MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, June 8, 2016
Meeting Minutes

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

Topic	Discussion
Welcome & Introductions	Chris Norton called the meeting to order and welcomed committee members, board members and observers to this special meeting regarding the challenges of measure alignment given the changes in Medicare. Chris reviewed the agenda, and noted that MARC members will conduct a brief MARC meeting prior to the strategic discussion.
Adoption of Minutes	The committee reviewed minutes from the April 2016 meeting. **Allan Ross made a motion to accept the minutes; Mark Sonneborn seconded the motion. Motion passed.**
Strategic Discussion: MACRA and STARS – Implications for Aligning Measurement in Minnesota	Chris introduced Jim Chase from MNCM who briefly explained that the goal of this discussion was to determine what MN Community Measurement should do in terms of alignment of measures with the Medicare Access & CHIP Reauthorization Act (MACRA) with the intent of producing an alignment plan to bring to the MNCM Board for consideration. <u>MACRA 101</u> Jim introduced Ann Greiner, the Vice President of Public Affairs with the National Quality Forum (NQF), to present a primer on MACRA. Ann began by praising Minnesota's leadership in the health care quality realm and providing background on NQF including their structure and strategic priorities. She then explained that MACRA is a complex bill passed in March 2015 and signed into law in April 2015. The congressional goals for MACRA are to: • Replace the Sustainable Growth Rate (SGR) Formula with a payment system based on value • Reduce reporting burden • Engage physicians in developing measures and advanced Alternative Payment Models (A-APM) • Provide more flexibility and choice MACRA establishes the Quality Payment Program (QPP). The QPP has two pathways: the Merit-based Incentive Payment System (MIPS) and A-APM. The performance year begins in 2017 with the first payment adjustments in 2019. The MIPS composite performance score (CPS), which is a scale from one to 100, will factor in performance in four categories. Three of the four categories build on existing programs: • Quality: The Quality component will initially account for 50 percent of the MIPS score, but will eventually reduce in weight to account for 30 percent of the score. This Quality measurement will replace the Physician Quality Reporting System (PQRS). There are currently 200 measures to choose from to meet the requirements of the Quality component. • Resource Use: The Resource Use component will replace the current Value-Based Payment Modifier (VBPM). This Resource Use measurement will initially account for 10 percent of the MIPS score, eventually increasing in weight to 30 percent. Resource Use has no reporting requirements for clinicians as all measures are calculated from claims data. • Advancing Care Information: The Advancing Care Information component will replace Meaningful Use and will account for 25 percent of the MIPS score. • Clinical Practice Improvement Activities (CPIA): CPIA is a new area and will account for 15 percent of the MIPS score. This component is based on attestation or data submission related to 90+ CPIA. Full automatic credit is granted for accredited patient centered medical homes (PCMH). Clinicians are given half credit for participating in non-advanced APM. Initially, most clinicians will be in MIPS. The Center for Medicare and Medicaid Services (CMS) estimates that in 2017 only 4 percent of clinicians will be in A-APM. Providers eligible for MIPS in years one and two include physicians, physician assistants, nurse practitioners and other advanced practice nurses. In year three, the Health and Human Services (HHS)

Secretary can broaden the scope of eligible providers. Clinicians who will not participate in MIPS include those in their first year of Medicare Part B participation, those that have a low patient volume, and certain participants in A-APM.

MIPS payment adjustments will be based on a clinician's CPS and its comparison to the CPS threshold. The thresholds have not yet been set. CMS will look at the performance of all providers to determine threshold cut points. The constraints of the threshold determination is that the QPP is designed to be a budget neutral system where the adjustments for poor performers fund the adjustments for high performers. An advisory group that was convened by the Government Accountability Office (GAO) will continue to advise CMS on some of these issues. In terms of risk adjustment, the measures included in the MIPS CPS have clinical adjustments where appropriate but are not currently adjusted for socio-economic factors. Clinician MIPS CPS will most likely not be publicly reported until at least 2019 to coincide with the start of the payment schedule.

Due to the limited number of A-APM's and specificity of requirements, very few clinicians are likely to be participating in an A-APM. MACRA does not change how existing A-APM's function or how they reward value. MACRA does create extra incentives for participation in an A-APM. Between 2019 and 2024, A-APM qualifying participants receive an automatic five percent annual incentive payment on top of any potential incentive they may receive for participating in the A-APM. Beyond 2015, A-APM qualifying participants receive a 0.75 percent annual update versus 0.25 percent for those in MIPS.

