MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, May 13, 2015
Meeting Minutes

Members Present: Howard Epstein, Allan Ross, Ann Robinow, Bill Nersesian, Caryn McGeary, Chris Norton, Dan Walczak, Dan Trajano, David Homans, David Satin, Jeff Rank, Jordan Kautz, Kris Soegaard, Laura Saliterman, Mark Sonneborn, Matt Flory, Rahshana Price-Isuk, Robert Lloyd, Stefan Gildemeister, Sue Knudson, Tamiko Morgan
MNCM Staff: Anne Snowden, Gunnar Nelson, Jasmine Larson, Rachel Mlodzik, Tina Frontera
Members Absent: Bruce Penner, Tim Hernandez

Topic	Discussion
Welcome & Introductions	Howard Epstein welcomed committee members and observers. He extended a special welcome and introduction of a new committee member, Dr. Tamiko Morgan. Dr. Morgan is a physician and chief medical director at Metropolitan Health Plan. She is a board-certified pediatrician and continues to practice one day a week. She is also a new member of the MN Community Measurement Board of Directors. Dr. Morgan will serve as one of the committee's health plan representatives. Howard 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 April 2015 meeting. **Dan Trajano made a motion to accept; Laura Saliterman seconded the motion. Motion passed.**
Action Item: Recommendation for changes to MNCM's Established Patient Criteria	Jasmine Larson presented recommendations to the committee regarding the Established Patient Criteria that is used in MNCM's Optimal Diabetes, Vascular and Asthma Care as well as Colorectal Cancer Screening measures. Committee members received background information and details about the two recommendations in the MARC packet, and Jasmine reviewed the highlights of that information during this meeting. The two recommendations were: 1. Change the established patient criteria to be defined by CPT E&M codes for Established Patients: 99211, 99212, 99213, 99214, and 99215. 2. Implement established patient criteria changes for Report Year 2017. The current established patient criterion uses a two-year look back period to identify at least two face-to-face visits with a relevant diagnosis (e.g., diabetes, vascular, etc.) in order for a patient to be included in the measure. At the time the criterion was established (2007), the use of CPT Evaluation and Management codes to identify patients was tested but was found to be burdensome for medical groups to query the transaction-level detail in their systems. The visit counting criterion was ultimately chosen as the most feasible way to remove patients who were new to a clinic. Since then, medical groups' use of EHRs and their abilities to efficiently query their systems has evolved dramatically. In the past few years, MNCM has developed, successfully tested and implemented numerous measures that use CPT codes to define the denominators including the Total Knee Replacement, Spinal Surgery and Pediatric Preventive Care measures. As part of an overall effort to align measure definitions across the broad landscape of measurement activity and simplify reporting for medical groups, MNCM solicited comments from its Direct Data Submission Technical Advisory Committee regarding a move to established-patient criteria driven by CPT E&M codes. This committee consists of representatives from medical groups that submit data to MNCM. All responding members indicated the change was technically feasible and were generally supportive of the proposal. Other benefits of a change to the established patient criteria include: • The appropriate inclusion of some patients that may meet the intent of the measure but are currently being excluded; and, • The inclusion of patients who may be optimally managed but don't require face-to-face encounters with a physician, and thus have a level I visit performed by another member of the care team and supervised by a physician. The drawbacks of a change to the established patient criteria include: • Longer lag time for data to be available for collection and reporting purposes, internally and to MNCM; and,

- May result in a one year loss of the ability to trend performance, with the potential to impact improvement targets that are being used in payer contracting, compensation, provider reviews, etc.

The first recommendation to this committee is to change the established patient criteria to be defined by CPT E&M codes for established patients: 99211, 99212, 99213, 99214 and 99215.

To effectively plan for the transition, MNCM would conduct testing of the proposed criteria with volunteer medical groups. This testing would allow MNCM to better understand the impact and provide an opportunity for issue spotting. Specifically, the impact on data collection and the impact on each measure's denominator size, characteristics and performance rates would be assessed.

As such, the subsequent recommendation to this committee is to implement the proposed change to the established patient criteria for Report Year 2017.

Questions/Comments/Discussion:

Sue Knudson asked Jasmine when the testing for this change in established patient criteria would occur. Jasmine answered that MNCM expects to perform the testing later this year with volunteer medical groups. There were at least four medical groups that have indicated willingness to participate. Sue further asked where the CPT codes will be sourced from in the specifications and if the problem list is a sourcing option. Jasmine answered that the CPT codes will be gathered from billing data. Medical groups will be querying for an accompanying diagnosis code in the active problem list or the code can be attached to the actual visit.

