MN Community Measurement
Measurement and Reporting Committee
Wednesday, September 10, 2014
Meeting Minutes

Members Present: Tim Hernandez, Howard Epstein, Allan Ross, Ann Robinow, Bill Nersesian, Caryn McGeary, Chris Norton, Dan Walczak, Darin Smith, David Homans, Jeff Rank, Kris Soegaard, Larry Lee, Laura Saliterman, Mark Nyman, Mark Sonneborn, Matt Flory, Rahshana Price-Isuk, Robert Lloyd, Stefan Gildemeister, Sue Knudson
MNCM Staff: Anne Snowden, Collette Pitzen, Jasmine Larson, Rachel Mlodzik, Tina Frontera (Guest speaker: Vicki Olson, Stratis Health)
Members Absent: David Satin, Julie Krenik

Topic	Discussion
Welcome & Introductions	Tim Hernandez welcomed committee members and observers. Tim 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 meeting discussion. If there are any questions or comments following the meeting, guests can email info@mncm.org.
Approval of Minutes	The committee reviewed minutes from the August 2014 meeting. **Sue Knudson made a motion to accept; Bill Nersesian seconded the motion. Motion passed.**
Action Item: Total Knee Replacement Pilot and Year One Results; Recommendations for Measures	Tim Hernandez introduced the first agenda item to the committee: to review the pilot and first year results of the Total Knee Replacement (TKR) measures and vote on recommendations. Collette Pitzen from MNCM presented the results. The TKR measures were developed under a contractual relationship with the MN Department of Health with the intent to include the measure/s in the Statewide Quality Reporting and Measurement System (SQRMS). This measure set is for patients undergoing TKR; while very similar in philosophy and construction to the spine measure set, the results and the subsequent recommendations are very different. Collette thanked the workgroup members for their hard work. Those attending the meeting included Gregg Strathy, MD (Park Nicollet) and Scott Marston (HealthPartners). The workgroup chair, Marc Swiontkowski from TRIA Orthopedics, was unable to attend. The pilot did not provide useful results and the first year of statewide implementation for these measures was less than successful. Although the exact cause for this lack of success could not be determined, contributing factors likely include 1) difficulty in implementing patient reported outcome (PRO) assessment tools in orthopedic practices that care for many conditions; 2) reluctance of orthopedic specialists to see the value of reporting outcomes for this patient population; and 3) specialty inexperience with participation in a measurement process. In May 2010, MARC reviewed the impact of potential measure development for the measure concept of TKR and recommended measure development activities proceed with consideration for measures of functional status and appropriateness of procedure. The workgroup explored measures for knee function and overall health related quality of life. MARC reviewed and approved the measures for pilot testing in February 2011. In March 2012, surgeons on the workgroup submitted a letter to the MN Commissioner of Health expressing their concerns about the measure, risk adjustment and MNCM's measure development process. These concerns were reviewed by the MNCM Board of Directors, and MNCM held a community meeting to better understand the concerns. Several adjustments were made to the measure development process as a result. These included the appointment of an external chair; a new policy and procedures for measure development workgroup composition; and more stringent conflict of interest review processes. The measures for the TKR patient population assess the average change between pre-operative and post-operative status. Functional status of the knee and health-related quality of life are measured using PRO tools, which are standardized survey tools with strong psychometric properties (validity, reliability, sensitivity and specificity to change). Patients are assessed within three months prior to the operation and then twice during the post-operative period at three months and one year. It's noteworthy that only the one year measures were included in the SQRMS rule; thus many providers view the three month measures as optional. The outcome measures are: 1. Average change between pre-operative and one year (9 to 15 months) post-operative functional status, as measured with the Oxford Knee Score.

2. Average change between pre-operative and one year (9 to 15 months) post-operative health related quality of life, as measured with the EQ5D-5L. At the request of the workgroup, the volume of procedures should be displayed along with outcome rates.

The patient population is adults age 18 and older (no upper age limit) who undergo a primary or revision total knee replacement with a procedure date during the measurement year. Outcome rates are stratified by primary (first knee replacement on one knee) and by revision (second knee replacement on the same knee); these rates should always reported separately. Patients who undergo bilateral knee replacements or sequential knee replacements (one after the other) are included in the measure. There are no exclusions for these measures.

