MN Community Measurement

Measurement and Reporting Committee

Wednesday, November 13, 2013

Meeting Minutes

Members Present: Tim Hernandez, Howard Epstein, Ann Robinow, Caryn McGeary, Chris Norton, Darin Smith, Ernie Valente, John Frederick, Kris Soegaard, Linda Walling, Mark Nyman, Mark Sonneborn, Matt Flory, Rahshana Price-Isuk, Robert Lloyd, Stefan Gildemeister, Sue Knudson,
MNCM Staff: Alison Helm, Anne Snowden, Gunnar Nelson, Jasmine Larson, Tina Frontera
Members Absent: Terry Cahill, Craig Christianson, Jeff Rank, Laura Saliterman, David Homans, David Satin
Guests: Kris Kopski (Alternate for David Homans)

Topic	Discussion
Welcome & Introductions	Tim Hernandez welcomed the committee members and everyone introduced themselves. Tim also introduced Kris Kopski, a physician from Park Nicollet, who attended the meeting as David Homans' alternate. Tim reminded MARC members that they have the option of appointing an alternate to attend the MARC meeting if they are unable to attend. Tim also noted that alternates do not have the authority to vote. He encouraged members to contact Anne if they would like to designate an alternate so she can include them on the email distribution list and prepare tent cards. Members with a designated alternate who is planning to attend a MARC meeting are asked to give notice to the chairs, via staff, prior to the meeting.
Approval of Minutes	Chris Norton made a motion to accept the September 2013 meeting minutes. Mark Sonneborn seconded. Motion passed.
Update from Nominating Committee meeting	Anne Snowden provided an update from the Nominating Committee meeting. She noted that the MARC has openings for five members at the end of 2013 because terms are ending. Anne mentioned that MNCM received approximately 2-3 applicants for each opening. Selections were made based on established criteria. New MARC members will start their terms in February 2014, but were invited to attend the December meeting to become familiar with the committee process ahead of time. Anne reviewed the names of the newly selected MARC members: **<u>New MARC member/Type of representation</u>** Bill Nersesian, MD – Fairview Physician Associates (FPA)/Large, metro medical group Dan Walczak – UCare/Health Plan Allan Ross, MD – Ortonville Area Health Services/Small, non-metro medical group Ann Robinow/Consumer Julie Krenik, MD – Hutchinson Health Clinic/Medium, non-metro medical group She noted that this slate of new members was approved by the MNCM Board chair and all new members have been notified and sent orientation materials. In 2014, there will be four openings on the MARC and we will follow a similar process for notifying the community about these opportunities.
REL Reporting Plan for Hospitals	Mark Sonneborn provided his annual update regarding Race, Ethnicity and Language (REL) data collection and reporting by hospitals in Minnesota. The Minnesota Hospital Association (MHA) collects administrative claims data from most Minnesota hospitals. As part of the Aligning Forces for Quality (AF4Q) grant from the Robert Wood Johnson Foundation, there was an expectation to stratify publicly reported measures by Race, Ethnicity, and Language (REL) by 2013, beginning with readmissions measures. The dates for key milestones were noted. In addition to REL data being useful for quality measurement activities and accurately assessing disparities, various stakeholders (DHS, MDH, grant foundations, academic researchers) have also expressed a need for REL data. With the recent rapid adoption of Electronic Health Records (EHRs), primarily fueled by Meaningful Use requirements, the administrative costs in collecting and transmitting REL information has been significantly reduced to the point where collection may be fiscally feasible for hospitals. One current use of data reported to MHA is calculating quality measures such as readmissions and mortality rates at both institutional and aggregate levels. This method of data collection differs from the methods employed by MN Community Measurement, which gathers numerator/denominator numbers on specific conditions such as diabetes. Hospitals that

