CHAPTER 4654
DEPARTMENT OF HEALTH
HEALTH CARE QUALITY MEASURES

4654.0100 APPLICABILITY.

This chapter applies to all providers who are required to submit standardized information on quality measures associated with patient care under Minnesota Statutes, section 62U.02, and all health plan companies that collect data related to quality measures from providers.

Statutory Authority: *MS s 62U.02*

History: *34 SR 905*

Published Electronically: *January 13, 2010*

4654.0200 DEFINITIONS.

Subpart 1. **Scope.** For purposes of this chapter, the following terms have the meanings given them in this part.

Subp. 2. **Administrative data.** "Administrative data" means information contained on a health care claim or equivalent encounter transaction provided by a provider to a health plan company or third-party administrator.

Subp. 2a. **Ambulatory surgical center.** "Ambulatory surgical center" is an outpatient surgical center and has the meaning given in Minnesota Statutes, section 144.55, subdivision 2a, and is also certified under the Medicare program.

Subp. 3. **Applicable quality measure.** "Applicable quality measure" means a quality measure that pertains to a service provided by a physician clinic, hospital, or ambulatory surgical center.

Subp. 4. **Clinical staff.** "Clinical staff" means physicians, advanced practice registered nurses, and physician assistants.

Subp. 5. **Commissioner.** "Commissioner" means the commissioner of health.

Subp. 6. **Complete submission.** "Complete submission" means quality measures that a data submitter has submitted to the commissioner or commissioner's designee containing the required quality measures in a format that allows for further review and verification of the data's accuracy.

Subp. 7. **Data submitter.** "Data submitter" means a physician clinic, hospital, or ambulatory surgical center.

Subp. 8. **Health plan company.** "Health plan company" has the meaning given in Minnesota Statutes, section 62U.01, subdivision 8.

Subp. 9. **Hospital.** "Hospital" means any entity licensed under Minnesota Statutes, section 144.50, subdivision 2.

Subp. 10. **Material error.** "Material error" means omission of data or submission of inaccurate information that significantly changes the results of the analysis of quality measures.

Subp. 11. [Renumbered Subp. 2a]

Subp. 12. **Payer mix.** "Payer mix" means the distribution of insurance coverage for a provider's patient population including private insurance, Medicare, state public programs, self-pay, and uninsured.

Subp. 13. **Physician clinic.** "Physician clinic" means any location where primary or specialty care ambulatory services are provided for a fee by one or more physicians in the state of Minnesota. Physician clinic includes ambulatory surgical centers and hospital-based outpatient locations that provide primary or specialty care ambulatory services for a fee. With the exception of ambulatory surgical centers, multiple clinic locations may be considered a single physician clinic when the multiple locations have common ownership and a majority of common clinical staff working across the multiple locations, and the total clinical staff across all locations is no greater than 20 full-time equivalent employees.

Subp. 14. **Provider or health care provider.** "Provider" or "health care provider" has the meaning in Minnesota Statutes, section 62U.01, subdivision 10.

Subp. 15. **Publicly reported measure.** "Publicly reported measure" means a standardized quality measure established by the commissioner that is stated in Appendix A, B, or C, which is incorporated by reference in part 4654.0800.

Subp. 16. **Quality measure.** "Quality measure" means a specific qualitative or quantitative indicator that measures health outcomes, processes, structures, or patient experience, access, or safety, or other desirable results for a defined population of patients. Quality measure does not include information:

A. associated with assessing medical necessity for an individual patient;

B. used to determine medical appropriateness of treatment for a particular patient;

C. related to patient safety or adverse health events for an individual patient;

D. related to a health care provider's qualifications or scope of practice; or

E. necessary to detect and prevent fraud and abuse in the billing and payment of services.

Subp. 17. **Risk adjustment.** "Risk adjustment" means a process that adjusts the analysis of quality measurement by accounting for those patient-population characteristics that may independently affect results of a given measure and are not randomly distributed across all providers submitting quality measures. Risk adjustment characteristics include, for example, severity of illness, patient demographics, or payer mix.

Subp. 18. **Standardized electronic information.** "Standardized electronic information" means the specific required data format as described in Appendix E, which is incorporated by reference in part 4654.0800.

