Public Comments Sought

The Minnesota Department of Health (MDH) is inviting public comment on the implementation of legislative requirements to stratify five measures in the Minnesota Statewide Quality Reporting and Measurement System by race, ethnicity, preferred language, and country of origin.

Overview

Minnesota’s 2008 Health Reform Law requires the Commissioner of Health to establish a standardized set of quality measures for health care providers. This standardized quality measure set is known as the Minnesota Statewide Quality Reporting and Measurement System (Quality Reporting System). MDH updates the measure set annually. MDH published its proposed rule and standardized measure set for 2016 reporting on October 26, 2015 with a 30-day public comment period.

The Quality Reporting System includes clinic and hospital quality measures that are submitted via different mechanisms from three primary data sources:

1. Providers’ patient medical records, which are increasingly stored in an electronic health record (EHR) system;
2. Patient experience of care surveys that providers dispense to patients through survey vendors; and
3. Administrative claims, which are stored in a practice management system and are also referred to as “discharge data” in the hospital setting.

To cover essential roles such as data collection, measurement development and maintenance, provider education, and making recommendations for changes to the measurement set, MDH contracts with a consortium of vendors that is led by Minnesota Community Measurement (MNCM) and includes Stratis Health and the Minnesota Hospital Association.

Health Equity

Although Minnesota ranks among the healthiest states in the nation, it simultaneously experiences significant and persistent disparities in health outcomes for some segments of the population. To eradicate these disparities, it is important for the State to foster health equity, which means creating the “conditions in which all people have the opportunity to attain their
highest possible level of health”.\(^1\) One of the challenges related to developing and evaluating programs to address and eliminate health disparities is the relative lack of data on many of the contributing socio-demographic factors, including data directly available to communities that are most impacted by health disparities and inequities.\(^2\)

The need for a consistent, statewide requirement for data reporting on race, ethnicity, and language in Minnesota has been noted among the recommendations in several prior legislative reports from MDH. In its 2014 Advancing Health Equity report, MDH recommended the creation of race, ethnicity, and language data collection standards and requirements that would be implemented across all programmatic areas, and stressed that any data collection, analysis or dissemination approaches needed to be developed in close collaboration with communities that experience disparities.

Quality measure stratification

Socio-demographic characteristics are important for understanding system-wide variations and disparities in quality of care because evidence shows that many of the factors that most heavily impact a person’s health status exist outside of the healthcare system. Reporting on quality of care in the absence of socio-demographic characteristics may actually deepen the inequities and disparities that currently exist in our health care system by creating incentives for providers to minimize or avoid treating patients from communities that experience disparities and are less likely to contribute to strong performance on existing measures of quality of care.\(^3\)

One way to combine socio-demographic factors with quality measures is to report measure results by different groups or combinations of groups—also known as “stratifying” results. “Stratification” refers to calculating health care performance scores separately for different patient groups based on some characteristic. For example, groups could be constructed based on race and performance scores computed for each group. Stratification enables the identification of healthcare disparities for certain patient groups and it can unmask healthcare disparities by examining performance for groups who have been historically disadvantaged compared to groups who have not been disadvantaged.

Legislative requirements

Recognizing these issues, in 2014, the Minnesota Legislature directed MDH to develop an implementation plan for stratifying Quality Reporting System measures based on disability, race, ethnicity, language, and other socio-demographic factors that are correlated with health disparities and impact performance on quality measures.\(^4\) The legislation required MDH to develop the plan in consultation with: consumer, community and advocacy organizations representing diverse communities; health plan companies; providers; quality measurement

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\(^4\)Minnesota Laws 2014, Chapter 312, Article 23, Section 10.
organizations; and safety net providers that primarily serve communities and patient populations with health disparities. MDH submitted this plan to the Legislature in early 2015. The Legislature then enacted requirements that MDH stratify five quality measures by race, ethnicity, preferred language, and country of origin.

Current data collection and reporting

Clinic measures

Most Minnesota clinics already capture patient race, ethnicity, preferred language, and country of origin information in their EHR systems. MNCM has been voluntarily collecting race, Hispanic ethnicity, preferred language, and country of origin information from medical groups since 2010, building on earlier voluntary efforts begun by a number of medical groups as early as 2006. MNCM issued a report in January 2015 that stratified five quality measures by these sociodemographic factors statewide and by geographic region. These measures—which are also in the Quality Reporting System—are: Optimal Diabetes Care; Optimal Vascular Care; Optimal Asthma Care—Adult; Optimal Asthma Care—Child; and Colorectal Cancer Screening. Additionally, the clinic patient experience of care survey that is in the Quality Reporting System asks respondents for their age, gender, education level, race, and ethnicity. However, there is currently no public reporting on patient experience of care in Minnesota that is broken out by those factors.

Hospital measures

Minnesota hospitals capture patient race, ethnicity, and preferred language information to a significant extent to meet federal requirements. Because nearly all EHR-based and patient experience hospital measures in the Quality Reporting System are highly aligned with federal measurement specifications and rely on submission of the data to federal agencies, MDH has little control over the content of data submission and relies on summary data reported by federal agencies. Although key federal programs require hospitals to submit race and ethnicity information when reporting quality measures with data populated by EHRs, this data is not available publicly and it is not clear whether CMS will release patient socio-demographic information upon request.