	want to qualify as "meaningful users" of EHRs must collect REL data as part of each patient's demographic profile. The CMS Medicare and Medicaid EHR Incentive Programs began registration in January 2011 and 2016 is the final year hospitals may initiate participation and receive any payment (incentive payments are reduced over time providing motivation to start early). Further, hospitals that have not demonstrated meaningful use by 2015 will experience payment adjustments in their Medicare reimbursement. The administrative claim form has designated REL fields, but these fields are currently labeled as "not used" when submitting claims for payment. At the end of 2011, virtually no hospital in Minnesota was populating these fields on the form. MHA has engaged select hospitals in using these fields as a means of REL data collection, and is working with this select group in mapping these elements to standard OMB categories within the administrative claims database. MHA has found that the ideal way to collect Minnesota hospital REL data is to have it submitted on the claim form, where feasible. However, with continuing research and implementation, an alternative method may be more viable for hospitals. Further, a "mixed mode" method (i.e., some hospitals submit REL data via claims and others submit REL data separately from claims) may yield the largest participation. Mark provided a summary of the progress of MHA's efforts in REL data collection. MHA conducted a survey regarding REL data collection, quality, usage, and extraction capabilities. The survey was similar to the National Public Health and Hospital Institute survey used to conduct research for the report "Race, Ethnicity, and Language of Patients" (2006). Responses from 122 of the 135 hospitals in the state were received meaning there was a 91% response rate, providing valuable insight into the current status of REL data collection, frameworks and policies used by hospitals, current usage of REL information at hospitals collecting it, and their ability to extract and send REL data to MHA. Among affiliated hospitals which are part of a system, Epic was the most commonly used EHR vendor. For non-affiliated hospitals, Epic was the third most commonly used with Meditech and Healthland being the first and second most used, respectively. Other findings were also shared. Hospitals identified the top three barriers to REL data collection as 1) Reluctance of patients to provide the information, 2) Reluctance of staff to ask, and 3) Confusion about race and ethnicity categories. In addition to the survey, a pilot group of hospitals have been engaged to submit REL data to MHA over the past year. Currently, 49 hospitals are submitting at least some REL information on their billing records, which is slightly short of the 40% participation target. Initially, this target seemed attainable as 55 hospitals were submitting REL information in 2012 or 2013; however, but some hospitals dropped REL submission due to software changes that occurred when they became acquired by a larger system. A successful strategy in recruiting hospitals to participate has been to request the inclusion of REL information during their conversions of the new electronic claims format. Work is currently underway with some hospitals to map REL codes to OMB categories in the administrative claims database. At present, 53 hospitals have supplied REL master lists. Initial steps have also been taken to analyze completeness of the REL data. As anticipated, the completeness of the data varies from hospital to hospital. Next steps will determine whether this is due to transmission issues or the REL data collection issues. Mark wrapped up his report with a review of future plans. **Questions/Comments/Discussion:** Tim Hernandez asked why some health plans seem to require REL data and others do not. Mark shared that the health plans are not requiring the REL data. Kris Soegaard asked why claims would be rejected if they contained REL information. Mark explained that the REL data components are in a "not used" category and some, but not all, health plans are set up to reject claims when there is information entered into the "not used" category. Kris then asked if there will be penalties for not collecting this information. Mark shared the requirement that REL information is to be collected in the EHR for Meaningful Use; the penalties for not collecting REL data via EHRs starts in 2015. Mark clarified that the REL data he had been referencing was collected on the claims form which is separate from the EHR; thus, there are no penalties associated with not collecting REL information using the claims form.
Interim Progress Report on Total Cost of Care measure development process – Results of Phase 1 data test	Gunnar Nelson provided an interim report on the Total Cost of Care measure focusing primarily on results of the Phase 1 data test. He recognized the MARC members who serve on the Total Cost of Care technical advisory group: Ernie Valente, Howard Epstein, Kris Soegaard, Mark Sonneborn, Stefan Gildemiester, and Sue Knudson. Gunnar shared that Total Cost of Care (TCOC) is a NQF endorsed measure of a provider's cost effectiveness at managing a specific population of patients. This is an attributed population and includes all costs associated with treating patients including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. The interim objective is to have commercial insurance plans report TCOC to MNCM and to eventually report a Total Resource Use measure using all claims-based data. Since cost, defined for this measure as allowed payment available in

administrative claims, is a continuous variable and is greatly impacted by health risk of each patient, outlier rules and risk adjustment is required.

Gunnar provided a history and background on the measure development process for the TCOC measure that occurred between April 2012 and July 2013. The remainder of his report highlighted results from the Phase 1 data test that occurred between August and November 2013. Blue Cross and Blue Shield of Minnesota and HealthPartners participated in the data test and MNCM tested a distributed data model. This data was analyzed, overall results were reviewed, blinded medical group results were analyzed, and findings were reported to MARC and Board of Directors.

One health plan used their established protocol and software for the risk adjustment software and the other health plan used MNCM's limited license from the Johns Hopkins ACG. The results were comparable and the data was produced in a reasonable amount of time. MNCM then aggregated the results and successfully merged medical group level risk adjusted total cost of care files between the two plans with reliable output and without concerns of sharing PHI or confidential business intelligence. The TCOC results per medical group showed a normal distribution range.

