# APPENDIX

# Methodology

## 2018 MINNESOTA HEALTH CARE DISPARITIES BY INSURANCE TYPE

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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) 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.

# DIRECT DATA SUBMISSION (DDS) MEASURES

DDS 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 2018 DDS guides. These guides provide detailed steps and instructions to ensure clinics submit data in a standard format.

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 provided in the 2018 DDS Guides. All appropriate Health Insurance Portability and Accountability (HIPAA) requirements are followed.

MNCM staff conduct an extensive validation process including pre-submission data certification, post submission data quality checks of all files, and audits of the data source for selected clinics. For medical record audits, MNCM uses NCQA's "8 and 30" File Sampling Procedure, developed in 1996 in consultation with Johns Hopkins University. For a detailed description of this procedure, see www.ncqa.org. Audits are conducted by trained MNCM auditors who are independent of medical groups and/or clinics. The validation process ensures the data are reliable, complete and consistent.

## Eligible Population Specifications

The eligible population for each measure is identified by a medical group on behalf of their individual clinics. MNCM's 2018 DDS Guides provide technical specifications for the standard definitions of the eligible population, including elements such as age.

# Numerator Specifications

For DDS measures, the numerator is the number of patients identified from the eligible population who meet the numerator criteria. The criteria are specified by MNCM in the 2018 DDS Guides and technical specifications. 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 – this includes data primarily from Minnesota clinics but may include some data from clinics located in surrounding communities.

# 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 measures included in this report, a minimum threshold of 30 patients per clinic is required.

# Race and Hispanic Ethnicity Analyses

For the seven DDS measures, the race and ethnicity data is submitted by medical groups through MNCM's DDS process. Please refer to the MNCM ***"Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups"*** for more information about this data. For this report, race and Hispanic ethnicity results are reported at a statewide level.

## Best Practices for Clinical Quality Measures

Race and Hispanic ethnicity 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 and Hispanic ethnicity
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 race and Hispanic ethnicity.

## Assigning Insurance Type for Measures Collected by Direct Data Submission

To identify insurance type (i.e., commercial, Medicaid, Medicare, uninsured) for the DDS 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). The Definitions section in the 2018 Health Care Disparities Report includes of list of HEDIS measures by data collection method.

## 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. 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.

## 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.

## Data Analyses Identifying High Performing Medical Groups

Medical groups with performance rates and 95 percent confidence intervals fully above the MHCP statewide average are defined as high performers for each measure. High performing medical groups were highlighted if they achieved above average performance for MHCP patients on at least 50 percent of the measures on which they were reportable (see *Table 5* on page 30 of the report).