Frequently Asked Questions (FY18)

as January 2017

On February 17, 2017, all Massachusetts specialists were sent details of their Clinical Performance Improvement Initiative tiering designations.

On February 22, all Massachusetts Primary Care Physicians who had sufficient quality and efficiency data to be scored were sent details of the Clinical Performance Improvement scoring data.

NEW FOR FY 2018:

- The GIC has authorized HPHC and Tufts Health Plan to use their own tiered products based on group cost and quality performance. For these plans, tier placement for GIC members will be determined by the physician's performance within their respective HPHC physician group and Tufts Health Plan IPA group. *Tier placement will apply to both Specialists and PCPs.*
    - For additional information please refer to the following web pages:
        - www.harvardpilgrim.org/providers > Products > The Harvard Pilgrim GIC Plans
        - https://tuftshealthplan.com/provider/news/2017/-gic-tiering-info
- Each physician, covered by the CPI Initiative, will receive the same tier assignment from the following GIC plans: Fallon, HNE, NHP, and UniCare.

CPII Tier Assignment information is only applicable to Fallon, HNE, NHP and UniCare plans

PCP copay information is only applicable to POS plans within HPHC physician groups and Tufts Health Plan IPA groups.

If a provider has misplaced this mailing and would like another copy, please send an email to: Mark.Wolin@state.ma.us

1. **Why did I receive a tiering designation letter and packet?**
   Six health plans provide health insurance to Massachusetts State and certain municipal employees and retirees through the Group Insurance Commission (GIC). The health plans tier Massachusetts specialist physicians as part of a project known as the Clinical Performance Improvement (CPI) initiative. If you are a specialist who practices in Massachusetts, you may have received a letter from the health plans that participate in the CPI initiative, describing your tier placement. In addition to the letter, the mailing includes additional information about your patients' claims data and the quality and efficiency scores that arose from that data which led to your tier assignments.

2. **The letter I received says I will be tiered differently this year for HPHC and Tufts. Please explain what this means.**
   HPHC and Tufts Health Plan will be adapting their own group-tiering methodology. Physician tier placement will be based on group cost and quality performance as determined by performance within each HPHC physician group and Tufts Health Plan IPA group respectively. Tier placement will apply to both Specialists and PCPs. For additional information please refer to the following web pages:

   - Harvard Pilgrim Health Care - The Harvard Pilgrim GIC Plans
   - https://tuftshealthplan.com/provider/news/2017/-gic-tiering-info

3. **In previous years the letter I received included a tier assignment from each health plan. Why did I receive only one tier assignment?**
   Previously, health plans individually assigned a tier to each specialty physician in their network based on that physician's performance. Although the methodology is consistent across the plans, due to the varying size of each plan's network, physicians could be assigned to Tier 1 in one health plan and Tier 2 in another. To address this issue a single, universal tier will be assigned across all the plans.

   Note: *CPII Tier Assignment information is only applicable to Fallon, HNE, NHP and UniCare plans. For HPHC and Tufts Health Plan see FAQ #2 for tiering information.*

4. **I am not a specialist. Why did I receive a mailing about my performance from the six health plans?**
   This year the same six health plans also mailed information to primary care physicians (internists, pediatricians, and physicians specializing in general or family medicine). Most primary care physicians who practice in Massachusetts learn how they performed relative to their peers on the CPI quality measures. PCPs will also receive information about their patients' claims data in the mailing.
   Note: PCPs will be tiered and member copays will apply for HPHC Independence POS and Tufts Health Plan Navigator POS. See FAQ #2 for more information.

5. **Some physicians in my practice received a letter and packet with their tiering information, but I didn't. Why would that be?**
   You may not have received a CPI mailing for a number of different reasons, the most common of which are: (1) your specialty was identified as one which is not tiered as part

of the CPI initiative, (2) if you practice out of more than one office, your mailing may have been sent to (one of) your other office(s), or (3) the volume of claims data attributed to you was insufficient for you to be tiered.

6. **What is the physician ID number (shown at the top of each page)?**
   The physician ID number printed on each page of this mailing is a number assigned to you specifically for this project -- it is not your NPI number.

7. **How will my tier assignment affect my patients' copayment amount?**
   Patients' office visit copayments are determined by your tier assignment. The patient is charged less for a visit to a tier 1 specialist, and more for a visit to a tier 3 specialist. *Note 1: CPII Tier Assignment information is only applicable to Fallon, HNE, NHP and UniCare plans. For HPHC and Tufts Health Plan see FAQ #2 for tiering information*

   Note 2: PCPs will be tiered and member copays will apply for HPHC Independence POS and Tufts Health Plan Navigator POS. See FAQ #2 for more information.

