MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, September 9, 2020
Meeting Minutes

Members Present: Sue Knudson (Co-chair), Barb Anderson, Janet Avery, Cristina Baker, Lori Bethke, Joe Bianco, Cara Broich, Clarissa Cox, Karolina Craft, Matt Flory, Sue Gentilli, Stefan Gildemeister, Greg Hanley, Steve Inman, Jennifer Lamprecht, Asif Mujahid, Christine Norton, Christopher Restad, Jonathan Rose

Absent: Rahshana Price-Isuk (Co-chair), David Satin

MNCM Staff: Trisha Brinkhaus, Liz Cinqueonce, Collette Cole, Jess Donovan, Sandy Larsen, Gunnar Nelson, Julie Sonier

<table>
<tr><th>Topic</th><th>Discussion</th></tr>
<tr><td>Welcome & Introductions</td><td>Sue Knudson called the meeting to order and welcomed committee members.

This meeting was conducted via Zoom so a roll call of committee members was taken. MNCM staff and observers also introduced themselves.</td></tr>
<tr><td>HEDIS Measure Impact</td><td>Sue introduced Gunnar Nelson, MNCM's health economist for an update on HEDIS measures for 2019 dates of service.

BACKGROUND
• HEDIS measures are quality measures that MNCM obtains from health plans
• Two types of measures: administrative (claims only) and hybrid (claims and chart audits)
• Significant work is done during second quarter of calendar year, which was interrupted by COVID-19 and the associated disruptions to business operations
• Medicare has a more stringent auditing/validation process, which not all health plans completed this year
• MNCM also has health plans pull an additional sample of data for Medicaid patients (Minnesota Health Care Programs (MHCP))
  ○ Controlling High Blood Pressure and Childhood Immunization Status (Combo 10) require chart abstraction, which could not be completed because of COVID-19 related disruptions

IMPACT
MNCM typically reports 11 HEDIS measures. The following table provides a summary of how the above will impact reporting the 2019 dates of service data:

<table>
<tr><th>IMPACT</th><th>MEASURES</th><th>RATIONALE</th></tr>
<tr><td rowspan="3">No impact – reporting as usual</td><td>Chlamydia Screening</td><td rowspan="3">Age range does not include Medicare population and measures do not require chart MHCP specific abstraction.</td></tr>
<tr><td>Immunizations for Adolescents</td></tr>
<tr><td>Cervical Cancer Screening</td></tr>
<tr><td rowspan="4">Can report:
• Commercial rate
• MHCP rate
Cannot report:
• Medicare rate
• Overall rate</td><td>Breast Cancer Screening</td><td rowspan="4">Specific groups are missing more Medicare claims than others (i.e., it is not random). Because of the missing Medicare claims, an overall rate cannot be reported.</td></tr>
<tr><td>Diabetes Eye Exam</td></tr>
<tr><td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td></tr>
<tr><td>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis</td></tr>
<tr><td rowspan="2">Can report:
• Commercial rate
Cannot report:
• MHCP rate
• Medicare rate
• Overall rate</td><td>Controlling High Blood Pressure</td><td rowspan="2">These hybrid measures require chart abstraction. Chart abstraction for the MHCP sample was not able to be completed.</td></tr>
<tr><td>Childhood Immunization Status (Combo 10)</td></tr>
<tr><td>Can report:
• MHCP rate
Cannot report:
• Commercial rate
• Medicare rate
• Overall rate</td><td>Follow-up Care for Children Prescribed ADHD Medication</td><td>Incomplete results for commercial patients.</td></tr>
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	Cannot report any rates	Osteoporosis Management in Women who had a Fracture	There is a significant and non-random distribution of missing denominator of patients.

Plan for Existing Measures

Sue introduced Collette Cole, MNCM's clinical measure developer, to provide information on MNCM's plan for inclusion of telehealth visits and home blood pressures in existing measures.

