MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, March 9, 2016
Meeting Minutes

Members Present: Cara Broich, Ariam De Leon, Peter Dehnel, Stefan Gildemeister, Tim Hernandez, Jordan Kautz, Janet Keysser, Sue Knudson, Robert Lloyd, Caryn McGeary, Tamiko Morgan, Bill Nersesian, Chris Norton, Rahshana Price-Isuk, Jeff Rank, Jonathan Rose, Allan Ross, Laura Saliterman, Kris Soegaard, Mark Sonneborn
Alternate: Roli Dwivedi
MNCM Staff: Anne Snowden, Gunnar Nelson, Collette Pitzen, Amy Krier, Tina Frontera
Members Absent: Howard Epstein, Matt Flory, David Homans, Bruce Penner, David Satin

Topic	Discussion
Welcome & Introductions	Tim Hernandez called the meeting to order and welcomed committee members and observers. He announced his appointment as the MN Community Measurement Board chair. Due to this new appointment, he stepped down as MARC co-chair at the end of 2015, but will continue as a MARC member. Tim noted that he was filling in as co-chair for this first meeting of 2016 as Howard Epstein was unable to attend. Tim introduced Chris Norton as the new MARC co-chair who will be serving with Howard. Chris is a member of the MNCM Board and has been a consumer member of MARC since 2009. She has also been chair of MNCM's Measure Review Committee for the past two years. Tim reviewed the MARC Charter and then introduced the new MARC members: Jonathan Rose, consumer; Janet Keysser, consumer; Ariam De Leon, health plan representative. Jonathon has a PhD and has been a research and development engineer at 3M for over 27 years. He is the board chair of the Sierra Leone Community in Minnesota and has extensive experience in research and advocacy initiatives that focus on socioeconomic disparities in Minnesota, and is well versed in data and measurement. Janet has an MBA and is a retired public health professional. Prior to retirement she was employed at the Minnesota Department of Health. She brings extensive background in infectious and chronic disease programs and brings a solid knowledge of data and measurement. Ariam is a physician and the medical director of Medical Policy and Clinical and Quality Operations at UCare Minnesota. He has over 25 years of health care management experience including but not limited to operations, regulatory requirements, data analyses/informatics, and financial management. Tim also welcomed five returning MARC members: Robert Lloyd, government agency representative; Jeff Rank, single specialty group representative; Matt Flory, consumer; Chris Norton, co-chair and consumer representative; and Mark Sonneborn, hospital representative. Although the terms for these representatives ended in 2015, they completed the application to be considered for membership renewal and were found to be the best candidates for their respective roles. MARC members and observers introduced themselves. Tim reminded MARC members about MNCM's Conflict of Interest (COI) policy. All MARC members received a copy of the policy and have signed and returned the disclosure form. These forms were reviewed by a joint MNCM/ICSI COI committee and all MARC members were approved for full participation. Tim reminded members to notify Anne Snowden if their circumstances change during the year.
Approval of Minutes	The committee reviewed minutes from the December 2015 meeting. **Bill Nersesian made a motion to accept the minutes; Laura Saliterman seconded the motion. Motion passed.**
Relative Resource Use (RRU) Pilot results and recommendations for public reporting – for approval	Tim introduced the Relative Resource Use (RRU) agenda item and reminded committee members that MNCM has been publicly reporting Total Cost of Care (TCOC) for the last two years. He noted that the introduction of RRU measures is a logical next step in better understanding what is driving the variation in health care costs. Tim then introduced Gunnar Nelson, MNCM Health Economist, to present the pilot results of the RRU and utilization measures. The purpose of Gunnar's presentation was to bring a recommendation from the Cost Technical Advisory Group (TAG) to expand the total cost of care methodology to include (RRU) and utilization measures. He indicated that this expansion will create 28 new data points for providers and health plans. Recommendations about public reporting the measures will be brought back to MARC later in 2016.

