

**MN Community Measurement
Measurement and Reporting Committee**
Wednesday, November 12, 2014
Meeting Minutes

Members Present: Tim Hernandez, Howard Epstein, Allan Ross, Ann Robinow, Bill Nersesian, Darin Smith, David Homans, David Satin, Jeff Rank, Larry Lee, Mark Nyman, Mark Sonneborn, Rahshana Price-Isuk, Robert Lloyd, Stefan Gildemeister, Sue Knudson, Bruce Penner

MNCM Staff: Anne Snowden, Gunnar Nelson, Rachel Mlodzik, Tina Frontera

Members Absent: Caryn McGeary, Chris Norton, Dan Walczak, Kris Soegaard, Laura Saliterman, Matt Flory

Topic	Discussion
Welcome & Introductions	Tim Hernandez welcomed committee members and observers. He reminded everyone that the committee strives to make their meetings and decisions as transparent as possible, but noted that only official MARC members can participate during the discussion. Questions or comments following the meeting can be sent to info@mncm.org .
Approval of Minutes	The committee reviewed minutes from the October 2014 meeting. David Satin made a motion to accept the minutes; Sue Knudson seconded the motion. Motion passed.
Action Item: Total Cost of Care Measures – Technical Advisory Group Recommendation	<p>Tim Hernandez introduced the first agenda item: reviewing recommendations for the Total Cost of Care (TCOC) measures from the Technical Advisory Group (TAG). Tim introduced MNMCM's Health Economist, Gunnar Nelson, who presented background on the TCOC measure development process as well as data testing and validation. Next, Tim introduced April Seifert, chair of the TAG. Tim explained that April has a doctorate in social cognitive psychology and studied health decision-making; that she has worked for health plans, employers, providers and consultants in healthcare analytics; and that her work has included developing and refining risk-adjustment models and creating reporting used to support provider TCOC arrangements. April presented the overall results that are ready for public reporting.</p> <p>Gunnar indicated that after three years of work, the TAG is delighted to bring a recommendation to MARC for public reporting of the TCOC measure. Forty-three individuals (excluding MNMCM staff) were involved in the development of the measure, including providers, health plans, consumers, advocacy groups, employers, associations and economists. The creation of the TCOC measures started with a MNMCM Board of Directors charge in 2011 to find and publish a cost measure that would not only round out MNMCM's reporting of the Triple Aim of cost, quality and patient experience but also help inform the public on the variation in cost of care within our community and aid providers in quality improvement. The original charter was created in July 2011.</p> <p>The TAG explored various options to determine what measure would be appropriate. They felt a TCOC measure would be valuable because it was all encompassing. They felt episode costs also have value, but selected TCOC as the best place to start measure development. The overall methodology for the TCOC measure was approved by MARC in December 2012, including the attribution and risk adjustment methodology and unit of measure specifications. The TCOC measure is also NQF-endorsed, which aids credibility and reliability.</p> <p>In August 2013, updates on the process and testing for the TCOC measure were presented to MARC. And in November 2013, MARC reviewed public comments that were received on the methodology.</p> <p>Gunnar paused to thank MARC members who were involved in the process: Howard Epstein, Stefan Gildemeister, Mark Sonneborn, Kris Soegaard, Mark Nyman and Caryn McGeary. Gunnar also gave a special thanks to Sue Knudson for her guidance and the work of her staff during this process.</p> <p>The TCOC measure includes all costs throughout the year for a patient (based on administrative claims) and assigns the patient to a particular medical group based on an attribution process. The results are adjusted for known risk factors and ultimately the average risk-adjusted cost per patient is calculated. This value is then compared to the market average.</p> <p>The measure is currently looking only at commercial patients, and the definition of cost is the allowed amount (what the payer pays the provider plus the patient responsibility). The attribution process is based on primary care activity in an office setting; this method was thoroughly discussed by the TAG and created by providers and health plans. The denominator includes all commercial patients who were enrolled at least nine months of the year in a single health plan. The unit of measure is the medical group because it was the most accurate way to define provider groups across multiple health plans and it was repeatable. The risk adjustment was done using the Johns Hopkins University Adjusted Clinical Groupings (ACG) algorithm that is part of the NQF-endorsed process.</p> <p>To be eligible for public reporting, a medical group must have a minimum of 600 patients attributed to them across all four health plans.</p>

