THE CLINICAL PERFORMANCE IMPROVEMENT INITIATIVE AND PHYSICIAN TIERING

UniCare State Indemnity Plan’s FY 2017 Physician Tiering Program

This brochure describes the UniCare State Indemnity Plan’s physician tiering program for fiscal year 2017.

Spring 2016
Why we are assigning specialty physicians to tiers

Over ten years ago, the Group Insurance Commission (GIC) asked all of its participating health plans to develop and implement a physician tiering program for the non-Medicare products they offer to GIC members. This initiative, known as the GIC’s Clinical Performance Improvement (CPI) Initiative, introduced the application of quality performance measures and cost-efficiency standards as a method to differentiate physicians and inform consumers of those differences.

On an annual basis, UniCare, along with the other health plans offered by the GIC, has participated in the CPI program and has tiered physicians in Massachusetts. At the present time, the tiering program for UniCare applies to all non-behavioral health specialty physicians who may be selected by our members for their care.

The immediate objectives of the CPI Initiative are four-fold:

1. To provide members with information about the relative quality and efficiency (as defined by the CPI assessment) of specialists so they can make more informed choices about their health care options
2. To offer incentives to GIC members, through tiered copays for specialists, to take advantage of that information
3. To encourage providers to use the outcome of the quality assessment to become more compliant with the quality measures over time
4. To encourage providers to examine their use of medical resources compared to their peers, in the interest of becoming more cost-efficient

A variety of health policy experts believe that modifying consumer and provider behavior is one of the keys to increasing the level of quality and reducing the rising cost of health care in the United States. The CPI Initiative is one of the methods promoted by the GIC and its health plans to bring about change that will both improve health care quality and restrain the growth in health care costs.
How our tiering program works

While UniCare is committed to tiering physicians based on an evaluation of both quality measures and cost-efficiency standards, in fact, many specialties have not yet developed a sufficient number of generally accepted quality measures. As a result, when faced with a lack of sufficient quality data to tier a physician, UniCare has assigned the physician to a tier using the efficiency score data alone, when possible.

For more than a decade, the GIC, Mercer Health & Benefits LLC and its partners GDIT, Resolution Health, Inc. (RHI) and the GIC’s six participating health plans have worked together to build and enhance a database to support the CPI Initiative. Each plan contributes its book-of-business commercial claims from the three most currently available calendar years. The claims submitted are “de-identified” to remove any member-identifying information, and pertain only to enrollees in Massachusetts. This CPI Database contains detailed claims data for approximately 15,000 Massachusetts physicians, and is used as the source to assess the quality and cost-efficiency of each physician’s medical practice.

The UniCare State Indemnity Plan uses a three-tier approach for categorizing specialty physicians and tiers them at the individual level, as described more fully below. Members in our non-Medicare plan options pay different office visit copays for specialty physicians, depending on which of the three tiers their physicians have been assigned to.

<table>
<thead>
<tr>
<th>For office visits with:</th>
<th>Members pay:</th>
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<tbody>
<tr>
<td>Tier 1 physicians</td>
<td>$30 copay</td>
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<tr>
<td>Tier 2 physicians</td>
<td>$60 copay</td>
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<tr>
<td>Tier 3 physicians</td>
<td>$90 copay</td>
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More about the CPI process

The GIC adopted version 7.6 of OPTUMInsight’s Episode Treatment Grouper (ETG), which provides severity-adjusted data in the assessment of cost-efficiency. The use of severity-adjusted data means that the relative complexity of a physician’s patient population is taken into account when comparing the use of resources in the treatment of those patients to that of other physicians.

Also, to more accurately reflect appropriate resource use for those physicians whose specialties tend to be more procedurally based, the type of treatment (procedural versus non-procedural) has been taken into account in developing the comparative norms for those specialties. This methodology applies to the following specialties: Dermatology, Cardiovascular Disease, ObGyn, Otolaryngology, Orthopedic Surgery, Hematology and Oncology, Ophthalmology, Urology, Podiatry and General Surgery.
Note: UniCare does not tier primary care physicians (PCPs), but does provide them with the quality score produced by the assessment process. We encourage PCPs to find ways to use these data in their practices. PCPs can request the more detailed data reports upon which the quality score is based. Copays for PCPs are not determined on the basis of tiering.