Gunnar noted that the RRU and utilization measures use the same claims, attributed patients and risk score as TCOC; resulting in a significant return of information with minimal additional resources from health plans and providers. Gunnar acknowledged the efforts of Blue Cross Blue Shield of Minnesota, HealthPartners, Medica, and PreferredOne as their efforts were integral in the production of the measure results.

Gunnar went on to explain that TCOC is a comparison of all patient costs for commercial patients attributed to a single medical group. Results adjusted for patient risk. Although TCOC demonstrates the variation in costs between groups, it does not explain the reason for the variation: whether variation is due to differences in price or differences in utilization. TCOC is the comparison of cost if all groups had the same patient population. RRU is the comparison of cost if all groups had the same patient population and the same fee scale.

The RRU value is obtained by using the HealthPartners NQF endorsed TCRRV™ algorithm. There are CMS relative weighting systems for physicians and hospitals that are used for calculating payment. HealthPartners took the CMS standard scales and developed an algorithm that reprices all the patient claims to a standard, neutral fee scale.

Once the RRU and TCOC ratios are calculated, (using the same data), the TCOC ratio can be divided by the RRU ratio to arrive at a price ratio. This price ratio is a directional indicator of price as a comparison between entities. The price ratio cannot be used to determine specific pricing or conversion factors.

RRU is a function of both the number of services performed and the intensity of the service performed. For example, one MRI is the same relative units as seven x-rays. To help understand what is driving resource use – volume or intensity – the data can be used to produce standard utilization metrics along with an expected value based on the patients' risk, age and gender. For example, the number of ER visits for the patients attributed to the medical group is compared to the average number of ER visits that would be expected given the mix of patients for that group. The expected value is not the gold standard or ideal amount; rather, it is the average for each group's patient population. This methodology will produce standard utilization metrics on inpatient admits including length of stay, ER use, outpatient surgery, office visits, lab, radiology and pharmacy utilization.

Pilot testing of the expanded methodology used the same input claims that were used for the 2015 TCOC report (2014 dates of service). The health plans ran the data through the TCRRV™ algorithm and supplied the results to MNCM. After a thorough validation process, the medical groups participating on the Cost TAG reviewed their pilot results. All medical groups shared that the calculations were reasonable, clear and useful.

Gunnar requested approval of the recommendation to expand the TCOC methodology to include RRU and utilization; and the reporting of blinded results to medical groups and health plans. This phased release of results will help inform decisions on which facets of RRU should be publicly reported to consumers. Again, the recommendation for public reporting of RRU and utilization will be brought back to MARC later this year.

Questions/Comments/Discussion

Tim requested a clarification of the definition of "cost" in the context of these measures. Gunnar explained that "cost" is the total amount paid by the commercial health plan plus member responsibility.

Bill Nersesian noted that he uses the cost information often, finds it very helpful, and appreciates that the health plans are doing the work. He asked for an explanation of the variables used for risk adjustment. Gunnar noted that ACG software was used to place patients in actuarial-based cells with the addition of age and gender variables. The ACG software factors in the number of problems the patient has and takes into account the severity of the problems. Sue Knudson noted that HealthPartners worked on this NQF-endorsed methodology for over a decade. It was trademarked to keep the methodology in the public domain free of charge. She noted that the usability was vetted very thoroughly by the NQF committee.

Cara Broich commented that, from a health plan perspective, they were excited for the RRU measure and the depth of information it will add to the TCOC data.

Peter Dehnel asked if other methodologies were considered. Gunnar explained that building a new methodology from scratch or re-pricing to the Medicare fee schedule, were other options; however, both would have taken more time without gain. Using the methodology established by HealthPartners saved a considerable amount of time. Sue explained that this methodology is the only population-based, NQF-endorsed measure. There are others for subsets of the population, but the HealthPartners methodology can drill down. Plus, it uses the same methodology as TCOC so they're viewed as companion measures.

