APPENDIX: METHODOLOGY

Minnesota Health Care Disparities by Insurance Type Report

RELEASED APRIL 2024

MN Community MEASUREMENT

DEPARTMENT OF HUMAN SERVICES

METHODS

The measures in this report are collected from two separate data sources: clinics and health plans. Direct Data Submission (DDS)/Process Intelligence Performance Engine (PIPE) measures use data from clinics. This data enables reporting of results by clinic location as well as by medical group. In contrast, the Healthcare Effectiveness Data and Information Set (HEDIS) measures use data from health plans. This data enables reporting of results by medical group only.

DDS/PIPE MEASURES

DDS/PIPE measures use data submitted directly to MNCM by medical groups and clinics. Most of these measures are developed and maintained by MNCM.

DATA COLLECTION

Data submission requirements are specified by MN Community Measurement in our 2022 Measurement Year (MY) DDS guides and PIPE Data File Filed Specifications. These documents provide detailed steps and instructions to ensure clinics submit data in a standard format. The most recent version of these documents can be found on MNCM's Knowledge Base in the "PIPE Resources" and "Direct Data Submission (DDS) Resources" sections.

Data are reported at two levels: by clinic site and medical group. Clinics are defined as single locations where patients received care. Medical groups usually consist of multiple clinics. Often, the medical group provides centralized administrative functions for multiple clinics.

Clinic abstractors collect data from medical records either by extracting the data from an electronic medical record (EMR) via data query or from abstraction of paper-based medical records. Medical groups complete numerous quality checks before data submission. Detailed instructions for medical groups/clinics conducting quality checks are available on MNCM's Knowledge Base. All appropriate Health Insurance Portability and Accountability (HIPAA) requirements are followed.

DATA VALIDATION

After clinical quality data is submitted, MNCM completes the following validation of the preliminary results to ensure accuracy and comparability.

Quality Checks

After the medical group submits a data file for numerator calculation, MNCM evaluates the preliminary results for unexpected outcomes and conducts a review of the data file as necessary. The results are compared to the prior report year. To facilitate the review, the medical group provides information at the time of data submission about any substantial changes to the denominator and numerator from the prior report year.

Audit of the Data Source

All medical groups are subject to an audit of the data source (patient record). MNCM contacts the medical group if selected for audit, and a list of records are shared securely on Home page of the MNCM Data Portal. Other audit details:

- The medical group or clinic representative participates in the entire audit process.

DATA VALIDATION CONTINUED

Audit of the Data Source Continued

  - For data that resides in an electronic record, the audit is conducted via a HIPAA secure, online meeting service. The medical group or clinic representative retrieves and displays the selected records and screens necessary to verify the submitted data.
  - For data that resides in a paper record, the audit is conducted onsite.

- Patient names or other personal information in the patient record may be blinded. MNCM uses date of birth to verify the patient.
- The medical group has the following information available for the audit:
  - ALL requested patient records.
  - The "crosswalk" between the unique patient identifier and the patient's name and date of birth, as necessary.
  - Data collection forms and other notes describing where various data elements were located in the patient record.
  - List of patients that were excluded.

NCQA 8 and 30 Audit Process

MNCM utilizes the National Committee for Quality Assurance (NCQA) "8 and 30" process for audits.

- MNCM randomly selects 33 records from each applicable clinic site for validation. At most, 30 records for each clinic site will be reviewed. The additional three records are oversamples to ensure 30 records will be available on the day of the review.
- The MNCM auditor reviews records one through eight in the sample to verify whether the submitted data matches the source data in the medical record.
- If no errors are found in these eight records, the compliance rate is 100 percent, and the clinic site is determined to be in high compliance. The MNCM auditor may determine no further record review is necessary. The MNCM auditor communicates results to MNCM staff.
- If the auditor identifies one or more errors in these eight records, the auditor will continue auditing records nine through 30 and a compliance rate is calculated (e.g., 27/30 records compliant, 90 percent). If the compliance rate is less than 90 percent, MNCM discusses a corrective action with the medical group.

Two-Week Medical Group Review of the Preliminary Statewide Results

The two-week medical group review is an opportunity for medical groups to review and comment on the preliminary statewide results before final results are published. MNCM provides a data file of the preliminary statewide results to the registered contacts of all participating medical groups. Each medical group is responsible for reviewing their own preliminary results, investigating any concerns and submitting evidence to MNCM if a change in results is requested. In that event, MNCM staff will review the information provided and decide whether to publicly report the results.

ELIGIBLE POPULATION SPECIFICATIONS

The eligible population for each measure is identified by a medical group on behalf of their individual clinics for DDS data submission. For medical groups submitting data through PIPE, the PIPE system identifies the eligible population for each measure.

NUMERATOR SPECIFICATIONS

For DDS/PIPE measures, the numerator is the number of patients identified from the eligible population who meet the numerator criteria. Clinical quality data the medical group submits is used to calculate the numerator; this data is verified through MNCM's validation process.

