

HEALTH CARE DISPARITIES IN MINNESOTA

By Insurance Type

For care delivered in 2023



ABOUT MN COMMUNITY MEASUREMENT

MN Community Measurement (MNCM) is an independent nonprofit organization that empowers health care decision makers with meaningful data to drive improvement in health care quality, cost and equity. These decision makers include health plans, health care providers, employers, consumers and state government.

In addition to its roles in collecting, aggregating, validating, and publicly reporting data, a crucial component of MNCM's work involves convening stakeholders to agree on common priorities for measurement. MNCM is also nationally known as a developer of quality measures, particularly for outcomes of care and for patient-reported outcome performance measures (PRO-PMs). Many MNCM-developed measures are endorsed by the National Quality Forum and/or used in Medicare quality reporting and incentive programs.

Beyond its role in performance measurement and reporting, MNCM is an active partner with others to drive improvement. These efforts include modernizing data collection and reporting to reduce burden on health care providers and health plans, meeting evolving stakeholder needs related to timely, consistent information to support value-based care, and actively partnering with state agencies and other nonprofits on key initiatives such as improving mental health and affordability of care.

ABOUT MN DEPARTMENT OF HUMAN SERVICES

The MN Department of Human Services (MN DHS) is the state Medical Assistance (Medicaid) agency responsible for purchasing health care services for approximately 1.4 million Minnesotans¹, about 25% of the state's population. Most Minnesotans enrolled in Medicaid receive services through the state's contracted managed care organizations. Minnesota Medicaid plays a critical role in ensuring access to high quality care for vulnerable populations including children, persons with disabilities, and seniors. DHS's mission is, working with others, to help people meet their basic needs so they can live in dignity and achieve their highest potential.

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This report is made possible by the engagement the MN Department of Human Services, medical groups, payers and MNCM's Data Validation and Data Analysis teams. Each are committed to continuous improvement and recognize the important role measurement plays in helping our community establish priorities and improve together.

MNCM extends our thanks to all medical groups and payers for contributing the data necessary for measurement, to the State of Minnesota for its support through the Statewide Quality Reporting and Measurement System and to the many members of MNCM committees, workgroups and staff providing ongoing guidance to shape this important work.

Note: UnitedHealthcare group is not currently represented in the data for this report.

SECTION 1: REPORT OVERVIEW

For over 15 years, MNMCM has partnered with DHS to measure health care quality by insurance type. This report summarizes MNMCM's analysis comparing key measures for Minnesotans enrolled in a Minnesota Health Care Program (MHCP). The measures featured in this report (summarized on right) include those meeting legislative requirements (MN Statute 256B.072 Section 1d)², plus additional measures chosen by DHS and MNMCM to identify and examine gaps in quality for patients enrolled in MHCP, with the goal of informing community efforts on improvement.

DHS uses these data to inform contractual terms that they sign with the Managed Care Organizations (MCOs) that determines their obligations in order to receive state funding. This report has been used to guide performance improvement projects (PIPs), Withhold Measures, and other various performance monitoring activities.

MHCP enrollees often face socioeconomic challenges, with higher representation of persons of color, Indigenous populations, individuals with disabilities, and elderly adults—factors that can create barriers to optimal care compared to those with commercial insurance.

This report highlights health care quality for MHCP Managed Care (MHCP MCO) enrollees, comparing results by insurance type and, where available, by race, ethnicity, country of origin, and preferred language. Additionally, the report provides comparisons of patients insured through the managed care components of MHCP (Medical Assistance and MinnesotaCare) to those insured through Other Purchasers (e.g., commercial, Medicare).

The data collected in this report were collected by MNMCM in 2024 for 2023 dates of service.

QUALITY MEASURES

Below are the measures featured in this report:

Preventive Health

- Breast Cancer Screening*
- Childhood Immunization Status (Combo 10)*
- Colorectal Cancer Screening

Chronic Conditions

- Controlling High Blood Pressure*
- Optimal Asthma Control – Adults
- Optimal Asthma Control – Children
- Optimal Diabetes Care, plus five components:
 - Blood Pressure Control
 - Daily Aspirin Use
 - HbA1c Control
 - Statin Use
 - Tobacco-free
- Optimal Vascular Care, plus four components:
 - Blood Pressure Control
 - Daily Aspirin Use
 - Statin Use
 - Tobacco-free

Mental Health

- Adolescent Mental Health and/or Depression Screening
- Adolescent Depression Suite:
 - Follow-up at Six Months
 - Response at Six Months
 - Remission at Six Months
 - Follow-up at 12 Months
 - Response at 12 Months
 - Remission at 12 Months
- Adult Depression Suite:
 - Follow-up at Six Months
 - Response at Six Months
 - Remission at Six Months
 - Follow-up at 12 Months
 - Response at 12 Months
 - Remission at 12 Months