MNCM did not create this measure in isolation. Not only is it based on work by HealthPartners and Patient Choice, but also the work of others across the nation. Through a Robert Wood Johnson Foundation grant, MNMCM is helping coordinate TCOC methodology with other regions. A portion of the grant included a national seminar for physicians on using and responding to this type of measure. MNMCM was fortunate to be able to send Dr. David Satin from University of Minnesota Physicians and Dr. Laurie Bethke from Entira Family Clinics to participate.

David shared two main points from the seminar: 1) Cost is a necessary part of the Triple Aim; quality without cost is an unclear value proposition. 2) Physicians have a culture-shift to embark on and along that journey are things that we can immediately change and have control over and things that we cannot immediately change and do not have control over. David shared that the measure will not be perfect in the beginning, and we will learn where refinements need to be made over time. Hopefully, the release of this measure will spur clinicians to start thinking about this. We need to root out the unwarranted variation and unnecessary costs. He said this is not going to fix our health care spending problem, but it will be part of the solution.

Gunnar continued by re-stating that the TCOC measure methodology was developed and approved in 2012. In 2013, MNMCM solicited public feedback and presented it to MARC in November. Also that year, MNMCM developed and tested a distributed data model where, similar to HEDIS, the health plans collected the unadjusted cost and ran the attribution and risk cell assignments. MNMCM audited the output, merged the files, determined the risk weighting and created the provider reports.

It was determined that for the system to be transparent, medical groups needed access to the list of patients attributed to them; the health plans collectively agreed to make the lists available upon request.

The data flow and attribution assignment process were tested in 2013 using two health plans and five medical groups. No patient assignment concerns were reported, but MNMCM did adjust the data delivery process for providers based on feedback.

Subsequently, the calculations were built, tested and verified by an outside firm. Around the same time, the TAG added two subcomponent measures – adult patients and pediatric patients. The primary measure includes all patients; these two subcomponent measures allow providers and consumers to see data segmented by age.

Since the TCOC measure used a distributed process model, an important step in the process was to verify that all health plans were following the same process. The data specification guide was developed in collaboration with health plans to ensure it was feasible to run the process as designed. MNMCM had the software vendor (DST) meet with each health plan to guarantee the model was run the same way by each plan. DST also reviewed the distribution results with MNMCM. MNMCM met with all health plans (analysts and programmers) to walk through the measure requirements, including the timing of data pulls, so they would be synced up. All input files were audited for adherence to specifications and to evaluate if distributions of cost and risk were similar across health plans. This should be the case since all data was for commercial patients from the same competitive market. All input files were also audited a second time by an outside firm. The final step was to compare the data to the unaudited 2012 data, which was gathered through the testing process. This allowed us to look at change over time and make sure there were no large changes that would suggest something unusual. There was a 4.6% increase in costs for attributed groups from 2012 to 2013; Minnesota health care CPI was 4.2%. The percentages are very similar.

Earlier this month, MNMCM's Quality Audit Committee reviewed the validation process for the 2013 data, and approved the Policy and Procedure for the data validation.

After data validation was completed, the measure reports were created and verified by the outside firm. MNMCM sent reports to 116 medical groups, covering over 1.5 million patients and \$8 billion dollars (see page 19 of packet for list). Medical groups could request the list of patients attributed to them; 25 medical groups representing more than 1 million patients requested their lists. One medical group had a tax identification number (TIN) change so their data is being re-processed, but no other medical groups found patient attribution problems.

