MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, October 14 2015
Meeting Minutes

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

Topic	Discussion
Welcome & Introductions	Howard Epstein called the meeting to order and welcomed committee members and observers. Howard reviewed the agenda.
Approval of Minutes	The committee reviewed minutes from the September 2015 meeting. **Chris Norton made a motion to accept the minutes; Dan Trajano seconded the motion. Motion passed.**
Recommendation on public reporting of TKR outcome measures – For Approval	Howard introduced the recommendation to publicly report the Total Knee Replacement (TKR) outcome measures. He reminded the committee members that the previous approval of process measures for TKR was intended as an intermediary step prior to the reporting of outcome measures. The intent was to focus on increasing the usage of the patient reported outcome tools in practices. Howard then introduced Jasmine Larson, MNCM Manager of Health Care Measurement Development, to present the agenda item. Jasmine provided background on the TKR measures and the public reporting recommendation being brought to MARC today. The TKR measures were developed under a contractual relationship with the MN Department of Health with the intent to include them in the Statewide Quality Reporting and Measurement System (SQRMS). This measure set - which focuses on change in functional status, change in health related quality of life and the use of standardized instruments for measuring these domains - was piloted in 2013 and the subsequent first-year reporting results were brought to this committee in September 2014. The pilot test demonstrated very low rates of the required tool administration to patients undergoing surgery. The first year of statewide implementation saw marked improvement; however, concerns remained regarding the overall low use of the tools in practices and outcomes calculated from those tools. In an effort to support continued improvement in the uptake of the patient assessment tools, the measure development workgroup recommended reporting the process measures surrounding tool administration as an interim step to eventual public reporting of the outcome measures. In September 2014, MARC approved the recommendation to not publicly report outcomes on the first year of TKR data. MARC also approved the public reporting of three process measures in the interim: percent of procedures with pre-operative functional status tool administration; percent of procedures with post-operative functional status tool administration; and percent of procedures with pre/post-operative functional status tool administration Based on the above experiences and the recommendations approved by MARC, the Slate of MNCM Measures for 2015 Reporting also replaced the TKR outcome measures with process measures focused on tool administration. This was done with the intent to evaluate the data once it was submitted in 2015 and bring a recommendation to MARC if the evaluation suggested public reporting of outcome measures was warranted. Jasmine further reminded MARC that a patient-level data file of all TKR procedures is submitted by each medical group in the measure. All procedures are included in the file whether or not patient assessment tools were administered. Process measures are calculated from this data to measure rate of tool administration. Outcome measures can only be calculated for patients that had a tool administered pre/post-operatively. This causes a change in N size between the process and outcome measures. The outcome measures calculate the average change between the patient's pre/post-operative scores, with larger changes indicating more improvement. TKR data for 2015 was submitted by 39 medical groups, reporting on a total of 10,123 surgeries. The statewide rate of patient reported outcome tool administration for 2015 (~25%) compared with the prior year (~20%) and pilot (~5%) clearly demonstrates an upward trend. The outcome measures calculated from the results of the administered patient reported outcome tools were evaluated for

variation and the ability to statistically differentiate results. Based on 2015 data, 15 medical groups reached the minimum reporting volume for the calculation of the outcome measures (30 assessed patients), resulting in performance scores calculated from a total of 2,290 procedures. The range in scores for average change in functional status is 12.5 – 18.6 on a 48 point scale, with a statewide average of 16.9.

Additionally, in an effort to proactively evaluate whether the portion of patients for whom practices have a pre/ post-operative patient reported outcome tool result is a representative sample of a medical group's TKR patients, MNCM analyzed whether certain patient factors (age, gender, insurance product) were key drivers in completion of pre and/or post-operative tools. This demonstrated, overwhelmingly, that the most highly correlated factor with tool completion was the medical group itself. The analysis showed little to no difference between other population subgroups and their relative rates of tool completion.

Jasmine then stated that, in recognition that the reporting plan for the process measures was intended to be an interim step towards the reporting of outcome measures in the TKR measure set, MNCM staff recommends that public reporting of the TKR functional status and health related quality of life outcome measures be added to the 2015 Slate of Measures.

Questions/Comments/Discussion

Dan Trajano asked if a change in the measure construct (i.e., include patients in the denominator of the outcome measure whether or not assessment tools had been administered) could be a way to push groups to administer the tools pre/post-operatively. MNCM Clinical Measure Developer Collette Pitzen stated that during measure development, there was no appetite for a target-based measure; although she said she would be open to discussion of assigning a change value of zero for missing assessments. Jasmine noted that while this type of measure change is possible, she has doubts of its acceptance in the orthopedic community.