David Satin asked if a patient that he saw for a headache that carries a diagnosis of diabetes would meet the denominator criteria. Jasmine answered that the patient would meet the denominator criteria if he or she is an established patient to that subspecialty at that practice. This is not different from the current patient established criteria. David commented that this method would just be a different way of tracking patient visits. Jasmine clarified that in order to use a CPT code, the patient must have a visit to that sub-specialty in that practice within the previous three years. It is embedded in the use of the code as opposed to the more manual process involved in looking back and visit counting. The new criteria will require one established patient visit within the measurement period.

Laura Saliterman asked if one of the visits requires an attached diagnosis code for a particular measure. Jasmine clarified that the new criteria will only require one visit that meets the established patient criteria. The diagnosis code can be tied to any visit within the measurement period or present on the active problem list. Laura further asked if we are then including patients that are not coming in for a visit related to their attached diagnosis code. Jasmine answered that those patients would be included in the denominator. She added that in the current criteria, this situation can still happen. A patient could have two visits in the previous measurement period with a diabetes diagnosis code attached to them and then come in for a visit in the current measurement period for a different reason (e.g., sore throat) and still be pulled into the measure denominator. Laura added that her organization does offers what they call Easy Care, where a patient could come in for a sore throat and have an asthma diagnosis code on their problem list that was a carryover from several years ago. She explained that problem lists are not necessarily always up-to-date.

David Homans added that the 2013 ACC/AHA guidelines are narrower on how ischemic vascular disease (IVD) is defined. He asked if MNCM will revise their vascular guidelines to reflect this change. Jasmine answered that as part of MNCM's work of transitioning to ICD-10, we are reviewing all diagnose code lists for all of our measures. Collette Pitzen added that typically the definition for IVD has been included all coronary vascular disease. MNCM's vascular guidelines align with the guidelines brought forth by NCQA for their HEDIS measures. All in all, MNCM's definition of IVD is broad. David commented that we need to be aware that we are not precisely matching the current guidelines put forth by the ACC/AHA. He noted that in some of the advanced scanning techniques, modest grades of atherosclerosis can be observed without any clinical events; depending on how those incidents are coded, we could be including events with dubious clinical significance. Jasmine answered that this issue is worth investigating and addressing regardless of what is determined around the established patient criteria. We should reconfirm that how we have defined vascular disease to date is how we want to continue to define it for the future.

Caryn McGeary commented on one of the potential challenges to this established patient criteria change being longer lag time; however, from her perspective, she believes it would likely be the same. She asked if Jasmine could verify the following: with the current face-to-face visit criteria, if a patient had a visit due to a laceration, they would be included in the denominator. And with the new proposed established patient criteria, this same patient may not be coded with an established patient code, ultimately removing them from the denominator. Jasmine responded that this scenario would be correct.

Dan Trajano commented that this established patient criteria change is trying to address reporting burden. The Direct Data Submission Technical Advisory Committee indicated that this criterion is easier to use than our current method of evaluating

established patients. We are also addressing whether or not the correct attribution logic is being used in our measures. He wondered whether this new criteria would potentially worsen our attribution logic and if this new criteria would increase the likelihood of double counting a patient in a denominator. Jasmine clarified that, in addition to the technical alleviation of some of the burden, we are working to align MNCM measures with how established patients are defined by other measure stewards/programs, such as PQRS and Meaningful Use. In regards to the possible double-counting, she answered that this is a potential issue in our current criteria as well. To clarify, there is no risk for double counting within a medical group since each unique patient is assigned to a single clinic within that medical group; however, there may be some double counting when a patient visits two separate medical groups and meets the established patient criteria at both groups. Jasmine does not know if this issue is of the same magnitude in both criteria, but testing will help inform us.

Kris Soegaard commented that she did not see/hear any reference about bringing the testing results back to MARC before the committee votes on a recommendation. She thinks that it would be important and interesting to understand what the denominators look like under both specifications.

Sue Knudson commented that she agrees with Kris' suggestion of bringing the testing results back to MARC before a recommendation is made by the committee. She also acknowledged that we are also revising definitions for the statin exceptions for the diabetes and vascular measures right now. This proposed testing would be confounded by the fact that we are changing the attribution logic and the metrics for the coming year in 2016. The measure definition will be changed for two reporting years in a row (2016 – statin definition change; 2017 – established patient criteria change). She thinks it makes good sense to harmonize with Meaningful Use, PQRS and others. The nature of these changes is that they create more work before less work for medical groups. She thinks there also should be a plan around the disruption of trending and how this will affect payer and purchaser agreements. Managing this change and the communication around it will be very important.

