MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, December 1, 2021
Meeting Minutes

Members Present: Sue Knudson (Co-chair), Rahshana Price-Isuk (Co-chair), Barb Anderson, Janet Avery, Joe Bianco, Cara Broich, Matt Flory, Sue Gentilli, Stefan Gildemeister, Greg Hanley, Kate Hust, Steve Inman, Craig Johnson, Jordan Kautz, Jennifer Lamprecht, Jodi Morris, Christine Norton, Jonathan Rose, David Satin, Reetu Syal, Abbie Zahler
Absent: Lori Bethke
MNCM Staff: Liz Cinqueonce, Collette Cole, 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. MARC members, MNCM staff, Board members and observers also introduced themselves.</td></tr>
<tr><td>UPDATE: Review of 2020 Measurement Year HEDIS and Cost Results</td><td>Gunnar Nelson, Health Economist, provided a review of the 2020 measurement year HEDIS and Cost measure results.

COST MEASURES KEY TAKEAWAYS AND NOTES:
o The cost measures are based on 2020 dates of service for patients with commercial insurance with attribution based on services in primary care. The method for determining total cost of care and resource use is based on HealthPartners software. Participating health plans include Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica and PreferredOne. About 65% of the patients were attributable to a medical group and virtual care was added to the methodology for 2020.
o For the first time since tracking these measures (9 years), costs and utilization per patient decreased in 2020 as compared to 2019. Inpatient costs decreased by 5.2% and outpatient by 8.4%. Pharmacy costs were noted as the only category with an increase of 11.1%, the highest noted increase over several years. Outpatient surgery utilization decreased by 19%. These decreases in cost are not unexpected given the impact of the COVID-19 pandemic changes to the health care delivery system. At a medical group level, groups' total cost of care generally stayed in the same quartile as 2019. In other words, if they were higher than average cost prior to the pandemic, they remained higher than average cost.
o The use (count) of any services by age and gender, surprisingly did not decrease. It was noted that there was an increase in the percentage of adults who had any claims, especially for men. Although information to understand the detail beneath the utilization categories is not available, there are factors that could contribute to increase in the share of members with any level of utilization (e.g., COVID-19 testing). MARC members commented that females are more likely to utilize care because of pregnancy and more consistent, specific preventive needs. It was noted that required vaccinations drive office visits, thus explaining the blips in data at certain ages for children and adolescents. MARC member commented that 2020 is a tough year to look at, providers were advancing prescriptions early in the pandemic and you may not see those pharmacy costs come down until first or second quarter of 2021. Other impacts include an immediate shift to virtual visits, packed ERs, increase in hospital admissions and changes in care practices.

