MN Community Measurement (MNCM)

Measurement and Reporting Committee (MARC)

Wednesday, April 12, 2017

Meeting Minutes

Members Present: Barb Anderson, Janet Avery, Cara Broich, Peter Dehnel, Howard Epstein, Matt Flory, Stefan Gildemeister, Greg Hanley, Tim Hernandez, David Homans, Jordan Kautz, Sue Knudson, Deb Krause, Robert Lloyd, Bill Nersesian, Chris Norton, Rahshana Price-Isuk, Jeff Rank, Jonathan Rose, Allan Ross, Laura Saliterman, David Satin, Mark Sonneborn

MNCM Staff: Tina Frontera, Amy Krier, Collette Pitzen, Anne Snowden

Topic	Discussion
Welcome & Introductions	Howard Epstein called the meeting to order and welcomed committee members and observers. Howard reviewed the committee charter. MARC members introduced themselves followed by the meeting observers. Howard then noted that Conflict of Interest (COI) disclosures for all MARC members were reviewed by a joint MNCM/ICSI COI steering committee and that all members were approved for full participation on MARC.
Approval of Minutes	The committee reviewed minutes from the December 2016 meeting. **David Satin made a motion to accept the minutes; Mark Sonneborn seconded the motion. Motion passed.**
Recommended changes to DDS measurement specs for Colorectal Cancer Screening (2018RY) – for approval	Howard directed committee members to the handout that included the recommended changes to the Colorectal Cancer Screening measure for the 2018 report year and noted that these recommendations are part of the continuous measure alignment process. Howard then introduced Collette Pitzen, Clinical Measure Developer at MNCM, to present the recommendation. Collette explained that the intent of measure alignment, all aspects of measure specifications, is to ensure results are comparable. She noted that in Minnesota we are fortunate to have agreements across stakeholders to use a centralized source and one set of specifications for measurement, noting that is not necessarily true on the national level. Collette reviewed the history of the adaptation of the HEDIS colorectal cancer screening measure into the MNCM Direct Data Submission (DDS) measure that is utilized today. There is currently a Colorectal Cancer Screening measure, stewarded by the National Committee for Quality Assurance (NCQA), included in the Merit-Based Incentive Payment System (MIPS) Quality performance category. MNCM's DDS Colorectal Cancer Screening measure is entirely aligned with NCQA's measure in MIPS, except for two items: 1. Death during the measurement period a. MNCM allows exclusion of patients that die during the measurement period, though it is not a required exclusion; the NCQA measure does not allow this exclusion. b. Including these patients is expected to have a minimal impact based on the screening method chosen. With the exception of annual stool blood testing, most screening modalities cover the patient for multiple years. Currently, 4.8% of patients choose annual stool blood testing as compared to 95% of patients being screened via colonoscopy. c. Average life expectancy in the state of Minnesota exceeds the age parameters of the measure (patients aged 50 to 75). 2. Encounter type criteria a. NCQA includes new patient office visits as well as home visits; MNCM's measure specifications do not currently include these visit types. b. Impact of including these two new encounter types is expected to be minimal. **RECOMMENDATION** Modify specifications for the Colorectal Cancer Screening measure in the 2018 report year to align with MIPS: 1. Remove the exclusion for death during the measurement period; AND 2. Expand the encounter type criteria to align the measure as specified in MIPS to include new and established patient office visits and home visits. **<u>Questions/Comments/Discussion</u>** Howard noted that federal programming is going to be a large driving force in measurement in the future. Sue Knudson commented that for PQRS GPRO Web Interface submissions, CMS removes deceased patients before calculating results. Collette noted that GPRO Web Interface specifications are different than Registry specifications. Sue noted that many practices utilize the Web Interface submission option and expressed concern that the specifications may be