The patient level attribution test is currently being completed by a small set of medical groups and final results were not yet available. The distributed data model is unique in that it allows medical groups to receive attributed patient lists directly from the health plans and this allowed for a true test of attribution. The NQF Methodology for this measure requires a minimum of 600 patients per medical group before public reporting. Typically, a single plan can report on an average of 85 medical groups; two plans can merge results and report about 112 medical groups, and four health plans can report on an estimated 130 medical groups. Therefore, there is a 53% increase (compared to a single health plan) in the number of reportable medical groups by combining results across health plans.

Pharmacy costs per patient were estimated separately from medical costs and distribution was found to be stable across medical groups. The TCOC methodology also has an "outlier rule" which states that the cost per patient is limited to $100,000 per year. When this rule was used during this test, we found that 8% of dollars were removed and the impact varied by medical group.

The attribution methodology has a two-step attribution process: 1) Patients were first attributed based on their primary care activity in the measurement year 2) Patients who were unable to be attributed based on their primary care activity in the 12 months of the measurement year, were attributed using the 12 months prior to the measurement year and only if the patient had activity in the 4th quarter of the prior measurement year. The second step of attribution added 6% more attributed patients to the denominator and this was distributed almost equally among medical groups. There was also evidence that those patients had a lower average cost per patient but had a higher percentage of outlier dollars.

Public comments were collected between August and November 2013 using MNCM's standard process. Gunnar reviewed the comments and MNCM's response for each comment.

Questions/Comments/Discussion:

John Frederickson asked how specialty care was attributed using the TCOC attribution method. Gunnar shared that specialty care was attributed to a primary care provider and their tax ID number.

Kris Kopski asked if data was sent back to medical group/clinic with patient names attached and their total cost of care. She feels this may be helpful to medical groups/clinics in order to address patients who incur higher costs. Gunnar shared that medical groups/clinics receive patient names in order to correctly attribute patients, but they do not receive the costs each patient incurs. He shared that this is out of scope for the TCOC measure.

Howard Epstein asked if health plans have the option of calculating total cost of care using their own methods for their own purposes. Gunnar confirmed that this is correct. He also noted that the MNCM TCOC measure is an attempt to standardize the method of calculating the costs for public reporting purposes. Howard then asked for the key takeaways from the Phase I data test. Gunnar shared that the data flow occurred as expected although some items will have to be fine-tuned, but that there are no major issues. He also shared it is a work in progress and communication about the measure needs to be developed to clarify the scope of the project to a variety of stakeholders. Tim Hernandez asked if part of the work was to standardized methodology to provide common language to medical groups and consumers. Gunnar shared that the intent was to develop a common, standard methodology for health plans to use without imposing on other current methods.

Sue Knudson shared that as a representative from a health plan, she feels that TCOC differs from quality measures and was developed using a different model than health plans have used in the past. She shared that it would take time for health plans to be able to evaluate and report data using the new method. She also shared that the current methods health plans are using are involved in current contracts. She feels provider and health plan contracts may affect the