8. **I am "Not Tiered" by a health plan. How does that affect my patients' copayment?**

   Copayments for office visits to "not tiered" specialists are the same amount as the plan's standard specialist (tier 2) copayment. *CPII Tier Assignment information is only applicable to Fallon, HNE, NHP and UniCare plans*

9. **I do not agree with the tier (or the specialty) that I was assigned. Who do I contact to request a review of my tiering designation?**
   Please use the health plan contact information contained in the cover letter to contact the plan with any questions or if you would like to request that the plan review your tier assignment.

10. **How long do I have to request that the health plan(s) review my tier assignment?**
    You have until March 3, 2017 to request a review from the health plan(s). The plan(s) then have three weeks to respond to your appeal.

11. Can I use information from my patients' medical records as part of my request for review?

The tiering methodology is based solely on the medical and pharmacy claims you have submitted to the health plans. For any completed measure there should be a corresponding claim submitted. Therefore requests for chart reviews will not be accepted as part of the review of your tier assignment.

12. What information may I use to support my request for review?

The following types of information are allowed to support the review of your tier assignment:

- Error in physician identification or specialty designation
- Error in physician attribution to an episode, quality measure, or patient
- Error in application of tiering methodology
- Other (please explain)

13. WHAT IS AN "EPISODE OF CARE"?

An "episode of care" is a grouping of a patient's health care claims for a unique occurrence of a particular illness or injury, or a year of claims for a chronic condition. The claims that are grouped include the medical, ancillary, ambulatory surgical, other hospital, emergency, inpatient, and pharmacy services that are involved in diagnosing and treating the patient's condition. The diagnosis codes on these claims also describe a patient's underlying clinical conditions related to the episode and complications and comorbidities. The services within an episode may be provided by more than one physician; the episode is attributed to a single provider based on the preponderance of the costs associated with physician services that the patient received during the course of his or her treatment for that illness, injury, or chronic condition.

14. WHAT IS AN "EPISODE TREATMENT GROUP" (ETG)?

ETGs are a clinical condition classification methodology that categorizes clinically homogeneous episodes into groups. Each episode is assigned to a unique group (an episode treatment group) and its severity level is assessed (reflecting the primary clinical condition for the episode and the complications, comorbidities and patient characteristics that impact treatment).

For more information see the white paper written by Optum, who developed the Symmetry ETG Grouper used by CPII, by going to www.mass.gov/GIC/CPIIDetails >>

"Information For Providers" >> "Scoring Methodology" and access the link under "Efficiency Score".

15. Why did I receive a Quality Detail Report?

You received a Quality Detail Report either because a) you had sufficient quality data to receive a quality score as indicated, or b) you did not have sufficient data to receive a quality score BUT you did have 5 or more observations in a quality measure. **If you are a specialist, you received information on all measures for which you had data. If you are a Primary Care Physician, we included the top 10 measures by number of observations in which you had any observations.** You may have additional observations that were not included in the report. If you would like access to this additional information, please contact one of the health plans using the contact information contained in your cover letter.

16. What does an adjusted quality score 0.856 mean?

Your Quality Score is calculated by comparing your compliance with a series of quality measures to that of peer providers practicing in your specialty, adjusting for measure, patient, and sample size effects. The highest-quality providers have quality scores closest to one. Click below for a detailed explanation of the Quality Scoring Model:

RHI Statistical Model

17. On the Efficiency Detail report, some of the procedures are listed as *Del_12345.* What does this mean?

The claims data that we analyze for this project encompasses the most recent three years' of the health plan's commercial claims data. Occasionally, a procedure code is "retired" and is deleted from the current CPT-ICD9 manual, but, because we are still using this data, the procedure code appears as ***del_12345***. Since the report includes the top procedures by frequency impacting that specific episode, a procedure with a retired code may appear on the report.

18. Can you explain the proxy price methodology?

Proxy pricing is a mechanism used to substitute meaningful standard prices for costs of healthcare across multiple Health Plan data so that contract bias between individual Plans and physicians is filtered out of the CPII process (i.e., so that the cost comparison is measuring physician performance and not contract terms). Proxy pricing is commonly

used throughout the healthcare industry in situations like these. The CPII proxy pricing process was developed by Mercer and the GIC in conjunction with the Plans during the first few years of CPII. Part of that process depends on the use of a list of standardized prices for medical and other services incurred during an episode. These standardized prices are based on the book of business data from the GIC's six health plans.

19. If the physician review process validates my request to reconsider my tier assignment, to which tier will I be assigned?

You would be assigned to Tier 2 as the default tier. Since tier assignments depend on evaluating the entire data base set, effectively you will be removed from the tiering process for this year.