MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, June 14, 2017
Meeting Minutes

Members Present: Barb Anderson, Janet Avery, Cara Broich, Peter Dehnel, Howard Epstein, Matt Flory, Stefan Gildemeister, Greg Hanley, Tim Hernandez, Jordan Kautz, Sue Knudson, Deb Krause, Robert Lloyd, Bill Nersesian, Chris Norton, Rahshana Price-Isuk, Jonathan Rose, Laura Saliterman, David Satin, Mark Sonneborn
MNCM Staff: Tina Frontera, Amy Krier, Gunnar Nelson, Collette Pitzen, Anne Snowden, Julie Sonier
Members Absent: David Homans, Jeff Rank, Allan Ross

Topic	Discussion
Welcome & Introductions	Chris Norton called the meeting to order and welcomed committee members and observers. MARC members introduced themselves followed by the meeting observers. Chris thanked observers for attending the meeting reminding the guests that only official members of the committee participate in the meeting discussion and to direct questions to info@mncm.org.
Approval of Minutes	The committee reviewed minutes from the April 2017 meeting. **Janet Avery made a motion to accept the minutes; Laura Saliterman seconded the motion. Motion passed.**
MNCM Announcements	Chris introduced Julie Sonier and Tina Frontera, President and Chief Operating Officer (COO) at MNCM respectively, to share updates from MNCM. Julie began by introducing herself to the committee sharing her professional background. Tina then announced her planned retirement. Tina explained that she planned to continue onboarding work with Julie and would stay to onboard the new COO but plans to leave her position by the end of the year. Julie noted that the COO position would be posted in the next week or so and encouraged the committee to share suggestions to fill the position.
Measure Review Committee (MRC) Recommendation on DDS measures – for approval	Chris then turned the discussion over to Collette Pitzen, Clinical Measure Developer at MNCM, to present the recommendation brought forward by the MRC. Collette explained that the Measure Review Committee (MRC), a sub-committee of MARC, met earlier this month to review several direct data submission (DDS) measures. The MRC is charged with the annual review of DDS and HEDIS measures reported by MNCM. It is convened twice per year. Based on their review, the MRC can recommend the following actions be made on measures: • Continue without changes to the measure construct • Higher level review; refer to measure development workgroup • Transition to monitoring; collect without public reporting • Retirement The measures that were reviewed at the June 5 meeting, and resulting recommendations, include: **Measures Reviewed** — **MRC Recommendation** Optimal Diabetes Care — Continue Optimal Vascular Care — Continue Optimal Asthma Control — Continue Colorectal Cancer Screening — Continue Maternity Care: C-section Rate — Retire in 2018 report year Pediatric Preventive Care: Overweight Counseling — Retire in 2018 report year Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening — Continue Depression measures were not included in the review because of recent redesign. Maternity Care: C-Section Rate Rationale for Retirement: • Some improvement (decrease) in rate noted the first 2 years, but the last 3 years rate is flat at 22.2 percent • Rate is 3.5 percent below the national primary C-section rate of 25.7 percent