Bill Nersesian asked if MNCM knows how many groups are eligible to report data for this measure. He additionally asked what can be done about groups that are eligible but are not reporting data. Jasmine responded that MNCM does not comprehensively know the number of eligible practices that exist in the state that did not report, but MNCM is aware of two large Metro area orthopedic practices that chose not to submit data. In terms of the state rule, Stefan Gildemeister responded that under current law, the implications of not reporting are limited to being pointed out as not being in compliance with the requirements. He stated that, in the past, MDH has chosen not to push compliance because reporting has been seen as an evolving process. He also said that MDH has heard a lot of discussion amongst primary care providers who question why specialists should receive special treatment when they have had enough time to get used to the process. Stefan recommended a conversation with primary care providers and specialty providers to determine when it would be appropriate to begin applying more compliance pressure. MNCM Chief Operating Officer, Tina Frontera, commented that the adoption of measures by others in the community - such as health plans and employers in their contracting or pay-for-performance strategies - may encourage more participation in the measures because of greater incentive and transparency.

Sue Knudson inquired whether there was latitude through SQRMS or at MNCM to indicate that a group has chosen not to transparently report. She stated that this information could be educational to consumers, as well as other organizations using it in applications such as pay-for-performance. Stefan responded that this could be done through SQRMS, but wondered if there is a full understanding of why some of the specialty providers are not able to achieve higher administration rates in their practices. Jasmine responded that, in general, the medical groups that are reporting data to MNCM for these measures have had year-over-year improvements in tool administration rates. She felt that low administration rates were often an issue of internal process improvement and integration in clinical work flows. For example, MNCM has received requests from groups with lower administration rates asking information on the process and workflow best practices from groups with higher administration rates. Jasmine said she could not speak to the factors behind some groups' decisions not to report at all.

Chris Norton asked what feedback MNCM has received in terms of burden in reporting this measure. Jasmine stated that specialty care providers express burden but are not as accustomed to quality measurement activity, particularly as compared to primary care providers who have had over ten years of experience with reporting. Jeff Rank commented that there is a financial burden to reporting that puts groups that do report at a disadvantage to groups that do not; therefore, there is reason to push for some type of compliance pressure.

Stefan commented that there is the opportunity to work on compliance at multiple levels, such as working with payers to set expectations; communicating who does and does not report as well as a short analysis report; and directly reaching out to groups that are not reporting to ensure they understand the requirements. He questioned whether this issue would also be found in the Spine Surgery measures. Jasmine commented that the tool administration rates are significantly higher in the Spine Surgery measures than in the TKR measures.

David Satin asked how many TKR procedures were performed in the state last year. Jasmine speculated that approximately 15,000 were performed in Minnesota, 10,000 of which were captured via reporting.

