**MN Community Measurement (MNCM)**
**Measurement and Reporting Committee (MARC)**
Wednesday, December 9, 2015
*Meeting Minutes*

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

| Topic | Discussion |
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| **Welcome & Introductions** | Howard Epstein called the meeting to order and welcomed committee members and observers. Howard announced that Tim Hernandez will become chair of the MNCM Board of Directors and therefore will no longer co-chair the MARC committee. Tim will, however, continue as a member of the MARC committee. Howard thanked Tim for his years of service as committee co-chair. Howard also introduced Cara Broich of Medica, who is joining MARC as a Health Plan representative and replacing Dan Trajano. Howard thanked Dan for his work on the committee. Howard then reviewed the agenda. |
| **Approval of Minutes** | The committee reviewed minutes from the November 2015 meeting. **Chris Norton made a motion to accept the minutes; Sue Knudson seconded the motion. Motion passed.** |
| **Cancer Care Measure Development Workgroup Recommendations – for approval** | Howard introduced the Cancer Care Measure Development Workgroup recommendations by reminding the group that MARC approved the preliminary charter of the workgroup at the April 2015 meeting. The scope of the workgroup's charge was:<br>• To develop measures for oncology practices<br>• To explore measure development activities that focus on symptom management during cancer treatment<br>• Preference for outcome measures utilizing patient-reported outcome tools<br><br>Howard introduced Collette Pitzen, MNCM Measure Developer, and Dr. Nicole Hartung, oncologist and chair of the measure development workgroup.<br><br>Collette began by thanking the workgroup members for their ongoing commitment. The committee strove to remain focused on patients while keeping an eye toward feasibility in data collection. The workgroup decided to be inclusive by not restricting the measure by cancer type, as symptom management was the desired goal regardless of cancer type or treatment intent. Engaged in all aspects of measure construction with attention to detail, the group reviewed 17 different Patient Reported Outcome (PRO) tools and worked through several iterations of the measure construct before reaching consensus on the measure specifications.<br><br>The workgroup determined the eligible population criteria to include patients aged 18 and older that were newly diagnosed with cancer and that were embarking on their first course of chemotherapy. This is narrowed by focusing on chemotherapy that is prescribed and managed by an oncologist and does not include biotherapy type drugs for other conditions (e.g., Rheumatoid Arthritis, Psoriasis, Crohn's Disease). The measure does not include primary care providers that are seeing cancer patients for other conditions.<br><br>Additional eligible population criteria includes an index event that occurs when a patient has a New Patient Evaluation and Management office visit and the Cycle 1 Day 1 date of chemotherapy treatment that occurs within 90 days of the new patient visit. Both elements must occur during the index period.<br><br>Chemotherapy is typically given in cycles, which is a plan of treatment followed by a period of rest. A course of chemotherapy is comprised of multiple cycles. Each course is different, but generally consists of four to six cycles. The typical duration of a cycle is anywhere from one to four weeks. Cycle 1 is the first cycle in a course of treatment and Day 1 is the first day of drug administration.<br><br>The index period for these measures is the first six months of the 12 month measurement period. The remaining six months of the measurement period is utilized for assessment of patients with an index event occurring during the index period.<br><br>Collette explained that the measure denominator consists of a count of chemotherapy cycles, not the number of indexed patients, as each chemotherapy cycle is an opportunity for assessment. As most patients complete three cycles of treatment |

within four months of their treatment start date, the workgroup decided to measure the first three treatment cycles for each indexed patient with the caveat that Cycle 1 Day 1 must happen in the index period. So if 40 patients were indexed during the six month index timeframe, this would create a denominator count of 120 representing three treatment cycles for each of the 40 patients.

The overall goal is to keep the controllable symptoms of pain, nausea and constipation at a minimal (low or none) level to increase the tolerance of chemotherapy and the likelihood of treatment completion. The workgroup is recommending four measures that can be captured from one PRO tool and one data file submission: one process measure, administration rate of the PRO tool; and three outcome measures, one each for pain, nausea & constipation.