*Healthcare Effectiveness Data & Information Set (HEDIS) measure

KEY FINDINGS

The *Health Care Disparities in Minnesota by Insurance Type* report highlights disparities and trends in various quality measures among MHCP patients. Key findings include:



RATE CHANGES FROM 2022 TO 2023 FOR MHCP

- **Improvements:** Colorectal Cancer Screening had the largest rate increase from 2022 (2.1 percentage points), while Optimal Diabetes Care and Adolescent Mental Health Screening also had slight, but significant improvements.
- **Stable Measures:** The rates for Breast Cancer Screening, Controlling High Blood Pressure, Optimal Vascular Care, Optimal Asthma Control (Adults & Children), and Depression Remission at Six Months (Adults & Adolescents) remained unchanged from 2022.
- **Declines:** The rate for Childhood Immunization Status (Combo 10) declined by almost five percentage points from 2022 to 2023 in the MHCP population. This finding is not unique to the MHCP population and was observed at the statewide level as well.



GAPS BETWEEN MHCP AND OTHER PURCHASERS

- Across all measures, the MHCP population had lower rates of health screenings and outcomes compared to the Other Purchasers population.
- The largest gap in rates between the populations was observed in the Childhood Immunization Status (Combo 10) measure, with a difference of almost 28 percentage points.



DISPARITIES IN RACE, ETHNICITY, LANGUAGE, AND COUNTRY OF ORIGIN

- Patients who are Black or Indigenous/Native and Hispanic/Latinx patients consistently experienced lower rates across cancer screenings, immunizations, and chronic conditions.
- For rates for Black and Indigenous/Native patients were below the statewide MHCP MCO rate for over half of the measures (7 out of 11 measures, or 63.3% of measures).
- Non-English speakers had lower rates of both Colorectal Cancer Screening and Adolescent Mental Health Screening compared to the MHCP statewide rates.
- Patients born in the United states had lower rates of both Optimal Diabetes Care and Optimal Vascular Care compared to the MHCP statewide rates.
- These findings emphasize the need for targeted interventions to address areas needing improvement, reduce care gaps, and eliminate disparities in care.

TABLE 1: Comparison of Current MHCP Statewide Rates to Previous Year

The table below displays the statewide rate changes from the current year to previous year for the MHCP MCO population for each quality measure.

Measure	2022 MHCP MCO Statewide Rate	2023 MHCP MCO Statewide Rate	Percentage Point Change (2023 Rate – 2022 Rate)
PREVENTIVE HEALTH			
Breast Cancer Screening	57.4% (N = 59,404)	58.1% (N = 59,745)	0.7
Childhood Immunization Status (Combo 10)	34.9% (N = 3,634)	30.2% (N = 9,275)	-4.7*
Colorectal Cancer Screening	52.7% (N = 143,247)	54.8% (N = 147,216)	+2.1*
CHRONIC CONDITIONS			
Controlling High Blood Pressure	66.1% (N = 11,514)	67.0% (N = 11,178)	+0.9
Optimal Diabetes Care	34.9% (N = 46,869)	36.2% (N = 49,141)	+1.3*
Optimal Vascular Care	43.3% (N = 17,642)	43.7% (N = 18,708)	+0.4
Optimal Asthma Control – Adults	42.8% (N = 33,974)	43.6% (N = 34,338)	+0.8
Optimal Asthma Control – Children	48.9% (N = 17,968)	49.5% (N = 17,966)	+0.6
MENTAL HEALTH			
Adolescent Mental Health and/or Depression Screening	91.3% (N = 37,830)	92.3% (N = 38,558)	+1.0*
Adolescent Depression: Remission at Six Months	5.8% (N = 4,503)	6.2% (N = 2,961)	+0.4
Adult Depression: Remission at Six Months	7.5% (N = 24,685)	7.8% (N = 19,308)	+0.3

*Statistically significant difference based on 95% confidence intervals ($p < 0.05$)

NA = Not applicable

N = Total number of patients (denominator)

TABLE 2: Summary of Statewide Rate Differences by Insurance Type

The table below displays the difference in statewide rates between the MHCP MCO population and the Other Purchasers population. The results shown represent the 2023 measurement year.

