

MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
 Wednesday, March 13, 2019
Meeting Minutes

Members Present: Howard Epstein, Rahshana Price-Isuk, Barb Anderson, Janet Avery, Cara Broich, Karolina Craft, Sue Gentilli, Stefan Gildemeister, Greg Hanley, Sue Knudson, Deb Krause, Chris Norton, Christopher Restad, Jonathan Rose, Allan Ross, Laura Saliterman, David Satin, Mark Sonneborn, Dan Trajano

Absent: Lori Bethke, Matt Flory, Jordan Kautz, Jess Wheeler

Guests: Todd Ginkel (Spine Redesign Workgroup)

MNCM Staff: Jess Amo, Liz Cinqueonce, Collette Pitzen, Anne Snowden, Julie Sonier

Topic	Discussion
Welcome & Introductions	<p>Rahshana Price-Isuk called the meeting to order and welcomed committee members, Spine Redesign Workgroup members and observers. Rahshana introduced herself as the new MARC co-chair and the MARC members introduced themselves. Rahshana then welcomed and introduced two new MARC members: Christopher Restad and Lori Bethke. Lori was unable to attend the meeting but plans to attend the April meeting.</p> <p>Rahshana reviewed the committee charter, thanked members for submitting Conflict of Interest (COI) disclosures, and noted that all MARC members were approved for full participation on MARC. Rahshana also highlighted the MARC Member Competencies and Expectations, included in the meeting packet.</p>
Approval of Minutes	<p>The committee reviewed minutes from the December 2018 meeting. Sue Knudson made a motion to accept the minutes; Chris Norton seconded the motion. Motion passed.</p>
Spine Surgery Measure Redesign Workgroup Recommendations	<p>Rahshana introduced Collette Pitzen, Clinical Measure Developer at MNCM to present the recommendation from the Spine Surgery Measure Redesign Workgroup. Collette began by sharing that this redesign was a MNCM priority without contractual obligation. Six of the spine surgery measures are currently in the Quality Payment Program (QPP).</p> <p>Background: The spine surgery measures were originally developed in 2010/2011, with pilot testing occurring in 2012. These measures are based on Patient Reported Outcome (PRO) tools, which included functional status measured with Oswestry Disability Index (ODI), back and leg pain with a Visual Analog Pain Scale (VAS), and health-related quality of life with the PROMIS Global-10. They were designed to measure the practice's average change from pre-op to post-op. Two populations are assessed: lumbar fusion (any number of levels) assessed at one year (nine to 15 months) and discectomy laminotomy (narrow population with one CPT code for diagnosis of disc herniation) assessed at three months (six to 20 weeks).</p> <p>In 2015, with support from the American Alliance of Orthopedic Executives (AAOE), three measures were submitted for consideration to CMS's Quality Payment Program (QPP). In 2016, three more spine surgery measures were submitted to the QPP. In total, six spine surgery measures were accepted into the QPP:</p> <ul style="list-style-type: none"> • QPP #459: Average Change in Back Pain Following Lumbar Discectomy/Laminotomy • QPP #460: Average Change in Back Pain Following Lumbar Fusion • QPP #461: Average Change in Leg Pain Following Lumbar Discectomy/Laminotomy • QPP #469: Average Change in Functional Status Following Lumbar Fusion Surgery • QPP #471: Average Change in Functional Status Following Lumbar Discectomy/Laminotomy • QPP #473: Average Change in Leg Pain Following Lumbar Surgery <p>While CMS liked these PRO measures, they provided some feedback regarding the measure construct. They explained that benchmarking an average change measure is difficult. Additionally, the current 'average change' construct does not protect against denominator self-selection. While not a concern for all providers, there is a risk that providers could choose to not administer a tool if the patient is not doing well, which would cause these patients to fall out of the denominator. The 'average change' construct requires a patient to have both a pre- and post-op assessment in order to be included in the denominator. To address these concerns, CMS suggested that we consider moving to a target-based measure, while still accepting the measures into the QPP. However, they added a stipulation for QPP use in which medical groups would need to administer pre- and post-op assessments to at least 50 percent of their patients. Many of the medical groups in Minnesota would not meet this stipulation. CMS appreciated MNCM's willingness to consider redesign and accepted the 'average change' measures into the QPP.</p>

When first developed, providers anticipated administration rates of approximately 70 percent of all patients undergoing the lumbar spine procedures. However, actual tool administration rates are much lower at 40 percent, resulting in a loss of 60 percent of the denominator. These tool administration rates have not improved over time.

