Frequently Asked Questions

On January 4, 2016, all Massachusetts specialists were sent details of their Clinical Performance Improvement Initiative tiering designations.

On January 15th, 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. Since Primary Care Physicians were not scored, they did not receive tiering designations.

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. 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), even though they are not tiered as part of the CPI initiative. 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.

3. In other years I received multiple letters from the health plans - how is this different, and why?
In previous years, each health plan sent out its own letter and information packet to specialists who were tiered as part of the CPI initiative. The plans now collaborate to create a combined mailing that provides more detailed information on the data behind each physician's quality and cost-efficiency scores.
4. 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.

5. 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.

6. Why am I assigned to Tier 1 for one health plan and Tier 2 in another?
Although all the health plans use the same quality and efficiency data, plans have different physician networks. In determining your tier placement, each plan had to compare your performance with that of the rest of its network of physicians in your specialty, and tier you accordingly. Thus, it is possible that a physician may be assigned to Tier 1 in one plan and Tier 2 in another.

7. Why am I assigned a Tier in one network, but listed as “Not Tiered” in another?
A physician listed as "Not Tiered" for a particular health plan may be due to any of the following reasons:
   1. You are not in that health plan's network
   2. That health plan does not tier your specialty
   3. Your records with that health plan show you as a non-Massachusetts physician

8. How will my tier assignment(s) affect my patients’ copayment amount?
Patients' office visit copayments are determined by your tier for each health plan. The patient is charged less for a visit to a tier 1 specialist, and more for a visit to a tier 3 specialist. However, as the amounts charged for tier 1, tier 2 and tier 3 office visits vary from one health plan to another, and are subject to change prior to the beginning of the plan year (July 1, 2016), the copayment amounts were not included in this letter. You may be a specialist who has patients whom you treat for primary care-type conditions. Although physicians whose specialties are internal medicine, general medicine, pediatrics, or other primary care specialties are not subject to tiered copayments, it is your specialty that determines your copayment, not the type of service you provide the patient at a particular office visit. For tiered specialists, the copayment for the tiered specialty applies, regardless of the service provided at the office visit.
9. 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.

10. 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?
   Each health plan assigns physicians in their network to a tier independently. 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.

11. How long do I have to request that the health plan(s) review my tier assignment?
   You have until January 22, 2016 to request a review from the health plan(s). The plan(s) then have three weeks to respond to your appeal.

12. 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.

13. 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)

14. 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 an evaluation of the claims data to determine which provider was responsible for the overall management of the care that the patient received during the course of his or her treatment for that illness, injury, or chronic condition.

15. 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”.

16. 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.

17. Can you explain how the percentiles are calculated on the Summary of Your Episode Treatment Groups (ETGs) Report? I.e. What is the “abacus chart”?
Your performance relative to your peers is shown in the form of an “abacus chart”. Using Total Unweighted Proxy Cost, these abacus charts show your percentile rank within your specialty, where the middle of the chart represents the median cost for the ETG. Your placement on this chart may not directly relate to the Amount Above/Below Peers number, as this number shows your percent above or below the mean. The abacus chart shows your placement above or below the median, which is influenced by the number of peers being measured.
18. Can you explain how the percentiles are calculated on the Quality Detail Report?
The percentiles shown on the Quality Detail Report are the percentage of physicians in your specialty whose compliance rate was less than or equal to yours. The peer rankings include all physicians in your specialty, which includes a number of providers with a low volume of observations for that particular measure (e.g. a physician who had one observation for that given measure will have either a 0% or a 100% compliance rate).

The effect of this approach is that you may see what appear to be odd pairings of “peer compliance rate” and “your percentile”. For example, if there were eight physicians in a particular specialty who had observations for a specific measure, and their compliance rates were 100%, 100%, 100%, 100%, 90%, 0%, 0%, and 0%, the peer compliance rate would be 61.25%, while the physician whose compliance rate was 90% would be in the 50th percentile. By providing you with both the peer compliance rate and your percentile, we hope to provide you with information that helps you better understand how your performance compares with that of your fellow specialists.

19. 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.

20. 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.