The denominator for the measure calculation is based on patients who have both a pre-operative and post-operative assessment; patients missing either assessment are not included. As a result, tracking the rates of PRO tool administration within these populations is very important. We have some process measures for tool administration rates that allow us to assess stability of the measure.

Two PRO tools were used for measuring the change in functional status and health-related quality of life. The Oxford Knee Score (OKS) is used to assess the functional status of the knee. The OKS is a proprietary tool. MNCM received permission for free use of this tool in Minnesota and bordering communities for these measures. It consists of 12 structured questions that quantify subjective experience into measureable terms. Examples of question categories include pain intensity, getting in and out of the car, walking, standing after sitting, night pain, walking down one flight of stairs and other activities of daily living. The tool is easy to score and reflected as a total sum, with high scores indicating better knee function.

The second tool is the EQ5D tool to measure health related quality of life. The spine and TKR workgroups both independently selected this tool. The workgroups worked in tandem to resolve issues related to the EQ5D (proprietary, extremely restrictive in terms of who the tool could be used for and methods of administration) and arrived at the same decision. The workgroup recommendation was to: 1) retire EQ5D-5L for measuring health-related quality of life and transition to PROMIS Global-10 for patients undergoing procedures as of 1/1/2015; and 2) Enhance the MNCM Data Portal to convert all PROMIS-10 scores back to EQ5D for patients undergoing procedures in 2013 and 2014 who were assessed pre-operatively with EQ5D and post-operatively with PROMIS-10.

Part of the measure development process included workgroup discussion and selection of variables that could be relevant in the future risk adjustment model for the outcome measures. We need to collect the data to determine its performance in a model and if there is truly disparate differences in the population. Standard variables included age, gender, zip code and product. Clinical variables included height and weight for BMI calculation, tobacco use, diabetes, and primary diagnosis. Additionally, the pre-operative scores for function and quality of life can be assessed within a future model. For this measure set, it is premature to test or discuss performance of a risk adjustment model until the outcome measures are more stable.

Pilot:
The results of pilot testing were not considered successful due to low participation and extremely low utilization of the PRO tools. The latter made evaluation of the outcome measures based on those tools unfeasible. Two practices participated in the pilot with dates of procedures occurring during the second half of 2011. Only 14.5% of patients completed a pre-operative OKS assessment, resulting in 85% of TKR patients automatically dropped out of the denominator. This inhibited the ability to assess the performance of the outcome measures. Participants in the post pilot survey indicated difficulty in tool administration with patients and ranked this higher in difficulty than building the capacity within EMR systems to store and extract results. After reviewing the pilot results, workgroup members discussed the possibility of making a recommendation to MARC to abandon the measures and this effort all together; however, decided to defer further analysis and recommendations until receiving the results of the first year of full implementation which would include a wider representation of orthopedic practices.

Year One Results - Focus on OKS Tool Administration:
The workgroup reconvened at the end of July to review the results of the first year of implementation under SQRMS. These results captured procedure dates occurring during 2012, with a 15-month assessment period ending 3/31/2014. Forty practices submitted data for over 10,000 primary TKR procedures; this included 28 multi-specialty practices (e.g., Park Nicollet, HealthPartners, Mayo Clinic) and 12 orthopedic practices. Two of the state's largest orthopedic groups did not submit data.

Primary Knee Replacement Average OKS Tool Administration Rates:

- Pre-operative = 36.6%
- One year post-operative = 32.0%
- Patients with both pre-operative and post-operative OKS = 18.2%

With only 18% of patients having completed both the pre- and post-operative assessment, it was again unfeasible to evaluate

the outcome measures. When compared to the Lumbar Fusion Spine Surgery pilot rates (77% pre-operative and 58% one year post-operative), PRO tool administration rates for TKR patients are dismal at best.

The workgroup discussed at length the possible reasons for these low rates, particularly as compared to the spine measures. Possible explanations included:

- Difficulty incorporating knee-related functional status tools into busy orthopedic practices that see a wide variety of musculoskeletal conditions. In comparison, a spine surgery practice sees primarily patients with either upper or lower back pain.
- Difficulty timing the pre-operative period because many patients are assessed for knee pain, but not all are ready or appropriate for total knee replacement when they're assessed. It may be months or years before the procedure is scheduled and staff was unclear if they should give the assessment tool again.
- Total knee procedures have not undergone the same level of scrutiny that lumbar spine procedures (e.g., prior authorizations, denials based on failure of conservative therapy). Some health plans required the use of OKS in addition to other attestations prior to approval of spine surgery.