CALCULATING RATES

Due to the dynamic nature of patient populations, rates and 95 percent confidence intervals are calculated for each measure for each medical group/clinic regardless of whether the full population or a sample is submitted. Rates are first calculated for each medical group/clinic and then a statewide average rate is calculated. The statewide average rate is displayed when comparing a single medical group/clinic to the performance of all medical groups/clinics to provide context. The statewide average is calculated using all data submitted to MNCM for Minnesota residents only.

THRESHOLDS FOR PUBLIC REPORTING

MNCM has established minimum thresholds for public reporting to ensure statistically reliable rates. Only medical groups and clinics that meet these thresholds are reported. For DDS/PIPE measures included in this report, a minimum threshold of 30 patients per medical group/clinic is required.

RACE, ETHNICITY, COUNTRY OF ORIGIN, PREFERRED LANGUAGE (RELC) ANALYSIS

For the DDS/PIPE measures, the RELC data is submitted by medical groups through MNCM's process. Please refer to the MNCM Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups available on MNCM's Knowledge Base for more information about this data. For this report, RELC results are reported at a statewide level for the DDS/PIPE measures.

BEST PRACTICES FOR CLINICAL QUALITY MEASURES

RELC data collection undergoes a unique validation process to ensure that medical groups collect these data elements from patients using best practices. Best practices are defined as:

1. Patients self-report their race , ethnicity, country of origin and preferred language
2. Patients have the option to select one or more categories for race (i.e., medical groups/clinics do not collect data using a multi-racial category).
3. Medical groups/clinics have the ability to capture and report more than one race as reported by the patient.

A medical group/clinic must meet all the criteria for each data element to achieve best practice status and to have their data included in the rate calculation. Only validated data, collected using best practices, are used to calculate rates by RELC.

ASSIGNING INSURANCE TYPE FOR MEASURES COLLECTED BY DDS/PIPE

To identify insurance type (i.e., commercial, Medicaid, Medicare, uninsured) for the DDS/PIPE measures, MNCM uses information from medical groups and health plans.

HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS) MEASURES

HEDIS measures are a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). There are two types of data collection methods for HEDIS measures: (1) the administrative method that uses only health care claims data; and (2) the hybrid method that uses health care claims data plus medical record review data).

DATA COLLECTION

HEDIS technical specifications provide standard definitions for the eligible population for each measure including data elements such as age and continuous enrollment. Continuous enrollment is the minimum amount of time a person must be enrolled in a health plan before becoming eligible for a measure. It ensures that the health plan has enough time to render services. Using continuous enrollment criteria is necessary to standardize measurement, but it can reduce the number of individuals represented in the measure.

For administrative measures, the entire eligible population is the denominator. For the hybrid measures, the eligible population serves as the frame from which to draw a random sample of patients for chart audit and is used as the reference for weighting results.

ELIGIBLE POPULATION SPECIFICATIONS

The eligible populations for the administrative and hybrid measures are identified by each participating health plan using its respective administrative claims database. Health plans assign patients to a medical group using a standard medical group definition based on a tax identification number (TIN). Administrative billing codes determine the frequency of a patient's visit to a medical group. For most measures, patients are assigned to the medical group they visited most frequently during the measurement period. Patients who visited two or more medical groups with the same frequency are attributed to the medical group visited most recently in the measurement period. The TIN is used as the common identifier for aggregating data across health plans.

NUMERATOR SPECIFICATIONS

For HEDIS administrative measures, the numerator is the number of patients from the eligible population who met the numerator criteria. For HEDIS hybrid measures, the numerator is the number of patients from the sample who met numerator criteria.

CALCULATING RATES

HEDIS administrative and hybrid measures are reported at a medical group level and are expressed as percentages. Rates calculated for administrative measures are straightforward; however, rates calculated for hybrid measures require weighting because of sampling procedures. Rates and 95 percent asymmetrical confidence intervals are calculated for each measure for each medical group.

CALCULATING RATES CONTINUED

Asymmetrical confidence intervals are used to avoid confidence interval lower bound values less than zero and upper bound values greater than one hundred. Medical group rates are first calculated for each medical group and then a medical group average is calculated. The medical group average is used to compare medical groups for the performance ratings. The statewide average includes attributed and unattributed patients and is displayed in the charts.

THRESHOLDS FOR PUBLIC REPORTING

MNCM has established minimum thresholds for public reporting to ensure statistically reliable rates. Only medical groups that meet these thresholds are reported. For the HEDIS administrative measures in this report, a minimum threshold of 30 patients per medical group is required. For the HEDIS hybrid measures in this report, a minimum threshold of 60 patients per medical group is required.

RACE AND HISPANIC ETHNICITY ANALYSES

For the three HEDIS measures, the race and ethnicity data for MHCP is submitted by health plans. Health plans receive this information through the state public program enrollment process. Country of Origin and Preferred Language data are not available for the HEDIS measures.

DATA LIMITATIONS

Data used to calculate rates for the HEDIS measures reflect patients insured through 10 health plans doing business in Minnesota. Patients who are uninsured, self-pay, or who are served by Medicaid/Medicare fee-for-service are not reflected in the HEDIS results. UnitedHealthcare group is not currently represented in the data for this report.