Task 1: Consider changing measure construct to target-based

Many of MNCM's PRO-based measures are currently seeking a target score (e.g., depression, asthma, cancer). For the orthopedic measures, average change between pre- and post-op scores within a practice was being calculated instead. A target-based measure considers whether a patient has met a particular goal. If the patient is not assessed, they are not hitting the target.

To determine what an appropriate target would be for functional status and pain, several steps were taken:

- Conducted literature reviews for outcome results
- Reviewed large studies that utilized the Spine Tango registry
- These studies determined the correlation between PRO tools and a Patient Acceptable Symptom State (PASS). The PASS is the highest level of symptom beyond which patients consider themselves well. These analyses found that the following scores indicated the achievement of an acceptable symptom state and can be used as a criterion for treatment success:
 - An ODI score of less than or equal to 22
 - A VAS score for back and leg pain of less than or equal to 3

While a target ODI of less than or equal to 22 was the most patient-centric, because of the inclusiveness of all levels of fusion in the lumbar spine measure, the workgroup was uncomfortable with a target alone and opted for two ways to meet the numerator for both ODI and VAS (leg and back pain):

- Post-op ODI score of less than or equal to 22 **OR** a change of 30 points or greater between the pre- and post-op ODI scores
- Post-op VAS score of less than or equal to 3 for back and leg pain **OR** a change of 5.0 points or greater between the pre- and post-op VAS scores for back and leg pain

Since literature regarding change scores was not available, MNCM used data from past medical group submissions and worked with their statistician to establish an appropriate methodology. Over 1,000 patients in each population had achieved the desired target ODI or pain score and had a pre- and post-op score. The change targets are represented by the mean change that was achieved by patients who were hitting the desired target.

Thus, the measure becomes a target in which all eligible patients remain in the denominator. If a patient is not assessed, they are not meeting the target. This recommended construct will incentivize medical groups to increase tool administration and allows for benchmarks to be assessed. The construct also does not always require pre- and post-op assessments; however, collection of pre-op assessments is strongly encouraged for use in risk adjustment. Additionally, if the patient does not meet the target, pre- and post-op assessments are needed to measure the change.

The workgroup reached consensus on changing the measure as follows:

- Post-op ODI score of less than or equal to 22 **OR** Change of 30 points or greater
- Post-op Back Pain score of less than or equal to 3.0 **OR** Change of 5.0 points or greater
- Post-op Leg Pain score of less than or equal to 3.0 **OR** Change of 5.0 points or greater

Task 2: Expand denominator for discectomy/laminotomy population

Task 2 is a technical necessity and was not a suggestion made by CMS. The original decision from the workgroup was to have a homogenous population by using the most frequently used CPT code (63030) for the most frequent diagnosis of disc herniation (ICD9 722.10). At the time, MARC was okay with using a narrow population for the discectomy/laminotomy population if the fusion population was expanded. The narrow population for the discectomy/laminotomy population worked well when using ICD-9 codes but was not as successful when translating the 722.10 code to ICD-10. As a result, the denominator decreased dramatically, with most groups becoming unreportable (less than 30 procedures).

MNCM recommended that the workgroup consider expanding the denominator to be more inclusive and represent all discectomy/laminectomy procedures without narrowing by diagnosis. The workgroup reached consensus for expansion but also added exclusions to be consistent with the lumbar fusion population: cancer, acute fracture, infection and scoliosis.

Task 3: Discussion of Quality of Life Tool and Results

The PROMIS Global-10 tool is currently being used as a quality of life tool and is reported on two different subscales: physical health and mental health. Despite widespread use of the PROMIS tools following a 10-year NIH grant, the literature is limited to validation studies, making it difficult to find an appropriate target to align with the other measure constructs. Many entities that are administering the tool are having difficulty analyzing, using and reporting these measures. However, there is a relationship to other MNCM-developed measures, including the total knee replacement measure. The PROMIS Global-10 was recommended as one of the preferred tools by the Joint Commission and the American Joint Replacement Registry.

The workgroup did confirm that these metrics are still valuable to collect and report. Additionally, they felt that these could be valuable pre-op risk adjustment variables for other outcome measures (e.g., function and pain) as well.