The reports provide both the calculations and results along with a high-level analysis of where the medical group's costs are coming from. Large medical groups may have some of this information, but it will be brand new for some smaller providers. There are cost expectations by type of claim and risk category.

Provider communications about this measure have been extensive, beginning with informational presentations in 2012 and 2013. Communications have included: direct emails to all potentially impacted medical groups, multiple articles in MNMCM's *Measurement Minute*; published article in *Minnesota Physician* (April 2014); two separate webinars, along with recordings available on mncm.org; breakout sessions at ICSI Colloquium in 2013 and 2014; breakout sessions at MNMCM's Annual Seminar in 2013 and 2014; and a presentation to the Minnesota Medical Association in June 2014.

At this point, Gunnar turned the presentation over to April who presented the overall results. She first reviewed some of the figures in the MARC packet. The graphs show normal distribution of the results. In the top graph, we arranged all medical groups from the lowest cost ratio to the highest cost ratio; many medical groups fell in the middle, as you would expect for a normal distribution of data. One standard deviation above and below the mean (the state average) were drawn in these graphs, which will be the cut points used to indicate to the public whether a particular medical group's individual cost ratio was higher or lower than average. Many medical groups will be indicated as equal to the average.

Two main aspects resulted in the data being normally distributed: 1) having a higher patient count minimum prevented large impacts by a single, high-utilizing patient; and 2) the risk adjustment methodology.

April noted the elements that are recommended for public reporting. MNMCM will show the risk-adjusted cost per patient, total cost index (medical group/Minnesota average), and how a particular medical group fell in comparison to the average.

The calculation methodology is detailed and will be available to all medical groups for their review. Providers will also be given their costs by claim type: inpatient, outpatient, primary, other medical, and pharmacy. This will let them see what areas are driving their costs. A section of the report to medical groups will also include details of the ACG risk methodology and the number of patients that fell into each ACG grouping for that medical group. April added that countless studies have been done by the Society of Actuaries and other independent groups that have validated the methodology under Johns Hopkins ACG risk adjustment categories.

The results of the TCOC measure are very stable. Additionally, conversations with the providers and health plans indicate that the results are close to what they see when they run other cost measurements utilizing other methodologies. Both of these indicate a valid, reliable measure.

Gunnar noted that one medical group voiced concerns about the application of this methodology for their practice. The concern was discussed in depth at the October 28, 2014 TAG meeting and the TAG voted unanimously not to alter the methodology for a particular medical group. The medical group that raised this concern is currently reviewing its options.

In summary, the TCOC methodology was approved; public comment was received and reviewed; the process was tested; the data files were audited by two different organizations; the results distributed to 116 medical groups which provided overall positive feedback; and, on October 28, the TAG unanimously approved a recommendation for public reporting. The TAG recommendation is to publicly report the medical group level, risk-adjusted Total Cost of Care measure for all patients and, if sample size allows, two subcomponent measures for adult and pediatric patients.

Questions/Comments/Discussion:

Bill Nersesian asked what the highest cost ratio was for a medical group in this year's data. Gunnar explained that there were a couple of medical groups that had a higher cost ratio than 1.4, but they were considered outliers.

David Satin shared two additional points based on what he heard at the national conference about the cost methodology. First, risk adjustment works as long as coding is done correctly. Second, while MNMCM's methodology cannot do this yet, some other states were able to separate out utilization versus price. That is a useful goal in the future. Gunnar added that the TAG will remain active and utilization will be a discussion for next year. Jeff Rank commented that a resource measure would be highly valuable. He asked if the TCOC data is in parallel to quality data or free standing. Gunnar answered that the TCOC measure was created with the intention of sitting alongside quality data at the medical group level. While, there is no overall quality rating for medical groups, TCOC, patient experience and quality data will eventually be reported together on MNHealthScores.org. April Seifert added that currently there is nowhere for consumers to get this information. The baseline knowledge of the average health care consumer is not on the same level as individuals in the industry, so showing cost and quality data sets side-by-side will be very valuable for consumers.