In summation, Ann shared items to consider:

- There is an exceedingly brief period of time between the finalization of the rule and the start of the reporting year for a very complex payment program. This means that clinician education programs will need to be robust and timely.
- There is a long-term desire for clinicians to be in A-APM's and a short-term reality that the majority of clinicians will be in MIPS.
- Will the budget neutrality of MIPS set up competition between providers and stymie collaboration?
- How will be the MIPS CPS model work?
- Congressional interest is focused on implementation of this bill.
- What affect might a change in Administration have on implementation?

Jim noted that the focus of Ann's presentation had been primarily on fee-for-service Medicare programs but noted that patients in Minnesota are largely enrolled in Medicare managed care programs.

A public attendee [Jeff Schiff] asked, given the inclusion of Medicaid and other non-Medicare payments starting in 2021, whether CMS was aiming for multi-payer alignment by that date. Ann agreed that was the goal.

A MARC member [Stefan Gildemeister] inquired whether the main focus of the MACRA bill is payment rather than public reporting. Ann noted that, historically, the annual Medicare fee schedule rule has included provisions for public reporting via the Physician Compare program on Medicare.gov. She was unsure if public reporting is included in MACRA.

<u>MIPS, MNCM and Core Measures; Gap and Alignment Areas</u>
Jim then introduced Jasmine Larson of MN Community Measurement to present background on the current status of measure alignment across programs.

Jasmine reviewed some of the current and future measurement and reporting programs to which many MNCM stakeholders are bound. She presented information about misalignment of measures across these programs. She also summarized the measurement and reporting priorities for stakeholders in Minnesota including alignment, consideration of burden, impact on community health, measurement innovation, value, and maintaining a patient-centered focus.

She explained that to address the challenges of measure alignment as well as stakeholder priorities, MNCM will draft a report that will include guiding principles for how to balance priorities for a core philosophy that seeks maximum value for maximum stakeholder groups. The report will also contain short-term and long-term recommended measure changes to speak to the issue of alignment. Discussion at today's meeting will be used to help develop these principles and build an initial list of recommendations. MNCM will then solicit comments on the report and present the report to the MNCM Board and MARC to get approval for next steps.

<u>Facilitated Discussion</u>
Jim facilitated the discussion regarding MACRA and the alignment of measures across programs. The discussion was opened up to MARC members, board members, and observers.

	Jim asked how organizations are looking at MACRA and specifically the situation of MIPS versus A-APM participation. A MNCM Board member [Craig Acomb] pointed out that the initial incentives in the MIPS program outweigh the incentives of A-APM participation. He inquired whether there seemed to be an initial disincentive for groups to participate in A-APM. A MNCM Board member [Beth Averbeck] commented that organizations were still in the research phase in terms of the MACRA bill but noted that Minnesota is a lower reimbursement state for Medicare and that point was factoring into the decision making process. Jim commented that there are incentives for participating in A-APM, but he was unsure if the incentives would be enough to overcome the obstacles of A-APM participation. He noted that the focus may need to be at the conjunction of the Star and MIPS programs and the MNCM slate of measures. A MNCM Board member and MARC member [Tim Hernandez] noted that providers are stunned by MACRA. He went on to explain his concerns that providers' reactions to the bill and the enormity of the changes that would need to be made will deter them from collaborating in transformational change. A MNCM Board member [Bob Meiches] noted that MACRA is perceived by providers as higher burden than existing programs. He additionally commented that an important piece of this puzzle is to identify who the end user is in this work: the community, the commercial or government purchasers, etc. He also noted, referencing the Institute of Medicine (IOM) report discussed in September 2015, that an important question to explore is whether the current available measures are the ones that will advance health in our community. A MARC member [Janet Keysser] inquired whether the measures included in MIPS have data to prove they improve health. Ann responded that CMS does not yet have performance data on all of their measures, but will in the next year or two. Ann noted that is clearly an important missing piece and hoped that NQF could learn from stakeholders the types of performance data they are seeking. A MARC member [David Satin] commented that while the current PQRS measures may be measuring the wrong thing (granular, disease specific measures), they are not weak measures. In fact, many of them have a substantial amount of data supporting them. He noted that a strength of MNCM is a proven track record that can be used to promote innovative measures; however, it would be difficult to argue that MNCM's measures are better than existing PQRS measures. Jim pointed out the comparison of the MIPS Diabetes measure versus the MNCM Diabetes measure that Jasmine reviewed during her presentation. He noted that there were components of the MIPS Diabetes measure that MNCM chose not to include in the MNCM Diabetes measure, but there isn't an argument that those components are unimportant. One of the MARC co-chairs [Chris Norton] asked what MACRA will mean for consumers: better care or more burden on providers that will negatively impact the care provided. Ann stated that policy makers hope MACRA will encourage the delivery of better, less costly, patient-centered care. Chris then asked how this will be measured. Ann noted that CMS is required to produce a public report every three years to explain how measurement is driving better care but it will takes time to come to a definitive answer. A MNCM Board member [Beth Averbeck] suggested flexing MNCM measures to align where appropriate but also exploring whether similar but unaligned measures could be used side-by-side to measure a continuum of care along a patient's lifetime (e.g., MNCM's measure for optimal HbA1c control for younger patients as well as MIPS's measure for poor HbA1c control for older patients) and adjust age criteria in MNCM's measures accordingly. She also suggested a focus on patient reported outcome measures as a focus for measure innovation going forward. A MARC member [Allan Ross] expressed concern that increasing the number of measures increases the areas of focus during patient visits. This in turn increases the number of required visits and tests and increases the out of pocket costs for patients. He also voiced concerns that clinics in rural areas do not have the same advantages in measurement as clinics in more heavily populated areas. One unintended consequence could mean reduced patient access to providers in rural areas. Another MARC member [Mark Sonneborn] expressed worry that the MIPS program seemed fraught with potential for gamesmanship by allowing clinicians to pick measures to maximize their scores. He acknowledged that it is likely better than the current pay for volume program, but the chance for gamesmanship is still there. An additional MARC member [Sue Knudson] noted that the priority of a patient-centered focus could cross cut all Minnesota priorities. Balancing the portfolio of measures will be very tricky as it is a complex system. She also commented that the measurement and reporting community in Minnesota needs to stay true to a lot of the standards that have been in place in previous years while being willing to let go of measures that don't make sense and collaborate where it does make sense. A MARC member [Jeff Rank] noted the burden of making EHR changes for another set of new measures where the value of the measure for the patient is not yet known. He felt the burden of constant change needs to be considered. Another MARC member [David Homans] stated that these changes have created an identity crisis for MNCM. He noted that MNCM had

