Methods

The measures reported are collected from two sources: electronic health records (EHR) and payer administrative claims. Electronic health records data is submitted directly to MNCM by medical groups and clinics for the calculation of MNCM clinical quality measures. The Healthcare Effectiveness Data and Information Set (HEDIS®) and Total Cost of Care (TCOC) measures use data from payers.

MNCM Quality Measures

Quality measures stewarded and/or maintained by MNCM rely on EHR data submitted directly to MNCM by medical groups and clinics.

Data Collection

MNCM is in the midst of transitioning its data collection for the clinical quality measures reported by medical groups to a modernized system known as PIPE. The previous data collection system, known as Direct Data Submission or DDS, required providers to separately identify the relevant population for each measure. DDS was sunset in August 2024. PIPE identifies the eligible population, denominators, numerators, and performance rates for each measure centrally. The transition to PIPE is expected to be completed in 2025.

Rate Calculation

These clinical quality measures enable the calculation and reporting of results by clinic location as well as by medical group. The statewide average is calculated using all data submitted to MNCM which may include some data from clinics located in neighboring states.

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. The statewide average rate is displayed when comparing a single medical group/clinic to the performance of all medical groups/clinics to provide context.

Risk Adjustment

Risk adjustment is a technique used to enable fair comparisons of clinics/medical groups by adjusting for the differences in risk among specific patient groups. It is especially important for outcome measures that are influenced by factors outside the control of health care providers. MNCM uses an “Actual to Expected” methodology for risk adjustment. This methodology does not alter a clinic/medical group’s result as the actual rate remains unchanged. Instead, each clinic/medical

group's rate is compared to an "expected rate" for that clinic/medical group based on the specific characteristics of patients seen by the clinic/medical group, compared to the total patient population.

All expected values for clinical quality measures reported by medical groups are calculated using a logistic regression model including the following variables:

Measure	Risk Adjustment Variables
Colorectal Cancer Screening	Insurance product, deprivation index, patient age
Optimal Asthma Control	Insurance product, deprivation index
Optimal Diabetes Care	Insurance product, deprivation index, patient age, diabetes type
Optimal Vascular Care	Insurance product, deprivation index, patient age
Depression Care Suite	Insurance product, deprivation index, patient age, depression severity

Insurance product types include commercial, Medicare, Medicaid, uninsured, unknown.

The **deprivation index** was added in 2018 and includes ZIP code level average of poverty, public assistance, unemployment, single female with child(ren), and food stamps (SNAP) converted to a single index that is a proxy for overall socioeconomic status.

A Chi-square test is used to determine whether there is a statistically significant difference between the expected and actual rates of optimally managed patients attributed to each clinic/medical group. The methodology uses a 95 percent test of significance.

Measures that are not risk adjusted include: Adolescent Mental Health and/or Depression Screening and the PHQ-9/9M Utilization measures. This is because these are process measures that are not generally influenced by factors outside of a health care provider's control.

Medical Group and Clinic Level Results

Medical group and clinic level results and ratings can be found via MNCM's MNHealthScores. This platform offers unbiased, trustworthy performance data for medical groups and clinics, enabling consumers to make informed decisions based on quality and cost ratings.

Threshold for Public Reporting

MNCM has established minimum thresholds for public reporting of clinical quality measures reported by medical groups to ensure statistically reliable rates. Only medical groups and clinics that meet the threshold of 30 patients in the denominator of a measure are publicly reported.

HEDIS® Measures

HEDIS® is a national set of performance measures used in the managed care industry that were developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS measures use data from the administrative or hybrid data collection methodology.

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 for a member/patient to be enrolled in a payer to be eligible for a HEDIS® measure. It ensures the payer has enough time to render services. If a member/patient does not meet minimum continuous enrollment criteria, they are not eligible to be included in the measure denominator.

Administrative Method: These HEDIS® measures use payer claims data to identify the patients who are eligible for the measure (denominator) and for the numerator.

- Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis
- Breast Cancer Screening
- Chlamydia Screening in Women
- Diabetes Eye Exam
- Follow-up Care for Children Prescribed ADHD Medication
- Osteoporosis Management in Women Who Had a Fracture
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD

Hybrid Method: These HEDIS® measures use payer claims data to identify the patients who are eligible for the measures. Numerator information comes from payer claims and medical record review data. Because medical record review data is costly and time-consuming to collect, payers select a random sample from the eligible patients to identify the measure denominator. For the immunization measures, payers also use data from the Minnesota Immunization Information Connection (MIIC).

- Cervical Cancer Screening
- Childhood Immunization Status (Combo 10)
- Controlling High Blood Pressure
- Immunizations for Adolescents (Combo 2)

Patient Attribution

The eligible populations for the administrative and hybrid measures are identified by each participating payer using its respective administrative claims database. Payers 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 visits 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 payers.

Rate Calculation

HEDIS® administrative and hybrid measures are reported at a statewide and medical group level and are expressed as percentages. Rates calculated for hybrid measures require weighting because of the sampling procedures applied. Rates and 95-percent asymmetrical confidence intervals are calculated for each measure for each medical group (Asymmetrical confidence intervals are used to avoid confidence interval lower bound values less than zero and upper bound values greater than one hundred). The medical group overall average is used to compare to the individual medical group's rate for the performance ratings. The statewide average includes attributed and unattributed patients.

Risk Adjustment

The HEDIS® measures are not risk adjusted.

Medical Group Level Results

Medical group level results and ratings can be found via MNCM's MNHealthScores. This platform offers unbiased, trustworthy performance data for medical groups and clinics, enabling consumers to make informed decisions based on quality and cost ratings.