Subp. 19. **Standardized quality measure.** "Standardized quality measure" means:

A. any measure listed in Appendix A, B, C, or D, which is incorporated by reference in part 4654.0800;

B. any measure required to be reported under Minnesota Statutes, section 62U.05 or 256B.0751, subdivision 6, paragraph (a);

C. any quality measure that a health plan company or provider is required to collect or report by the Minnesota Department of Human Services;

D. any structural quality measure; or

E. any quality measure that a health plan company is required to collect or report by federal or state law or regulation.

Subp. 20. **Structural quality measure.** "Structural quality measure" means a measure of provider capacity, scope of services, or feature of the setting in which care is delivered that is independent of the care delivered to any individual patient.

Subp. 21. **Third-party administrator.** "Third-party administrator" means a vendor of risk management services or an entity administering a self-insurance or health insurance plan as defined in Minnesota Statutes, section 60A.23, subdivision 8.

Subp. 22. **Urgent care center.** "Urgent care center" means a medical facility where ambulatory patients can walk in without an appointment and receive services required to treat an illness or injury that would not result in further disability or death if not treated immediately, but requires professional attention and that has the potential to develop such a threat if treatment is delayed. Urgent care center does not include physician clinics offering extended hours for patient care.

Statutory Authority: *MS s 62U.02; 62U.06*

History: *34 SR 905; 35 SR 802; 36 SR 615; 37 SR 747*

Published Electronically: *January 9, 2013*

4654.0300 PROVIDER SUBMISSION REQUIREMENTS.

Subpart 1. **Physician clinics.**

A. Each physician clinic, except ambulatory surgical centers, must register annually with the commissioner or commissioner's designee beginning January 1, 2010, as specified in Appendix E.

B. Each physician clinic, except ambulatory surgical centers, must submit to the commissioner or commissioner's designee data required to calculate the applicable quality measures, including the data necessary to perform risk adjustment for each applicable quality measure in Appendix A, which is incorporated by reference in part 4654.0800, according to the schedule for each measure in Appendix A for all health care services provided by the physician clinic. The physician clinic must submit the data using the standardized electronic format and procedures specified in Appendix E, which is incorporated by reference in part 4654.0800.

C. Each physician clinic with an electronic medical record in place for an entire measurement period must report on a full population basis in the subsequent reporting cycle.

D. If less than ten percent of a physician clinic's population is age 18 or older, that physician clinic is exempt from reporting on quality measures in Appendix A applicable to patients age 18 or older.

Subp. 2. **Hospitals.**

A. Each hospital must submit to the commissioner or commissioner's designee data required to calculate the applicable quality measures, including the data necessary to perform risk adjustment for

each applicable quality measure in Appendix B, which is incorporated by reference in part 4654.0800, according to the schedule for each measure in Appendix B for all relevant health care services provided by the hospital. The hospital must submit the data using the standardized electronic format and procedures specified in Appendix E, which is incorporated by reference in part 4654.0800.

B. If less than ten percent of a hospital's patient population is age 18 or older, that hospital is exempt from reporting on quality measures in Appendix B applicable to patients age 18 or older.

Subp. 3. [Repealed, 39 SR 1046]

Subp. 4. **Provider subcontractors.** The commissioner or commissioner's designee will accept data submitted on behalf of a provider by a single subcontractor.

Statutory Authority: *MS s 62U.02; 62U.06*

History: *34 SR 905; 35 SR 802; 38 SR 848; 39 SR 1046*

Published Electronically: *January 22, 2015*

4654.0400 DATA VALIDATION PROCEDURES.

Subpart 1. **Complete submissions.**

A. The commissioner or commissioner's designee must notify a data submitter of a data transmission receipt within two business days of a data submission. Within 30 days after receipt of the data transmission, the commissioner or the commissioner's designee must notify the data submitter whether the data qualifies as a complete submission.

B. If a data submitter receives notice that a data submission is incomplete, the commissioner or commissioner's designee must state in the notice why the data submission is incomplete. The data submitter must resubmit the complete data or request an extension or reconsideration within ten business days after the data submitter receives the notice.

Subp. 2. **Material error.**

A. If the commissioner or commissioner's designee notifies a data submitter of a material error in a complete submission, the data submitter must file a corrected submission or request an extension or reconsideration within ten business days.

B. If a data submitter discovers a material error in a complete submission, the data submitter must immediately inform the commissioner or commissioner's designee of the error and, within 15 business days, file a corrected submission.