TELEHEALTH

- Telehealth visits have significantly increased nationally and locally because of COVID-19
- Telehealth is likely here to stay – patients like the convenience; makes sense for certain visits
- CMS has started to pay for telehealth visits at the office rate
- Other payers utilizing multiple telehealth codes
- Because CMS is paying for telehealth visits at the office rate with modifiers, MNCM's measure denominators are largely unaffected
    - However, with the change in care delivery and continuation of COVID-19, it is appropriate to include telehealth codes into measure definitions
- NCQA updated telehealth guidance in 40 HEDIS measures – telephone, e-visits and virtual check-ins are all added as outpatient visits
    - Also lifted restrictions in blood pressure – now allows blood pressures reported or taken by the member
- CMS has also asked measure stewards to consider adding telehealth and audio-only encounter codes to measure definitions
- The following DDS measures that are impacted by the addition of telehealth codes are:
    - Optimal Diabetes Care
    - Optimal Vascular Care
    - Optimal Asthma Control
    - Adolescent Mental Health and/or Depression Screening
    - Colorectal Cancer Screening (NCQA is measure steward)
- The Depression measure suite already includes telehealth

THE PLAN

- Alignment with national measures
- Add telehealth codes for 2020 dates of service
- Value sets will be provided to medical groups in November

BLOOD PRESSURES

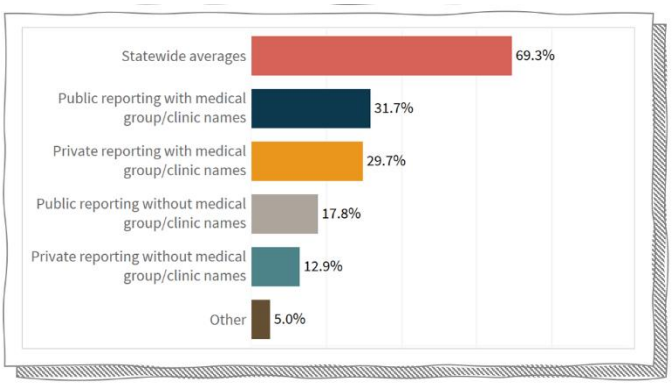
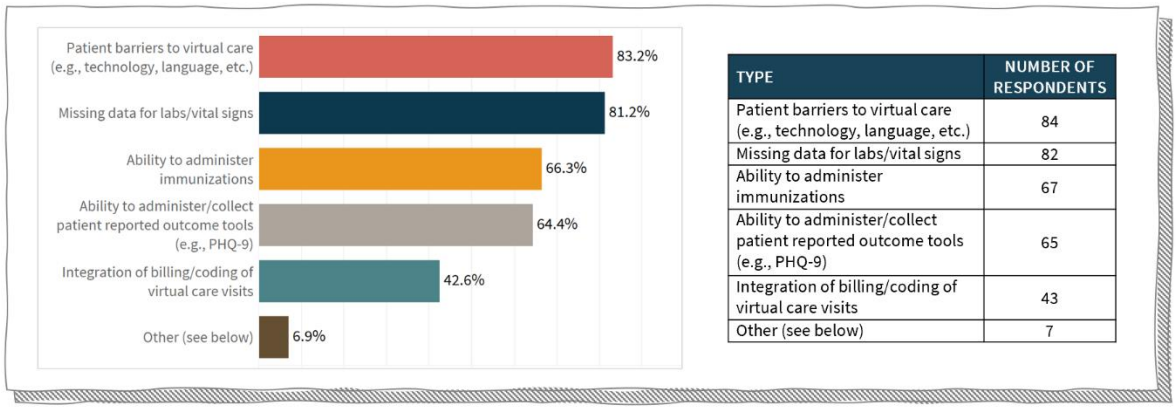
- MNCM's Optimal Diabetes Care and Optimal Vascular Care measures do not currently allow for home blood pressures (i.e., blood pressures taken by the patient)
- MNCM tries to align with NCQA's Controlling High Blood Pressure measure
- MNCM convened a workgroup in 2018 to evaluate ACC/AHA guidance for electronically submitted BPs
    - Workgroup decided not to allow these into MNCM's measures; however, they did not disagree with accepting these BP readings – just not collecting these readings at that time
- In July 2020, NCQA removed the exclusion of BPs reported or taken by the member. Per NCQA's measure spec:
    - BP must be taken on digital device – cannot be done via manual cuff
    - Must be the most recent BP during measurement year (no change)
    - Exclude BPs taken during inpatient stay/ED/procedure (no change)

THE PLAN

- Allow BP readings reported or taken by the patient during a virtual visit for 2020 dates of service
- Alignment with NCQA's Controlling High Blood Pressure specifications
- Field specifications will be updated and provided to medical groups in November

DISCUSSION/CLARIFICATION

- Committee members support plan and alignment with NCQA
- One member asked for clarification on how home BPs will be captured in the EHR. Data field specifications will specify that BPs need to be taken by the patient on a digital device only. The EHR will need to store systolic and diastolic values along with the date the reading was taken. Direct electronic transmission from the digital device to the EHR will not be required. Additionally, medical groups will not need to provide additional data to distinguish where the reading is coming from (i.e., from home versus in the office).