It was noted by some workgroup members that practices could give the PRO tool to all patients presenting with knee pain and use it as a way to assess function without worrying when/if the patient was going to have surgery.

Year one results offer two glimmers of hope in terms of PRO tool administration. When pre-operative and post-operative administration rates were plotted on a graph, nine practices fell in the "good" quadrant by having pre-operative rates above 60% and post-operative rates above 40%. Some of these were practices had a fairly large volume of knee replacements, indicating more successful uptake of PRO tools into clinical work flows. Another 12 practices had low pre-operative rates but demonstrated one year post-operative rates greater than their pre-operative rate.

The workgroup explored alternatives to promote PRO tool administration that could allow the eventual reporting of the outcome measures. They proposed an interim, temporary plan to publicly report three process measures related to tool administration. This recommendation was not made lightly, nor considered easy by the workgroup. Concerns were also noted that some groups could become discouraged if MNCM publicly reported the low rates of OKS tool administration, and choose to give up and not participate. Ultimately, the workgroup felt they had come too far to abandon attempts to measure outcomes.

The workgroup recommended publicly reporting three process measures as an interim step to promote tool administration, with the goal still to eventually report the functional status outcome measures as planned. MNCM has a similar measure used in public reporting (the rate of administration of the PHQ-9 tool to patients with depression) which is NQF endorsed and included in Meaningful Use. The PHQ-9 measure is a paired measure to support the outcome measures of response and remission. Rate distributions of the proposed measures demonstrate variability and opportunity for improvement and reflect tool administration rates for both primary and revision procedures.

The workgroup concluded that the pilot and first year results demonstrate difficulties/barriers to successfully administering PRO tools to patients undergoing TKR procedures. There is need to consider reporting alternatives to support the increase of PRO tool use and continue evaluating the rates of pre-operative and post-operative tool administration to determine suitability of outcome measures for future public reporting. Ideally, a fairly high pre-operative rate is expected and a target goal of 70% post-operative capture. Though not subject to MARC approval, the workgroup also suggested the following activities to increase tool administration rates: 1) direct medical groups to review and compare results within the MNCM Data Portal; 2) ascertain and share information from successful strategies and processes from practices with higher pre- and post-operative tool administration; and 3) ask health plans and the Minnesota Health Action Group to consider PRO tool administration measures for pay for reporting of process measures as a precursor to eventually pay-for-performance of outcome measures.

Recommendations:

1. Retire EQ5D-5L for measuring health-related quality of life and transition to PROMIS Global-10 for patients undergoing procedures as of 1/1/2015.

Ann Robinow made a motion to accept recommendation one to transition from EQ5D-5L to PROMIS Global-10 for patients undergoing procedures beginning 1/1/2015; Sue Knudson seconded the motion. Motion passed.

2. To not publicly report outcomes on the first year data.

Bill Nersesian made a motion to accept recommendation two to not publicly report outcomes on the first year data; Larry Lee seconded the motion. Motion passed.

3. Publicly report the following process measures:
    a. Percent of procedures with pre-operative OKS tool administered
    b. Percent of procedures with one year post-operative OKS tool administered
    c. Percent of procedures with both pre-operative and one year post-operative OKS administered

Chris Norton made a motion to accept recommendation three to publicly report the three process measures listed in the recommendation in 2015; Sue Knudson seconded the motion. Motion passed.

Questions/Comments/Discussion:
Larry Lee commented on the need for some sort of enabler to increase the administration of the PRO tools. This could be in the form of requiring OKS administration as part of prior authorization for total knee replacement. From the health plan perspective, this would be relatively straight forward for the pre-operative tool, but the post-operative component would be more difficult. An alternative could be a pay-for-performance payment based on achieving a threshold of post-operative completions. He indicated Blue Cross Blue Shield of Minnesota is willing to add pre-operative tool administration as a documentation requirement for prior authorization.

David Homans said he would describe the implementation process of a new patient reported tool as "creating some tension." He appreciated the issues involved in implementing new processes in practices where multiple conditions are treated. His primary care practice collectively agreed to pursue quality of life measures as an overall strategy to improve their care. Creating some tension by implementing these tools is the right thing to do, but it is not going to spontaneously happen.