	timeline of adopting the new TCOC method. Ernie Valente agreed. Gunnar also shared that the aggregation and attribution model is similar to the one that MNCM uses for HEDIS measures and that it is the least expensive way to calculate results for this measure. Howard Epstein asked for context on how Minnesota compares to other states in terms of TCOC reporting from a national perspective. Gunnar shared that there is national interest in the TCOC methodology. Tina Frontera shared that other organizations and states are reviewing this methodology, but that Minnesota is unique in using the distributed data model.
Measure Review Process and Structure and Formation of Measure Review subcommittee – For approval	Jasmine Larson shared MNCM's measure review process and structure. Jasmine sought approval for the formation of a Measure Review subcommittee of the MARC. MNCM's strategic planning for 2013 included an overall measurement framework and the recommendations approved by the Board included a general process to update and/or retire measures. The purpose of this agenda item was to: • Educate MARC about MNCM's measure review process and the criteria used to determine the appropriate level/depth of review • Obtain approval from MARC on the formation of a Measure Review subcommittee of MARC, to be involved in the Level I review process and to make recommendations to MARC • Initiate recruitment of MARC members to serve on the Measure Review subcommittee To date, a review of existing measures has been conducted by MNCM staff. However, there is opportunity to formalize the review process, increase stakeholder participation and influence, and increase the transparency/awareness of the process through a more formal structure. Jasmine reviewed handouts of the measure review process as well as a flow chart which outlined the various levels of review. Jasmine reviewed the Measure Review Committee structure and composition. This committee would consist of 8 – 10 MARC members including a chairperson and would have a similar composition as the MARC with representation from medical groups, health plans and consumers. The MARC co-chairs would approve the roster and the committee would meet twice per year - February and August. The first meeting would occur in February 2014. This committee would be involved in Level I – the Annual Measure Maintenance process. At the February meeting, there would be a review of the DDS/ASC/Patient Experience of care measures and recommendations would be brought to MARC in April. At the August meeting, there would be a review of the HEDIS measures and recommendations would be brought to MARC in September. A consensus based decision making process for recommendations would be used by the committee. Jasmine also reviewed the Measure Evaluation Criteria anticipated to be used to determine a measure's value. The criteria are consistent with NQF criteria for measure endorsement. Jasmine then reviewed each review level separately: Level I review is an annual review of our measures. MNCM personnel conduct a scan of the environment and review any changes in a measure's alignment with the evaluation criteria. A report of the findings for each measure will be prepared for the Measure Review Committee. Only minor changes in CPT, ICD9, ICD10 codes, or modifications for alignment/harmonization with national measures or guidelines would be considered for a Level I review. The Measure Review Committee would evaluate the measures based on information provided by staff and make measure-specific recommendations to MARC, which may include: • Continuation of the measure, as-is or with minor modification as described • Recommend for further review and/or redesign • Remove from public reporting, but continue to monitor (collect and report privately) • Retirement using the following criteria: o Loss of measure validity o Loss of opportunity for improvement o Evidence of undesirable consequences of implementation o Replacement by a superior measure Level II review is a focused review performed on an ad-hoc basis. It is meant to evaluate the impact of technical measure changes or changes in evidence that may affect alignment with the measure evaluation criteria. For example, the ACCORD study resulted in a change or update to practice guidelines that required a Level II review of our Optimal Diabetes Care measure. Reconvening the measure development work group may occur during a Level II review. Level III review is applied to NQF endorsed measures only and includes a systematic literature review and submission of the NQF endorsement maintenance application.

	Level IV review is needed to review major changes to a measure which may include redesign. This level mirrors the measure development process and would include a systematic literature review, reconvening of the measure development work group for in-depth discussion and measure redesign of numerator, denominator and/or exclusions. Possible recommendations include recommending no changes; redesign of measure with revised specifications; replacement of measure with specifications; or retirement of measure. **Questions/Comments/Discussion:** Tim Hernandez asked about the level of involvement of the subcommittee in Levels II, III and IV. Jasmine shared that as a part of a Level I review, the subcommittee may recommend a level II or IV review but doesn't actively participate in Level II, III or IV reviews. Sue Knudson asked if the Measure Review Committee would consist only of MARC members or if there would be other representation. Jasmine stated that it would only be comprised of MARC members which would ensure that members have a level of familiarity with the measures. Howard supported the value in having MARC members on the subcommittee given that they are involved in the in-depth discussions about our measures and could represent the issues when recommendations are brought to MARC for approval. Sue shared she feels it would be beneficial to have an additional 'representation type' on the subcommittee – someone with clinical and technical expertise who has an understanding of operational workflows and could provide feedback on the feasibility and burden of any proposed changes specifically in regards to EMR functionality, reportability, and burden. Sue also shared that she feels it is still valuable to the consumer to report on measures that otherwise would be retired. Chris Norton agreed and shared she feels that consumers would appreciate information and that a balance of burden and reporting should be reached. Sue also noted that she would like other factors (i.e., community need) should be reviewed when considering retiring a measure rather than only looking at criteria outlined during the presentation and asked for a reasonability check regarding retirement of measures. In response, Anne Snowden shared that MNCM has received feedback from some medical groups that appreciate having their high rates publicly reported because it is a reflection of their good work. In other words, achieving high rates with little room for improvement might not be an automatic reason to retire a measure. John Fredrickson asked what is to be gained by continuing to publicly report a measure with high rates. Kris Kopski shared that continuing to publicly report a measure may offer the ability for other states and organizations to compare their rates to rates of clinics in Minnesota. Ernie Valente asked what is the value to the consumer to continue to report a measure and shared he feels the ability for consumers to compare results is important, but that should not occur at the risk of regressing a measure or rates. He feels that a value to the consumer is allowing a consumer to act and comparing allows consumers to act. Ernie shared that he feels this might be a reporting issue such as how are results displayed or what results are displayed. Sue Knudson shared that she agrees with Ernie and that decisions must be based on variation with everything else being equal especially when considering future steps in terms of the Triple Aim. Ernie Valente made a motion to accept the recommendation for the formation of a Measure Review subcommittee of the MARC. Chris Norton seconded the motion. Motion approved.

Next Meeting: Wednesday, December 11, 2013
7:30-9:00 am