Measure	MHCP MCO Statewide Rate	Other Purchasers Statewide Rate	Rate Difference (MHCP – Other Purchasers)	Rate Difference Over Time** (MHCP – Other Purchasers)
PREVENTIVE HEALTH				
Breast Cancer Screening	58.1%	79.7%	-21.6*	Gap Widened*
Childhood Immunization Status (Combo 10)	30.2%	57.7%	-27.5*	Gap Widened*^
Colorectal Cancer Screening	54.8%	72.6%	-17.8*	Gap Widened*
CHRONIC CONDITIONS				
Controlling High Blood Pressure	67.0%	72.4%	-5.4*	Gap Widened*+
Optimal Diabetes Care	36.2%	48.7%	-12.5*	Gap Widened*
Optimal Vascular Care	43.7%	57.7%	-14.0*	Gap Narrowed*
Optimal Asthma Control – Adults	43.6%	54.7%	-11.1*	Gap Stable
Optimal Asthma Control – Children	49.5%	56.5%	-7.0*	Gap Stable
MENTAL HEALTH				
Adolescent Mental Health and/or Depression Screening	92.3%	94.0%	-1.7*	Gap Narrowed*
Adolescent Depression: Remission at Six Months	6.2%	8.1%	-1.9*	Gap Stable
Adult Depression: Remission at Six Months	7.8%	11.0%	-3.2*	Gap Stable

*Statistically significant difference based on 95% confidence intervals ($p < 0.05$)

**Based on last five years (2019-2023)

^Based on comparison to 2020; 2019 results not available due to COVID-19 related interruptions.

+Based on comparison to 2020; 2020 was the first year of current measure specifications for this measure.

TABLE 3: Summary of Findings by Race/Ethnicity

The table below compares the MHCP MCO rate of each race/ethnicity group to the MHCP MCO statewide rate for the 2023 measurement year.

Measure	MHCP MCO Statewide Rate	Asian	Black	Indigenous/ Native	Multi Race	Native Hawaiian	White	Hispanic/Latinx	Not Hispanic/Latinx
PREVENTIVE HEALTH									
Breast Cancer Screening	58.1%	▲	▼	▼	●	●	▲	▲	●
Childhood Immunization Status (Combo 10)	30.2%	▲	▼	▼	●	NR	●	▲	●
Colorectal Cancer Screening	54.8%	▲	▼	▼	▼	▼	▲	▼	●
CHRONIC CONDITIONS									
Controlling High Blood Pressure	67.0%	●	▼	▼	●	NR	▲	●	●
Optimal Diabetes Care	36.2%	▲	▼	▼	▼	●	●	●	●
Optimal Vascular Care	43.7%	▲	▼	▼	●	●	●	▲	●
Optimal Asthma Control – Adults	43.6%	▲	▼	▼	▼	●	▲	●	●
Optimal Asthma Control – Children	49.5%	▲	●	▼	●	●	●	▲	●
MENTAL HEALTH									
Adolescent Mental Health and/or Depression Screening	92.3%	▲	▼	●	●	●	▲	●	▲
Adolescent Depression: Remission at Six Months	6.2%	●	●	●	●	●	●	●	●
Adult Depression: Remission at Six Months	7.8%	●	●	●	●	●	●	●	●

▲ Significantly above statewide MHCP MCO statewide rate

● Average (not significantly different than MHCP MCO statewide rate)

▼ Significantly below statewide MHCP MCO statewide rate

NR = Not reportable; did not meet the minimum number of patients needed for statistically reliable results

SECTION 2: PREVENTIVE HEALTH

Preventive health is crucial for early disease detection, improved treatment outcomes, and reduced long-term health care costs. Regular screenings and immunizations play a vital role in identifying and preventing serious health conditions, ultimately contributing to better population health.

This section highlights three key areas of preventive health: breast cancer screening, colorectal cancer screening, and childhood immunizations.