REVIEW OF RESULTS
Cost Results Trend
Changes in Utilization Per Patient</td></tr>
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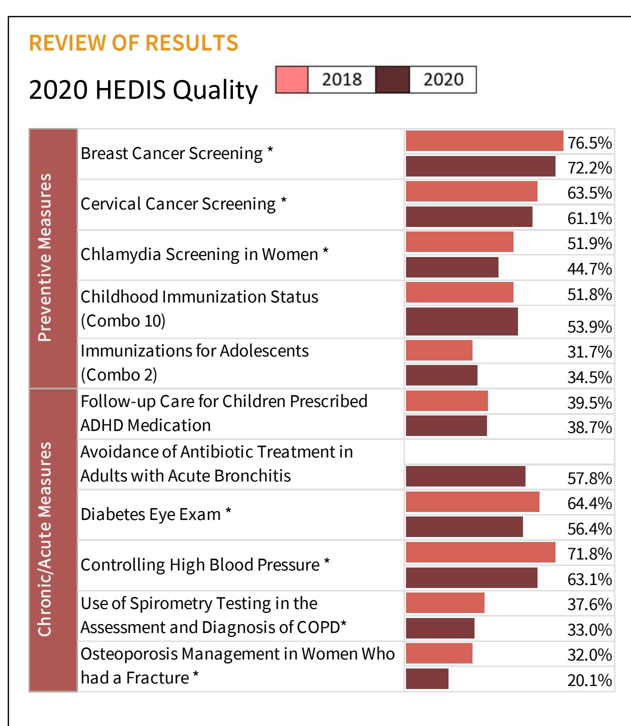
Topic	Discussion
	HEDIS MEASURES KEY TAKEAWAYS AND NOTES: ○ Due to the public health emergency beginning in 2020, data collection for these measures could not be completed for 2019 dates of service, and so the 2020 HEDIS results are compared to the results for 2018 dates of service. ○ Many screening measures (e.g., breast, cervical cancer, chlamydia, eye exams) had significant decreases from 2018 and are noted with an asterisk *. This was not unexpected given the interruption in non-essential procedures early in the pandemic. ○ Almost all of these measures require an element of in-person care, so the decrease in rates is not unexpected. ○ Immunizations increased slightly from 2018. MARC members shared that there was increased attention by pediatricians to keep kids on schedule as best they could, and this may in part explain slight increases in the immunization measures. It was noted that the immunizations are based on the age of the child and do not require a visit for a child to be included in the measure denominator. This report includes only attributed patients, however if all patients are included the results are similar. Immunization measure results can be impacted by timing, especially in the combo-10 series for children which spans a two-year period; rates may demonstrate a decrease in 2021. ○ Measure rates align with observed national trends published by NCQA  These results will be published as a Spotlight Report on December 14th
ACTION ITEM: Review of 2022 Slate of Measures	Collette Cole provided an overview of the proposed 2022 Measurement Year slate of measures that was included in the meeting packet. There is only one proposed change to the slate this year. Last year's slate was modified for reporting the clinical data submission measures only at a medical group level to accommodate the health care delivery system changes during 2020. The change proposed for this year is the return to clinic level reporting for the clinical data submission measures. The Measure Review Committee (MRC) did not meet this year to review measures because of the planned redesign of the measure review and prioritization process. However, a thorough review was conducted by the MRC in 2020 and current measure rates continue to demonstrate variability and opportunity for improvement. The first set of measures is the Healthcare Effectiveness Data and Information Set (HEDIS) measures used for health plan accreditation. This measure set contains 11 measures, all of which are NQF endorsed, included in CMS' quality payment program, used by health plans and nine are included in Core Quality Measure Collaborative measure sets. Many of the measures, as discussed, had a significant decline in rates as compared to pre-pandemic 2018 rates. The majority of these measures are process measures for screening, immunizations, testing and follow-up and all demonstrate continued opportunity for improvement and variability among practices. The second set of measures are the Clinical Data Submission measures, which are calculated from patient-level data submitted to MNCM via direct data submission (DDS) or PIPE. This measure set contains 30 measures, nine of which are NQF endorsed, ten included in CMS' quality payment program, ten included in a Core Quality Measure Collaborative measure set and six used in the Statewide Quality Reporting and Measurement System (SQRMS). All the measures demonstrate continued opportunity for improvement and variability among practices. One of the measures may appear to be approaching a topped-out status. Adolescent Mental Health and/or Depression

