

**MN Community Measurement
Measurement and Reporting Committee**
Wednesday, 13 March 2013
Meeting Minutes

Members Present: Tim Hernandez (co-chair) Howard Epstein (co-chair), Ann Robinow, Betsy Clough, Caryn McGeary, Chris Norton, David Homans, Deb Mielke, Jeff Rank, John Frederick, Kris Soegaard, Laura Saliterman, Mark Nyman, Matt Flory, Robert Lloyd, Stefan Gildemeister, Sue Knudson, Terry Cahill

MNCM Staff: Alison Helm, Anne Snowden, Erika Vetta, Gunnar Nelson, Tina Frontera

Members Absent: Craig Christianson, Darin Smith, David Satin, Ernie Valente, Linda Walling, Mark Sonneborn

Guests: Doug Wholey (U of M), Brian Whited (MNCM Board Member)

Topic	Discussion
Welcome & Introductions	<p>Tim Hernandez welcomed the committee. Committee members introduced themselves.</p> <p>Tim acknowledged new committee member, Caryn McGeary. Howard also reminded MARC that this would be Deb Mielkes's last meeting as she has resigned from MARC. The nominating committee will be reviewing applications received for this opening.</p>
Approval of Minutes	<p>The committee reviewed the minutes from February 2013. Chris Norton made a motion to accept these meeting minutes, Laura Saliterman seconded the motion. Motion passed.</p>
Risk Adjustment Primer	<p>Gunnar Nelson provided an overview of risk adjustment in order to allow the committee to have a common understanding and terminology base in preparation for the issues discussed later on the agenda.</p> <p>The concept of risk adjustment is based on the fact that not all patients have the same likelihood of achieving optimal health outcomes. There may be barriers to the patient achieving optimal health outcomes related to demographic, physical or socio-economic situations which may be outside the control of clinics. The risk adjustment presentation focused solely on clinic-based quality measures.</p> <p><u>Definitions</u></p> <ol style="list-style-type: none"> 1. Risk Adjustment: Use of patient-level information to explain variation in health outcomes 2. Segmentation: Dividing a population into meaningful categories. Using the insurance product category is the most common. <ol style="list-style-type: none"> a. There are limits to segmentation. For example, if insurance product is used, each clinic is reported four times (Commercial, Medicare, MHCP, Uninsured). If gender and age are also used, there may be as many as 32 different values for each clinic. This may not be very manageable. 3. Type of Risk Adjustment: Two basic styles of risk adjustment include: <ol style="list-style-type: none"> a. Standardized Mix: Adjustment of the clinic to match the entire population. b. Actual-to-expected: Adjustment of the entire population to match the clinic 4. Risk Variables: Barriers or indicators that are used to adjust the score <p>Two criteria of risk adjustment variables can be tested mathematically:</p> <ol style="list-style-type: none"> 1. Predicts outcome 2. Significant Variation between clinics <ol style="list-style-type: none"> a. If there was a difference in outcome between genders but all clinics had about the same mix of gender, there would be no reason to use it <p>There are three criteria that are more subjective:</p> <ol style="list-style-type: none"> 1. Is the risk adjustment variable beyond the control of the provider? 2. Is the risk adjustment variable free of unintended consequences? 3. Is the collection of the variable feasible and worth the cost? <p>There are a few notes to consider regarding risk adjustment:</p> <ol style="list-style-type: none"> 1. If it is not possible to measure a barrier directly, a proxy must be used. For example, a barrier could be a patient's ability to access care. Since this may be difficult to measure, insurance product type could be used as a proxy. 2. Variables are based on general behavior within a clinic and this assumes that groups will act the same way. However, there may be exceptions. 3. Dividing the clinic into multiple groupings creates the need to account for the stability, or credibility, of that group. <p>Gunnar also shared that impact must be considered in regards to risk adjustment. Questions about impact of risk adjustment include "How much does risk adjustment matters? What is the impact?" Risk adjustment creates a more normal distribution, but what that means in terms that most people care about must be considered. Gunnar reviewed a handout that illustrated that while risk adjustment does affect the results, but not drastically.</p>