Mark Sonneborn commented that the display of how TCOC would be publicly reported was outside the scope of the TAG. They received information from Erin Ghere at MNMCM regarding the planned display, but the workgroup was focused on methodology.

David Homans commented that this is very important work. When this information is made public, it will be important to specify that this is not a consumer's personal cost being reported, but their total cost of care. April commented that there has been much research done on how this data should be depicted to the public, what information should be front and center for the consumer to see, and how they have to click in to see more detail.

Larry Lee asked if there is a plan to do geo-mapping of these cost results to county, zip code, service areas, etc. Gunnar commented that we cannot get too fine grained and go city-by-city, since the measure is at the medical group level. However, MNMCM has developed methodologies that will allow us to map by region. Larry added that it is reasonable to expect some medical groups will do their own geo-mapping once the results are made public. This would allow for some interesting analytics based on income level, social demographics, etc.; it could provide some sort of affordability view. There also may be components of cost that are common within co-located medical groups, and those may become more visible if the geographic relationship is known.

Mark Nyman asked Gunnar to clarify the patient attribution. For example, if he was a primary care provider seeing a patient with diabetes for many years and this year, because of renal failure, the patient needed to undergo a transplant; would the cost of that transplant be attributed to the primary care practice or the referral practice? Gunnar answered that attribution is based on the majority of office visit-based claims for a primary care provider during the measurement year. If a patient saw their primary care provider at the original clinic for the majority of the days, the procedure cost would be attributed to that primary care medical group. Howard Epstein added that in the case of a kidney transplant, the truncation methodology would apply. April agreed that the truncation methodology would kick in, and further explained that the patient would presumably have a diagnosis code for renal failure which would increase their ACG risk score impacting that risk-adjusted cost. Gunnar clarified that the per patient cost is truncated at \$100,000 per patient per year. The patient would remain in the measure, but the costs would be capped at \$100,000. Mark asked if the intent of the algorithm was to attribute the cost back to the primary care source. Gunnar answered the cost would be attributed to the primary care provider with the most activity that year. Gunnar noted that the TAG decided it would not use health plan primary care provider indicators - office visit activity is the factor used here. Mark commented that attribution is the biggest challenge with total cost of care measures because to compare apples-to-apples, you want to compare all the primary care areas and their cost together and compare all the referral areas and their costs together. If a referral center is attributed a higher percentage of cases, their cost is going to look higher. Gunnar commented that the referral center's risk score would also be higher. Howard also added that if the referral center is only seeing specialty care patients, the cost still goes back to the primary care provider. Mark commented that the attribution logic is important because if there are a few patients that slip through and become attributed to the referral center, the referral center that sees more referral patients might get attributed those cases. When Mayo Clinic compared their primary care patients to patients referred to their medical group by other practices, the cost was five times more and the number of outliers was five times more. Howard commented that having the cost separated out by utilization and price in the future perhaps will help clarify this issue.

David Satin commented that he is well aware that there will be an attribution problem when someone comes to the University of Minnesota for a transplant. The patient will see the University's primary care clinic a few times whether or not the University was their original clinic. He suspects they will get some of that attribution. However, he said, this is part of the process and we will deal with this issue as we evolve the measure.

Bill Nersesian noted that we are mostly doing this for patients who want to check this information. This measure includes only commercial patients, and probably very few Medicare Advantage patients. If he was a 70 year old consumer checking the cost results, he would want to know if the costs for seniors correlate well with the costs of the working age population on commercial products. His hypothesis would be that if a medical group is expensive for commercial patients, they would most likely be expensive for senior patients. If MNMCM could get Medicare's data on a one-time basis and compare it to the commercial data and show whether there is a high correlation between the two data sets, senior citizens would know that they could check MNMCM's website for cost data that would hold true for them. He suggested that this may be something to consider doing in the future. He also added that MNHealthScores just underwent a renovation to make it more user-friendly, and he thinks including a rating for cost would be a good addition.