	• The true acceptable rate of C-section is unknown and is not zero; in many cases a C-section a medically necessary procedure as well as other variables including patient, provider or facility preference in addition to a high incidence of medical malpractice litigation. • Measure is somewhat burdensome to collect, only 24 percent of the practices are able to extract all of the information via query, 76 percent require manual abstraction. Technically challenging because the true data source of the outcome resides in hospital data systems where the procedure occurs. Pediatric Preventive Care: Overweight Counseling Rationale for Retirement: • Process measure that is now topped-out with statewide average at 89.9 percent • Numerator for acceptable types of documentation for counseling for nutrition and physical activity aligned with national measure and is relatively easy to achieve (checklist, giving the patient a pamphlet) with questionable impact on health behaviors. • Measure development workgroup anticipated this measure had the potential to top out once clinic processes and workflows were in place **<u>Questions/Comments/Discussion</u>** Janet Avery inquired as to why the Maternity measure results have been flat. Collette explained that we don't currently have enough information to determine the reason for the plateau in results. Laura Saliterman suggested that the plateau in rates could be representative of a normalized rate. Bill Nersesian, a member of the MRC, noted that he had voted for retirement not only based on the measure's faulty attribution model but he also felt that there was a financial incentive to performing a C-section over a vaginal birth, along with personal incentives (e.g., no need to wait until 3 a.m. for a vaginal birth), noting that there were associated factors that were difficult to measure. Deb Krause, also a member of the MRC, commented that she had voted against retirement of the measure though respected the decision making process of the committee. As a representative of purchasers, she felt there was value in the measure given that there are no other measures of this type in the community, a rate of 22 percent is still relatively high, the financial incentive that Bill mentioned, the risk involved in C-section procedures and the recurrence of the procedure once one is performed. Collette noted that there are other sources of C-section rates (e.g., hospital, state) that could be monitored. Gunnar Nelson noted that once results are risk adjusted for patient age and BMI, there is very little variation in rates. Tim Hernandez commented that DHS pays the same rate for C-section procedures and vaginal deliveries. He also noted that the culture of the hospital where the delivery occurs plays a large part in whether a C-section is performed. Rahshana Price-Isuk asked whether there were future plans for an outcome Pediatric Overweight Counseling measure now that it is known that the processes are in place. Collette stated that there had been discussion of a future outcome measure based on this process measure within the workgroup, but no outcome measure was developed. Laura, the chair of the Pediatric Preventive Care workgroup, noted that there were both challenges and burdens associated with the development of an outcome measure for this population requiring a new workgroup development committee. Pete added that while an outcome measure would be beneficial, provider attribution would be challenging as weight loss can be a multi-year process. Bill noted that the benchmark for overweight adults are those that have been able to attain a healthy weight and remain at that weight for two years; however, a child can grow significantly in two years meaning an outcome measure would have to look at BMI percentiles for children over a long period of time. Cara Broich commented that, from the perspective of the HEDIS version of this measure, it is truly a measure of EMR functionality and whether providers are able to document that the counseling occurred. Tim Hernandez and Rahshana both concurred with Cara. Rahshana additionally noted that the measured actions are happening in clinics even if they are not being documented. Tim noted that only one of the two measures for retirement is truly a primary care measure and recommended that the MRC look more closely at primary care measures for future retirement. **David Satin made a motion to approve the recommendations as presented. Peter Dehnel seconded the motion. Motion passed.**
MNCM Risk Adjustment Committee Recommendations – for approval	Howard introduced Gunnar Nelson, Health Economist at MNCM, to present the recommendations made by the Risk Adjustment and Segmentation Committee. Gunnar began by providing an overview of risk adjustment stating that the purpose of risk adjusting the DDS measures is to acknowledge that some patients bring with them unique challenges that are outside of the providers' control. As many of these challenges are difficult to account for proxies are used as variables (e.g., insurance product as a proxy for patient income). Gunnar reminded the committee that MNCM utilizes an indirect standardization approach to risk adjustment wherein the benchmark to which an entity's results are compared is adjusted by taking into account that entity's unique patient

mix. This method is different from direct standardization where the actual measure results are adjusted rather than the benchmark.

The Risk Adjustment and Segmentation Committee reconsidered the use of insurance product as a proxy for patient income in the risk adjustment plan for the Orthopedic measures. When insurance product was originally considered for the Orthopedic measures in 2015, the sample size was too small to confirm validity of the variable. With the ability to now evaluate multiple years of data, it can be confirmed that the addition insurance product as a risk adjustment variable is valid. Additionally, including insurance product as a variable for these measures would align the risk adjustment plan for these measures with other MNCM DDS measures.

In 2016, MARC approved the Risk Adjustment and Segmentation Committee's recommendation that MNCM not use race, ethnicity, preferred language, or country of origin (RELO) as risk variables because it is impossible to separate the societal impact of race from the racism within the health care system. However, in the Risk Adjustment and Segmentation Committee's study of the use of RELO as risk adjustment variables, the University of MN made two separate recommendations to consider patient location as a proxy for social-economic factors. By recommendation of MARC, MNCM studied the impact of patient location on measure results.

MNCM currently collects patients' five digit ZIP code. The ZIP code would be utilized in conjunction with US Census Bureau data on socio-economic conditions in a given area to create a deprivation index for each patient. The formula developed to create the deprivation index includes:

- Percentage of population with SNAP Benefit
- Percentage in poverty
- Percentage unemployed
- Percentage on public assistance
- Percentage of households that are single female with children

Testing found the effect of zip code level Census information to be very small but still mathematically significant.