Rahshana Price-Isuk commented that she feels we are asking surgical groups to make the transition that primary care has already made in many areas. With every new tool that comes out, an EMR needs to be re-configured to incorporate the new data. We are asking orthopedic practices to share in the responsibility of quality of life reporting. She feels we need to continue to push this forward and ask for shared responsibility.

Chris Norton asked Collette what the practices are currently using to objectively determine their patients' status after surgery. Collette answered that when the workgroup discussed potential tools in 2010, a couple of the medical groups were using OKS, but there was not much data collection occurring in a way that could be used for comparable measurement. Chris noted that consumers need this information.

Ann Robinow said there is an educational opportunity for the public to understand how important it is to know if their doctor is objectively measuring how they are doing before, during and after surgery. If a doctor is not collecting this information, how do they know the surgery is working? She would like to see an increase in consumer awareness and demand. This could be another enabler in this situation.

Laura Saliterman commented in terms of looking at the situation from the carrot vs. stick approach, the stick would be publicly reporting results on MNCM's website and the carrot would be including these measures in health plan P4P programs. If we do not publicly report these measures, what is the likelihood we can get the health plans to use them for P4P? She also noted that many screenings done by pediatric groups do not qualify for reimbursement. She understands getting the information into an EMR and retrieving it electronically takes effort, but tool administration should not be that difficult.

Dr. Gregg Strathy mentioned one of the challenges in an orthopedic practice is that a doctor is seeing patients with wide variety of concerns (e.g., hip, knee, shoulder), so it is difficult to identify which patients should be administered this specific tool among this rather heterogeneous patient group. Through the measure development process, the workgroup identified two main challenges. The first challenge is to identify the patients that need the survey upfront. The second is that, in an environment where this is not standard practice, the transition to using these tools has proven difficult. He said his orthopedic specialty practice has been trying to do this for several years.

Jeff Rank commented that administering any kind of tool will have some sort of cost. The culture of the practice needs to reflect that this assessment is important.

David Homans added he would think twice about sending his hip/knee patients to a specialist if they cannot figure out an effective way to administer this tool. Under-funded primary care practices have already had to deal with the burden of tool administration, but have found it useful in improving care. He does not feel there is going to be much sympathy for orthopedic surgeons on this matter.

Mark Nyman commented that, generally, it is difficult to get patients to fill out surveys. It is considered "good" if you obtain a 50-75% response rate. It will be a paradigm shift for orthopedic surgeons and their patients to emphasize the importance of this tool. To do survey research on every single patient has posed a bit of a challenge. From the pilot phase to first year

	implementation, there was substantial uptake in the number of completed surveys. Mark asked if MNCM will be reporting the proposed tool administration measures on procedures in 2012 reported in 2015. Collette confirmed this statement and added that MNCM hopes to report the outcomes measures in the following year. Howard Epstein speculated that standalone orthopedic practices may not have basic quality improvement cultures and processes within their offices. If that is the case, there are plenty of educational opportunities in our community for practices and, with dedication and commitment, improvements can occur. Orthopedic providers should know their current scores and how to improve them over time. Ann Robinow asked if the doctors want to know how they are doing on the care they provide their patients. Dr. Gregg Strathy answered that current outcome information is based on individual physicians' anecdotal experience; however, that is not always transferable to other orthopedic practices; thus, it's difficult to build consensus on best practices. Ann replied that in her experience, the value an organization like MNCM can bring to these practices is apples-to-apples comparable results based on measures developed from multiple viewpoints using consensus. Trying to gain consensus from within a practice can be very difficult, and we have the opportunity to influence what occurs in the medical field in a way that individual practices cannot.
Action Item: MNCM Slate of Measures for Reporting in 2015	Tim Hernandez introduced the next agenda item: to review and approve the MNCM Slate of Measures for Reporting in 2015. Every year, MARC reviews the slate to note any changes to the measurement specifications that may occur for the next year and to approve the entire slate for the next reporting year. MARC had already discussed and approved most the information in the slate earlier in the year. **<u>Hospital Measures</u>** Anne Snowden introduced Vicki Olson from Stratis Health, who was invited to provide background on the process used for selecting hospital measures for SQRMS and describe the subset of hospital measures recommended for public reporting on MNCM's consumer website, *MNHealthScores.org*. Vicki began by highlighting some of the upcoming changes to the hospital measure selection process which is overseen by the Hospital Reporting Steering Committee. First, steering committee members have committed to participate through December 2015 in order to provide more continuity. Second, the committee will convene periodically throughout the year rather than once annually and will also seek additional feedback from expert workgroups. Vicki noted the preliminary slate of hospital measures for SQRMS will be developed by April 15 each year to match the ambulatory measures recommendation process. The hospital measures recommended for 2015 public reporting are on the MNCM slate and, in general, are <u>not</u> already publicly available on Medicare's Hospital Compare website. They include: • CMS – 3 mortality measures • AHRQ Quality Indicators – 8 composite measures • Vermont Oxford Network (VON) – 1 NICU measure • CDC's National Healthcare Safety Network (NHSN) – 1 CLABSI • HCAPHS survey – 10 domains **<u>Quality Measures</u>** Anne Snowden and Jasmine Larsen reviewed the remainder of the slate. Jasmine began with an overview of MNCM's Measure Review Process and shared results from the Measure Review Committee (MRC) meetings. Jasmine presented the recommendations for the 2015 Slate of Measures, which reflect recommendations made by the MRC for the measures under review. Last November, MARC approved the formation of the MRC as an enhancement to MNCM's measure review process. The formation of this committee allows for increased stakeholder participation/influence and transparency/awareness of the measure review process. The MRC's purpose is to annually review the DDS and HEDIS measures on the MNCM slate to ensure their collection and reporting continue to be of value to the community. Limited resources are available for collecting data, measuring performance and reporting performance results; therefore, it is important to weigh the potential impact of reporting with the associated burden. While the MRC is not under the directive to retire measures that continue to be of value, retirement is explicitly considered during review. Recommendations within the MRC's scope are to: • Continue the measure • Recommend further review and/or redesign of the measure • Remove the measure from public reporting, but continue to monitor (collect and report privately) • Retire the measure, using the following criteria: o Loss of measure validity