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	screening with an average rate of 88.7% actually demonstrates significant variability with boxplot quartile rates 60 to 100% and some clinics with rates as low as 30%. CMS defines topped out as a rate of 95% or greater, so there is no current need to consider the retiring of this measure. Data collection was paused for the spine surgery and total knee replacement measures as well as the oncology measures for symptom control during chemotherapy for a planned phase 2 build in PIPE. It is anticipated that these measures will be reported in 2023/2024. The last set of measures are cost/utilization and the hospital measures (mortality, readmission, safety, patient experience). Except for the emergency transfer communication measure, all are NQF endorsed and used by health plans. Several are included in the Core Quality Measure Collaborative (CQMC) sets and several more are slated for inclusion in the coming year. Discussion included the following: o It is often difficult to explain all of the depression measures and timeframes to front-line staff. CMS discontinued the six month remission measure (MIPS program) but continues with the 12 month measure. Has MNCM considered discontinuing some of these measures? No, this has not been considered. Collette explained that the denominator is exactly the same for the remission and response measures, but the patient is being assessed at two points in time for a decrease or remission of depression symptoms. Frequent monitoring of the patient is important to determine if they are responding to a stepped approach to treatment. o The Optimal Asthma Control, Optimal Diabetes Care and Optimal Vascular Care composite measures are all less than 60%. How would we respond to questions about why they are not higher? Collette shared that because they are patient level all-or-none measures, a patient needs to hit all the target components of the measure. Rates of individual components are indeed higher, but the patient benefits the most from simultaneously reducing as many risk factors as possible. For example, a patient with diabetes could have excellent blood pressure control (e.g., 110/70) but have blood sugars way out of control (e.g., a1c 11.0). This patient would be at serious risk for complications down the road. MARC members indicated that the most difficult component to change/ have an impact is tobacco use. Additionally, the asthma measure requires a visit with the health care to be included in the denominator, but if a child presents for another reason, they may not be assessed for their asthma symptoms and not included in the numerator. o Clarified that planned reporting for the spine and total knee measures is slated for 2024 because it takes two years to collect the data; one for identifying the denominator of patients who have a procedure during a twelve month period and then allowing 15 months for the one year post-operative follow-up assessment. Additionally, a MARC member asked why we are measuring this condition at the surgical end of the spectrum, when so much of the care and treatment occurs in primary care and does not result in surgery. Collette shared that many years ago, the concept of low back pain was brought to MARC for consideration of measure development and the MARC decided that the focus of development should be on measures for specialty care. Another MARC member commented that primary care physicians have been pushing for development of specialty care measures as well because it takes a village to care for these patients. Co-chair Sue Knudson summarized the discussion indicating that there were no concerns expressed with the slate and asked if there was a motion to recommend approval of the 2022 Measurement Year Slate of Measures and the return to clinic level reporting for the clinical data submission measures. Matt Flory made a motion to recommend approval of the 2022 Measurement Year Slate of Measures and the return to clinic level reporting. Chris Norton seconded the motion. All MARC members voted favorably; the motion carried.
MNCM Strategic Priorities and Board Requests for MARC in 2022	Please refer to the proposed charter and workplan for the MARC Subcommittee on Measure Review and Prioritization. Julie Sonier presented the strategic priorities surrounding this initiative and walked through the goals and the intent of the redesign. This work is directly connected to priorities in a new strategic plan that was adopted by the MNCM Board of Directors earlier this year, including a component of the strategic plan that makes health equity a central part of MNCM's work. Two components of the strategic plan are directly relevant to this upcoming effort. The first one is maintaining and enhancing MNCM's core strengths, reputation and influence related to meaningful measures and high-quality, objective data collection and reporting. To accomplish this, we need to ensure that the measures that we're using are meaningful and relevant to stakeholders – by adding and deleting measures as appropriate and by developing new measures where there are important gaps in what is needed to meet stakeholders' priorities.

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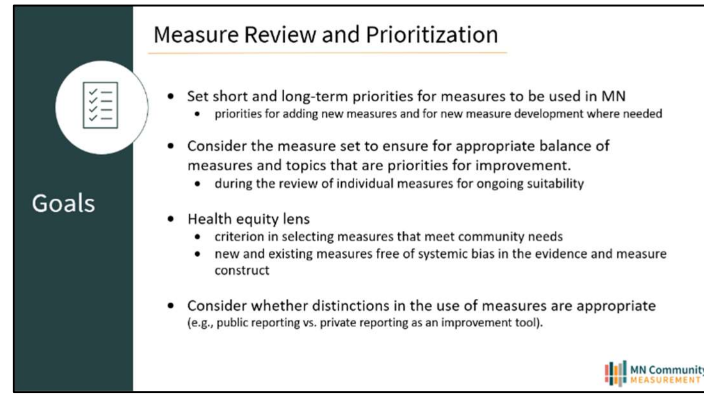
The second strategic priority is making health equity a priority that is embedded in all areas of MNCM's work. To do this, we need to ensure that equity is a key consideration in selecting measure priorities and in the design and development of measures.