	Collette commented that the reason MNCM does not comprehensively know the number of orthopedic practices in Minnesota that are not reporting is that not all groups follow the SQRMS annual registration requirements. If all groups registered, MNCM could better identify who is not reporting. David inquired whether this orthopedic specialty cultural pattern was the same as primary care providers ten years ago and these practices will eventually acclimate to quality measurement. Bill responded that there are some factors that make it less likely for orthopedic practices to comply with reporting requirements than primary care practices, primarily that orthopedic providers are near the top of the reimbursement scale and thus don't have a lot of financial incentive to report. Tim Hernandez also commented that another difference between orthopedic and primary care is that orthopedic practices provide episodic care, rather than the continuity of care provided by primary care, which leads to feeling less ownership of the population. Bill stated that Medicare is encouraging 90-day bundles for these procedures (pre-op, operative care, post-op and physical therapy), which should encourage more involvement in the population. Dan Walczak commented that UCare has been studying these types of procedures for three years and their data corroborates what MNCM's data is showing. Anne Snowden, MNCM Director of Performance Measurement and Reporting, commented that MNCM has avoided using language on the consumer website that would draw specific attention to groups that did not submit data; however, she said MNCM staff could explore this. **Bill Nersesian made a motion to approve the recommendation to publicly report the TKR outcome measures; Chris Norton seconded the motion. Motion passed.** Stefan inquired about the timeframe of the measure and when the result of potential compliance interventions would be evident in the measure data. Jasmine stated that if interventions were implemented now, results would be seen in 2017 reporting as the measure allows 15 months after a procedure for follow up. She expects to see continued improvements. Stefan commented that given that timeframe and the amount of time groups have been given to be able to comply with the data reporting requirement, medical groups that do not report are being given an unfair advantage. He noted that it is probably time for MDH, together with MNCM, to determine how to encourage non-reporting medical groups to report. Chris asked if MNCM would be able to more clearly identify groups that have not reported when the data is publicly reported in November. Tina noted that the committee recommended MNCM consider options for this type of reporting. Anne stated that MNCM can't commit to the delineation between groups that submitted with a small sample size and those that chose not to report until staff has had an opportunity to discuss. Anne will plan to bring something back to MARC in the future.
Recommended framework for selection of risk adjustment variables for DDS measures – For Approval	Tim Hernandez introduced the discussion around the recommended framework for the selection of risk adjustment variables for Direct Data Submission (DDS) measures. Tim informed the committee members that the Risk Adjustment and Segmentation Committee set a goal to pull together a framework by the end of 2015 for MARC approval. He then introduced MNCM Health Economist, Gunnar Nelson, to present this agenda item. Gunnar began by clarifying that this framework discussion involves risk adjustment of DDS clinical measures only. He explained that the process of determining risk adjustment variables begins with the measure development workgroups, which select potential variables. Those variables are then evaluated by staff and reviewed by the Risk Adjustment and Segmentation Committee. That committee prepares a recommendation to be considered by MARC. Gunnar stated that measures are risk adjusted because it is accepted that there are patient factors that are outside of health providers' control. The goal of risk adjustment is to isolate provider performance in the measurement from other factors. For example, he explained that an 18 year old, uninsured patient with Type 1 Diabetes has a 6 percent likelihood of being optimally managed compared to a 66 year old, commercially-insured patient with Type 2 Diabetes who has a 50 percent chance of being optimally managed. As not all providers have the same distribution of patient types, the intent of risk adjustment is to level the playing field for all providers. Additionally, Gunnar explained that risk adjustment does not change the measure or the clinic's result. If a clinic has a 6 percent rate, they have a 6 percent rate. Instead, the patient factors are used to calculate a fairer evaluation. MNCM's risk adjustment methodology compares a clinic to a population that has the same patient characteristics as that clinic. This method is referred to as "Actual to Expected" where the Actual is the clinic's unadjusted rate and the Expected is the statewide population result adjusted to represent the population make-up of the clinic. This is also referred to as Indirect Standardization.

	The Risk Adjustment and Segmentation Committee created a defined set of parameters to determine what makes a valid and useful risk adjustment variable. They began with the risk parameters that MARC approved in 2012, as well as incorporated a set of parameters published by the National Quality Forum (NQF) in 2014. Gunnar introduced the six tenets of the Risk Adjustment Framework and Guiding Principles: 1. The adjustment has to make clinical sense. A logical theory has to explain the association between the factor and the outcome. 2. The variable has to show either a statistical impact on the data or have strong face validity. (An example of strong face validity is choosing to separate Uninsured from MHCP, even though the two groups almost always have the same outcome. It is done because there is no harm to the results and it makes logical sense.) 3. The variable cannot be part of the quality of care. If the variable is part of the measure, it cannot be part of the adjustment. 4. The variable must be resistant to gaming and cannot be within the provider's control. 5. The variable must be feasible to collect. It needs to be repeatable, reliable and affordable to obtain. 6. The variable has to contribute to the unique variation. (For example, differences in results may be evident by gender; however, it usually does not impact the results across clinics and therefore cannot be used as a variable.) Gunnar further stated that this framework also includes guidelines for segmentation of results which are intended to highlight differences in patient demographics, not for evaluation, but to inform. In summary, Gunnar said this framework is a combination of previously-approved MARC principles and NQF recommended parameters. **Questions/Comments/Discussion** Mark Sonneborn asked if any consumer research had been done on the displaying of Actual to Expected rates. Gunnar stated that MNCM did some research when measures were first publicly released with Actual to Expected data. However, he acknowledged there is limited consumer understanding about what Actual to Expected results means. He also pointed out the Actual to Expected data is used to determine a clinic's HealthScore and the HealthScore is generally where consumers focus, rather than the raw results data. Jasmine mentioned that the default display on MNHealthScores.org is the HealthScore icon alone rather than the rates and the consumer has to actively choose to see the rates. Mark followed up by asking about the level of understanding of the providers. Gunnar stated that providers have generally been more concerned about the impact of a specific product on their Expected value. Sue Knudson recalled from her experience on the Risk Adjustment and Segmentation Committee that the methodology was changed based on input from providers, which led to the recommendation and approval of the Actual to Expected process. Mark expressed concern about the limited understanding of Actual to Expected methodology outside of the involved committees. David Statin commented that while the risk adjustment would favor clinics that see a lot of medically- and socially-complicated patients to produce an adjusted rate without complication of other data, the Actual to Expected methodology is a good intermediary. This is because of how the HealthScores are displayed on the website; the data is available on the site for those that want more information and it doesn't whitewash the clinics true rate, which is important for health disparities. Mark clarified that he's most concerned about public understanding of the methodology. David stated that when patients are asked what they feel is a determining factor in a clinic's low quality measurement result; the patient response is typically that the clinic has a more complex patient population. **Dan Trajano made a motion to approve the recommended framework for selecting risk adjustment variables for DDS clinical measures as presented; Mark Sonneborn seconded the motion. Motion passed.**
Recommendation on risk adjustment variables for Maternity Care measure – For Approval	Tim again turned the discussion over to Gunnar who presented the final agenda item on risk adjustment variables for the Maternity Care measure. Gunnar, with input from Jasmine, briefly explained the Maternity Care C-Section Rate measure, including the key elements: • Reported at medical group level • If a medical group has a provider that performs C-section procedures, all clinics in that medical group must report • First time deliveries only • Excludes breech presentation and multiple gestation deliveries Gunnar explained that using the now-approved guidelines, the Risk Adjustment and Segmentation Committee considered risk adjustment variables for the Maternity Care C-section Rate measure. The committee evaluated the standard variable set (age and insurance product), as well as variables recommended for consideration by the measure development committee (patient BMI, tobacco use and tobacco counseling).