- Loss of opportunity for improvement
- Evidence of undesirable consequences of implementation
- Replacement by a superior measure

This year's MRC review did not include the Optimal Diabetes Care, Optimal Vascular Care and Optimal Asthma Control measures due to ad-hoc measure development workgroup reviews of those occurring already in 2014. The recommendations reflected on the slate for these three measures were previously approved by MARC.

Jasmine directed MARC to review the handout containing the MNCM measures that were recommended for public reporting in 2015. The slate is rearranged to more visually reflect our measurement framework, which is aligned with the National Quality Strategy and IOM's quality domains.

Healthy People and Healthy Communities –
Jasmine outlined that the MRC reviewed six of the measures in this category and recommended continuation of those reviewed. They included: Breast Cancer Screening, Childhood Immunization Status, Cervical Cancer Screening, Colorectal Cancer Screening, Chalmydia Screening in Women, and Immunizations for Adults. During the MRC's review of the Cervical Cancer Screening measure, analysis of the different data collection methods was not yet available. The committee felt strongly that this measure continues to be important and valuable to the community. The committee deferred a final decision about the timing of reporting for this measure to the September MARC meeting when the analysis could be presented. Not reviewed by the MRC were the Adolescent Depression/Mental Health Screening and Pediatric Overweight Counseling measures, which are new for 2015 and were previously approved by MARC for implementation. The Adult Health Lifestyle/Risk Reduction measure set is currently in pilot without plans for reporting in 2015.

Cervical Cancer Screening Measure
Anne reviewed the Cervical Cancer Screening analysis comparing the administrative method of data collection to the hybrid method. She thanked the health plans for actively participating in this testing. Based on the analysis, the recommendation is to use the hybrid method of data collection for this measure. It is the method that reflects the most accurate Cervical Cancer Screening rate for medical group public reporting.

The analysis revealed significant differences in rates for each method at a statewide level and by health plan product. Fifty-five percent of the medical groups tested had statistically different rates when using the hybrid versus administrative methods. Additionally, 45% of the 29 medical groups that could be compared had a rating category difference. This means 13 out of 20 medical groups had a different rating. For example, some groups had a "Below Average" rating using the administrative method but an "Above Average" rating when using the hybrid method.

The draw-back in using the hybrid method is that the number of reportable medical groups will be considerably lower than the administrative method. One very important finding was that medical groups with a higher proportion of Medicaid patients represented in their denominator tended to have higher CCS rate using the hybrid method.