Percentile distributions for tier assignments

The GIC and its health plans have adopted a consistent methodology for tiering physicians across all the plans. This methodology uses percentile distributions as the method for assigning specialists to tiers, as follows:

- In specialties where a quality score is available, physicians are assigned Quality Designations of either A, B or C.
- All physicians with Quality Designations of C are assigned to Tier 3. (A Quality Designation of C means that a physician’s performance on compliance with the quality measures was in the lowest third of all physicians in a given specialty.)
- Twenty percent of the physicians in each specialty are assigned to Tier 1, based on the cost-efficiency scores of those physicians.
- Fifteen percent of the physicians in each specialty are assigned to Tier 3, and these include all those physicians with Quality Designations of C and additional physicians with the highest efficiency scores.
- All remaining physicians in a specialty are assigned to Tier 2.
- As explained below, two adjustments are made to the assignment process:
  - Those physicians whose efficiency scores vary by a very small margin at either the 20% or 85% percentiles are subject to reassignment to the next highest tier.
  - Physicians with Quality Designations of “A,” and not initially assigned to Tier 1, are reassigned to Tier 1 if their efficiency scores are greater than the 20th percentile but less than or equal to the 30th percentile for all physicians.

Why some specialists aren’t assigned to tiers

Some specialty physicians may continue to be designated as “ID” or Insufficient Data. These are physicians for whom we received no data at all from the data analysis, or for whom there is inadequate data to evaluate efficiency. A physician may also be assigned to “ID” status as the result of a request for reconsideration.
This can occur if UniCare determines that the reasons for reconsideration have merit, and we disregard the original scores for this CPI cycle, resulting in a default to a Tier 2 designation.

Radiologists, anesthesiologists, pathologists, emergency department physicians, hospitalists, intensivists and psychiatrists are not included in the CPI Initiative, so they are not tiered. As noted above, primary care physicians are also not included in the tiering process. With the exception of psychiatrists, the specialists are excluded from the tiering Initiative because they are not subject to patient selection or copays.

Psychiatrists are not tiered by UniCare because their copays are set by Beacon Health Options, the behavioral health administrator for the GIC.

Physicians who have been tiered, but feel they are in a similar situation as these excluded physicians, may use the procedures outlined on Page 8 of this booklet to request a review of their assignments.

Assessing quality

The measures used in the quality assessment process were developed by Resolution Health, Inc. (RHI) after a thorough review of the literature. This literature included practice guidelines from medical specialty societies, as well as a final review by physicians from all of the health plans participating in the CPI Initiative.

The quality assessment process is based upon the CPI Database. The use of this database ensures that sufficient data is available to evaluate compliance with the quality measures through claims analysis. Chart review and data from other sources are not included in the quality assessment, and cannot be substituted for the results of this analysis. The most recent two years of data are used as the basis for the quality assessment in the RHI process.

The RHI process starts with the calculation of a physician’s raw quality score, determined as the overall ratio of compliant measures to all opportunities for compliance. It then employs advanced statistical modeling to adjust that score to account for the following factors:

- The specific composition of a physician’s mix of measures, compared to the composition attributed to his/her peer group (measure effect)
- The differences in the likelihood that a physician’s patients will comply with care recommendations made by his/her physicians, controlling for various patient characteristics (patient effect), and
• The relative number of opportunities available in the data for evaluating a given physician (sample size effect)

This statistical model produces a probability distribution around a point estimate (i.e., the adjusted quality score) of a particular physician’s compliance with RHI’s quality measures. This adjusted quality score is the model’s “best” statistical estimate of the chance that a given physician will demonstrate compliance with the quality measures attributed to him or her, after the actual results have been adjusted for “measure effect,” “patient effect” and “sample size effect.” The probability distribution curve around this adjusted quality score also enables the determination of the relative probability that this score represents the “true” score for that physician versus any other score within the distribution.