MEASURE DEFINITIONS

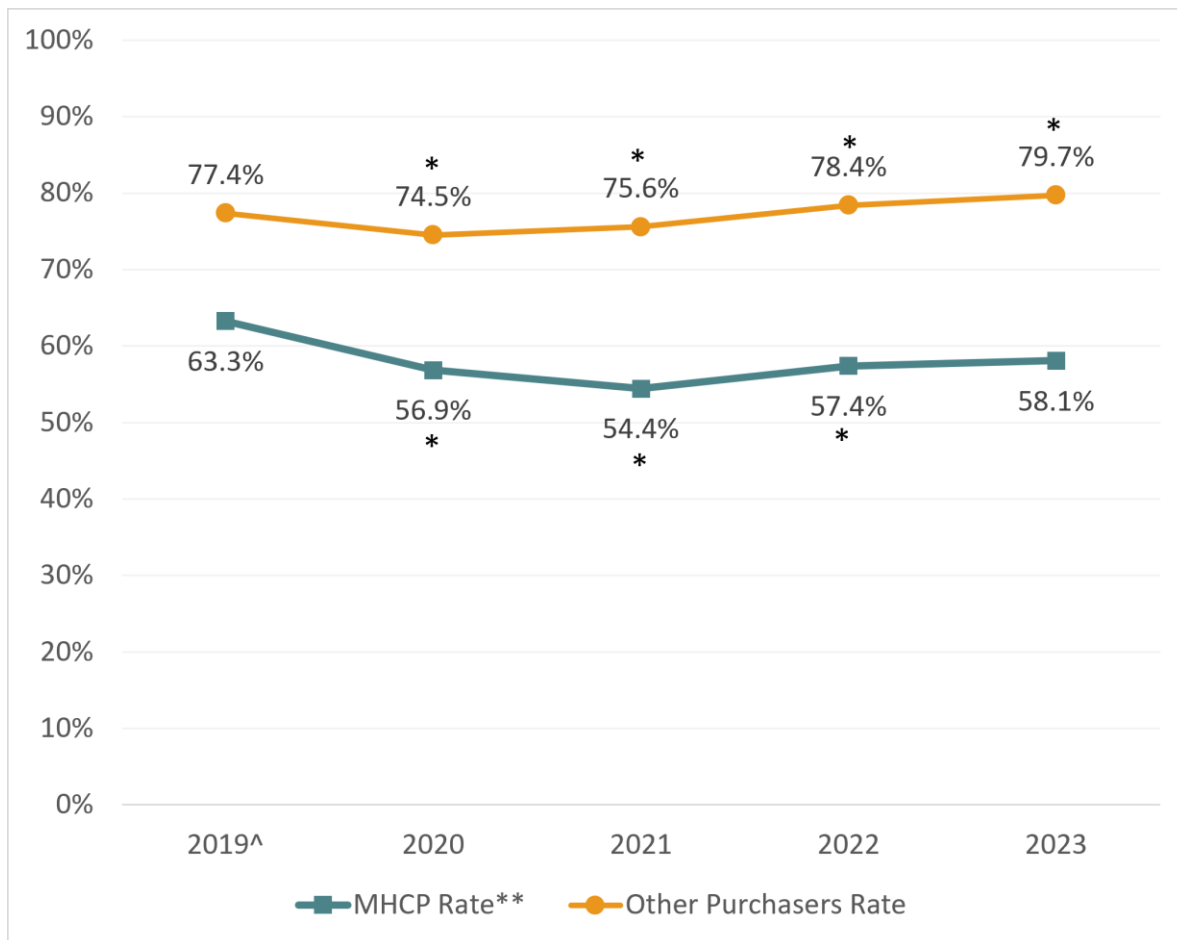
- **Breast Cancer Screening***: The percentage of women 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years.³
- **Colorectal Cancer Screening**: The percentage of adults 45 -75 years of age who are up-to-date with one of the following appropriate screenings:
 - Colonoscopy during the measurement year or the nine years prior OR
 - Flexible sigmoidoscopy during the measurement year or the four years prior OR
 - CT colonography during the measurement year or the four years prior OR
 - Fecal immunochemical test (FIT)-DNA during the measurement year or two years prior OR
 - Guaiac-based fecal occult blood test (gFOBT) or FIT during the measurement year
- **Childhood Immunization Status (Combo 10)***: The percentage of children 2 years of age who had all the following by their second birthday: Four diphtheria; Tetanus and acellular pertussis (DTaP); Three polio (IPV); One measles, mumps and rubella (MMR); Three haemophilus influenza type B (HiB); Three hepatitis B; One chicken pox (VZV); Four pneumococcal conjugate (PCV); One hepatitis A; Two or three rotavirus (RV); Two influenza vaccines.⁴

*HEDIS measure

BREAST CANCER SCREENING

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

[^]In 2019, the Other Purchasers population only included commercial patients.