- Process Measure #1: Symptom Severity Assessment During Chemotherapy
    - A treatment cycle is considered numerator compliant if Day 1 of the cycle occurred during the assessment period; the patient was assessed with the PRO tool during days five to 15 of the cycle; and all questions of the PRO tool were answered.
    - Cycles 1, 2 and 3 are eligible for measurement. The numerator and denominator from each cycle are combined to calculate the rate.
- Outcome Measures #2, #3 and #4: Symptom Control During Chemotherapy: Pain, Nausea and Constipation
    - The workgroup concluded that a composite measure of the three symptoms was not of added value and is recommending separate measures.
    - The PRO tool must be completed for the symptom to be included in the measure.
    - The measures assess symptoms as reported by the patient during days five to 15 of the treatment cycle.
    - A treatment cycle is considered numerator compliant for each measure (pain, nausea and constipation) if severity of the symptom being measured is reported as mild or none; numeric target less than two.
    - Cycles 1, 2 and 3 are eligible for measurement. The numerator and denominator from each cycle are combined to calculate the rate.

The PRO tool the workgroup selected is an excerpt from the National Cancer Institute's (NCI) 81 item PRO-CTCAE tool (Patient Reported Outcome Common Terminology Criteria for Adverse Events), a tool with validated psychometric properties at the item level. Collette noted that MNCM is working with NCI to finalize the necessary permissions for the use of this tool, which is expected to go public during the first quarter of 2016. NCI agrees with and supports the use of the excerpt. Formal license agreement is anticipated in early 2016 to coincide with pilot testing. No barriers for modes of administration or use of the tool in clinical practice are anticipated.

These measures have no exclusions. Of the standard demographic risk adjustment variables available, the workgroup estimates that health plan product and age will demonstrate potential value as risk adjustment variables in future testing of a model. Clinical variables selected for data collection and evaluation in a risk adjustment model include:

- **Emetogenic level** of the chemotherapy treatment; potential risk of nausea. The classifications of chemotherapy drugs known to be moderately or highly emetogenic are included in the specifications; groups to classify as 1 = high, 2 = moderate or 3 = low/ minimal. This is a fairly short list of highly (10) and moderately (21) emetogenic regimens which is based on the Multinational Association of Supportive Care in Cancer (MASCC) guidelines.
- **Treatment intent** (curative or palliative). Treatment intent, curative versus palliative captures the aggressiveness of chemotherapy and is a clinical decision made early on that generally does not change during the first three cycles of treatment. Patients with a curative intent are more likely to be healthy but in an attempt to eradicate microscopic disease, their treatment is going to be more intense and likely to have more symptoms than a patient with macroscopic disease and palliative intent. The intent may not be captured by all practices, but is a requirement for ordering any chemotherapy course in the EPIC oncology module.

These potential risk adjustment variables allowed the workgroup to move forward with an eligible population that was more inclusive.

Public comment brought up no topics or concerns that were not already discussed during the workgroup process. Very positive comments were received from a researcher at the American Cancer Society. The measures have also received support through a collaborative relationship with the American Society of Clinical Oncology.

To allow pilot participants time to implement a new PRO-based assessment tool into their practices and clinical workflows, the workgroup seeks approval of pilot index dates of service from July 1, 2016 through December 31, 2016 and the assessment period through June 30, 2017 with data collection and pilot results anticipated at the end of 2017.

Nicole stated that the workgroup process was wonderful to be a part of and feels that the measures truly are groundbreaking. She stated that oncology practices don't generally have a formalized way of asking patients what their

symptom outcomes are. She noted that starting this type of measurement in Minnesota could lead to national attention. Jeff Rank noted that this could lead to the establishment of some best practices as well.

**Questions/Comments/Discussion**

Chris Norton inquired about the definition of a new patient and whether it had been considered to include patients that may not be new to chemotherapy, having recurrence years later, or who had switched oncologists during the first occurrence. Chris felt that these scenarios could be considered new patients. Collette explained that the workgroup had discussed the inclusion of all patients regardless of treatment status (first course of treatment or more), but decided to narrow and focus on newly diagnosed patients. Patients that are transferring care may be captured but the numbers would be small. The goals of symptom management would be the same. Collette stated that that information can be evaluated during pilot testing.