	Gunnar said two variables have a strong predictability for whether or not a patient will have a C-Section: the patient's age and the patient's BMI in the first trimester. Both variables met the construct of the framework: clinical sense, empirical data, outside the control of the provider, not part of the quality of care, and show variation in the community. These two variables are recommended by the committee. He explained that insurance product had less impact on the outcome of this measure than many others. As pregnancy is a reason some patients are on state public programs, it leads to a different demographic mix. The committee decided to recommend insurance product as a face validity value, as the variable is used for all measures and does not create harm. Stefan inquired whether the non-impact of insurance product was still true when looking at the age bands. David stated that it is true, as product and age are independent variables. Gunnar stated that tobacco use and tobacco counseling were not recommended for risk adjustment because of unclear empirical evidence along with the variables being more difficult to separate from the quality of care provided. David supplemented Gunnar's comments by explaining the difficulty in determining who is responsible for the tobacco status or counseling in the chain of the patient's care during pregnancy, as well as the committee's desire to avoid the perverse incentive of providers being better off with a patient who smokes because it would be adjusted for in the results. Dan Walczak commented that significant interaction between geography and smoking also exists. **Questions/Comments/Discussion** Dan Trajano asked how pregnancy affects BMI. Jasmine clarified that the BMI submitted by medical groups must be within six months prior to pregnancy or during the first trimester. David added that BMI prior to pregnancy would be most predictive of a need for a C-section. David asked how patients are attributed if care is transferred to another provider. Jasmine shared that the medical group that delivered is the attributable provider. If the patient did not have at least one visit with that provider prior to the onset of labor, then the patient is excluded. Bill mentioned that he had shared the information being considered with some OB/Gyn providers in his organization. The providers asked if they could give input and Bill directed them to contact Anne. Bill was curious if the committee could pass this recommendation today and still consider comments later. Gunnar stated that comments are always welcome, the process continues to evolve and each measure is reviewed annually. Stefan asked David if there has been discussion of evaluating socio-economic variables. He also wondered what other factors are critical to this birth outcome that cannot be determined from the data currently being collected and what activities would need to be put in motion today to access this data down the road. David explained that each committee meeting involves two components: maintenance of existing measures and forward thinking discussion. The committee has had discussions about the impacts of race, ethnicity and language as well as Area Deprivation Index (i.e., socioeconomic factors of a neighborhood), and is working hard to consider new factors. David commented that, as the chair of the Risk Adjustment and Segmentation committee, he is not satisfied that they are risk adjusting sufficiently to do justice to the providers and the data. He stated that this is the best that can be done with the data available, and it is better than not applying risk adjustment variables. The committee will continue to do more in the future. **Chris Norton made a motion to approve the recommended risk adjustment variables for the Maternity Care C-section Rate measure as presented; Dan Trajano seconded the motion. Motion passed.**
Meeting Adjournment	Tim Hernandez wrapped up the conversation with some final comments. He reminded MARC members that the next MARC meeting will be Wednesday, November 11.

Next Meeting: Wednesday, November 11, 2015