	placed a lot of emphasis on being innovative and suggested a shift in driving focus from innovation to community health. Given the complexity of the issue, focusing on one priority may make the most sense. Another MARC member [Rahshana Price-Isuk] commented that MNCM may have a responsibility as an innovator and an organization of influence to begin to align nationally rather than centering focus on Minnesota. The Minnesota community is changing and becoming more diverse. She suggested that alignment at a national level will help to produce measures that are more inclusive. MNCM Board member [Craig Acomb] built on that comment by stating that he hoped MNCM would continue to be a leader and innovator in measurement and reporting rather than lowering standards for the sake of national alignment. Jim asked how MNCM grows from current practices and builds on strengths but is also realistic about what works for everyone in the community. He noted that it may be beneficial to continue to be innovative to find ways to drive change for patients but to also include practical projects that are already in use for the sake of alignment. A MARC member [David Satin] noted that whether or not measures align, it is the providers' responsibility to make informed clinical practice decisions above and beyond measurement requirements. He went on to say that while MNCM does have influence in the measurement and reporting community, MNCM will not be able to fix everything. Another MARC member [Cara Broich] expressed her belief that MNCM has a large influence on the direction of measurement and what gets focused on for improvement, and that it is MNCM's responsibility to be proactive rather than reactive to national changes in alignment, even if that means that MNCM chooses to remain unaligned. An additional MARC member [Ariam De Leon] commented that MACRA is asking providers to make serious investments in infrastructure and behavioral changes two years before it is known whether there will be any value in the changes. He feels this is a serious problem. Jim stated that MNCM's focus doesn't have to be solely around public reporting for consumer use. There can be work done that is specifically tailored for the use of providers, health plans, and consumers as well as for the purposes of driving innovation in the larger community. Jim additionally noted that the ideas and guiding principles that were gathered in this discussion will be collected in a report for presentation to MARC and the MNCM Board. The report will have a public comment period prior to committee presentation.
Meeting Adjournment	Howard Epstein wrapped up the conversation by summarizing the key discussion points and by making some final comments. Tina noted that a representative from CMS will be presenting on the topic of MACRA at MNCM's annual seminar on September 15, 2016. Howard reminded MARC members that there is no meeting scheduled in July; therefore, the next MARC meeting will be Wednesday, August 10. Meeting adjourned.

Next Meeting: Wednesday, August 10, 2016