Jeff Rank mentioned that different chemotherapy treatment types could have different time intervals between cycles. He wondered if the five to 15 day assessment window would capture all treatment cycles. Collette stated there were extensive discussions around the timing of the assessment to ensure the most accurate response from patients. Not so early in the cycle that they would not yet be experiencing symptoms, but not so late in the cycle that the symptom experience would require a lot of recall on the patient's part. Sixty percent of chemotherapy regimens have an infusion day that is within the five to 15 day timeframe which could support the PRO tool administration within clinical workflows. Nicole Hartung noted that it would be easiest to assess the patient's symptoms for the first cycle at the time of the start of the second cycle when they are seeing the oncologist in the office, but patient recall of symptoms diminishes significantly after two weeks and subsequently the tools validity and reliability is impacted. Collette explained that the top two tools for consideration asked the patient about their symptoms "now" or "in the last 24 hours". It isn't very practical or feasible to get the PRO tool to the patient at the exact time that they were having their symptoms. The workgroup determined that the assessment of symptoms during days five to 15 of the cycle, plus a tool that asked about the severity of symptoms with a seven day recall, was the most reliable method to capture the symptoms of interest.

David Satin asked whether all cancer types have similar chemotherapy treatment cycles. Nicole responded that 75 percent of patients receiving chemotherapy are receiving it for breast, lung or colon cancer. Those three cancer types are treated similarly. David S. then asked whether the type of malignancy could cause some of the symptoms being measured. Nicole noted that the workgroup did discuss narrowing the population to a specific cancer type but ultimately decided that including all cancer types levels the playing field as most practices see a fairly even mix of cancer types. Collette indicated that one of the recommended clinical risk adjustment variables is intent of treatment: curative or palliative. The intent of treatment typically indicates the level of aggressiveness of the chemotherapy regimen.

David Homans asked whether the duration of days of nausea factor into the PRO tool assessment. Collette noted that the tool collects the frequency as well as severity of the patient's nausea. The numerator is based on the patient's response to the severity portion of the question, but the frequency could be considered for future measurement.

Laura Saliterman inquired whether there was truly a level playing field in Greater Minnesota compared to the Metro area, where patients tend to receive their treatment. Nicole responded many Greater Minnesota patients will come to the Metro area for a second opinion or to receive a scan, but that patients generally receive their chemotherapy treatments close to home.

David S. asked whether the oncologists are assigning the emetogenic level to the chemotherapy drugs given. Nicole responded that the emetic risk category is assigned to all of the drugs based on MASCC guidelines.

David S. inquired whether a baseline is established for symptoms prior to assessment during treatment. Nicole noted that a baseline is not being collected; however, whatever the baseline symptoms are, they will get worse during the course of chemotherapy treatment if the symptoms are not being managed. Bill Nersesian acknowledged the difficulty in assessing a patient's baseline for these symptoms from chart review. Collette stated that the workgroup had discussed setting a baseline but decided that it causes complexity and burden. Regardless of the symptom source, the symptom needs to be managed. Bill noted that all providers have patients with some baseline symptoms and therefore it is another way to level the playing field.

David S. followed up by asking if there was a discussion of risk adjustment by culture, race, ethnicity, country of origin or preferred language. Collette indicated that this data was being collected and could be analyzed.

David H. said he felt that these measures were groundbreaking. He wondered if the members of the workgroup that did this work every day felt this measure set was a good one. Nicole and Collette noted that there were a number of people on the workgroup that have an oncology background and there was extensive discussion around getting at an ideal measure while still making the measure feasible in practice.

