

# THINC RHIO, Inc.

Taconic Health Information Network and Community

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## *Quality & Clinical Committee*

*October 23, 2008*

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A meeting of the Quality & Clinical Committee of the THINC RHIO, INC., a New York not-for-profit corporation (the “Corporation”), was held on October 23, 2008, beginning at 1:00 PM.

Participating were:

- Deb Chambers
- Sanford Cohen, MD
- Francois De Brantes
- Luis Estevez
- David Hassoun
- Rainu Kaushal, MD
- Paul Kaye, MD
- Karen Kvalovsky
- Ravinder Mohini, MD
- Thomas Murray
- Jeff Ross, MD
- Jerry Salkowe, MD
- Jessie Singer
- Randy Solomon, MD
- Jessie Sullivan, MD
- Cliff Waldman, MD
- Jim Walters

  

- John Blair, III, MD
- Susan Stuard
- Asha Upadhyay

### **I. Welcome and Introduction; Approval of September 2008 Meeting Minutes.**

Susan Stuard welcomed the committee members. A motion was made to approve the minutes of the September 2008 meeting. The motion was seconded and the minutes were unanimously approved.

Susan Stuard made a power point presentation to the Committee which included a recap of the project status, review of the physician attribution logic, incentive payment approach and incentive payment thresholds.

### **II. Recap of project status**

Susan Stuard informed the committee that MedAllies has successfully completed the ViPS contract. The proposed contract between MedAllies and the health plans has gone out for review. THINC and MedAllies have had several calls with the participating health plans to discuss the contract. Dr. Blair asked the health plans to expedite the review of these contracts as we are on a tight timeline for production of the first quality report card. Dr. Cohen asked if the contract that has been sent to the health plans reflect the contract with ViPS. Dr. Blair said yes this is correct.

MassPro is being engaged by THINC and TIPA to support the medication home practice transformation. TIPA will also be engaging TranforMED for practice transformation work. The November committee meeting will discuss how the transformation work will be occurring. THINC has been notified by the New York State Department of Health (NYSDOH) that they are requiring that the numerator and denominator information be sent to IPRO by the end of 2008. THINC has discussed this with IPRO. They are aware that not all the health plans will be able to supply the data to ViPS by the end of 2008. THINC is talking to ViPS about how and when we can get these data to IPRO.

THINC expects the first quality report to come out in Q1 2009 based on the 2007 data for the 10 HEDIS measures. The second report will come out in Q4 2009 based on the 2008 data, the 10 HEDIS measures, and the clinical EMR measures. In addition, this second report card will inform about the status of physicians achieving Level 2 NCQA Medical Home recognition. Dr. Cohen asked if there will be protected health information (PHI) on the quality reports and if THINC can share the data specifications that ViPS is requiring. THINC will send Dr. Cohen the data specifications from ViPS. Dr. Blair said that the reports will not have PHI information but the data submission to ViPS will have PHI and will be protected with use of a business associate agreement.

### **III. Review of physician attribution logic**

Susan Stuard said that over the next two to three months the committee will need to make a recommendation about the attribution logic. THINC has received requests from the health plans to use both the NYQA and the United logic. She said that she would like to review both of them today to generate some familiarity and set the stage for further discussion.

#### **NYQA Methodology:**

The NYQA methodology relies first on enrollment PCP and then moves to calculation of the imputed PCP. United methodology appears to rely on the imputed PCP. She said that the health plans' perspectives will be strongly shaped by which group they are participating with.

Susan Stuard reviewed the NYQA enrollment PCP methodology. NYQA selects an enrollment PCP as a members PCP when a provider exists on the enrollment record on the last day of the reporting period. The enrollment PCP will be selected for a member in an HMO or POS product where applicable. The enrollment PCP will be selected regardless of the claim submission. NYQA is working within the concept that only one provider will be selected for each member measure combination. This will not be a part of the THINC project.

The NYQA imputed PCP methodology selects a provider as the member's attributed provider when that provider has the greatest number of E&M visits during the 12 month period prior to the end of the measurement period. This is the primary criteria. They are looking at who has the most utilization. The member must have at least one preventive care visit or two E&M visits with the selected provider in the most current 12 months of the measurement period to be the imputed provider. The provider with the greatest number of visits will be selected for each member measure combination. The hierarchy for the attribution selection will result in the provider with the greatest number of visits being selected. One preventive visit does not take precedence over 2 E&M visits.