	<p><u>Question/Comments/Discussion:</u></p> <p>David Homans asked how much variation in outcomes could be explained using known risk adjusters and how much could be explained by other, residual variation. Doug Wholey referenced a recent JAMA article that found that the majority of variation is due to patient characteristics; however, he also expressed caution about the statistics referenced in this article noting that since there is already minimal variation within a homogenous population (i.e., all patients have diabetes for the ODC measure) there may not be as much random variation within the outcomes of those measures.</p> <p>Sue Knudson shared one advantage of moving to an “Actual-to- Expected” risk adjustment methodology noting that clinics are benchmarked based on their actual population compared to how other clinics (with a similar patient mix) perform. She also noted that the risk adjustment process will evolve over time.</p>
<p>Recommendations to MDH per SQRMS contract on Risk Adjustment variables for 2014 data collection (clinic-based quality measures) – for approval</p>	<p>Erika Vetta presented recommendations on variables to be required data elements for collection under the Statewide Quality Reporting and Measurement System (SQRMS) as potential risk adjusters for the clinic-based measures (2014 report year; 2013 dates of service). MN Community Measurement has a contractual obligation with MDH to annually review new and existing measures currently included in SQRMS. Part of the review includes testing and analyzing the data submitted by the clinics from the prior report year to specifically assess risk adjustment for the clinic-based measures. As part of the health reform law that was passed in 2008, the Commissioner is charged with developing a standardized set of measures to assess quality of health care services offered by health care providers and establishing a system for risk adjusting quality measures. The recommendations that were brought forth were specific to the contractual relationship with the Minnesota Department of Health (MDH) to assist MDH and the Commissioner carry out their legislative directives to implement SQRMS. The recommendations brought forth specifically addressed variables as risk adjusters to be included as required data elements for submission under SQRMS.</p> <p>MNCM contracted with researchers at the University of Minnesota to conduct the analysis of risk adjustment for each quality measure included in SQRMS for the 2013 report year (2012 dates of service) data collection for clinic-based quality measures. Erika introduced Doug Wholey from the U of M. Doug and his team led the work and he attended MARC as a guest to assist with questions about the analyses results. Erika informed MARC that the meeting packet contained seven reports (one for each quality measure) which informed the recommendations. The recommended data elements would be required for data submission in the next iteration of the Administrative Rule, which would reflect 2014 report year (2013 dates of service).</p> <p>MDH uses a standardized statewide average mix risk adjustment methodology and payer type has been used as the risk adjustment variable for all measures excluding Depression Remission at Six Months. The payer type mix used 3 categories (Commercial, Medicare, Minnesota Health Care Programs (MHCP)+self-pay/uninsured). The methodology for the Depression Remission at Six Months measure has used a distribution mix by severity based on the initial PHQ-9 score instead of payer type.</p> <p>The testing conducted for each measure was similar, including the variables that were assessed: age, gender, distance traveled to clinic, and primary payer type/insurance coverage.</p> <p>For each measure, the following data components were used to serve as proxies for more direct measures of income and race/ethnicity: median income, percent African American, and percent Hispanic using patient zip code data. Last year, the MARC discussed the impact of income on quality and outcomes. Definitive results regarding the impact of income were not obtained and further exploration of this data component is still needed.</p> <p>The recommendations for required data elements were intended to maintain a reasonable balance between the needs to adequately risk adjust each measure while also managing the administrative burden of data collection for providers. Each recommendation was discussed separately:</p> <p><u>Optimal Diabetes Care (ODC)</u></p> <p>MNCM recommended that primary payer type continue to be collected as a proxy for socioeconomic status using 3 categories (commercial, Medicare, MHCP+uninsured). Results of the testing indicated that primary payer type has a statistically significant effect on achieving optimal diabetes care. In addition, MNCM recommended including age and diabetes type as required variables for collection. These two variables along with primary payer type showed the greatest impact.</p> <p>MNCM recommended primary payer type, age (categories: 18-25, 26-50, 51-65, 66-75) and diabetes type as required data elements for the ODC measure.</p> <p><u>Question/Comments/Discussion</u></p> <p>Terry Cahill asked if codes would be specified in order to identify diabetes type. Erika shared that codes are currently provided in the collection guides, but we would be sure to highlight this information and provide more detail; MNCM would also audit this information after data submission.</p> <p>Deb Mielke made a motion to accept the recommendation. Chris Norton seconded the motion. Motion passed.</p>

Optimal Vascular Care (OVC)

Similar to the ODC measure, both primary payer type and age had a statistically significant effect on achieving optimal vascular care. Primary payer type had been used to date for risk adjustment purposes, and MNMCM recommended that primary payer type continue to be required along with age. MNMCM recommended primary payer type and age (categories: 18-25, 26-50, 51-65, 66-75) for required data collection elements for the OVC measure.

Chris Norton made a motion to accept the recommendation. Jeff Rank seconded the motion. Motion passed.