	Chris asked whether the results of these measures would benefit consumers. Gunnar explained that MNCM makes every attempt to display the cost information with quality measure results to depict value. Sue noted that, as an industry, there needs to be a better way to illustrate triple aim results. We have a ways to go to bridge the education gap for consumers around health care costs. These measures are a small slice of that education, but a step in the right direction. Gunnar explained that the measure also gives more information about the types of resources being used in different regional areas. Allan Ross asked if this data could make a specific hospital look better or worse. Gunnar explained that the measure results don't identify hospitals, but will show how much hospital-based resources are attributed to the medical group. Ariam De Leon noted that the Johns Hopkins ACG was used in this methodology. He inquired whether this methodology allows for other ACG models to be used. Gunnar acknowledged there are other models available, but pointed out that the Johns Hopkins ACG is part of the NQF-endorsed process and it would have cost more to use one of the others. Additionally, there is evidence that the Johns Hopkins ACG produces stable results and is trusted. He noted that if there were consensus to move to another method that would be possible, but the resulting measure would no longer be NQF endorsed. When pooling data from multiple health plans, a common risk adjuster must be used by all. **Bill Nersesian made a motion to approve the RRU and utilization measure methodology and for un-blinded results to be reported to providers and health plans; Mark Sonneborn seconded the motion. Motion passed.**
Community Transformation Grant (CTG) measure set – Pilot results; discuss incorporation into SQRMS	Chris introduced the next agenda item by welcoming guest Cherylee Sherry, from the Minnesota Department of Health (MDH) explaining that Cherylee would present background on the original Community Transformation Grant (CTG) and rationale for the measure development activities supported by this CDC-sponsored grant. Chris also introduced Collette Pitzen, MNCM measure developer, explaining that Collette would review the pilot results from measure testing. Chris noted that MDH requested a MARC discussion about these measures and possible future incorporation into SQRMS as a deliverable under the current contract. Cherylee provided background on CTG and noted that this grant funded the original development of the Healthy Lifestyle/Risk Reduction Measure set. She also presented information about the new CDC Community Wellness Grant (CWG) recently awarded to MDH, explaining how the requirements of the new grant relate to the measures that were tested. Collette reviewed the history of the measure development activities noting that the previous MDH contract included measure development and testing. At that time, there was no plan for widespread implementation of the measures beyond pilot testing in the 22 communities within the CTG grant. MDH appreciated MARC's input throughout the measure development process. In 2013, MARC reviewed and approved the measures for pilot testing. At that time, it was understood that any further use of the measures beyond the original intent would require further MARC discussion. Under the current contract, MDH requested that MNCM staff bring the results of pilot testing to MARC and facilitate a discussion about potential inclusion of a measure(s) from the measure set into SQRMS. The measure set includes: 1. Optimal Risk Reduction (patient level all-or-none composite) a. BP < 140/90 for ages 18 to 59; BP < 150/90 for ages 60 to 75 b. Tobacco-free c. BMI < 25.0 for ages 18 to 64; BMI < 30.0 ages 65 to 75 2. Blood pressure elevation without diagnosis of hypertension 3. Cessation counseling for tobacco users Collette presented the results of the pilot testing for these three measures. Six medical groups representing 31 clinics participated in the pilot and over 37,000 patients were included in the analysis. • Optimal Risk Reduction: The composite measure rate was 25%. Individual numerator component rates included Blood Pressure at 90.1%, Tobacco-free at 76.1% and BMI at 28.8%. • Blood Pressure Elevation without Diagnosis of Hypertension: This measure's rate was 6%, confirming the workgroup's desire to have a measure to allow tracking and follow-up of these at-risk patients. • Tobacco Cessation Counseling: 47.8% of tobacco users received cessation counseling as defined by the AMA's measure which is a bit lenient in its definition of counseling. As part of MNCM's measure testing process, pilot participants provided feedback about the feasibility of the measure. Nearly all data elements for these measures are a part of the existing construction of another measure or a component of a meaningful use measure. All of the pilot participants were able to extract the needed data elements without additional chart abstraction. The majority of pilot participants rated the data elements needed for measure calculations as very easy to obtain.