**For this measure, MHCP includes both MCO and FFS as separation of the two is not available.

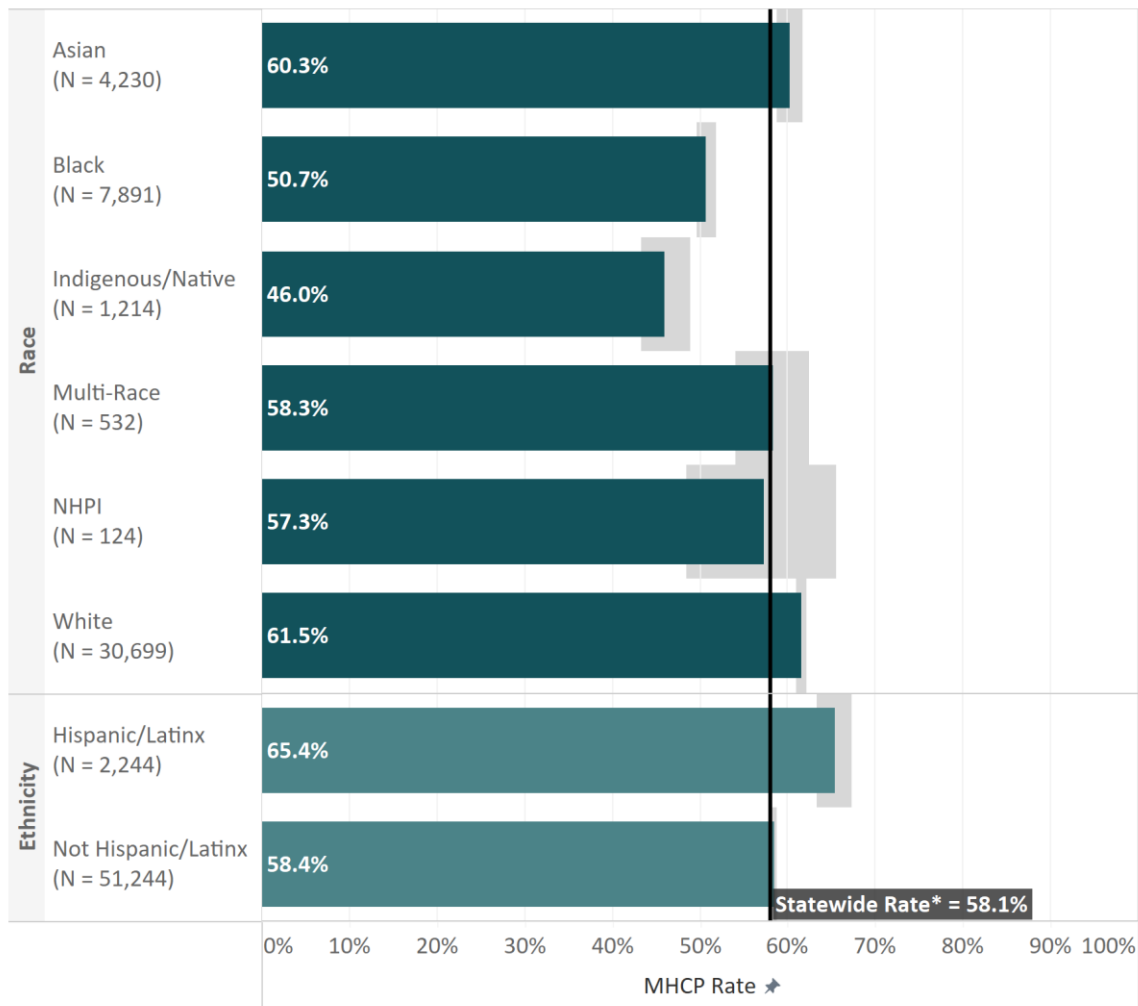
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Breast Cancer Screening rate for MHCP MCO patients remained stable.
- In 2023, there was a significant 21.6 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (58.1% and 79.7%, respectively).

BREAST CANCER SCREENING

MHCP Rates by Race/Ethnicity⁺

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

+ Stratification by Preferred Language and Country of Origin is not available for this measure. See Methodology appendix for more information.

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP population only. This measure does not allow for separation of managed care (MCO) and fee-for-service (FFS), so rate includes both.

Grey shading next to bars represents 95% confidence interval.