Summary of Recommendations

- **Modify the measure construct to reflect new target-based measures for all populations**
 - 2020 report year will include fusion dates of procedure from 1/1/2018 to 12/31/2018 and disc/lami dates of procedure from 1/1/2019 to 12/31/2019 (private reporting only for disc/lami)
 - Functional status is less than or equal to 22 **OR** a change of 30 points or greater on the Oswestry Disability Index (ODI)
 - Back pain is less than or equal to 3.0 **OR** a change of 5.0 points or greater on the VAS Pain scale
 - Leg pain is less than or equal to 3.0 **OR** a change of 5.0 points or greater on the VAS Pain scale
- **Expand discectomy/laminotomy population**
 - No longer narrow population by diagnosis code and add additional CPT codes
 - Privately report for 2019 dates of procedure and publicly report in 2021 (2020 dates of procedure) to allow for groups to implement clinical workflow changes during 2019 to increase tool administration
 - Add same exclusions that are currently used for lumbar fusion population: spine-related cancer, fracture or infection and scoliosis (neuromuscular, idiopathic or congenital)
 - Move up submission timeframe to be more in-line with the measure (i.e., no longer waiting until 1-year follow-up is completed for fusion population)
- **Continue to explore meaningful reporting of quality of life measures using an average change construct**
 - Potential for future target-based measure with more literature and experience with tool score
 - Workgroup recommends the pre-op quality of life scores (physical and mental health subscales) be considered for inclusion as risk-adjustment variables for the functional status and pain measures in a future risk-adjustment model

Questions/Comments/Discussion:

Stefan Gildemeister asked why so many patients are not receiving the PRO tools and wondered to what extent the measure change will help improve administration rates. Collette stated that while the statewide administration rate is low, there are groups that do have high administration rates. Collette added that administration rates may improve by introducing these tools into clinical workflows; however, there are different factors that affect administration rates, including adoption of the tool, commitment to administering the tool and technological capabilities (e.g., administering electronically versus mailing tool). Collette also added that the average change construct does not incentivize medical groups to administer the tool, while the proposed construct does.

Dan Trajano inquired as to whether the workgroup discussed potential unintended consequences (i.e., overuse of surgery). Collette confirmed that this was discussed by the workgroup. Additional analyses showed that some patients who were starting with a low (or better) ODI score also had corresponding high (or worse) back and leg pain scores. David Satin added that he had similar concerns and wondered if it would be possible to consider an overall denominator requirement of a pre-op ODI greater than 22 OR a back pain score greater than 3 OR a leg pain score greater than 3. Collette stated she did consider this option in formulating different constructs found that 1) it added to the complexity of an already complex measure and 2) would not protect against denominator self-selection. Dan suggested analyzing the distribution of pre-op scores on an annual basis to assure that there is not an unintended consequence of lower average pre-op scores. Collette and Dan agreed that the analysis could be reviewed by MNCM and the Measure Review Committee (MRC) as well as MARC. Sue Knudson also agreed that this would be an important evaluation.

Chris Restad asked for clarification regarding the purpose of the measure. Collette stated that the measure is aimed at measuring a patient-centric outcome by assessing functional status as reported by the patient. Collette added that, at the time of development, the workgroup felt that pain and quality of life were also important to measure. The measure