	• Another member asked for clarification of the timing of when telehealth codes will be added. For both DDS and HEDIS measures, telehealth codes will be added for 2020 dates of service.
Results from Community Survey	Sue introduced Jess Donovan, MNCM's clinical measurement analyst, to provide a summary of the community survey regarding the impact of COVID-19 on quality measurement and reporting. **OVERVIEW** • Three-question survey sent via MNCM's Measurement Minute and social media pushes to community members between June 24th and July 31st • 83% completion rate with 121 respondents total (regardless of completion) • Majority (86%) of respondents were associated with medical groups/clinics (e.g., physicians, nurses, data analysts) **LEVEL OF REPORTING** **Question:** Which of the following levels of reporting do you feel are most appropriate for 2020 dates of service? Select all that apply.  | SELECTIONS	N	%
---	---	---
Statewide rates only	23	23%
Statewide rates Public reporting with names	14	14%
Public reporting with names only	13	13%
Statewide rates Private reporting with names	13	13%
Private reporting with names only	6	6% | The bar graph represents how frequently each option was selected. The table shows the top five combinations of selections made by respondents. **ISSUES IN DELIVERY OF CARE** **Question:** Which of the following issues related to virtual care delivery are a concern for you related to quality measurement and reporting? Select all that apply.  | TYPE	NUMBER OF RESPONDENTS
Patient barriers to virtual care (e.g., technology, language, etc.)	84
Missing data for labs/vital signs	82
Ability to administer immunizations	67
Ability to administer/collect patient reported outcome tools (e.g., PHQ-9)	65
Integration of billing/coding of virtual care visits	43
Other (see below)	7 | The bar graph represents how frequently each option was selected. Breakdown of the combinations was not completed because most respondents chose almost all options. Respondents also shared issues related to business operations, specifically in terms of furloughs, reduction in staff, clinic closures and re-allocation of resources. **OTHER CONCERNS** **Question:** What are other concerns you have related to quality measurement and reporting of 2020 dates of service? • This was an open-ended question for respondents

	 This word cloud represents commonly referenced concerns. The top concern was provider burden. *For the full summary of the survey results, please see meeting packet.*

Discussion/Round robin	Sue asked each member to consider and share their input on the following questions:
	• Based on the community input and your own experience, what do you feel is the most appropriate level of reporting in 2021?
	• Is there additional information needed to inform recommendations for reporting?
	• Are there additional technical considerations that have come to light through the survey that also needs to be addressed?
	
	OVERVIEW OF DISCUSSION
	• All committee members felt that reporting 2020 dates of service is necessary; however, opinions on whether public reporting should include medical group names varied among members.
	• In general, members stated that public reporting is critical during COVID-19 to:
	  ○ Understand a new baseline of health care in the community
	  ○ Determine what areas need improvement and incentivize necessary changes within health systems
	  ○ Understand patient barriers and challenges, including access to care and disparities
	• The effects of COVID-19 will likely go beyond 2020 dates of service and may continue to cause delays in administering vaccines, providing screenings and collecting patient reported outcome tools
	• A caveat or asterisk needs to be provided when reporting 2020 dates of service that explains the various variables that have affected rates
	• Rates may not be reflective of typical quality due to COVID-19 related disruptions but will provide important information as we transition beyond 2020
	
	INCLUSION OF NAMES IN PUBLIC REPORTING
	• Most committee members felt that full transparency (i.e., including names) is necessary to understand the impact of COVID-19 on health care and where improvements need to be made
	• A few committee members felt that medical group level reporting with names is appropriate but perhaps not clinic level reporting with names. Some health systems have shifted care among their clinics so reporting at the clinic level may not be useful.
	• A few members felt that while reporting is necessary, medical group/clinic names should be left out because of all the different variables that may affect medical groups/clinics differently
	
	ADDITIONAL INFORMATION REQUESTED
	• Additional information collected since the survey (e.g., more disruptions in care since July?)
	• Additional outreach to local public health and consumers for input
	• Understanding the impact of national telehealth provider organizations on patient care (e.g., patient use of Teladoc, LiveHealth, etc. for virtual care in addition to normal source of primary care)
	
	NEXT STEPS
	Through November, MNCM staff will engage with the Measure Review Committee, update value sets with appropriate telehealth codes and draft a recommendation for reporting in 2021 for the MARC to consider during the December MARC meeting.

Meeting Adjournment	The next meeting will be Wednesday, December 2, 2020. Sue adjourned the meeting.

Next Meeting: Wednesday, December 2, 2020