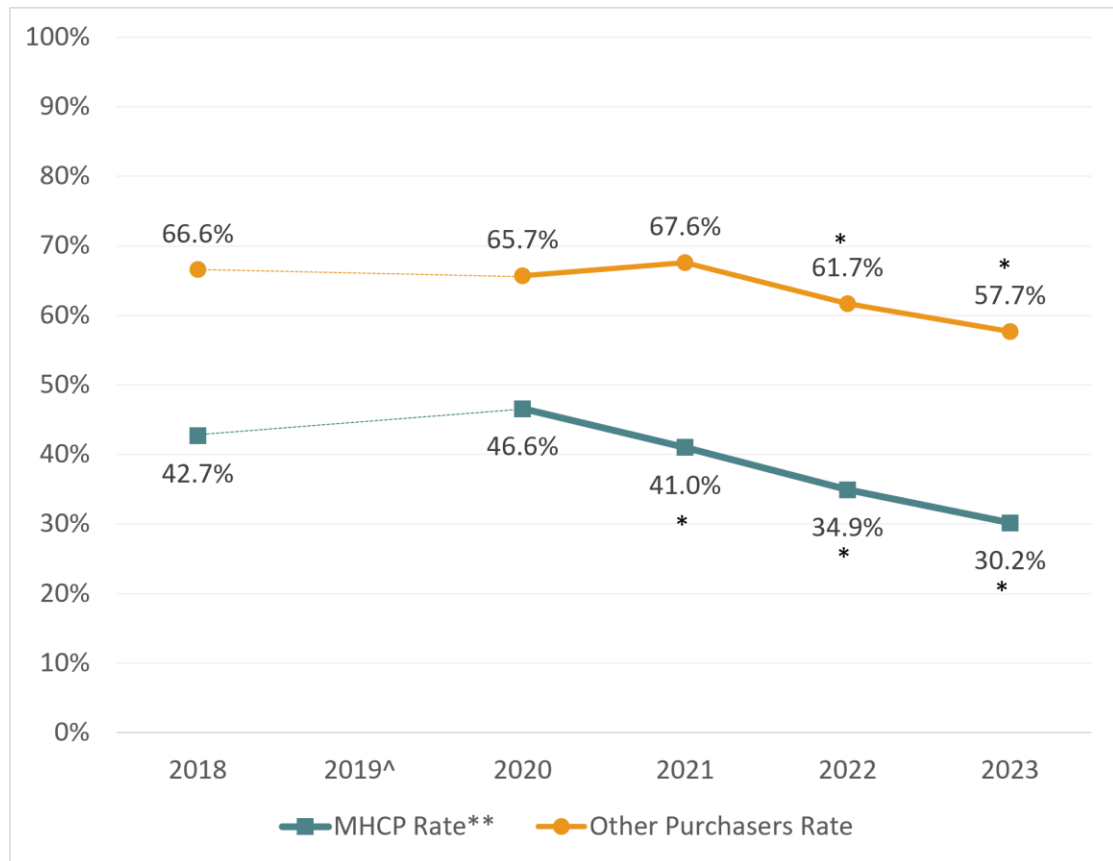
KEY TAKEAWAYS

Compared to the MHCP statewide rate, lower rates of screening were observed among patients who are Black or Indigenous/Native.

CHILDHOOD IMMUNIZATION STATUS (COMBO 10)

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year.

^Due to COVID-19 related interruptions, 2019 rates are not available for this measure.

**For this measure, MHCP includes both MCO and FFS as separation of the two is not available.

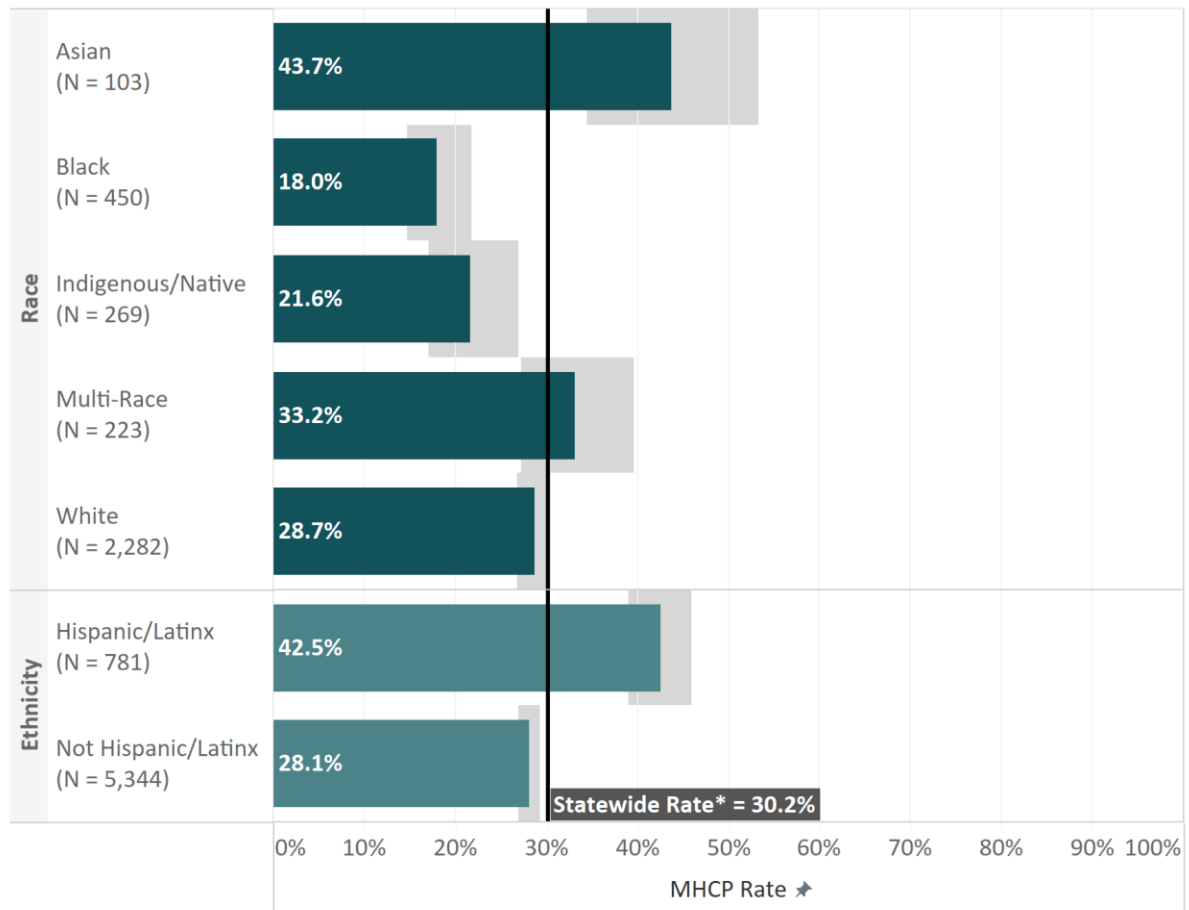
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Childhood Immunization Status (Combo 10) rate for MHCP MCO patients significantly decreased by 4.7 percentage points. This drop is not unique to the MHCP population, as a similar drop is shown in the Other Purchasers population as well. Additional analyses provided in MNMCM's [Health Care in Minnesota: Summary Report on Quality, Disparities, and Cost report](#).
- In 2023, there was a significant 27.5 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (30.2% and 57.7%, respectively).