	<p>is not intended to measure appropriateness. Rahshana shared that she felt that this measure is a good place to start to better understand the questions being asked regarding selection, pain, etc.</p> <p>Howard inquired about the sense of consensus felt in the workgroup surrounding the decisions made. Collette shared that there was a lot of thorough discussion and the workgroup reached solid consensus after two meetings. Deb Krause, one of the workgroup members, agreed with Collette and added that the workgroup felt that the measure was a work-in-progress and should continue to be monitored. Chris Norton, another workgroup member, agreed and added that while there was some initial hesitancy in the workgroup, additional analyses in the second meeting helped the group reach consensus.</p> <p>David Satin made a motion to approve the measure with an amendment that MRC/ MARC receive a trend report of the average pre-op ODI, leg and back pain scores to monitor the potential unintended consequences previously mentioned. Chris Norton seconded the motion. Motion passed with amendment.</p>
<p>Update of Optimal Diabetes Care measure re-endorsement</p>	<p>Anne Snowden provided a brief update on the NQF re-endorsement process for the Optimal Diabetes Care (ODC) measure. While the diabetes measure has been NQF-endorsed for several years, all NQF endorsed measures go through a maintenance re-endorsement process every three years. The application for ODC re-endorsement was submitted in the fall of 2018 and passed criteria, including a new scientific methods panel. It was recommended by the Primary Care and Chronic Illness Committee for re-endorsement and is currently in the public comment phase.</p> <p>During this phase, some medical societies have been vocal about their dislike of the composite nature of the measure and the HbA1c component of < 8.0 being too stringent for the frail elderly (measure caps at age 75 and excludes nursing home residents, hospice and palliative care). Anne asked if MARC members could submit a positive comment for the measure. Anne shared that she will send a link to MARC members so that they can submit their comments. After the public comment phase, the comments are sent to the committee. Based on comments, the committee will sometimes revise their recommendation.</p>
<p>Update on MNMCM Reports</p>	<p>Anne provided an update on the state of MNMCM’s reports. MNMCM has four overarching reports that are released annually:</p> <ol style="list-style-type: none"> 1. Quality (since 2004) – first report produced by MNMCM 2. Disparities by insurance type with DHS (since 2007) – comparing measure results for people enrolled in Minnesota Public Programs to the results of people enrolled in commercial and/or Medicare. This was one of MNMCM’s first efforts to segment rates. 3. Cost (since 2014) – provides perspective on total cost of care, resources use and price as drivers of total cost, utilization and average cost per procedure. Each of these concepts related to cost of care is important on their own and combining them into an overall picture helps shed light on important trends and variation in Minnesota’s health care marketplace. 4. Equity (since 2014) – focuses on segmenting rates by race, ethnicity, language and country of origin (RELC) for specific measures. The title of this report will be changing to “Disparities by Race, Ethnicity, Language and Country of Origin”. <p>While these reports contain valuable information, they had become narrative-dense, lengthy and time-consuming to produce. With MNMCM’s new leadership, MNMCM took a step back to re-assess what the reports are trying to accomplish. The new reports provide more visual representations of the data (e.g., more charts, figures, tables), have a more compelling structure for easier use, provide more interpretation, and are easier to navigate.</p> <p>In addition to the annual overarching reports, MNMCM has developed topic-specific reports. These topic reports bring together performance results on both quality and equity for measures relevant in each category. The new topic reports include: Depression Care, released in October 2018; Chronic Conditions, released in December 2018, and; Preventive Health Measures, released in January 2019. Anne shared illustrative examples from these new reports. Graphs in the reports include statewide results by measure, trends, and segmentation by geography, age, gender and RELC, if available. High performing medical groups are also recognized in these reports. In the future, MNMCM is considering a Pediatric topic report and is making plans to spread out the release of these reports.</p> <p>Anne thanked Deb Krause from the Minnesota Health Action Group and Matt Flory from the American Cancer Society for their support and partnership of the Depression Care and Preventive Health Measures reports, respectively.</p> <p>Discussion</p> <p>Sue Knudson inquired as to whether the data contained in the reports only includes residents of Minnesota (based on the title of these reports). Anne explained that the data represents all data submitted from Minnesota and bordering</p>

	<p>communities such as Wisconsin, North Dakota, South Dakota. Sue commented that MNMCM has a broader reach than just the state of Minnesota and that titling it as 'care in Minnesota' is somewhat limiting.</p>
<p>Update on MDH Report to Minnesota Legislature</p>	<p>Howard introduced Stefan Gildemeister, State Health Economist and Director of the Health Economics Program at the Minnesota Department of Health, who provided an overview of the report released to the Minnesota legislature – A Framework for a Healthier Minnesota.</p> <p>Stefan provided a brief background. The legislature governs rules, statutes and the standardized measurement set and has done so for more than 10 years. The standardized measurement set is referred to as the Statewide Quality Reporting Measurement System or SQRMS. In 2017, the legislature directed MDH to create a framework for measurement, which was driven by two primary factors:</p> <ol style="list-style-type: none"> 1) Minnesota has been a leader in measurement for many years. However, over the years, there has been a lot of development in terms of measurement at the national level (e.g., MIPS, value-based contracting), which can lead to measurement fatigue. 2) Re-assessing what the priorities are in measurement and what has been accomplished <p>The framework addresses these driving factors, identifies the most important elements for assessing quality of care, establishes quality improvement goals, ensuring clinical relevance while also focusing on alignment and defining state quotas. Stefan thanked David Satin, Mark Sonneborn, Julie Sonier and Karolina Craft for their input on creating the framework.</p> <p>The first phase included forming a workgroup, conducting small group interviews with more than 100 participants and completing an environmental scan. Based on these activities, there was a strong desire to ensure that Minnesota aligns as best we can at the national level, while ensuring that we do not take any steps backward and continue to be a leader in measurement. Additionally, there was strong commitment that measurement goes beyond just that of quality of care (e.g., health is informed by many factors). Measurement should also not be static and should be tied to improvement goals. Finally, communities that experience disproportionate health disparities should have an equal part of the measurement discussion as decision-makers. Additional key findings can be found in the report released last month.</p> <p>Phase two will take a deeper look at these items and determine how to establish and implement these goals. MDH will work with stakeholders and form a steering team to inform these decisions. They hope to have a report completed by the end of 2019.</p>
<p>Meeting Adjournment</p>	<p>The next meeting will be Wednesday, April 10, 2019. Howard adjourned the meeting.</p>

Next Meeting: Wednesday, April 10, 2019