Threshold for Public Reporting

MNCM has established minimum thresholds for HEDIS® public reporting to ensure statistically reliable rates. Only medical groups that meet the thresholds of 30 patients in the denominator of HEDIS® administrative measures and 60 patients in the denominator of HEDIS® hybrid measures are publicly reported.

Limitations

Patients who are uninsured, self-pay, served by Medicaid/Medicare fee-for-service, or insured by payers not participating in MNCM data collection are not reflected in the HEDIS® results.

Payers Contributing Data

- Blue Cross Blue Shield of MN
- HealthPartners

- Hennepin Health
- Itasca Medical Care
- Medica
- Preferred One (2022MY was the last year of data contribution)
- PrimeWest Health
- Sanford Health
- South Country Health Alliance
- UCare

Cost and Utilization

MNCM has one of the most robust public transparency efforts in the nation related to health care costs, which provides perspective on total cost of care and resource use and price as drivers of total cost.

Data Collection

Total Cost of Care (TCOC), TCI (Total Cost Index) and TCRRV (relative resource use) measures were developed and are maintained by HealthPartners and are endorsed by the Partnership for Quality Measurement (PQM).

The data source for the TCOC measure is administrative claims from local payers that were adjudicated and processed as of May 1st of the report year. All data elements and processing rules were specified by MNCM in its data guide and specifications. The data specifications were developed and tested by MNCM's Cost Technical Advisory Group, with assistance from HealthPartners. This guide provides detailed steps and instructions to ensure the payers processed and submitted data in a standard and consistent format.

Cost data includes all allowed payments associated with attributed patients including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.

The population is commercially insured patients only, including all fully-insured and self-insured commercial plan patients where the payer has access to final adjudicated claims, and group and individual plan patients. Patients must be enrolled in the health plan for at least nine consecutive months within the measurement period. Patients must be at least one year and no more than 64 years old at the end of the measurement period.

Patient Attribution

Patients are attributed to primary care providers only. Primary care specialties are defined as Family Medicine, Internal Medicine, Pediatrics, Geriatrics and OB/GYN. Payers assign patients to a medical group using a standard medical group definition based on a tax identification number (TIN). Patients

are attributed to the medical group with the majority (>50 percent) of the patient's primary care provider office visits during the measurement period. Patients can be attributed to only one medical group. There is not a requirement of evaluation and management CPT code. Denied claims and claims where a payer is not the primary payer are excluded.

All costs are assigned to the medical group with the patient's majority of primary care activities, including in-person and telehealth visits.

Calculation of Total Cost of Care, Relative Resources and Price Index

TCOC is reported at a statewide and medical group level and expressed as cost per member per month. Total Cost Index (TCI), Relative Resource Use (RRU), and Price Index (PI) are expressed as a ratio. The base calculation is the average of all the medical group's case mix adjusted costs divided by the average for all patients in the measure. The measurement period is 12 consecutive months and includes all claims where dates of service occurred within the measurement period. All attributed patients are included in the risk score and population-wide outputs (e.g. statewide total cost of care average). The calculations are based on the total members months.

If a patient has more than $125,000 in total allowed payments in the measurement period, the total cost of care calculation truncates (caps) the expense at $125,000.

For further details on the calculation, go to the ***HealthPartners TCOC page***.

The confidence interval for the TCOC measure is calculated by "bootstrapping with replacement" which is a process where many samples are pulled from the full data set, each time calculating the outcome. MNCM calculated the 95 percent confidence interval for the TCOC for each medical group by repeating the process 600 times from unique randomly selected subsets of the data.

The confidence interval is calculated as the 2.5th percentile and 97.5th percentile of the 600 repeated calculations.

Risk Adjustments

Patient cost is adjusted for known risk factors that are reported in administrative claims. The Johns Hopkins Adjusted Clinical Groupings (ACG) grouper (www.hopkinsacg.org) is the agreed-on risk grouper and is also part of the PQM endorsed methodology. Lab and radiology claims are excluded from risk adjustment via the specific grouper software standard rules. Risk score calculations use the same truncation methodology noted above. The risk score is based on the Minnesota weight file using actual current data from participating providers and payers. The time period for the data included in the risk score calculation is the same as the measurement period. The number of diagnosis codes available per claim must be the same for all payers that input data to the process. Therefore, in order

to have a level impact of risk score, the number of codes must be equal to the minimum available from all participating payers.

Utilization Risk Adjustment

The Utilization measures use the same patients, attribution and administrative claims that are used for the total cost of care, relative resource use and price index. The observed values were calculated using the same HealthPartners developed methodology as noted above. The commonly accepted way to compare medical groups is using the ratio of observed events to expected events.

The Utilization Observed versus Expected uses an Indirect Standardization Risk Adjustment. Expected rate is calculated for each medical group based on the patient distribution of medical risk, age and gender. Patient risk is defined using the Johns Hopkins Adjusted Clinical Grouping categories. The ACG System measures the morbidity burden of patient populations based on disease patterns. It relies on the diagnostic information found in insurance claims. Patient age is grouped into three categories: 1-17, 18-39, and 40-64.

Medical Group Level Results

Medical group level results and ratings can be found via MNCM's MNHealthScores. This platform offers unbiased, trustworthy performance data for medical groups and clinics, enabling consumers to make informed decisions based on quality and cost ratings.

Threshold for Public Reporting

MNCM has established minimum thresholds for public reporting to ensure statistically reliable rates. Only medical groups that meet the thresholds of 600 attributed patients are publicly reported.

Limitations

Patients who are served by Medicaid/Medicare, or insured by payers not participating in MNCM data collection are not reflected in the results.

Payers Contributing Data

- Blue Cross Blue Shield of MN
- HealthPartners
- Medica
- Preferred One (2022MY was the last year of data contribution)