Howard Epstein asked if MNCM staff could comment on the feasibility of the lag time and studying this issue, and bringing the results back to MARC. Jasmine answered that, in internal discussions, MNCM has been considering having the medical groups perform the testing on the data just submitted for the Cycle A measures as opposed to waiting and conducting the testing on the next round of data submission. We would allow the participating medical groups to test this change with their own resources and within their own time window, and not require them to go through a formal data upload. She thinks it is perfectly reasonable and feasible to bring the testing results back to MARC towards the end of this year. The only drawback she saw to this approach is that it would take longer to signal the change to stakeholders, particularly those that may need to plan for impacts to improvement targets for payer contracting, incentives, etc.

Dan Trajano asked for clarification around the proposed changes: one change is around the E&M code attribution methodology and the other is the use of the problem list? Jasmine answered that the use of the problem list will not be a requirement but an option for identifying diagnoses. With the current criteria, the use of an active problem list is not allowed. Dan commented that this criteria includes a soft "or," not a mandated "or." Jasmine answered that medical groups will have to specify how their denominator population will be pulled (e.g., using the active problem lists) in the pre-submission data certification form. Rahshana Price-Isuk asked if these criteria could be used in combination. Collette answered that groups could use a combination of the methods. MNCM has experimented with using active problem list diagnoses for the denominator, and the feedback we've received is that the problem lists are still not adequate to use for conditions that are episodic in nature. Collette used the vascular measure as an example of a chronic condition that should remain in the active problem list, and commented that this is also true for the other impacted measures: diabetes and asthma. She stated that for the vascular measure, in particular, half of the denominator may fall out of the measure under the current criteria because a patient could have just one visit coded in two years with that diagnosis. For this measure, the proposed criterion is the more clinically appropriate method to use since those patients who dropped off meet the intent of the measure.

David Satin commented that he is fairly ignorant on how data from the problem list flows in reporting and if this is an automated process or not. Several committee members answered that it depends on the medical group's system. Collette commented that the some of the feedback MNCM received when looking at an active diagnosis of depression was that providers are very good at providing the initial code but not as good about closing the diagnosis. Jeff Rank commented that he believes that the assumption that problem lists are not useful is wrong. From a realistic standpoint, a provider does not always have the time to review a patient's active problem list when they are trying to treat their serious illness. David Satin commented that chronic diagnoses codes would not be removed from the active problem list.

Sue Knudson clarified that the committee was not asked to review the whole specification today. If this was the case, the committee would see the surrounding context of the denominator definition, including the eligible specialty requirement, and this might address some of the concerns discussed this morning. The harmonization piece is very compelling to her. MNCM and MARC just needs to work through these details.