Better Care – Effective and Reliable –
Jasmine reported that the MRC reviewed and recommended continuation of the following measures in this category: Controlling High Blood Pressure, the entire Depression measure set, Follow-up for Children Prescribed ADHD Medications and Spirometry Testing in their Assessment and Diagnosis of COPD. Of note, the MRC had concerns about the technical complexity and action-ability of the depression measure set. MNCM will review these measures to identify improvements and/or simplifications of technical aspects, particularly around the re-indexing of patients.

The changes noted on the slate for the Asthma, Diabetes and Vascular measures were previously approved by MARC and include the removal of the written asthma management plan component for the asthma measure and the suppression of the cholesterol component for the diabetes and vascular measures.

The Spine Surgery measures are new for 2015 reporting and approved by MARC last month for implementation; the Total Knee Replacement measure reflects the recommendation discussed by MARC earlier in this meeting.

Additionally, a placeholder exists on the slate for a new measure concept that will be brought to MARC for consideration later this year with the intent to conduct measure development in 2015.

Better Care – Communication and Care Coordination –
Anne shared that there were no changes to the HIT survey for 2015 reporting.

	Better Care – Patient Centered – Anne shared that Patient Experience is an "every-other-year" measure. Last year, the 12-month CG-CAHPS survey was approved for implementation in 2014 with results to be publicly reported in 2015. Since it is implemented every other year, the survey tool will not change in 2015. MNCM plans to continue to report four domains: Access, Provider Communication, Courteous and Helpful Office Staff, and Rating of Provider. The two Health Care Homes measures in this section are currently on hold with no plans for reporting in 2015. ***Better Care – Appropriateness*** – Jasmine informed the group that the MRC reviewed and recommended continuation of all active measures in this category. The Colonoscopy Quality measure set is in development. MNCM is evaluating the work previously done and what has changed in this measurement area nationally since the pilot testing occurred. We are currently exploring an existing measure set on appropriateness and adenoma detection rates and evaluating its adaptation to DDS. ***Affordability*** – The decision regarding publicly reporting the Total Cost of Care results is still to be determined. MNCM plans to bring overall results, findings from the implementation process, feedback from providers and a recommendation for public reporting to MARC for review in November 2014. We anticipate reporting results in late 2014 or early 2015. Average Unit Price measures high frequency procedures, such as the average costs of an office visit, lab test, office-based radiology test, etc. MNCM has posted the average unit price results twice: once in 2009 and again in 2012. We anticipate the next refresh in June 2015. The goal of this measure is to show the variation of cost in high-frequency procedures and services. This area gets the highest number of hits on *MNHealthScores.org* so we know that consumers are interested in the information. The slate also included a recommendation to retire the ASC measures due to overall high performance, decreased use subsequent to the removal from SQRMS, and the measures not meeting validation standards for public reporting. Additionally, the HITECH diagnostic imaging and Readmissions measures that were previously listed as "on hold" on the slate have been removed due to feasibility barriers. **Questions/Comments/Discussion:** Tim Hernandez mentioned that the criteria used by the MRC for evaluation and retirement of measures were approved by MARC in November 2013. This was in response to significant concerns about data burden. Stefan Gildemeister asked if Jasmine could provide more detail regarding the timeline for the depression measure review. Jasmine answered that brainstorming/exploration of potential technical changes will occur in October or November 2014, and since the concerns around re-indexing and diagnosis requirement with a PHQ-9 score are complex requiring changes to the structure of the data files, any change will require advanced notice to medical groups to allow adequate preparation for changes. We will need to work through technical feasibilities and touch base with provider groups that have provided feedback on the measures. Thus, any potential changes would be applied to the 2016 report year. Pertaining to the cervical cancer screening measure, Ann Robinow asked for possible explanations for why medical groups with a higher proportion of Medicaid patients had a higher CCS rate using the hybrid method. Could it be due to patients going on and off Medicaid? Anne answered that could be the reason; other possibilities include patients enrolled in Medicaid didn't return for follow-ups as often, or are being seen at different sites of care. Matt Flory asked Anne if MNCM would only be reporting the 29 medical groups included in the analyses for the Cervical Cancer Screening measure in 2015. Anne answered that MNCM will not be reporting the test results used in the analysis as it was the prior year's data.
Meeting Adjournment	Tim Hernandez thanked everyone for attending the meeting and informed them that the next meeting will occur on Wednesday, October 8. Meeting adjourned.

Next Meeting: Wednesday, October 8, 2014