The United methodology program looks back 18 months and pulls all primary care claims with a designated code and all prescriptions written by primary care physicians. It selects a provider as the member's attributed provider when that provider has the most recent date of service connection with the

member. Namely, it is derived from "most current / latest service (or fill) date" connection of a member to a primary care physician (based on IM, FM, PEDS specialties). If there is a tie, then the methodology assesses the most utilization in the last 18 months. If there is still a tie, then most dollars spent. Susan Jessie Sullivan said that this method is heavily dependent on knowing the billing provider for the specialty and she is not clear on how and if the health plans are getting that information to ViPS. Susan Stuard said she does not have enough information to clarify this but she will look into this.

Susan Stuard said that THINC asked Cornell to review the two methodologies and Cornell raised a couple of issues that might impact the evaluation. NYQA uses the rolling attribution methodology where the information is updated every quarter. This could create a lot of noise in the evaluation. On the enrollment PCP, Cornell suggested that the group might want to add extra criteria of an actual visit with the enrollment PCP. Susan Stuard said that THINC might be able to use a hybrid approach and meet the great majority of needs. For example, use NYQA methodology with attribution to enrollment PCP, if applicable, then use United and/or NYQA methodology for imputed PCP.

Francois de Brantes said that there is no solution that is going to provide a clean output as long as you restrict the quality assessment attribution to a single attribution. He said that as part of the medical home we want to encourage care coordination. By forcing single attribution, it continues to push the concept of fragmentation rather than care coordination. He said it is not complicated to do multiple attributions. This helps you get out of the concept of "this is not my patient" and improves care coordination. Susan Stuard said that she would like to look into this and bring this back to the group for further discussion. David Hassoun said that he was under the impression that the United method used the assigned PCP and only used the imputed PCP if there was not an assigned PCP similar to NYQA. Susan Stuard said that she would like to follow up with David Hassoun on this item.

#### **IV. Recap of one-on-one conversations with the health plans regarding incentive payment approach**

With respect to the incentive payment approach, THINC's ideal goal is to define a payment approach that all participating health plans would use. If not possible, we would like to seek to establish a "floor" and health plans can have variation above that floor. We are focusing on operations of payment approach, not focusing on the dollar amounts – but how and when payments are made.

Susan Stuard informed the committee that she has had one on one conversations with the health plans about payment approach. She is presenting a draft model for discussion. She would like to take their comments today and then take the rest of the comments offline. She presented a graphical slide showing an 80/20 split. The slide shows that 500 physicians will receive a quality report card. And we are asking the health plans to provide 20% of the total incentive payments for achievement on the quality metrics. For the subset of the 250 physicians, who will be seeking to achieve Level 2 Medical Home recognition, an allocation of 80% of the total incentive pool is planned.

With respect to payment frequency, there is an overall preference by the health plans for one incentive payment by health plan in Q1 2010. The logistics of the payment by NYS DOH must still be worked out, but we expect that the NYS DOH matching incentive payment will follow on the heels of the health plans' payment. A few of the health plans are concerned about time delay and financial outlay for practices for medical home. For those health plans, THINC will seek to provide information regarding medical home level 2 as soon as it is achieved. We are still unclear about what time gap will be. It will

likely take most of 2009 to achieve Level 2 and incentive payment will be in early 2010. We will keep committee updated with regular reports on status of medical home achievement.

With respect to medical home payments, a couple of health plans were interested in providing incentives for achievement of Level 1. Susan Stuard clarified that the initial project design was that incentives would be paid only be for Level 2. She noted that THINC is not planning to focus on practice transformation work on items and paperwork that would lead to Level 1. We will instead focus all efforts on Level 2. THINC is open to reassessing this with the Committee in mid-2009.

Dr. Cohen asked what the time limit is to achieve Level 2 recognition. Dr. Blair said that the time limit is to end of 2009. If they do not achieve this, then they will be part of the quality reporting component of the project. Dr. Blair said that he hopes that those that do not achieve this by end of 2009 will continue to push forth then they will be eligible the next year.

## **V. Discussion of incentive payment thresholds**

Susan Stuard said that there her feedback from the health plans varies regarding the quality metrics thresholds. Some have own thresholds that they would like to use for incentive payments, while some are looking at developing a common methodology for thresholds. She said her instinct is to stay away from this issue in first phase. She would like the health plans define their own thresholds in first phase and, if there was a lot of interest, the committee could talk about consensus on thresholds in a later phase.

She said the next meeting will include a project recap, a more focused presentation on the Medical Home transformation and attribution logic. She asked the committee to feel free to reach out to her with any questions.

## **VI. NEW BUSINESS**

The next committee meeting is on November 20, 2008. There being no further business for discussion, the meeting was adjourned at 2:00 PM.

Reviewed and Approved:

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Dr. Gregory Spencer, Committee Chair