	Howard Epstein clarified with Jasmine that providers will have the option to use the problem list or not. Jasmine affirmed that providers will have that option, and clarified that they will have to tell MNCM how they will be using the problem list in the pre-submission data certification form. David Satin asked if there could be some medical groups that only submit visits based on the patient's diagnosis code attached to the visit and not use the active problem list. Jasmine answered that this discussion has not occurred. She believes this issue warrants more attention and consideration. David added that overall he thinks this idea is great and the right move. He thinks that the soft "or" in the criterion should be reviewed. David Homans asked if this change encompasses urgent care visits. Jasmine answered that, to her understanding, urgent care does not bill under E&M codes. David commented that he thought this specialty did use these codes. Howard Epstein commented that he believes it depends on the practice site. Howard Epstein commented that with both the previous and proposed criteria, there will be attribution noise and the question is to what extent one criterion outweighs the other. Caryn McGeary suggested that during the testing period it would be beneficial to see if an organization chose option 1 (the diagnosis code attached to the visit) and compare these results to if they had selected option 2 (active problem list). She would be curious to see how that would differ for any individual organization. David Satin agreed that this add would be beneficial during testing. Bill Nersesian added that his organization looked at this from a very practical view, and both criteria are imperfect. He remembers the struggle with keeping up-to-date active problem lists. His organization is in favor of the proposed criteria. He believes it would be difficult to "game" the system with such large denominator counts on most measures. Howard Epstein asked if MNCM staff had any final comments around testing and if they anticipate we will have any additional insights after testing. Jasmine answered that she anticipates testing will answer many of the committee's questions/concerns raised today. She believes it is reasonable for this committee to indicate they support the proposed change in general, but would like to reserve a final recommendation until after they review the results of testing. MNCM would target bringing the testing results back to MARC in November 2015. David Satin asked if this timeline is feasible for medical groups that need to implement this change in report year 2017. Anne Snowden answered that MNCM could communicate to medical groups this summer that this is a potential change to give adequate time. Howard Epstein agreed this timeline would be sufficient. **David Satin made a motion to preliminarily accept the recommendation to change the established patient criteria to be defined by CPT E&M codes pending a final approval after review of the testing results in November of this year; Jeff Rank seconded the motion. Motion passed.** **Jeff Rank made a motion to preliminarily accept the recommendation to implement the established patient criteria changes for report year 2017, pending a final approval after review of the testing results in November of this year; Matt Flory seconded the motion. Motion passed.**
Action Item: MNCM Risk Adjustment Committee Recommendation (depression outcome measures)	Gunnar Nelson explained that MNCM is seeking approval of a recommendation related to risk adjustment of the Depression Care measure suite. There are six measures in the suite: Follow Up, Response and Remission at six months and Follow Up, Response and Remission at 12 months. In March, the Risk Adjustment Committee recommended using the same set of variables to risk adjust all measures in the suite: Age Band, Product and Severity Level. As a reminder, the MARC formed a task force in 2012 to investigate the value and feasibility of risk adjusting MNCM clinic quality measures and publicly reporting the risk adjusted results on MNHealthScores.org. The Risk Adjustment Task Force offered recommendations that the measures should be adjusted as long as the adjustments met certain recommended criteria. In March 2013, the MARC approved the criteria for risk adjustment that had been recommended by the task force. In 2014, a Risk Adjustment Subcommittee of the MARC was formed to implement risk adjustment with the current measures and to create a framework for selection and study of future variables. Not all patients have the same likelihood of achieving optimal health outcomes due to barriers based on demographic, physical or socio-economic situations. Risk adjustment is the process of adjusting the measure to account for the barriers that are outside the control or influence of the provider.

	MNCM risk adjustment employs an Actual to Expected methodology where the actual measure result remains unaltered; rather, a risk-adjusted comparison is created based on same proportions of the risk factors that the clinic has. In late 2014, the subcommittee's first recommendation was to risk adjust six measures: Optimal Diabetes Care, Optimal Vascular Care, Depression Remission at Six Months, Optimal Asthma Care - Adult, Optimal Asthma Care – Child and Colorectal Cancer Screening. The variables to be used were the same variables previously approved by MARC in both 2013 and 2014. Results for five of the six have now been risk adjusted, segmented by major insurance product, and released to providers. They were also made publicly available on MNHealthScores.org and in the *Health Care Quality Report*. Depression Remission at Six Months was originally confirmed as part of the original six measures to be risk adjusted. However, after further consideration, the subcommittee agreed it would be inconsistent and confusing to risk adjust just one of the six depression measures. The Depression measures are in sequence for each time period; the patient must have the follow up to be eligible for the response measure, and the patient must meet the response requirement (50 percent improvement) to be eligible for the remission measure. After analyzing the entire Depression Care measure suite, the subcommittee reconfirmed that age, product and severity levels are important and significant factors in the outcome; present at the initial patient encounter; beyond the control of the provider; and already being collected by providers, resulting in no additional burden. In other words, they meet all of the MARC- and Board-approved requirements for risk adjustment. Gunnar provided a brief update on the public release of risk adjusted rates on for the other five measures on MNHealthScores.org, as well as the fact that reports containing results segmented by insurance products were made available to medical groups through the MNCM Data Portal. With approval from MARC, MNCM would move forward with risk adjusting and publicly reporting all six measures in the Depression Care suite in the same manner as the other five measures. A brief analysis of the impact of risk adjustment so far is included on page four of the risk adjustment section in the MARC packet. Most medical group and clinic rates do not move significantly due to risk adjustment. Rating shifts are rare; where they are most notable is among endocrinology clinics in the Optimal Diabetes Care measure. Risk adjustment tends to move more clinics/medical groups to average to create a bell shaped curve distribution. The Risk Adjustment Subcommittee is continuing to work on refining the guidelines for risk adjustment in general, and we expect to present an update on that work to MARC later this year. **Questions/Comments/Discussion:** Howard Epstein asked if the actual and expected rates are displayed on MNHealthScores.org. Gunnar Nelson answered that both rates are displayed on the site for comparison. Dan Trajano praised MNCM and the Risk Adjustment Subcommittee for their great work. He asked when risk adjustment is applied. Jasmine explained that product information is collected at the most recent patient visit. Risk adjustment is applied at the end of the measurement period. Rahshana Price-Isuk commented that PHQ-9s can be delivered using non-face-to-face methods, such as telephone. She explained that uninsured patients can still receive PHQ-9s over the phone, and the medical group needs to take responsibility for these patients' care. David Homans commented that risk adjustment is helpful in the fact that it encourages physicians to take on the care of harder patient populations, such as the uninsured population. Mark Sonneborn commented that risk adjustment was also part of the RARE campaign. He noted that community clinics, such as Rahshana's medical group, are "curve breakers" to the rate distribution and need to be adjusted for. **Allan Ross made a motion to accept the risk adjustment recommendations on the full Depression Care measure suite; Sue Knudson seconded the motion. Motion passed.**
Action Item: Update on Suite of Cost and Utilization Measures	Gunnar Nelson continued by updating MARC on progress made around cost and utilization measures. The Cost Technical Advisory Group (TAG) was formed in 2011 to develop a cost/efficiency/value measure for public reporting. Gunnar recognized the following MARC members that are also TAG members: Howard Epstein, Stefan Gildemeister, Sue Knudson, Bruce Penner, Kris Soegaard and Mark Sonneborn. The Cost TAG is accountable to the entire Minnesota community, including patients,