Subp. 3. **Dispute resolution.** If a data submitter disagrees with the commissioner or commissioner's designee's determination that a submission is incomplete or that it contains a material error, the data submitter may submit a written request for reconsideration to the commissioner within ten business days, stating its reasons that the submission should be considered complete or why it does not contain a material error. The commissioner's decision on the request for reconsideration is final.

Subp. 4. **Cooperation with data validation procedures.** Data submitters must cooperate with the commissioner or the commissioner's designee in carrying out data validation by doing the following:

A. attest to the accuracy of data submissions;

B. respond to data validation requests by the commissioner or the commissioner's designee; and

C. document calculation of all applicable measures and maintain the record for two years.

Statutory Authority: *MS s 62U.02*

History: *34 SR 905*

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4654.0500 MEASUREMENT DEVELOPMENT AND REVIEW PROCESS.

Subpart 1. **Review process.** The commissioner must review the standardized quality measures contained in "Minnesota Statewide Quality Reporting and Measurement System: Appendices to Minnesota Administrative Rules, chapter 4654," in part 4654.0800, and propose additions, deletions, or modifications by August 15 of each year. If the commissioner determines that a standardized quality measure should be added, deleted, or modified, the commissioner will use the expedited rulemaking process under Minnesota Statutes, section 14.389.

Subp. 2. **Recommendation process.** The commissioner shall consider recommendations for addition, removal, or modification of standardized quality measures that are submitted by June 1 of each year. To the extent practicable, recommendations must address how addition, removal, or modification of a quality measure relates to one or more of the following criteria:

A. the magnitude of the individual and societal burden imposed by the clinical condition being measured by the quality measure, including disability, mortality, and economic costs;

B. the extent of the gap between current practices and evidence-based practices for the clinical condition being measured by the quality measure, and the likelihood that the gap can be closed and conditions improved through changes in clinical processes;

C. the relevance of the quality measure to a broad range of individuals with regard to:

(1) age, gender, socioeconomic status, and race/ethnicity;

(2) the ability to generalize quality improvement strategies across the spectrum of health care conditions; and

(3) the capacity for change across a range of health care settings and providers;

D. the extent to which the quality measure has either been developed or accepted, or approved through a national consensus effort;

E. the extent to which the results of the quality measure are likely to demonstrate a wide degree of variation across providers; and

F. the extent to which the quality measure is valid and reliable.

Statutory Authority: *MS s 62U.02*

History: *34 SR 905*

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4654.0600 USE OF QUALITY MEASURES BY HEALTH PLAN COMPANIES.

Subpart 1. **Required quality measures.** A health plan company may not require providers to use or report quality measures that are not standardized quality measures. Health plan companies and providers

may voluntarily use and report quality measures that are not standardized quality measures. In addition, a health plan company may do the following:

A. derive quality measures from any data source not submitted to the health plan company by a provider; and

B. derive quality measures from administrative data.

Subp. 2. **Required use or report of quality measures.** For purposes of this part, requiring a provider to use or report a quality measure means contractually mandating, as a nonnegotiable condition of conducting business with a health plan company, that a provider use or report a specific quality measure.

Statutory Authority: *MS s 62U.02*

History: *34 SR 905*

Published Electronically: *January 13, 2010*

4654.0700 VARIANCES.

The commissioner may grant a variance to a data submitter for a reported quality measure collection or submission specification if the data submitter demonstrates good cause. To request a variance, a data submitter must submit a petition, according to the requirements of Minnesota Statutes, section 14.056, and demonstrate that it meets the following criteria:

A. failure to grant the variance would result in hardship or injustice to the data submitter;

B. the variance is consistent with the public interest, including patient safety; and

C. the variance does not prejudice the substantial legal or economic rights of any person or entity.

Statutory Authority: *MS s 62U.02*

History: *34 SR 905*

Published Electronically: *January 13, 2010*

4654.0800 INCORPORATION BY REFERENCE.

"Minnesota Statewide Quality Reporting and Measurement System: Appendices to Minnesota Administrative Rules, Chapter 4654," issued by the Minnesota Department of Health, December 2014, is incorporated by reference. It is available through the Minitex interlibrary loan system and the Minnesota Department of Health Web site at http://www.health.state.mn.us/healthreform/measurement/index.html. They are not subject to frequent change.

Statutory Authority: *MS s 62U.02; 62U.06*

History: *34 SR 905; 35 SR 802; 36 SR 615; 37 SR 747; 38 SR 848; 39 SR 1046*

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