Depression Remission at Six Months

Distribution mix by severity based on the initial PHQ-9 score using 3 bands of severity (moderate, moderately severe, severe) is currently used for risk adjustment. Severity was identified as the most important variable for risk adjustment during testing.

The testing also showed that individuals without private insurance were less likely to reach remission at six months than were those with private insurance. Both severity of initial diagnosis and insurance product had a statistically significant effect on achieving remission at six months. In addition, patients less than 66 years of age were 55% less likely to reach remission at six months.

MNMCM recommended severity bands, primary payer type and age (categories: 18-25, 26-50, 51-65, 66+) for required data collection elements for Depression Remission at Six Months.

Jeff Rank made a motion to accept the recommendation. Matt Flory seconded the motion. Motion passed.

Optimal Asthma Care (OAC)

The reports reviewed the two populations separately, children ages 5-17 and adults ages 18-50. For children and adults, those without private insurance were less likely to achieve optimal asthma care. Other variables did not identify as large of an impact as insurance product. Currently primary payer type is used for risk adjustment.

MNMCM recommended primary payer types for required data collection elements for OAC for both populations.

Chris Norton made a motion to accept the recommendation. Sue Knudson seconded the motion. Motion passed.

Colorectal Cancer Screening

Testing showed that, in comparison to patients with private insurance, MHCP patients were less likely to have had an appropriate screening completed. Patients younger than 66 were also less likely to have had an appropriate screening completed.

MNMCM recommended primary payer type and age (categories: 51-65 and 66-75) for required data collection element for the Colorectal Cancer Screening measure.

John Frederick made a motion to accept the recommendation. Chris Norton seconded the motion. Motion passed.

Maternity Care-Primary C-Section Rate

Testing showed that mother's age had an impact on likelihood of having a C-section. Mothers aged 30-35 were 45% more likely to have a C-section and mothers aged 36 and older were 146% more likely.

The results from the current data did not identify a statistically significant relationship between primary payer type and C-section rate; however, MNMCM recommended this data element for consistency purposes across the measures and to review the data an additional year.

MNMCM recommended primary payer type and age (categories: 17-, 18-20, 21-25, 30-35, 36+) as required data elements for collection for the Maternity Care-Primary C-Section Rate measure.

Jeff Rank made a motion to accept the recommendation. Chris Norton seconded the motion. Motion passed.

MNMCM Risk Adjustment Task Force for Recommendations (clinic-based quality measures) – for approval

Gunnar Nelson reported that the risk adjustment task force met three times in the past year and developed recommendations for MNMCM. He acknowledged the members who served on the risk adjustment task force. He then reviewed the recommendations of the risk adjustment task force for MNMCM:

1. As a general policy, publicly reported results should be risk adjusted.
 - a. There is not a universal answer to the question of which risk adjustment variables to select; there are no variables that influence every measure. Requirements for a valid and suitable risk adjustor variable:
 - i. Does it predict the outcome?

- ii. Is it a significant variable between providers?
 - iii. Is it beyond the control or influence of the provider?
 - iv. Is it free of unintended consequences?
 - v. Is it feasible – in terms of communication and understanding, and cost?
 - b. Insurance Product should be considered the first level of risk adjustment and it is usually, but not always appropriate.
 - c. Statistical significance should not be the only justification for inclusion as a risk variable. The variable must also make logical and medical sense and have a reasonable cost of collection.
- 2. When feasible, results should be segmented by insurance product (e.g., report Medicare results separately from commercial results) in addition to overall measure result.
 - a. When feasible and sample size allows, the uninsured category should be separated from MN Health Care Program (MHCP) and Medicare
 - i. Segmentation does not replace risk adjustment, but it may be appropriate to segment by one variable and risk adjusted by another. (e.g. Segment by Product, Risk Adjust by comorbidity within the segments)
- 3. The unadjusted rate has value for historical trending and indicator of impact on at-risk populations. Therefore it should be displayed.
- 4. The preferred method of risk adjustment is to use an “Actual-to-Expected” methodology.
 - a. The “Actual-to- Expected” methodology preserves reporting of the unadjusted rate, without adjustment, and creates a benchmark [average value] based on the same risk mix as the provider.
 - b. The advantage of “Actual-to-Expected” is that it evaluates the provider for the mix of risk at the clinic which is more of a true peer group evaluation. The other option, “Standardized Mix,” has the potential to exaggerate the impact of risk groups that the provider does not serve on a regular basis.
 - c. The major disadvantage of “Actual-to-Expected” is that it is more complicated to understand and more difficult to present to the public compared to “Standardized Mix.”
- 5. Any changes in public reporting display need user input before adoption. Before any major changes to the reports or MNHealthScores.com, user testing and/or market review of best practice research needs to be completed.
- 6. Variables used for risk adjustment will evolve over time. The task force recommends that MNCM create a standard process to research, review and recommend risk variables.
- 7. Socio-economic and demographic variables, such as income, patient’s ability to finance and ability to communicate are considered important factors to delivery of care. Many of those variables, however, are not yet available in a cost and provider burden acceptable manner. MNCM should continue to research and monitor methods for either collecting this data or use of proxies for this information.
- 8. While there is an accepted principle that process measures should not be adjusted, the definition of process measure vs. outcomes measure is not always clear. The Task Force did not determine a final definition of process and outcome measures and recommended that this issue be investigated in the near future.
- 9. All changes, even simple changes, come at a cost. This must be monitored throughout the process.
- 10. The focus of the task force was on the results published on MNHealthScores and not on the requirements of the Minnesota Department of Health’s SQRMS contract.