For purposes of quality assessment for the CPI Initiative, this relative probability is used to place physicians into one of three Quality Designations – the lowest third of the curve (Quality Designation “C”); the middle third of the curve (Quality Designation “B”); or the upper third of the curve (Quality Designation “A”).

- If a physician’s results indicate a 90% or greater probability of belonging to the highest Quality Designation (“A”), he or she receives a Quality Designation of “A.”
- If a physician’s results indicate a 90% or greater probability of belonging to the lowest Quality Designation (“C”), he or she receives a Quality Designation of “C.”
- All other physicians receive Quality Designations of “B.”

Assessing efficiency

GDIT uses Ingenix-Symmetry’s Episode Treatment Group (ETG) methodology to assess physician cost-efficiency. GDIT assigns proxy prices to all the services on the claims in the CPI Database across all the plans. The use of proxy pricing eliminates plan, market, contractual and geographic differences in the costs of services. The claims are then processed through the ETG grouper to determine complete ETG episodes. The resulting data is further refined to enhance the validity of the analysis by adjusting for various cost outliers and by deleting certain episodes, such as those with outlier status for cost (e.g., transplants).
GDIT uses the most recent three years of claims data in the CPI Database to conduct its efficiency assessment. GDIT begins by attributing responsibility for each episode within an ETG to a specific physician. After this, the average medical resource use, determined by the proxy prices, for each ETG within each specialty is calculated. The objective of this calculation is to create a specialty “peer” group against which each physician can be compared. The final set of resource estimates are progressively weighted such that the estimate from the most recent year of claims experience is weighted higher than the estimates from the preceding two years. The resulting weighted averages, by specialty, serve as the normative baselines for physician cost-efficiency evaluation.

**Determining the cost-efficiency score**

To derive a cost-efficiency score – or “e-score” – for a given physician, his or her resource use for the mix of ETGs, weighted by the number of episodes within each ETG attributed to him or her, is compared to the average resource use by same-specialty physicians, for the same weighted mix of ETGs. In other words, the analysis seeks to answer the question: how did this physician compare to his or her peers, within the same specialty, in terms of average resource use for managing the same set of conditions.

The answer to this question is expressed as a ratio (i.e., the e-score):

- A given physician’s proxy-priced, actual resource use estimate for a given set of ETGs serves as the numerator, and
- The average proxy-priced resource use for all physicians in that given physician’s specialty for the same set of ETGs serves as the denominator

Starting in FY 2014, these data were also severity adjusted so that the resource use comparison takes into account the complexity of the patients being treated by the physician.
A combined e-score of 1.00, then, indicates that a physician’s resource use for the weighted mix of ETGs that he or she treated was the same as the average resource use demonstrated by fellow specialists, for the same mix of episodes, over the same time period. A physician with a combined e-score of less than 1.00 indicates that he or she performed more efficiently than the average, while a physician with an e-score above 1.00 performed less efficiently than the average.

As part of our ongoing efforts to make the assessment process as fair and accurate as possible, starting in FY 2013 GDIT eliminated ETGs of questionable relevancy to a given physician’s practice, prior to applying the cost norms discussed above.

Assigning specialists to tiers
The following section outlines the approach we will be using to tier specialty physicians in FY 2017.

Step 1: Your quality designation is reviewed.
- If the quality assessment results determine that a physician received a Quality Designation “A” or “B,” or if there is insufficient data to complete a quality assessment of the physician, the process continues to Step 2.
- If the quality assessment results determine that a physician received a Quality Designation “C” with at least a 90% confidence level, the physician does not meet the quality threshold. That physician is assigned to Tier 3 and the tiering process will be concluded.

Step 2: The cost-efficiency data is evaluated.
- On a specialty-by-specialty basis, physicians are ranked by e-scores from lowest to highest.
- The physicians with the lowest e-scores in each specialty are assigned to Tier 1 to make up 20% of all physicians in that specialty.
- The physicians with the highest e-scores in each specialty are assigned to Tier 3 to make up 15% of all physicians in that specialty in that tier. Note that some of the physicians constituting that 15% of physicians include physicians already assigned to Tier 3 because of Quality Designations of C.
- The remaining physicians in each specialty are assigned to Tier 2.
Step 3: Final Adjustments to the tiering process.

- Those physicians who receive “A” Quality Designations, but whose e-scores fall just short of the Tier 1 cutoff, are moved to Tier 1 if their e-scores fall between the 20th and the 30th percentile.
- An adjustment is made to take into account those physicians whose e-scores vary by a very small margin at either the 20% or 85% percentiles so they are not penalized and assigned to a lower tier. Those physicians in Tier 2 or Tier 3, who are not assigned to the next highest tier because their e-scores are within .005 of the specialty’s cutoff point, are reassigned to the next highest tier, i.e., Tier 1 or Tier 2.
- The tiering process is concluded.

Obtaining more information from UniCare

If you have any comments, questions or requests for additional information regarding the CPI Initiative, you can direct them to UniCare Network Services staff in one of the following ways:

- By phone at (800) 480-7587
- By fax at (978) 474-6188
- By dedicated email at cpidata@anthem.com
- By the U.S. Postal Service – mail to: UniCare Life & Health Insurance Company, Attn: CPI Initiative Manager, 300 Brickstone Square, 8th Floor, Andover, MA 01810

If you disagree: requesting a review

Please note that, in conjunction with the GIC, all of the health plans have adopted a standard approach to physician requests for a reconsideration of CPI scores and/or tier assignments.

All requests that we review an individual physician’s score or tier assignment must be made in writing, via the above email address, fax number or U.S. mail address, on or before the end of the review period specified in our letter mailed to you in January 2016.

If you’d like UniCare to review your scores and/or tier assignment, consult our website at unicarestateplan.com for further details on the review process for FY 2017. On the Providers page, select Clinical Performance Improvement (CPI) Initiative under Quick Links; then select the link for FY 2017.
Communicating physician tiers to GIC members

During the GIC’s annual enrollment in the spring, we provide information about the CPI Initiative and physician tiering program to current and prospective members of our non-Medicare plans. We explain how practice quality and cost-efficiency measures for physicians are assessed, and how specialty physicians are assigned to tiers. We also provide physician listing information that indicates the tiering assignment of each physician, and we maintain a website with this information at unicarestateplan.com. We let members know that all physicians remain available to them within their specific plan options, regardless of their tier designations.

In our communications, we stress the need for plan members to act increasingly as “prudent buyers” when they obtain health care, to help preserve both the comprehensiveness of their existing benefits and the range of health care choices available to them. We explain that tiering results should only be one of the factors considered in choosing a physician. Finally, while we tell our members how the relative quality and cost-efficiency scores were determined and how physicians were assigned to tiers, at this time we do not provide actual, physician-specific scores in our member communications.

More resources

For additional resources on the CPI Initiative, specific information about ETGs, quality measures and other related topics, please visit UniCare’s website at unicarestateplan.com. On the Providers page, select Clinical Performance Improvement (CPI) Initiative under Quick Links; then select the link for FY 2017.

The data used in the CPI Initiative have been provided to UniCare Life & Health Insurance Company by Mercer Human Resources, Inc. and Resolution Health, Inc. pursuant to a contract between Mercer and the Massachusetts Group Insurance Commission (GIC), which requires Mercer to arrange for analyses of GIC health plan claims data in an effort to assess the relative quality and cost-efficiency of medical practice in the Commonwealth of Massachusetts. UniCare has relied on these data and analyses in its assignment of physicians to specific tiers under the GIC’s Clinical Performance Improvement (CPI) Initiative. UniCare assumes no legal responsibility for the accuracy and/or completeness of any of the information contained in these data.