CHILDHOOD IMMUNIZATION STATUS (COMBO 10)

MHCP Rates by Race/Ethnicity⁺

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander; this category had less than 60 patients for this measure, which is below the reporting threshold and so has been excluded from the chart above.

+ Stratification by Preferred Language and Country of Origin is not available for this measure. See Methodology appendix for more information.

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP population only. This measure does not allow for separation of managed care (MCO) and fee-for-service (FFS), so rate includes both.

Grey shading next to bars represents 95% confidence interval.

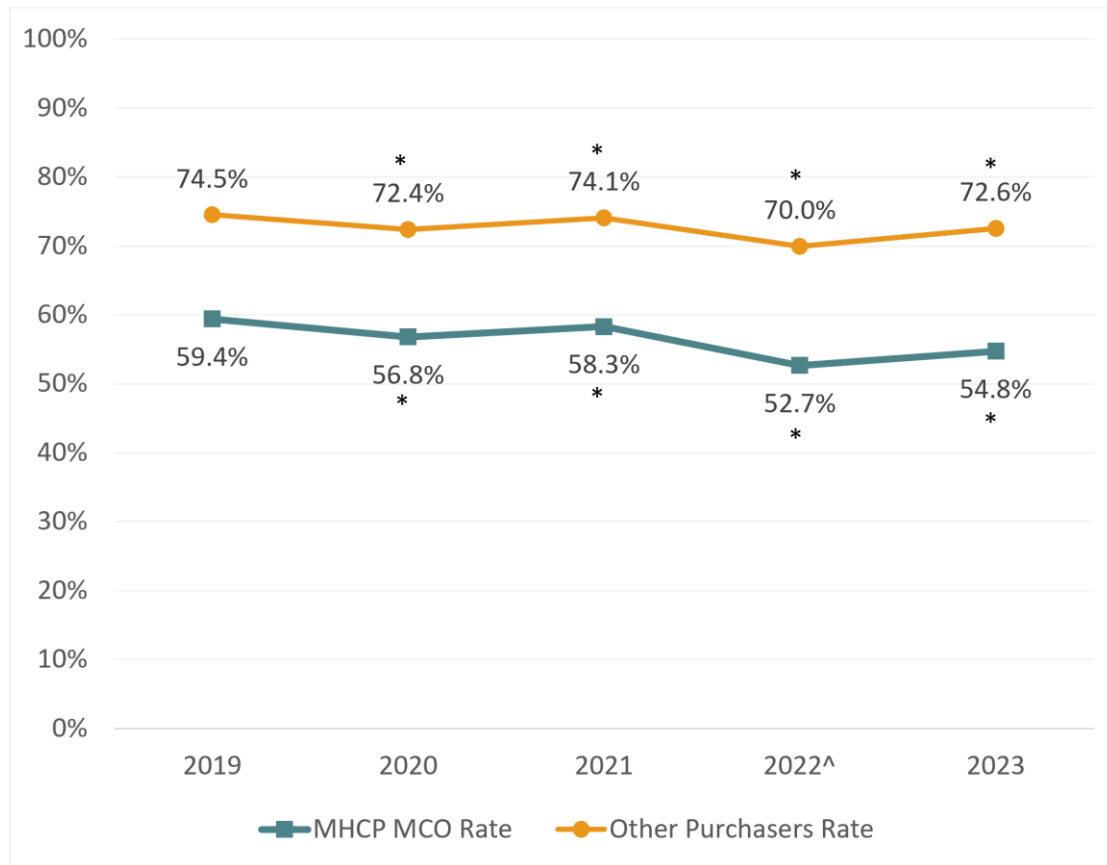
KEY TAKEAWAYS

Compared to the MHCP statewide rate, lower rates of immunizations were observed among patients who are Black or Indigenous/Native.