Provider organizations and health plans use administrative claims data to calculate quality measures, and some of these hospital measures are in the Quality Reporting System. These measures are developed and maintained by national and federal organizations, and they do not require the inclusion of race, ethnicity, preferred language, and country of origin in their calculation.

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www.health.state.mn.us/healthreform/measurement/SQRMSreportMarch2015.pdf

6Minnesota Statutes, 62U.02.


Implementing Stratification Requirements

MDH proposes initially stratifying five physician clinic quality measures by race, ethnicity, preferred language, and country of origin at statewide, county, and zip code levels as data quality permits. Considering the current system of voluntary reporting of race, ethnicity, preferred language, and country of origin on five quality measures to MNCM and the schedule under which data submission occurs, MDH proposes to require initial reporting of these four socio-demographic factors, for each of the five measures, under the schedule shown in the table below.

<table>
<thead>
<tr>
<th>Quality Measures</th>
<th>Dates of Service</th>
<th>Data Submission Dates to MNCM</th>
<th>MDH Public Reporting of Statewide, County, and Zip Code Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Optimal Asthma Control—Adult</td>
<td>07/01/2016 – 06/30/2017</td>
<td>07/01/2017 – 08/15/2017</td>
<td>Early 2018</td>
</tr>
<tr>
<td>2. Optimal Asthma Control–Child</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Colorectal Cancer Screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Optimal Diabetes Care</td>
<td>01/01/2017 – 12/31/2017</td>
<td>01/01/2018 – 02/15/2018</td>
<td>Mid-2018</td>
</tr>
<tr>
<td>5. Optimal Vascular Care</td>
<td></td>
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</tbody>
</table>

For initial stratification, MDH is only considering physician clinic measures, not hospital measures. While many hospitals capture these data elements within their electronic health records, the federal programs that have developed most of the hospital measures that are used in the Quality Reporting System do not publicly report these data elements in their measures. MDH will continue to monitor trends at local and national levels, and will seek comments on stratifying hospital measures in future years.

Stratification principles

The approach that MDH is considering is based on the following principles, which seek to balance legislative timeline expectations, provider burden, and feasibility:

- **Build on existing voluntary submission** of race, ethnicity, preferred language and country of origin data that is led by MNCM. While submission of data on these socio-demographic factors would now be mandatory rather than voluntary, in order to minimize provider burden, the variable specification for data submission on race, ethnicity, preferred language, and country of origin would be those that are already being used for voluntary submission, so that providers do not need to make changes to existing data collection processes.

- MDH would **not publish stratified data at the clinic level**, but rather at the statewide, county, and zip code levels as data quality permits.

- MDH would stage the implementation of data submission requirements so as to **give providers who are not already submitting this information to MNCM time to prepare for**
required submission. Providers that are not ready to submit these data elements could submit a request for variance to MDH⁹.
- MDH would not require providers to share any patient-level data on these factors with MDH.

Request for comment

MDH invites public comment on the implementation of legislative requirements, and specifically seeks input on the following questions:

1. Currently, MNCM is reporting race, ethnicity, preferred language, and country of origin data on a statewide and regional basis for Optimal Asthma Control–Adult; Optimal Asthma Control–Child; Colorectal Cancer Screening; Optimal Diabetes Care; and Optimal Vascular Care. Are these the five measures that should be prioritized for stratification now, or are there other physician clinic measures that should be prioritized?

2. Recognizing that data submission within a given calendar year involves dates of service from the previous year, when should required reporting of race, ethnicity, preferred language, and country of origin begin—2017 or 2018? For example, clinics will report the asthma and colorectal measures to MNCM in July 2017 for dates of service between July 2016 and June 2017; therefore, MDH could require clinic data submission for those measures to begin in July 2017. Clinics will report the diabetes and vascular measures to MNCM in January 2018 for January 2017 through December 2017 dates of service; therefore, MDH could require clinic data submission for all five measures to begin in January 2018.

3. What support (e.g., education, technical assistance) do providers need to be able to engage patients to share socio-demographic information, and to capture and report race, ethnicity, preferred language, and country of origin data?

4. What physician clinic measures should be prioritized for stratification in the future?

5. Which socio-demographic factors—and sources of this data—should MDH consider when developing its plans for broader stratification in 2018?

How to submit comments

MDH invites public comment on the proposed rule, appendices, measure specifications, and implementation of stratification requirements during the 30-day rulemaking comment period that closes at 4:30 p.m. on November 25, 2015. Interested persons or groups must submit comments or questions to: Denise McCabe, Minnesota Department of Health, P.O. Box 64882, St. Paul, MN 55164-0882, 651-201-5530, and health.reform@state.mn.us.

Minnesota Rule 4654.0700 provides discretionary authority for the Commissioner of Health to grant variances to a data submitter for a reported quality measure collection or submission specification if the data submitter demonstrates good cause.