David Homans commented that something to look at is what kind of behavior change this might drive. He thinks it drives direct communication between referral sources and primary care clinics to work together and that it is important to keep the methodology the way it is so people have to talk to each other directly and work together.

Jeff Rank wondered if he was a consumer and knew he was paying X amount of dollars for his care, would he rather go to a more or less expensive medical group? A consumer might think higher cost brings better care. He wondered from a consumer's standpoint what the measure actually drives. MNMCM is showing the consumer that, no matter what health plan they purchase, their cost will be the same. Howard Epstein answered that this notion has already been demonstrated in research; the assumption that higher cost means higher quality, but we know it is actually the inverse relationship. On MNHealthScores, quality and cost data will be displayed together so consumers get a more robust picture. Then it is a matter of acculturation and education.

Howard Epstein asked if there were any surprises from providers as they reviewed their data; were there any surprises compared to the data they were already getting from the health plans? Gunnar answered no; there was only one medical

	<p>group who had a concern that this methodology may not apply to them. One of the larger medical groups actually told MNCM that the MNCM data came out to be exactly the same as the health plan data. No medical group said the data conflicted with information they had from other sources. Howard commented that he assumes medical groups who are outliers in this methodology would be outliers in other methodologies as well. Gunnar answered for the most part yes, but methodologies do vary and have different thresholds.</p> <p>Howard Epstein noted that MARC previously accepted the methodology and specifications for the TCOC measure, so the recommendation currently being presented is for publicly reporting the measure.</p> <p>Larry Lee asked when the next set of results will be available. Gunnar answered the next results will come in the summer of 2015. Larry Lee further asked if we can expect all the same elements represented in the next round of reporting, so that everything will have a subsequent data point. Gunnar answered yes; all the same elements would be captured and reported.</p> <p>Ann Robinow commented that when she and others ran an almost identical approach 19 years ago, their PMPM cost was less than \$100. Over 20 years, costs have more than quadrupled in our community.</p> <p>Howard Epstein asked if MARC could get an email when the measure results were published online. Gunnar answered yes.</p> <p>Sue Knudson commented that this has really been an exceptional process; she thanked MNCM for convening the stakeholders. It was a tremendous team effort, and it goes to the nature to the collaboration in our state which is second to none.</p> <p>Bill Nersesian made a motion to accept the recommendation from the Technical Advisory Group to publicly report the Total Cost of Care measure; Larry Lee seconded the motion. There was one opposed. Motion passed.</p>
<p>Action Item: Risk Adjustment – Committee Recommendation for Phase 1</p>	<p>Howard Epstein introduced the next agenda item: reviewing recommendations for Phase 1 of Risk Adjustment from the MNCM Risk Adjustment Committee. Howard noted the document in the MARC packet that summarized the committee’s recommendations. Gunnar Nelson presented the recommendations, background, and a technical overview of the risk adjustment methodology.</p> <p>Gunnar stated that he had two specific agenda items for MARC: 1) seek approval to risk adjust the six measures outlined in the MARC packet; and 2) provide updates on the Risk Adjustment Committee’s plans for 2015. The recommendations are focused exclusively on clinical quality measures for use by MNCM. Hospital, patient experience and cost measures were out-of-scope. This recommendation is also independent of MNCM’s work for the Minnesota Department of Health and the Statewide Quality Reporting and Measurement System (SQRMS).</p> <p>Gunnar outlined MNCM’s risk adjustment history. A decision was made by MARC when MNCM first began publicly reporting results <u>not</u> to adjust for clinical or patient demographics because the original goal was to produce clear and understandable results, allow for trending over time, and show the variation in outcome.</p> <p>In 2012, MARC and the MNCM Board of Directors requested that the value and feasibility of adjusting the rates to account for variation that is beyond the control of the provider be investigated. From 2012 to 2013, the risk adjustment taskforce examined the principles behind risk adjustment and made recommendations to MARC that were ratified in 2013. They were to:</p> <ul style="list-style-type: none"> • Retain the actual (unadjusted) measure value • Use an actual-to-expected methodology • Segment results by insurance product, when feasible • Evaluate measures on a case-by-case basis – not all measure should be adjusted • Adjust when it’s affordable and understandable <p>In 2014, MARC formed a Risk Adjustment Committee to oversee the implementation of risk adjustment and provide future direction. Gunnar acknowledged the MARC members serving on the Risk Adjustment Committee: David Satin (Chair), Stefan Gildemeister, Sue Knudson, Mark Nyman, Jeffrey Rank, Ann Robinow, Laura Saliterman, Dan Walczak and Caryn McGeary.</p> <p>The reason to risk adjust is best explained through an example. According to our data, an uninsured, 18-year-old Type 1 diabetic patient has less than a 6% chance of being optimally managed whereas a commercially insured, 66-year-old Type 2 diabetic patient has a 52% chance of being optimally managed. That is a nine-fold difference between populations. If the distribution of these two types of patients was the same for all clinics, it would not have any type of impact on results; however, if some clinics have a higher share of young and uninsured patients, it is much more difficult for those clinics to achieve success.</p>