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| | Howard and Sue Knudson recommended changing the treatment intent risk adjustment language in the specifications from palliative to non-curative, as palliative care can represent many different levels or different types of services. Nicole and Collette agreed; field definitions for Treatment Intent will be modified to curative or non-curative.<br><br>Chris asked how the measure will include patients that are having oral chemotherapy treatments that produce these symptoms but aren't chemotherapy infusions or injections. Collette noted that intent of the measure is to include chemotherapy as well as biotherapy. The procedure codes used to identify the eligible population include IV therapies, but not oral therapies. Chris felt that leaving out the oral chemotherapy would skew the results in rural areas. Nicole explained that patients in rural areas would not be receiving oral therapies at a higher rate than in metro areas.<br><br>Keeping in mind oncology practices that would not be participating in the pilot would still need to implement use of the PRO tool in order to participate after pilot, Sue asked for specification of the post-pilot roll-out timeframe. Collette indicated that she could project out those timelines when recruiting for the pilot, but indicated it would not be until 2018 at the earliest. Post meeting note: Anticipated wide-spread implementation would be index dates of 1/1/2018 to 6/30/2018 and assessment dates through 12/31/2018. Data submission is anticipated for Cycle B in 2019.<br><br>Howard pointed out that the April MARC meeting included discussion of the unintended consequences of encouraging over utilization of anti-emetogenic medications and opioids by these measures. Nicole noted that these over-utilization issues were discussed in the workgroup. She acknowledged that there is a concern of overutilization. All anti-emetogenics are highly constipating, so trying to make one score better with anti-emetogenic drugs will make another score worse. There is already overutilization of anti-emetogenics so some health plans have started requiring pre-authorization for these higher cost drugs which somewhat mitigates the issue. Additionally, the opportunity for changes in care processes could also help. The issue may not be worth the burden of collecting the clinical prescription data though the direct data submission process from medical groups, however claims data could be made available from the health plans. Howard asked that the workgroup consider measuring this type of drug overutilization in the next phase of the measure when reviewing the pilot results.<br><br>**Bill Nersesian made a motion to approve the recommendations of the Cancer Care Measure Development Workgroup as presented; Chris Norton seconded the motion. Motion passed.** |
| **Update on testing of new "Established Patient Criteria" using CPT codes and Recommendation – for approval** | Howard introduced Collette Pitzen and Jasmine Larson, MNCM Manager of Measure Development, to present the Established Patient Criteria using CPT codes agenda item.<br><br>This recommendation was previously brought to MARC in May and, at that time; MARC gave preliminary approval with final approval pending pilot test results. Measures under this recommendation include Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Control and Colorectal Cancer Screening. The feedback received in May was appreciated and helped to structure the pilot testing, paying particular attention to the impact of urgent care only visits and testing various combinations of problem list and encounter diagnoses.<br><br>The current visit counting methodology was developed eight years ago in conjunction with the then new Direct Data Submission (DDS) process as a proxy for the continuous enrollment criterion that was used in health plan measures. An example of this methodology is found in the Optimal Diabetes Care measure: two or more face-to-face visits for diabetes in the last two measurement periods and at least one visit for any reason during the current measurement period. The intent of this criterion is to correctly identify patients with the diagnosis and established to the medical group for inclusion in a measure. It is known through experience and feedback from medical groups that the visit counting methodology can eliminate patients who do have the diagnosis or clinical condition and are established to the medical group, particularly in the Optimal Vascular Care measure. It is estimated that approximately half of the patients that should be included in the measure were being missed because they did not have two visits with the specific codes to define vascular disease in the timeframe.<br><br>With increased reliance on electronic medical records systems as a source for clinical measures and improved capability to efficiently query, it is time to consider new methods that align with measure science currently in use in PQRS and Meaningful Use. Collette clarified that there will be differences in the volume of patients included in the measures because this methodology is a new, different and more inclusive method of identifying patients.<br><br>When testing new criteria, it is important to keep in mind that the goals are to determine if 1) the patient truly has the diagnosis and should be included in the measure; and 2) the patient belongs to the medical group. |

