION 6. The rate setting commission established under section 32 of chapter 6A shall conduct a study of reports which provide comparative performance and other information concerning health plans, hospitals, physicians and other providers, and shall provide any recommendations that it might have for legislation to facilitate the production of such reports, and the reasons therefor, to the joint committee on health care by October 1, 1995.

In evaluating such reports and the methodologies used in producing such reports, and in developing its recommendations, the commission shall consider the following issues:

(a) the appropriate role of the commonwealth in developing such reports, and whether purchasers and providers reasonably can be anticipated to continue to develop such reports in response to market forces;

(b) the necessity or advisability of state mandates concerning the collection and evaluation of information for such reports;

(c) Means and methods for defining and protecting the reliability and validity of data and information, particularly with respect to variations in the relative severity presented by individual patients;

(d) the extent to which existing data sources and indicators are valid; and

(e) the costs of establishing and maintaining systems producing such reports, and possible sources of revenue to defray the same.

SECTION 7. Section 53B of chapter 111 of the General Laws, as appearing in the 1992 Official Edition, is hereby amended by striking the word "one" from line 33 and inserting the word "ten" in its place.

SECTION 8. Section 26 of chapter 221 of the General Laws, as appearing in the 1992 Official Edition, is hereby amended by striking out lines 1 through 9 and inserting in place thereof the following:—

Section 26. The clerk of any court in which a physician registered in this commonwealth is convicted of any crime, or in which an unregistered practitioner is convicted of holding himself out as a practitioner of medicine, or of practicing medicine, shall within one week thereafter report the same to the board of registration in medicine together with a copy of the court proceedings in the case. For the purposes of this section, a person shall be deemed convicted of a crime if he pleaded guilty or nolo contendere, or if he was found or adjudged guilty by a court of competent jurisdiction, or if sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction.