



In an effort to promote quality improvement and cost efficiency in the delivery of health care, in 2003 the Massachusetts Group Insurance Commission (GIC) established the Clinical Performance Improvement Initiative (CPII).

CPII involves aggregation of a consolidated multi-plan claims database from all GIC participating carriers to construct quality of care and cost-efficiency profiles used in developing a tiered network. All plans are required to use the quality data from Resolution Health Inc. as the initial quality hurdle. Final tiers are based on the quality and efficiency scores provided by Mercer after extensive analysis of the paid and denied claims submitted by the health plans and are applied by NHP **without** modification.

For SFY12, the GIC plan design will continue to include three tiers, with different office visit co-pay amounts assigned to each. Tier designations become effective July 1, 2011 and are reflected in the NHP provider directory for GIC participants, and other relevant GIC communication materials.

NHP's tiered network applies to GIC enrollees only. Tier assignments apply to office visit co-pay amounts only and do **not** affect current provider contract terms and/or reimbursement rates. A tier designation is not an endorsement or recommendation by NHP and does not suggest high quality or substandard care for an individual patient by any given practice or provider. In addition to quality designations, other factors such as a provider's medical training, hospital affiliation, malpractice history, appointment access and interpersonal skills should be considered by a member when selecting a provider.

#### STATE FISCAL YEAR (SFY) 2012

NHP tiers the following physician specialties:

• Cardiology	• Endocrinology	• ENT/Otolaryngology
• Gastroenterology	• Obstetrics/Gynecology	• Orthopedic surgery
• Pulmonology	• Rheumatology	• Primary Care

The overall statistical methodology for measuring quality remains unchanged. However, for SFY12 the GIC quality designation for tiered specialists is based upon two data sets, which include claims data from the current and previous reporting periods. A physician's total number of observations and opportunities for compliance are combined into an overall score for both reporting years.

## SPECIALTY CARE PROVIDERS

NHP tiers specialty providers at the **individual** level.

To improve the validity of the data and to be consistent with NCQA recommendations, a physician must have a combined total of at least 30 observations as reported by all carriers to be evaluated on quality. Otherwise, the physician is evaluated on cost-efficiency measures alone.

When evaluating for cost-efficiency, physicians with less than a combined 30 episodes of care are assigned to Tier 2.

### Quality of Care Assessment

The quality assessment for NHP specialty providers is based upon the Quality Designation scores provided by RHI.

- RHI assigns a Quality Designation of “A”, “B” or “C” where “A” is the highest quality of care.
  - Physicians who have a 75% or greater probability of a “C” Quality Designation as defined by RHI are automatically placed into Tier 3. No cost-efficiency assessment applies.
  - Physicians who have a Quality Designation score other than “C” are eligible for cost-efficiency assessment to determine their final tier assignment. This includes physicians who have insufficient data for measuring quality (i.e. less than 30 observations).

Please refer to the Brief Overview of the CPI Statistical Methodology for additional information on how quality designation scores are calculated.

### Cost-Efficiency Assessment

Cost-efficiency scores developed by Mercer/ViPs are used to establish upper and lower efficiency threshold limits for each physician specialty.

- Specialty physicians who exceed the upper Efficiency threshold limit are eligible for Tier 1.
- Specialty physicians who fall within the upper and lower Efficiency threshold limits are eligible for Tier 2. This designation also applies to Specialty physicians who have insufficient data for tiering (i.e. less than 30 episodes).
- Specialty physicians who fall below the lower Efficiency threshold are automatically eligible for Tier 3.

## PRIMARY CARE PROVIDERS

NHP tiers Primary Care Providers at the **group** practice level using combined scores of all PCPs within the group.

To improve the validity of the data and to be consistent with NCQA recommendations, physician groups must have a combined total of at least 30 observations as reported by all carriers to be evaluated on quality. Otherwise, the practice is evaluated on cost-efficiency measures alone. When evaluating for cost-efficiency, provider groups with less than a combined 30 episodes of care are assigned to Tier 2.

### Quality of Care Assessment

- NHP calculates a quality score for PCP groups using the average of **all** physicians within the group practice.
  - To be eligible for Tier 1, the Primary Care group must achieve scores **at or above** the 50<sup>th</sup> percentile for quality;
  - Primary Care groups performing above the 10<sup>th</sup> percentile for quality of care are then eligible for cost-efficiency to arrive at the final tier designation.
  - Primary Care groups that perform at or below the 10<sup>th</sup> percentile for quality are automatically assigned to Tier 3. No cost-efficiency assessment applies.

### Cost-Efficiency Assessment

- Cost-efficiency scores developed by Mercer/ViPs are used to establish upper and lower efficiency threshold limits.
  - Primary Care groups that exceed the upper efficiency threshold limit and perform above the 50<sup>th</sup> percentile for quality are eligible for Tier 1.
  - Primary Care groups that fall within the upper and lower efficiency threshold limits are eligible for Tier 2. This designation also applies to Primary Care groups who have insufficient data for tiering (i.e. less than 30 episodes).
  - Primary Care groups that fall below the lower efficiency threshold limit are automatically eligible for Tier 3.