MNCM is not doing this work in isolation, as we have all heard risk adjustment in many conversations. Both the National Quality Forum (NQF) and the Minnesota Department of Health have recommendations on how to do risk adjustment that are similar to what is being recommended today. Additionally, this committee and the MNMCM Board have already approved the general concept of risk adjustment at previous meetings.

MNCM is aligned with other groups from a definition and understanding perspective. Risk adjustment is the use of patient-level information to explain variation in health outcomes. That could include comorbidities, the patient's ability to get to care, and ability to understand care instructions. In mathematical terms, risk adjustment creates a more normal distribution. In practical terms, more clinics or medical groups will move to the middle of the distribution into the "average" category, and there will be fewer outliers. This is what we have seen in the work we have done.

Segmentation is the process of separating the results into meaningful categories, such as listing results for commercially insured patients apart from Medicaid-covered patients. Segmentation and stratification in this arena are interchangeable.

Risk adjustment variables are measurable indicators at the patient level that are used to alter the results; an example would be Type 1 and Type 2 diabetes.

The risk adjustment methodology is called "actual to expected." The important piece is that the clinic or medical group's results do not change. We are only changing the comparison point; another way to say this is that we are meeting the provider where they are at. How the "actual to expected" methodology works is best illustrated in an example. In the specific example, the sample clinic has a rate of 33%, and the state average is 38%, so they are considered below the state average. However, 75% of their patients are insured by Minnesota Health Care Programs (MHCP). If the state's full patient population was 75% MHCP, the state average would be 30% -- which is considered the clinic's expected rate. The clinic's actual rate is higher than its expected rate, so the clinic actually exceeds expectations based on its patient population. Note that the clinic's average is still 33%. Again, the clinic rate does not change, but we created an expected value for every clinic. This methodology is more difficult to display, but it accounts for unusual risk that a clinic might have.

The Risk Adjustment Committee decided to start applying this risk adjustment methodology with measures that have already been approved by MARC for risk adjustment. The measures include: Optimal Diabetes Care, Optimal Vascular Care, Depression Remission at Six Months, Optimal Asthma Care – Child, Optimal Asthma Care – Adult and Colorectal Cancer Screening. As a reminder, MNMCM is not making recommendations for SQRMS risk adjustment but is instead using the research and experience we have in-house to make recommendations on our own risk adjustment activities.