Question/Comments/Discussion:

Stefan Gildemeister shared that the distinction between MNCM risk adjustment plans and how it relates to the MDH SQRMS contract was very helpful. He shared that while MNCM and MDH have independent goals, the quality of risk adjustment and the way the data is displayed may benefit from being aligned. He suggested that MNCM and MDH work together in regards to reporting risk adjustment results.

Jeff Rank made a motion to accept the recommendation. Matt Flory seconded the motion. Motion passed.

Next, Gunnar Nelson reviewed the proposed MNCM Risk Adjustment Task Force implementation plan recommendations.

2013-2014 Implementation Year

1. MNCM will research optimal processes for display of both unadjusted and risk adjusted rates including research of best practices, user input and cost estimate of such a change
 - a. This process will be part of the overall communications plan
 - b. The results of this research will be presented by the end of 2013
2. Segmentation: while the research is being conducted, MNCM will segment files by major payer type categories.
3. Creation of an ongoing subcommittee of the MARC to evaluate variables to be used for risk adjustment. This scope will include cost of collection, stability of variables and impact on final results.
 - a. MNCM will conduct internal studies and possibly work with external researchers to investigate Return on investment (ROI) by variable and by measure.
 - i. The Quality Deviations Report 2013-02-05 from the University of Minnesota, included in the MARC packet, is an example of the type of work that will be used in the investigation.
 - b. Results presented to new subcommittee of MARC :
 - i. Subcommittee would meet 2-3 times per year.
 - ii. The charter for this subcommittee would be based on the 10 recommendations of the task force. The scope would be to review risk variables and the ROI of using the variables.
 - iii. The review of actual measures will be out of scope.
 - iv. All recommendations of this subcommittee will be brought to the MARC for final approval.
4. Ensure the standard measure development process will include an evaluation of risk adjustment variable.

2014 Implementation Year

1. Present recommendations to Board of Directors for Implementing in 2014/2015 recommendations from the 2013 study and risk adjustment process. The goal is to publish risk adjusted using "Actual-to-Expected" methodology results and includes appropriate segmentation.
2. Continue to research the feasibility and impact of variables for all measures published or produced by MNCM

Beyond 2015, ongoing

1. Continue to refine process to include adjustments for socio-economic variables whenever feasible and warranted.

Question/Comments/Discussion:

John Frederick asked for clarification on recommendation #4 under the 2012-2013 implementation year. Gunnar stated that every measure will be evaluated for possible risk adjustment, but upon evaluation it may be determined that risk adjustment variables will not be used. Sue Knudson shared that recommendation #4 is meant to assist in having an upfront discussion about risk adjustment during the measure development process.

Tim Hernandez suggested that part of the charge of the risk adjustment task force include community education regarding risk adjustment. Jeff Rank and Stefan Gildemeister also agreed that education about the importance of risk adjustment would be useful. Laura Saliterman asked if any of the research and discussions about the *Consumer Reports* article could be applied in this situation. Anne Snowden noted that indeed information garnered during the *Consumer Reports* article's editorial review process could be used to educate the public about risk adjustment. Stefan Gildemeister agreed and stated that making a list of references available to interested individuals may be helpful and noted that MDH could contribute to the list of references.

Deb Mielke asked if there should also be information about risk adjusted rates for patients/consumers to help them understand their role and the provider's role in performance rates. Doug Wholey commented that patients are mostly interested in their own risk and the extent to which it will change. He further stated that how this information is presented will take some work.

Sue Knudson made a motion to accept the recommendation. Chris Norton seconded the motion. Motion passed.

Next Meeting: Wednesday April 10, 2013