Strategic Priority	Key Activity/ Goal	FY 2022 Measure of Success
Maintain and enhance core strengths, reputation and influence related to meaningful measures and high-quality, objective data collection and reporting.	Ensure that measures in use remain meaningful and relevant to stakeholders by adding and deleting measures in response to changing needs; pursue opportunities to develop meaningful new measures to fill priority gaps identified by stakeholders.	Modernize process for identifying measurement priorities and update process for measure development/revision.
Make improving health equity a priority that is embedded in all areas of work.	Include equity as a key consideration in selecting measure priorities and in future measure development/design.	Develop action steps to be included in the modernized process for identifying measurement priorities, to ensure routine discussion and alignment of measurement priorities with efforts to support equity improvement. Develop a health equity component within the new measure development/revision process to ensure all newly developed and/or revised measures are reviewed prior to address any issues of bias or structural racism. Produce a brief on the formalized process that can be shared with national and regional audiences.

The charge to the subcommittee has two key components:

- Evaluate and make recommendations to MARC (and ultimately the MNCM Board of Directors) on revisions to modernize MNCM's process of measure review, selection, and prioritization
- Incorporate health equity into the review of existing measures and the development of new measures

It has been several years since the process that MNCM uses to select and review measures for ongoing use has been changed, and we have some concerns that the process has become a bit stale. Another reason why this issue is important and timely is that the transition to MNCM's new PIPE data infrastructure with a planned completion by the end of 2023, PIPE will create the ability for MNCM to be much nimbler in measurement – either changing the existing measure slate or modifying measures more easily in the future without any additional burden to medical groups. We have an opportunity to be strategic about how PIPE will change the ways that we set priorities and select measures, and that's an important part of the thinking that the subcommittee will help us with.



This subcommittee is about both defining the process in which measures will be reviewed and providing guidance in structuring a prioritization process. Historically, the MRC reviewed individual measures for ongoing suitability, but going forward there is a need for considering the measure set as a whole ensuring that it includes an appropriate balance of measures and topics that are priorities for improvement. An additional function of the revised review process needs to explicitly include health equity criteria and a lens for viewing both new and existing measures. Another goal for the subcommittee is to consider whether distinctions in the use of measures are appropriate. The MNCM measure slate has always been for public reporting purposes, but there may be value in distinguishing between public reporting and other uses in the future.

This is an ad hoc time-limited subcommittee with an expected duration of six months. A tentative schedule of the timing and topics for meetings is included in the draft subcommittee charter as well as a composition of MARC member types to ensure balanced representation.

Discussion:

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	○ If part of the goal is to engage the community into shaping measurement that is meaningful for the community, how will this be accomplished? Do you see this as part of the work of the subcommittee? We view this, obtaining feedback from a broader perspective, as an important topic for the subcommittee to consider. ○ Suggestion to have explicit and implicit bias training sessions that include full MARC. Incorporate tools that help the subcommittee apply a health equity lens. HEAL-Health Equity Advisory and Leadership Council is one possible resource. Additionally, the AMA is doing work in this area. ○ Concern expressed that there has been a lot of talk about health equity without any real action or change in outcomes. It is understood that there are many roles and contributors to inequalities in health. MNCM's role is limited to the data collection and reporting space, however there is a great deal of importance in what we choose to measure, having the foundational data and providing information in a useful, credible way. ○ A MARC member expressed a concern that health equity is such an important topic that it might warrant its own subcommittee. Julie noted that health equity is indeed a big topic, but it can't be siloed and needs to be applied as a criterion for reviewing measures. The work of the subcommittee is to develop a process for future use, but the actual work will take much longer. ○ One MARC member commented on her past experience with being on the Measure Review Committee and the valuable input that can be provided in terms of how the measures are used (value) and burden for data collection (feasibility). MNCM has a history of tacking some of the more difficult measure challenges (e.g., outcomes) in efforts to have measures that benefit patients. Burden of measurement can be alleviated with the new PIPE system. Another consideration is continued alignment with evolving national programs like CMS. ○ A MARC member commented that there has not been the needed quantum leap of change needed for health equity but believes that MNCM has made great measurement strides and will continue to do so.
Next Steps	▪ Recommendations for the 2022 MY Slate of Measures will be forwarded to the MNCM board of directors ▪ Following today's meeting, MNCM will reach out to the committee to solicit interest in serving on the subcommittee with a reminder email along with the draft minutes.
Meeting Adjournment	The next meeting will be Wednesday, March 9th. Rahshana adjourned the meeting.

Next Meeting: Wednesday, March 9, 2022 7:30am – 9:00am