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| | The established patient E&M codes are used in urgent care setting. For medical groups with urgent care services, this new methodology could unintentionally pull in patients who were seen only in urgent care. Historically, urgent care visits have been excluded in the visit counting methodology and the new methodology would continue to include exclusion criteria for urgent care visits.<br><br>The pilot testing utilized historical data from three volunteer medical groups from the DDS Technical Advisory Workgroup. Over 340,000 patients were included in the testing. All pilot groups confirmed that the new method was including patients with the diagnosis that were established to their medical group.<br><br>Pilot groups tested the distribution of where they were finding the patient's diagnoses, either on the problem list, the encounter diagnosis or both. The majority of patients had the diagnosis in both their active problem list and as an encounter diagnosis during the current or prior measurement period; however, proportions differed by measure. Patients with diabetes or vascular disease were more likely to have diagnoses found in both places. Approximately 70 percent of patients with asthma had the diagnosis on both their problem list and encounter diagnosis, but 20 percent had the diagnosis only on the problem list. The pilot participants were not surprised by this finding nor the increased number of patients being pulled into the measure. The latter is attributed to patients with mild intermittent asthma who have the diagnosis on the problem list (and are valid diagnoses) but not having a problem-focused visit.<br><br>Interestingly, when each pilot group was independently asked what they thought about this and if those patients should be included for measurement (have their asthma symptoms assessed for control), all felt strongly that these patients have the diagnosis, are at potential risk of exacerbation, should have their symptoms assessed and be included in the measure of asthma control.<br><br>As a result of better understanding the distribution, allowing groups to choose either the problem list or the encounter diagnosis is not a viable option. Based on this, staff recommend that the criteria is specified as an 'and/or' statement that includes both: "Include patients who meet either of the following criteria: Patient has the diagnosis coded for any contact during the current or prior measurement period OR the diagnosis is present on the active problem list anytime during the measurement period."<br><br>One unexpected finding as a result of pilot testing was a significant decrease in the denominator for the colorectal cancer screening measure. This population-based screening measure does not rely on diagnoses, other than exclusions, and shouldn't have decreased by 20,000 patients.<br><br>Using preventive service established patient E&M codes was not originally included in the proposed criteria. The pilot participants kindly did one more test with the addition of appropriate age-based preventive services criteria to all the measures to assess denominator volume. The addition of the preventive services codes corrected the original denominator deficit for the colorectal cancer screening measure and appropriately added patients to the disease-based measures. There were a fair number of patients with diabetes and vascular disease who only had the preventive service established CPT visit code; this may be related to a patient who is well managed without a problem-focused visit but should still be identified for the measure.<br><br>Collette presented the recommendation to amend the original proposed codes to include the appropriate age-based preventive services codes. For the disease-based measures, aligning with the correct ages specified for each measure, preventive services for established patients were added to the specifications. For the colorectal cancer screening measure, which is a population-based screening measure that is not dependent on diagnoses for inclusion, initial comprehensive preventive services codes and Medicare wellness visit codes were added in addition to the age-based preventive services codes for established patients. Approval is being sought for the change in methodology for identifying established patients for four measures that currently rely on visit counting. The specific recommendations are as follows:<br><br>**Recommendation 1:** Change the established patient criteria to be defined by CPT E&M codes for Established Patients: 99211, 99212, 99213, 99214, 99215, and the appropriate age-based preventive services established patient codes.<br>▪ Add an allowable exclusion for patients with only urgent care (UC) visits. All office visits during the measurement period occurred in an urgent care setting.<br>▪ Diagnosis criteria to include query of both the active problem list and the encounter diagnosis as the source for confirming diagnosis. Diagnosis is found on the active problem list and/or the encounter.<br>▪ Adding preventive services established patients codes; age based and differ per measure<br>✓ Diabetes and Vascular (18 to 75) add 99395, 99396, 99397<br>✓ Asthma (5 to 50) add 99392, 99393, 99394, 99395, 99396<br>✓ Colorectal Cancer Screening add 99396, 99397, 99386, 99387, G0402, G0438, G0439 |

**Recommendation 2:** Implement established patient criteria changes (Recommendation 1) for Report Year 2017.

**Questions/Comments/Discussion**

David S. asked for clarification on the use of the problem list and/or encounter diagnosis for determining patient measure eligibility. Collette explained that the diagnosis of interest has to be present on either the problem list or the encounter, and therefore medical groups will have to review both locations in the patient record to determine eligibility.

David S. followed up by asking the purpose of the exclusion for patients that were incorrectly coded for the diagnosis of interest. Collette noted that, particularly in the diabetes population and in some older record systems, patients being evaluated for pre-diabetes are often coded for diabetes and pulled into the patient population with that code. Then, as records are being manually abstracted, the abstractor will note that the patient was truly a pre-diabetes patient and therefore does not meet eligibility criteria. Jasmine clarified that the error that is being corrected by this exclusion is a coding error rather than a diagnostic error.

David H. inquired whether a history of the diagnosis of interest would also include the patient in the eligible population. Collette clarified that the "history of" administrative codes, V-codes in ICD-9 or Z-codes in ICD-10, are not included in the value sets for these measures.

Sue asked whether the use of problem list and/or encounter diagnosis requirement is consistent with PQRS and Meaningful Use. Collette indicated that it was.

David S. noted that he would like the requirement to utilize the problem list for measure inclusion to drive medical groups to clean up their problem lists. Collette noted that groups choosing to utilize the exclusion for diagnosis error would need to manually abstract that data.

Jeff expressed concern about the general inaccuracy of problem lists given the time constraints of clinic visits that inhibit the ability to remove erroneous or outdated issues and how those inaccuracies may incorrectly include patients in the eligible population. Collette explained that they specifically asked pilot members whether they felt this methodology was correctly identifying patients that should be included and the pilot members indicated that the results are reliable. David S. noted that in primary care it is important to maintain accurate problem lists.