David S., as the chair of the Risk Adjustment and Segmentation Committee, commented that the committee saw the development of this deprivation index as a small step forward. He noted that more socio-economic avenues are being explored and clarified that this ZIP code related process adds no additional burden to providers.

RECOMMENDATION

1. Addition of insurance product as a risk adjustor of Orthopedic measures in 2017 to align with all other DDS measures.
2. Addition of socio-economic data from the U.S. Census at the patient zip code level to the risk adjustment variable profile of all risk adjusted DDS measures.

Questions/Comments/Discussion

Howard inquired as to whether more orthopedic practices were reporting on the measures. Anne responded that every year more practices are added, though there is a finite set of practices. The largest practice is not yet participating but MNCM is meeting with them to continue discussions. Collette noted that MNCM is attempting to have orthopedic measures accepted into MIPS.

Rahshana inquired as to whether the recommended deprivation index risk adjustment variable assists stakeholders in looking at health equity and making actionable decisions rather than masking the issues. Gunnar noted that indirect standardization doesn't mask issues and pointed out the availability of the Health Equity of Care Report and the Health Care Disparities Report. Anne added that while risk adjustment creates a fair comparison across clinics, health disparity issues are more clearly seen through segmentation of results.

Barb Anderson inquired as to whether areas with large seasonal populations were taken into count. Gunnar responded that the formula is based on patient ZIP codes that are submitted.

Stefan noted that there will always be limitations in risk adjustment related to patient and environmental/community based factors that affect outcomes, but in the future there could be better methods to capture these factors and should continue this work. He also noted that if the intent is to address disparities, there are a range of tool sets in the policy environment that should be used above and beyond risk adjustment.

Howard inquired as to whether the inclusion of the deprivation index variable was worth the effort involved if the movement in results is slight. Gunnar noted that this variable does incur a very slight change and we do have to be

	cautious of creating the appearance that no other work needs to be done to create a better method. David S. noted that the Risk Adjustment and Segmentation Committee understands that more work needs to be done in this area, but what is being recommended now is a good first step. Janet inquired as to whether a ZIP code area is granular enough to accurately capture socio-economic status. Gunnar commented that moving to a more granular level (street address) would require a change to the data submission process for all measures and would create a larger burden on providers. Tim asked whether all variables in the deprivation index would be weighted evenly. Gunnar confirmed that they would be. Pete commented that the inclusion of the deprivation index variable would acknowledge that there are variations based on where a patient lives (beyond the provider's control), even if producing it at a ZIP code level isn't the ultimate solution. Sue Knudson noted that some health systems want to replicate these measures for real-time tracking, and the addition of this deprivation index variable would be difficult to replicate. Sue wanted the committee to be aware of unintended consequences and confusion that could be brought about with this change. She also expressed concern about the unit of analysis (ZIP code vs street address) stating that one ZIP code can cover a very socio-economically diverse community, noting that a community score may not be reflective of how a household would be scored. Rahshana commented that Minnesotans in general are slow to change and while communities are beginning to become more diverse, the state in general is still segregated and therefore creating the deprivation index at the ZIP code level would produce some useful information. **Mark Sonneborn made a motion to approve the recommendation to add insurance product as a risk adjustor for the Orthopedic measures in 2017 as presented. Bill Nersesian seconded the motion. Motion passed.** **Bill Nersesian made a motion to approve the recommendation to add socio-economic data from the U.S. Census at the patient zip code level as presented. Peter Dehnel seconded the motion. Motion passed.**
Update on Cost and Utilization Measures	Howard turned the discussion over to Gunnar to provide an update on the Cost and Utilization measures. Gunnar introduced Deb Krause as the new chair of the Cost Technical Advisory Group. He went on to explain that the current Total Cost of Care (TCOC) and Average Cost per Procedure measures are based on commercial claims. Results for these measures are displayed alongside the Medicare and Medicaid fee schedule values. Going forward, the Cost Technical Advisory Group will begin work on a Medicaid Total Cost of Care measure to be reported side by side with the commercial Total Cost of Care measure. Additionally the Cost Technical Advisory Group will be working on a Hospital-based Radiology Average Cost per Procedure and will expand the Average Cost per Procedure list by 30 procedures.
Meeting Adjournment	Howard noted that there would be no July MARC meeting. The next meeting will be Wednesday, August 9. Howard adjourned the meeting.

Next Meeting: Wednesday, August 9, 2017