	providers and purchasers. The primary impact is aimed at recognizing and identifying variation in cost and utilization in the community, and creating the opportunity to improve and strategically align with local and national initiatives. In December 2014, MNCM released the initial Total Cost of Care (TCOC) measure, first to providers and then published on MNHealthScores.org. The Cost TAG recommended that the 2015 TCOC measure (2014 dates of service) be run with the same specifications and methodology as the 2014 measure (2013 dates of service) in order to test the stability of the measure across time without impact of methodology changes. MNCM expects to have the results in July 2015 with publication in August or September 2015. In addition, MNCM is planning on updating the Cost Per Procedure measure in 2015. This is a measure of the commercial cost of 100 high-volume procedures, tests and office visit types. It was initially published in 2009 and refreshed in 2012. In addition to displaying commercial rates again this year, MNCM will add Medicare and Medicaid fee-for-service rates to the public reporting. The Cost Per Procedure measure is expected to be published at the same time as the 2015 TCOC measure. MNCM, under the guidance of the Cost TAG, is also studying the feasibility of adding a Relative Resource Use companion measure to the TCOC, as well as the ability to expand to case mix-adjusted utilization measures, such as Inpatient Admissions, Emergency Room Use, Pharmacy Use and Avoidable Admissions. Jasmine Larson explained that there is increasing national and local focus on potentially avoidable events, particularly hospital admissions and emergency department visits for ambulatory care sensitive conditions. Through the committee and TAG infrastructure already in place, MNCM can explore the technical feasibility of a Potentially Avoidable Admissions measure and test a proof of concept. As this technical feasibility is determined, a focus group would also be recruited to evaluate clinical appropriateness, meaningfulness and actionability of such a measure. Once the feasibility of the measures as been researched by the Cost TAG and MNCM, a report will be issued to the MARC. Finally, Gunnar updated the committee on MNCM's work with the National Regional Health Improvement (NRHI) and four other organizations over the past 18 months to investigate the use and specifications of a TCOC measure that could be utilized across regions. MNCM was just awarded a grant from the Robert Wood Johnson Foundation to continue this research with NRHI. The second 18-month phase will continue data collection and testing of commercial claims data across regions, as well as evaluate expansion of the effort to include Medicare and Medicaid claims data. **Questions/Comments/Discussion:** David Satin asked if the Cost Per Procedure expansion this year will include PMAP patients. Gunnar Nelson replied that Medicare and Medicaid fee-for-service payment rates will be added to this measure. Gunnar noted that the value of including this additional information is to display difference between payer types. Dan Trajano commented that he is in favor of the additional transparency that is being added to the Cost Per Procedure measure. He then asked whether the TCOC measure will include government programs at some point. Gunnar replied that adding a Medicare and or Medicaid TCOC measure is considered the next priority for the Cost TAG to consider after completion of the Relative Resource Use measure. Sue Knudson commented that Minnesota cost data is much more complete than other regions, and Medicaid difference across this region will be clearer as a result.
Meeting Adjournment	Howard Epstein thanked everyone for attending the meeting and informed them that the next meeting will occur on Wednesday, June 10. Meeting adjourned.

Next Meeting: Wednesday, June 10, 2015