Measurement and Reporting Committee (MARC)
Meeting Minutes

Wednesday, September 14, 2022

Committee members present: Barb Anderson, Lori Bethke, Cara Broich, Matthew Flory, Sue Gentilli, Greg Hanley, Craig Helmstetter, Kate Hust, Steve Inman, Stephanie Krieg, Jennifer Lamprecht, Chris Norton, Alisha Odhiambo, Reetu Syal, Abbie Zahler

Committee members absent: Joe Bianco, Stefan Gildemeister, Craig Johnson, Jodi Morris, David Satin, Denise Schneekloth

Staff members present: Liz Cinqueonce, Collette Cole, Jess Donovan, Julie Sonier, Ma Xiong
Observers: Kelsey Besse, Chris Bjerke, Jeanne Galle Franklin, Brett Lundsten, Denise McCabe, Angie Pokharel, Sherri Ryan, Bridget Schenten

DISCUSSION: Implicit Bias Training Debrief – Sue Knudson & Rahshana Price-Isuk
Sue and Rahshana opened the meeting by allowing opportunity for feedback related to the two implicit bias training workshops completed by the MNCM Board of Directors, MARC and MNCM staff in the summer. Discussion questions included:

- What was your reaction to the trainings on DEI and unconscious bias?
- What next steps would MARC lie to see for MNCM, in the short- and long-term?
- What else are you doing in relation to DEI within your own organizations that MNCM should be thinking about?

Highlights of the discussion by MARC include:

- DEI is a continuous learning process that should be approached with humility.
- The training helped members become more self-aware about their own biases.
- Approaches taken by various organizations include:
    - Utilizing specific DEI/equity committees
    - Annual or ongoing required equity trainings
    - Segmenting data to better understand gaps (e.g., RELC, gender, etc)

UPDATE: Measure Review & Prioritization (MRP) Progress – Jess Donovan
Jess Donovan provided an update on the progress made by the MRP subcommittee. This subcommittee was tasked with developing a refreshed measure review process for existing measures, developing an evaluative criteria for the review that incorporates a health equity lens and developing a process for prioritizing measures/measure topics. The subcommittee has met three times so far. The last meeting is scheduled for September 15th and will focus on the process of prioritizing measures. Recommendations will be presented to the larger MARC during the December meeting.

UPDATE & DISCUSSION: Social Risk Factors Data Collection – Collette Cole
Collette Cole provided an update on the recent work completed by the Social Risk Factor Technical Advisory Group (SRF TAG). One of MNCM's strategic priorities is incorporating health equity into all areas of work. The collection of SRF data has the potential for many different uses, but the primary

use is to gain an understanding of how SRFs affect health outcomes. This data can also support national value-based purchasing programs and emerging SRF measures.

MNCM conducted a survey in the fall of 2021 to gain engage providers and understand the current state of SRF data collection. The results of the survey and a summary of national activities related to SRF data collection were published by MNCM in the following issue briefs:

- SRF Data Collection: Lessons Learned from Minnesota's Experience Collecting RELC
- Summary of National Activity on Identifying and Addressing Health-related Social Needs

Based on this information, the SRF topics that were flagged for further exploration included:

- Food insecurity
- Housing stability
- Transportation
- Utility assistance
- Interpersonal violence
- Education
- Financial strain
- Social isolation
- Substance use (paused for privacy evaluation)
- Homelessness

The SRF TAG was convened in April 2022 to understand feasibility, define technical requirements and produce a roadmap outlining the necessary steps for use of social risk factor data by 2025. The main activities and findings accomplished by the TAG included:

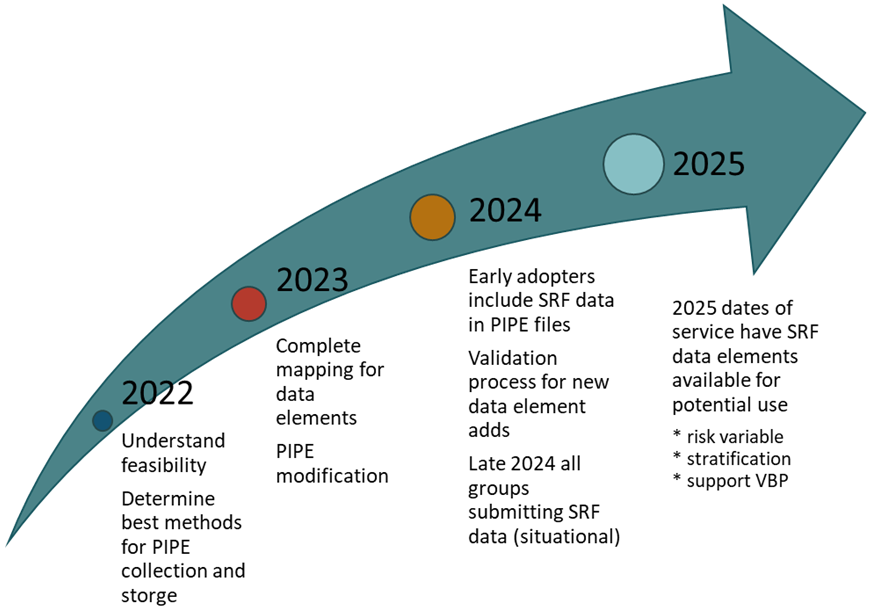
- Understanding current data collection and storage:
    - Provided input on the questions and diagnosis codes that are currently being used as well as how the data is being stored/extracted (via grid exercise)
    - Discovered that there is no single tool or PRO tool being used by groups - often groups are using questions built into EMR and sometimes modifying
    - SRF data can be captured by diagnosis codes ('Z' ICD-10 codes) but is relatively new and not widely used yet
    - SRF data is often stored as raw text fields for the question and response and contained in structured fields (e.g., flowsheet)
    - Due to slight variations in wording of question, TAG decided to collect the question and patient response and then provide programming to quantify and standardize the result across groups

- Recommending a methodology for collection in the PIPE data warehouse:
    - Two ways to obtain SRF data:
        1. Diagnoses documented on problem list and/or encounters
        2. Specific SRF questions and responses asked of the patient
    - TAG concluded that a new social history file needs to be added to PIPE to capture both ways:
        1. Value set created to identify which codes should be used for each SRF (flagged as positive for SRF if present on problem list or encounter)

2. Raw text questions and patient responses will be imported into PIPE where the question is mapped using programming to provide positive, negative or patient refused result for each SRF (mapping completed by MNCM)

- Building a library value set to support the build/mapping:
    - TAG decided to focus on single questions that reliably mapped to the intent of the SRF instead of questions that required complex scoring
    - Questions that were too broad for the SRF topic were not selected and the TAG recommended using diagnosis codes for those variables instead (e.g., education)
    - Currently, there are 52 questions and 100 responses mapped to positive or negative SRFs and over 490 diagnosis codes mapped to positive SRF in the library value set

- Establishing guiding principles for implementation:
    - TAG identified recommendations for groups who are just starting to collect SRF data:
        - Standardize questions as much as possible and customize only if necessary
        - Have a good introductory text to help patients understand why the questions are being asked
        - Educate the entire team and develop an intentional plan
        - Define the population that will be surveyed
- Timeline:



Highlights of the discussion by MARC include:

- One member asked if there are any local or national recommendations for how to standardize questions and if MNCM will convene any sort of workgroup to work out how to standardize questions. The SIREN and Gravity Project groups are some national groups that have some insight into that. However, we don't necessarily need to standardize the questions because mapping the questions will allow for slight modifications in questions and prevent medical groups from needed to change how they are collecting the information. Part of the mapping

process will allow medical groups to submit how the questions are worded to MNCM and MNCM will map them for the medical groups.

- One member asked about the frequency of which these questions will be asked. The TAG had a member who has had quite a bit of experience working with collecting this information offered that their practice collects the information every 180 days. From a measurement perspective, an assessment completed at least once during the measurement year would be sufficient.
- Another member asked if MNCM assessed the feasibility of collecting the 10 SRFs and if there was a specific plan for using these data. For the foreseeable future, medical groups are not going to be required to ask the SRF questions like the RELC data and they do not need to be collecting all SRFs. The social history file in PIPE will allow MNCM to also understand what percentage of patients are being assessed for SRFs as well.
- One member asked if the social risk data elements are in the USCDI data set. The TAG explored GRAVITY, which has some ties to HL7 and USCDI. However, it will be a continued consideration.
- One member brought up the need for connecting patients to resources if they indicate that they would like help with any concerns that are discussed. MNCM is currently working on a formal document that summarizes this work and includes guidance on potential resources. Additionally, AAFP has a summary document on the EveryONE Project that provides guidance on how to ask the questions and potential resources that could be used.

UPDATE: Orthopedic Measures and MVPs – Collette Cole

Collette provided an update on MNCM's orthopedic measures and brief overview of Merit-based Incentive Payment System Value Pathways or MVPs.