The Risk Adjustment Committee is also recommending, as was suggested by the guidelines MARC approved last year, to display results by major insurance product. The segmented results will be made available, but will not be a focus on MNHealthScores.

University of Minnesota studies have indicated risk adjustment does not have a substantive impact on the measures results. The majority of the clinics remain where they were before adjustment; if the clinic did well, they generally continue to do well.

Risk adjustment is a zero sum game: for every clinic that improves their rate using risk adjustment, there will be at least one clinic with a decreased rate. After discussions with the statisticians, it was decided that the best measure of the impact of risk adjustment is by looking at the change in comparison to the mean. In aggregate, 87% of clinics with reportable results had no change in the statistical comparison to the mean. MNMCM did not display the clinic names as the Risk Adjustment Committee analyzed the results.

David Satin added that the committee continually referred back to their mission: to identify, if all patient factors are similar, what is the clinic's impact on this measure? We are trying to isolate a clinic's contribution to the outcome we are measuring. The Risk Adjustment Committee initially wanted to methodologically isolate what the real factors were that were contributing to everything other than the clinic contribution; they wanted to measure those factors and then adjust by them. What they quickly realized was that the burden of measurement and the cost became enormous. The committee determined they need multiple phases to this process: Phase 1 was to take what we already collect and already know about these measures, and do the best we can with that as a start. The committee concluded that risk adjusting with the factors we had was better than nothing. This is what the committee recommended for Phase 1. They reserved Phase 2 of the plan for long term goals and questions such as: what do we really want to know; what are the things that we really think move the dial and are not just proxies or our best proxies?

Gunnar explained that the next step will be that the providers will see their results before the data is public. This will follow the same review process as the Direct Data Submission (DDS) measures.

Future Plans for Risk Adjustment

After Phase 1 is completed, Gunnar explained that the Risk Adjustment Committee will review the remaining DDS measures and develop a plan for risk adjusting these measures with the factors previously identified by measure development workgroups. Almost all measure development workgroups have recommended risk adjustment factors for their measures. The committee will begin with the remaining Depression Suite measures. All recommendations will be brought to MARC for approval.

David Satin outlined the Aims statement for the Risk Adjustment Committee. It is clear the committee's work will never be done; this is an iterative process. The Aims statement reads: "By October 1, 2015, we will recommend to MARC a process to guide measurement groups, risk adjustment of new measures and measurement review group's revised measures going forward. These recommendations may: a) be that no risk adjustment is needed; b) provide methodological considerations; c) provide factors to consider for risk adjustment in the short and long term; and/or d) include the role of limited exception reporting. We are to do this work acknowledging that other major institutions that deal in measurement reporting are also exploring risk adjustment. We do not want to do our work in a vacuum; we want to be informed of what other groups have already figured out in regards to risk adjustment. MARC will hear back from the Risk Adjustment Committee after October 1, 2015 with process recommendations."

Questions/Comments/Discussion:

Larry Lee asked if the risk adjustment being recommended still has underlying arithmetic of segmentation that could result in small cell size issues. Gunnar answered for the actual-to-expected methodology, this problem is not as profound as other methodologies. If you are the only group doing that, then you are just being compared to yourself. There is an adjustment in the math that accounts for it if a comparative cell gets too small, but this is very rare in this methodology. There is no credibility issue as there would be if a standardized mix was done.

Jeff Rank commented that these risk-adjusted measures may not be the best, but they are affordable and the risk adjusted factors have been studied and verified. The next step would be figuring out how we can make them better.

Sue Knudson commented that the committee used what is available today and reinforced that the committee believes this is an iterative process. Gunnar also noted that MARC's decision today does not lock these risk adjustment variables to these measures forever. The measure variables will be re-examined each year. He also noted that so far MNMC's risk adjustment work has correlated nicely with SQRMS (same measures and variables).