	Pilot results for all three measures demonstrated an opportunity for improvement and variability in rates between practices. After reviewing the results of pilot testing, the measure development workgroup made the following recommendations about the three measures: The workgroup concluded that measures #1 (Optimal Risk Reduction) and #3 (Cessation Counseling Intervention for Tobacco Users) are clinically sound, viable and feasible for use. The workgroup recommended minor modifications (e.g., no need for the pre-eclampsia/eclampsia exception to the blood pressure component). The workgroup reaffirmed its original use/purpose for measure #2 (Blood Pressure Elevation without Diagnosis of HTN); it is valuable for internal quality improvement and tracking of patients who need more follow-up to determine if hypertension is present. They emphasized that measure #2 is not appropriate for public reporting as a measure of accountability. MARC members received the final report including recommendations from the measure development workgroup. Collette opened the floor to discuss potential inclusion of the Healthy Lifestyle/Risk Reduction measures into SQRMS. **Questions/Comments/Discussion** Jeff noted the developing evidence that BMI itself is not an ideal indicator of obesity as compared to waist circumference and other types of metrics. He inquired as to whether other ways of determining overweight or obese status had been considered by the workgroup. Collette responded that there was a lot of discussion within the workgroup about obesity measurement, acknowledging that waist circumference may be more accurate but is less feasible to obtain so the workgroup proceeded with using BMI value in the measure construct. Bill expressed concern about the reporting burden with family practice and internal medicine providers carrying most of the burden of reporting. He suggested that if these measures were added that other measures be retired. Peter expressed concern that BMI and weight were not directly controlled by providers. Collette shared that the workgroup thoroughly discussed all the variables surrounding obesity and felt that there is a need to start addressing the obesity issue. Rahshana Price-Isuk noted that while the measure may not be burdensome to collect and report, the true burden to providers is achieving the outcome, moving patients to a healthier state, and having the time and resources to address multiple issues in a visit. Time constraints and multiple issues cause providers to ask patients to come back more often thereby driving up utilization and cost. Bill expressed his concern about competition from retail clinics which focus on the patient's reason for the visit and not on the patient's overall health. They are not being held to the same standards and measurements as primary care clinics. Retail clinics can then address patient issues more inexpensively because they don't need to address things like a patient's BMI, tobacco status, etc. He commented that primary care providers have many things to address and their workload is something to be considered. Tim noted there have been many community discussions about the volume of measures for primary care and the desire to retire measures if others are added. He also noted that many providers don't like composite measures. In light of the current volume of measures for primary care clinics, he was hesitant to recommend including these measures in SQRMS. Jeff noted that many of the issues addressed by these measures are as much a part of public health as they are the responsibility of clinicians. Requiring them in SQRMS puts accountability solely on the clinicians. Allan expressed agreement with Tim's comments and expanded on Rahshana's statement by saying that it is financially burdensome to patients to come back repeatedly to address all the issues necessary. He felt that the patient's financial burden also needed to be taken into consideration. Tamiko asked how these measures are different from what is being collected for HEDIS. Collette commented that the HEDIS obesity measures are process measures and therefore do not address the outcome. Sue noted that provider burden was a passionate piece of the discussion prior to the approval of the pilot for these measures in 2013. She asked if it would be worth exploring using similar HEDIS measures in place of this composite clinical measure if it would reduce burden. Janet commented that she likes the measures and encouraged consideration for widespread use. As consumer members, Janet and Jonathon both indicated that these health issues are important and should be addressed. Rahshana noted that, after hearing the full discussion, she would not want these measures included in SQRMS due to the measure construction (composite) measure and the increased accountability for patient's BMI and tobacco use. She commented that she would be more likely to support measures that reported change rather than measuring to a target.

	Given that the Minnesota Commissioner of Health makes the final decision about inclusion of this measure set in SQRMS, a formal vote was made to clarify MARC's collective input. **Jeff Rank made a motion that these measures not be incorporated into the Statewide Quality Reporting and Measurement System (SQRMS); Rahshana Price-Isuk seconded the motion. Motion passed with three votes against and two abstentions.**
Meeting Adjournment	Chris thanked Tim for his important contributions as MARC co-chair and many years of service. She read a special thank you statement from co-chair, Howard Epstein.

Next Meeting: Wednesday, April 13, 2016