Sue expressed concerns about the increase in eligible populations, particularly the asthma populations, causing the unintended circumstance of introducing unnecessary work to clinics to follow-up with patients that don't really need it because the patient's problem list isn't accurate. She felt it best for clinics to be able to proactively clean up their problem lists to avoid pulling in patients inaccurately. Howard inquired whether this change in established patient criteria isn't yet appropriate for the asthma measure. Tamiko Morgan indicated that she is more concerned about missing asthma patients than including too many. She also noted that asthma is a chronic disease that may be brought under control, but it would be less likely for the diagnosis to go away. Collette noted that the pilot participants felt that the patients captured in this pilot evaluation should have their symptoms assessed. Jasmine explained that diabetes patients considered to be in control still have their symptoms assessed based on guidelines and it is difficult to have a different standard for different disease groups.

Laura explained that pediatric asthma is different than adult asthma and has different needs. Parents of a patient who may have been diagnosed as having asthma at three years old but hasn't had symptoms in two or three years may be more reluctant to have the patient assessed for asthma control. Collette again noted that the administrative codes for the asthma measure do not include "history of" codes, but if the diagnosis remains on the patient's problem list, the patient would be included. Laura expressed concern in regard to the current state of problem lists as well as the transition of problem lists to ICD-10 coding that indicates the severity level of a patient's asthma. She wondered if the asthma measure is ready for the introduction of this new established patient criterion as it would include patients with mild intermittent asthma. Jasmine stated that if mild intermittent asthma were removed from the measure, it would change the definition of the measure.

Kris Soegaard asked what happens to the comparability of 2017 data to 2016 if this change were implemented and whether improvement rewards could be paid based on this data. Jasmine noted that comparisons between reporting years should be made with caution. Essentially, results between reporting years won't be comparable. Sue felt that the change could cause a drop off in performance so they would need to rebase for pay for performance programs as the new rates would no longer be comparable to the previous year's rates.

David H. explained that the difference between diabetes and asthma is that diabetic patients who are asymptomatic are still incurring a burden of disease that will affect them in the future. He wondered if there was evidence of something similar with patients who have their asthma under control and are not being aggressively managed such as an increased risk of severe COPD down the road. Laura noted that there is not solid data showing a connection and that it is a controversial area.

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| | David S. noted that he has seen patients who could be considered to have moderate asthma who may indicate that their asthma is under control but it is that way because they have modified their activities of daily living to avoid triggering their symptoms. He indicated that patients with no symptoms, take no medications and lead an active lifestyle could accurately be removed from the measure population. Patients who appear to be in control due to avoiding their triggers should still be followed. Tamiko noted that patients with moderate or mild-intermittent asthma could present in the emergency department at any time with an acute asthma exacerbation and are always at risk for severe asthmatic reactions. So while they may not have a vascular compromise, they are always at risk of a potential deadly asthma attack.<br><br>Howard summarized the discussion by noting consensus on the fact that problem lists are not always up to date and clinics need to address this. He also stated that there was not controversy around adopting these recommendations for the Optimal Diabetes Care, Optimal Vascular Care and Colorectal Cancer Screening measures, but there were concerns around the Optimal Asthma Control measure.<br><br>**Tamiko Morgan made a motion to approve the full recommendations of new Established Patient Criteria using CPT codes as presented; Chris Norton seconded the motion. Motion passed.** |
| **Update on Cost Measures – for information only** | Howard announced that due to time constraints, the update on the cost measures would not be presented at today's meeting. Gunnar Nelson, MNCM Health Economist, encouraged the committee to read the memo on the 2015 Cost of Care Suite of Measures included in their packet as it covers the majority of what he was going to present.<br><br>**Questions/Comments/Discussion**<br>Howard asked when an update on Relative Resource Use would be presented to the committee. Gunnar noted that this would most likely be presented in March 2016. |
| **Meeting Adjournment** | Howard noted that Dan Trajano, Dan Walczak and Ann Robinow will be stepping down from MARC. He thanked these members for their dedicated service to the committee. He additionally noted that the new MARC members and co-chair will hopefully be introduced at the February meeting.<br><br>Howard Epstein reminded members that the next MARC meeting will be Wednesday, February 10. |

Next Meeting: Wednesday, February 10, 2016