	different than those with which MNCM is trying to align. She suggested reaching out to stakeholders prior to recommending changes to have a greater understanding of the impact. David Satin expressed support for changes that align specifications with the measures included in MIPS. That said, he noted that the recommended change to remove the exclusion for patients deceased during the measurement period could disproportionately impact clinics that serve low income populations as these populations have a lower life expectancy and are more likely to receive a stool blood test rather than a colonoscopy. Allan Ross noted that while he's in favor of alignment, home visits, an encounter type included in the recommended changes, can also indicate chronic disease and can be impacted by removing the death exclusion. Tim Hernandez commented that including patients that died during the measurement period in the measure could be difficult for providers to accept. David Homans commented that while alignment is important, it is also important to consider the added burden of change management on practices as it adds staff hours whenever a measure change is made. Barb Anderson concurred. Howard expressed concern that if we delayed the decision to move forward with aligning the MNCM DDS specifications with the registry specifications, it doesn't change the fact that the different CMS program specifications are not aligned (GPRO WI versus registry specification). Collette reminded the committee that we are not the developer/steward of this measure and that it is unfortunate that measure specifications are not aligned across CMS programs and data sources. As a QCDR registry, MNCM must be aligned with the federal registry specifications which can be used for state, health plan and federal programs. Anne added that MNCM, along with the rest of the country, has been getting up to speed on the new requirements of the MIPS program and, provided that the CMS measures remain stable, it is anticipated that future changes will not require such a quick turnaround. Stefan Gildemeister noted that many aspects of healthcare measurement are currently in flux at state and federal levels. He pondered whether this decision should be delayed until state reporting requirements are settled in the legislature. Howard pointed out that we are already in the performance period and that CMS will be a primary driver of future measurement. Janet Avery inquired whether it was appropriate to make changes now given the potential federal program instability with the change in administration. Howard noted that MACRA has largely bipartisan support and he doesn't see it being in jeopardy. Sue commented that alignment is important, but there are still outstanding questions that need to be addressed. Anne noted that going forward MNCM will certainly try to influence change nationally, but for now we must align with what is already in the MIPS program. **Janet Avery made a motion to approve the recommendation as presented. Bill Nersesian seconded the motion. There were five opposed. Motion passed.**
Update on operational changes to Colorectal Cancer Screening and Optimal Asthma Control for 2018 Report Year	Chris Norton turned over the discussion to Anne Snowden, Director of Performance Measurement, Validation and Reporting at MNCM, to present an update on operational changes to the Colorectal Cancer Screening and Optimal Asthma Control measures. Anne explained that the Colorectal Cancer Screening and Optimal Asthma Control measures were included in the new Merit-Based Incentive Payment System (MIPS) Quality performance category for the CMS-defined 2017 Performance Period. In order for MNCM's data set to align with those specified in federal programs, dates of service, currently July to June annually, must change to calendar year (January to December). This will impact result trending for one year due to an overlap of dates of service measured in the transition year. From an operational standpoint, this alignment involves moving data submission for these two measures to Cycle A for the 2018 report year and thereafter, which occurs in January/February. The annual MIPS data submission deadline of March 31 is driving this change in timeframe. Anne noted that alignment of the dates of service and data submission timeframes would not only support medical groups in meeting federal MIPS reporting requirements but would also support health plans in meeting state and national reporting requirements. Anne noted that these changes do not apply to the Maternity Care: C-Section Rate measure as it is not included in MIPS and it is being considered for potential retirement for the 2018 report year by MNCM's Measure Review Committee.