Howard Epstein asked who the primary audience is for these risk-adjusted measures; do we think the public is going to use this data or is this primarily for clinics to demonstrate their populations are different and hinder their ability to provide optimal care? Jeff Rank added that the other thing risk adjustment drives is the "why:" why are there differences between clinics and is there anything we can do about those differences?

David Satin commented that if we are seriously trying to isolate the clinic's contribution to patient outcomes, the actual-to-expected results should be highly relevant for patients. The patient should be able to look at this data and determine what they should expect from a clinic. Howard Epstein added that the descriptor we attach to the risk adjustment pages on the website will be very important so consumers can understand this concept.

Stefan Gildemeister agreed that ultimately risk adjustment is trying to level the playing field. He thinks consumers would benefit from this too. Analytically he also thinks there are opportunities to ask how demographic or population factors drive variations.

Bill Nersesian commented that his organization uses quality measures for reimbursement around their shared savings contracts, so it is very important to get the rates as accurate as possible. All the Triple Aim components enter into how much reimbursement a clinic or medical group will get depending on how much they are able to save on that patient population in their contract.

Bill asked when the 2014 Health Care Quality Report will be ready for the public. Anne Snowden answered it would be completed by the end of the year. Bill noted that at the back of the report, there are risk-adjusted rate tables. He asked if MARC approves this recommendation, is there only going to be the expected rates in the tables or will both the actual and expected rates be included in the charts? Anne answered that we will have both rates: the actual and the expected.

Howard Epstein commented that perhaps risk adjustment is a way to direct more resources to reducing disparities among certain demographic groups.

	<p>Bill Nersesian commented that his organization’s endocrinologists have to report diabetes, and their scores have typically been lower than some primary care groups because they are referred the sickest patients. The patients with mild diabetes are treated by the primary care providers themselves. He thinks it is really important to allow the endocrinologists to finally show that when the rates are adjusted, they are doing better than originally indicated.</p> <p>Mark Nyman commented that this risk adjustment methodology will not fix the problem with referral practices because it is not assessing initial A1c, follow-ups, etc. A referral practice might see a patient with a high A1c because it is appropriate they should be seeing the very difficult cases. The referral practice gives a recommendation on how to take care of the patient’s diabetes and the patient is then sent back to the primary care provider. If the patient’s A1c gets under control, the primary care provider would get credit for that. He thinks this methodology is certainly moving in the right direction, but still has a ways to go.</p> <p>Tim Hernandez asked if burden will be a factor in the decision-making process for risk adjustment. David Satin answered yes; the committee realized early on that to get the data they really want would be extremely burdensome. The ideal is unattainable, so the committee is trying to figure out a balance between what’s attainable, what’s meaningful, and what’s burdensome. The committee will do research on burden before they recommend anything to MARC.</p> <p>Stefan Gildemeister commented that the State Legislature in 2014 required the Department of Health to lay out a plan for segmenting multiple measurements by race and ethnicity, and layout how these factors can work into risk adjustment. The report will lay out the challenges and opportunities; what MDH has learned from the work at MNCM; what others have done in regards to risk adjustment; and measurement burden.</p> <p>David Satin commented that he believes the right committee members are on the Risk Adjustment Committee with the necessary knowledge and background. He thinks the ultimate goal of this is to increase the community’s buy-in to MNCM to produce scientifically valid measures that accurately represent clinics contributions to outcomes. He noted that they will increase MNCM’s stature by doing this well.</p> <p>Sue Knudson commented that the committee discussed the importance of alignment. NQF’s report is now available and they have acknowledged the same challenges with risk adjustment as have been outlined today (e.g., data sourcing).</p> <p>Jeff Rank made a motion to accept the list of measures for risk adjustment for MNCM public reporting; Sue Knudson seconded the motion. There was one opposed. Motion passed.</p>
Meeting Adjournment	Howard Epstein thanked everyone for attending the meeting and informed them that the next meeting will occur on Wednesday, December 10. Meeting adjourned.

Next Meeting: Wednesday, December 10, 2014