Orthopedic measures

- MNCM's orthopedic measures (patient reported outcome measures for spine surgery and total knee replacement) were developed 12 years ago
- Measures evaluated average change from pre-op to post-op for functional status, quality of life and pain scores
- MNCM submitted seven orthopedic measures to CMS' Call for Measures and were accepted into the Quality Payment Program as MIPS measures
- CMS wanted the measures to be more "benchmarkable" so MNCM convened a workgroup in 2018 to redesign the measures to be target-based
    - CMS was pleased with the redesign and accepted the measure changes without re-submitted as new measures, which is a 2 year process
- Currently, MNCM is not currently collecting data on these measures until Phase II of PIPE implementation, which is anticipated to occur in 2024.
- In 2021, CMS added the TKR functional status measure into the MIPS MVP for lower extremity joint repair. MNCM anticipates that the spine measures may also be added to a future MVP.
- CMS also asked if there was a way to reduce the total number of spine measures. MNCM was able to reduce the overall number of measures from 6 to 3 through stratification within the measures, which allows the two populations to remain intact but gives the appearance of fewer measures.

MVP Overview

- There is an overabundance of measures in MIPS and specialty measures in clinical quality data registries to select a practice's six total measures that are required for reporting, which dilutes the ability to effectively measure and compare performance.
- CMS developed MVPs as a way to begin narrowing and prioritizing measures, while focusing sets of measures applicable to a practice area.
- The transition from MIPS to MVPs is set to occur over the next 4 years, which a consideration of making MVPs mandatory in the 2028 performance year and sunsetting the MIPS program.
- The first set of MVPs is for the 2023 performance year and involve the following areas: rheumatology, stroke, heart disease, chronic disease, emergency medicine, joint report and anesthesia.
- Of the 43 measures selected for these areas, several measures related to MNCM are included:

Measure	MVP/s	Notes
#398 Optimal Asthma Control ++	Chronic Disease	MNCM Measure
#470 Functional Status After Total Knee Replacement ++	Lower Extremity Joint	MNCM Measure
#441: Ischemic Vascular Disease (IVD) All or None Outcome Measure ++	Heart Disease Stroke Care	WCHQ version of OVC
#236: Controlling High Blood Pressure ++	Chronic Disease Stroke Care	HEDIS; on MNCM slate
#438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Chronic Disease Stroke Care	Component of ODC and OVC
# 006 Coronary Artery Disease (CAD) Antiplatelet Therapy	Chronic Disease	Component of ODC and OVC
++ Outcome		

<u>DISCUSSION</u>: Future of average cost of procedure (ACP) cost measure – Ma Xiong

Ma Xiong, MNCM's Director of Data Strategy and Analytics, provided some background on MNCM's average cost of procedure (ACP) measure.

- The goal of the cost measures is to draw attention to issues around health care cost and the factors that drive variation in health care cost.
- There are two components when thinking about health care cost:
    1. Cost and resource use comparisons by medical groups:
        - Uses method developed by HealthPartners Total Cost of Care (TCOC) and Total Resource Use measures
        - Endorsed by National Quality Forum (NQF)
        - Enables analysis of TCOC and contributions of resource use and price

    2. Comparison of average prices for specific procedures (average cost by procedure)
        - Developed by MNCM and community in 2009 and publicly reported since 2012
- ACP is a measure of the average amount paid to each medical group by commercial health plans for 120 commonly billed procedures and services
- MNCM aggregates health plan data submissions at CPT/medical group level for public reporting

- Purpose of measure is to provide the community more transparency on the actual cost of care and to help consumers compare the amount they might pay for procedure across providers.
- Measure does not allow individual consumers to evaluate their own costs (i.e., MNCM does not display individual health plan costs as part of MNCM policy).
- MNCM is reconsidering the future of public reporting of the ACP measure as the value to the community is unclear and MNCM has not received any comments or questions about the measure.
- There are also new federal regulations about price transparency:
    - Consolidated Appropriations Act (CAA) transparency and requirements
    - Provides consumers with access to cost specific to their health plan and provider
- More resources are also becoming available to consumers on price transparency data

Highlights of discussion by MARC include:

- Most members agreed that the ACP measure is not particularly useful to consumers, especially since many patients don't have a lot of choice over their health plan.
- One member reached out after the meeting after checking with their internal staff and mentioned that they use the ACP data for market comparisons and appreciate having a public source to point to when working with groups. As a result, they would like to keep the reporting in place.
- More discussion will take place during the December slate of measures MARC meeting.

UPDATE: Tour of MNCM's Dynamic Tables – Jess Donovan

Jess Donovan provided a tour of MNCM's new Dynamic Tables, which can be found here. These tables were created to replace the static, PDF appendix tables that used to accompany the Health Care Quality and Health Care Cost and Utilization reports published by MNCM each year. The new tables provide a user-friendly format that allows for easy filtering by measurement year, measure, medical group and clinic.

Next Meeting: Wednesday, December 14, 2022 7:30-9:00am