	In summation, Anne explained: 1. For the Colorectal Cancer Screening and Optimal Asthma Control DDS measures, MNCM will move to calendar year dates of service (January-December) starting in the 2018 report year (2017 dates of service) to help medical groups meet MIPS requirements and to support health plans with HEDIS data collection for state and federal requirements. 2. Starting in the 2018 report year, data files for these measures will be submitted by medical groups during Cycle A (Jan/Feb 2018). **Questions/Comments/Discussion** Peter Dehnel expressed concern that the change in reporting cycle could be potentially disruptive for health plans. Cara Broich, Greg Hanley and Howard Epstein noted that it would be beneficial for their health plan organizations to receive this supplemental data for HEDIS. Greg added that it would be particularly helpful with the colorectal cancer screening measure because of the 10 year look back for data. Barb inquired as to whether the new data submission deadlines and associated timelines had been set. Anne stated that work to determine the timelines was in progress and input or suggestions were welcome. Tim expressed concern that reporting in the first quarter of the year could become overwhelming to groups. He noted that primary care practices, which carry the burden for the majority of measures, have many reporting responsibilities in the first quarter of the year. Anne noted that MNCM has made efforts to ease the burden at the start of the year by moving annual registration earlier and by releasing Data Collection Guides and Tools earlier. She indicated that MNCM was making these changes to assist groups with meeting federal reporting requirements. Howard added that there is also a continued focus on measure retirement in an attempt to alleviate burden. Sue commented that this MIPS transition period is very challenging adding that it is beneficial to be discussing these issues in advance. Anne added that general communications about changes will go out later this month. Barb noted the increased lead time created by the early release of the Data Collection Guides is appreciated and agreed that stakeholder input in the decision on future timelines would be beneficial.
Update on MNCM Registry and measures activity for CMS Merit-Based Incentive Program (MIPS)	Chris then introduced Tina Frontera, Chief Operating Officer, to present an update on MNCM measurement activity. Tina reviewed the ways MNCM currently supports various measurement programs (e.g., Health Plan pay for performance programs, SQRMS, Health Care Homes, PQRS) and went on to explain MNCM's plan to become a CMS approved Qualified Clinical Data Registry (QCDR) to support the reporting of measures for the Quality performance category in MIPS. Tina noted that MNCM already collects data for some measures included in MIPS. QCDR's have the benefit of submitting other community-based measures not currently included in MIPS (non-program measures) for CMS consideration. If approved by CMS, MNCM's non-program measures could be utilized to help medical groups fulfill reporting requirements in the MIPS Quality performance category. The intent being that medical groups could submit data for current DDS measures and that one submission could satisfy state, federal and health plan requirements as well as public reporting goals. More information on this topic will released as it is available. **Questions/Comments/Discussion** Sue inquired as to how many groups MNCM expects to take advantage of MNCM's status as a QCDR. Tina noted that a survey to determine interest in the MIPS reporting service will be sent to all medical groups. She also shared that approximately 15 medical groups representing 500 providers participated in PQRS through MNCM this year. Sue noted that this is a nice service for smaller practices. Tina pointed out that the advantage of this service is potentially cutting down on resource burden for reporting requirements. David S. stated that one of the roles of MNCM is being strategic and forward thinking in relation to federal reporting requirements. He inquired as to the strategic vision of the future of MNCM. Tim responded that board level conversations have revolved around staying ahead of federal reporting requirements and changes in HEDIS measures as well as how that will look in terms of burden and establishing the proper systems to address changes in the landscape without losing what makes MNCM great. He noted that the board has had input from consultants in discussions on these topics. Some good decisions have come from those discussions but more work needs to be done around business and revenue generation. Tina noted that a general communication about MNCM's strategic plan is most likely needed. Greg noted that the movement toward outcome measures rests on access to data. With the movement by NCQA away from hybrid measures there is an opportunity for MNCM to fill the gap in sharing data from outcome measures with multiple stakeholders.

Update on 2017 MNCM Seminar – Wednesday, September 13, 2017	Finally, Chris turned the discussion over to Tina to provide an update on the 2017 MN Community Measurement Seminar. Tina noted that the annual seminar will be held on Wednesday, September 13, 2017 at the Earl Brown Heritage Center from 8:30 a.m. to 5:00 p.m. The keynote speaker will be Don Shelby. Shantanu Agrawal, the new President of NQF, will speak on the national perspective. There will be a panel on health equity as well as breakouts on Cost, Patient Experience and quality measurement as it relates to reporting alignment.
Meeting Adjournment	Chris shared that Julie Sonier will be the new President of MNCM effective May 1, 2017 and invited committee members to review the press release included in their packets. Jim Chase will be leaving MNCM on April 28 after 13 years as president. Chris also noted that there would be no May MARC meeting due to the ICSI Colloquium. The next meeting will be Wednesday, June 14. Chris adjourned the meeting.

Next Meeting: Wednesday, June 14, 2017