COLORECTAL CANCER SCREENING

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

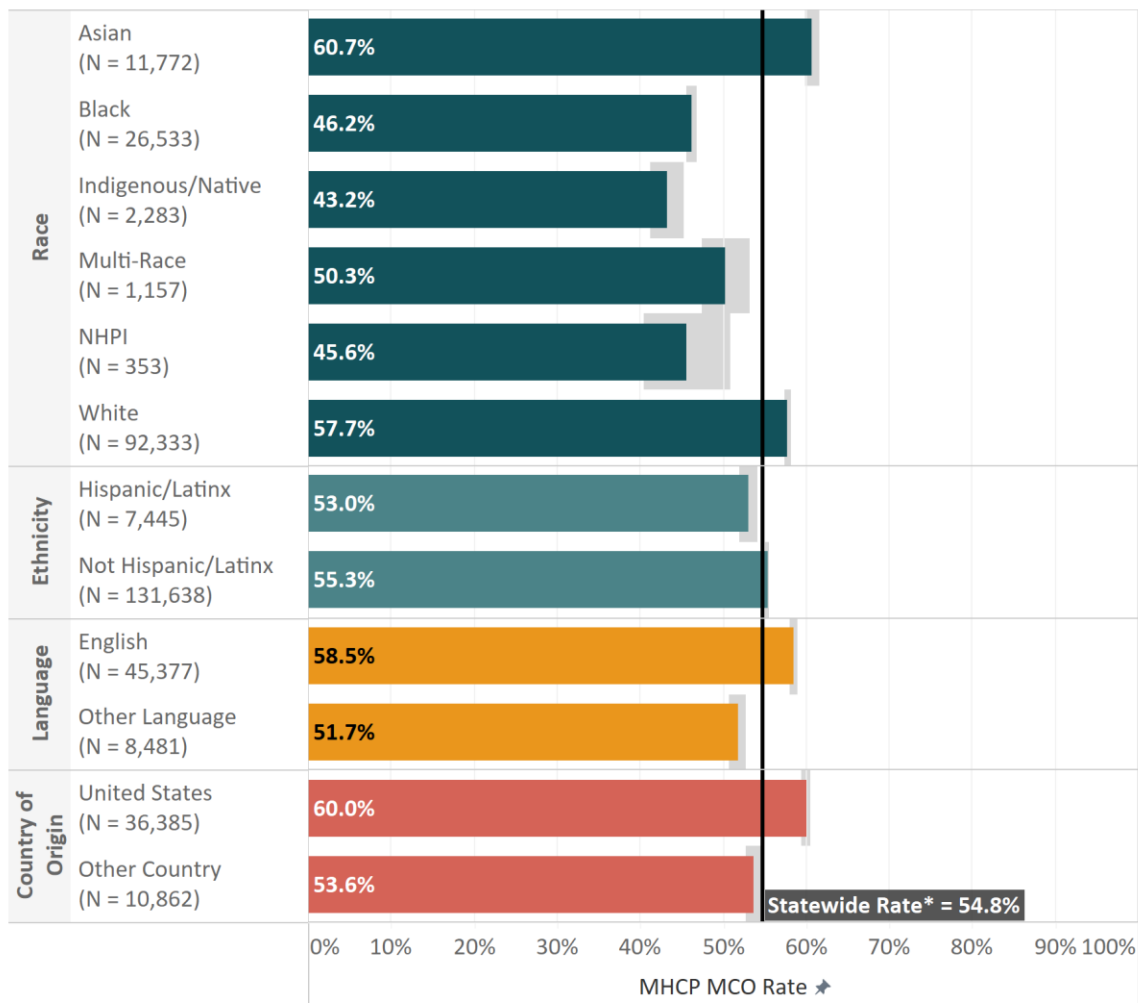
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Colorectal Cancer Screening rate for MHCP MCO patients significantly increased by 2.1 percentage points.
- In 2023, there was a significant 17.8 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (54.8% and 72.6%, respectively).

COLORECTAL CANCER SCREENING

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of screening were observed among patients who are Black, Indigenous/Native, Multi-Race, NHPI, and Hispanic/Latinx patients, as well as non-English speakers.

SECTION 3: CHRONIC CONDITIONS

The Centers for Disease Control & Prevention (CDC) estimates that approximately six in ten people in the United States have at least one chronic condition, and four in ten have two or more chronic conditions.⁵ Chronic conditions are the leading cause of death and disability in the United States and contributes to an estimated \$4.5 trillion annual health care costs.⁵ Optimal management of these conditions is crucial to improving health outcomes and reducing the overall burden on the healthcare system.

This section highlights three key areas of the management of chronic conditions: vascular health, diabetes care, and asthma control.

MEASURE DEFINITIONS

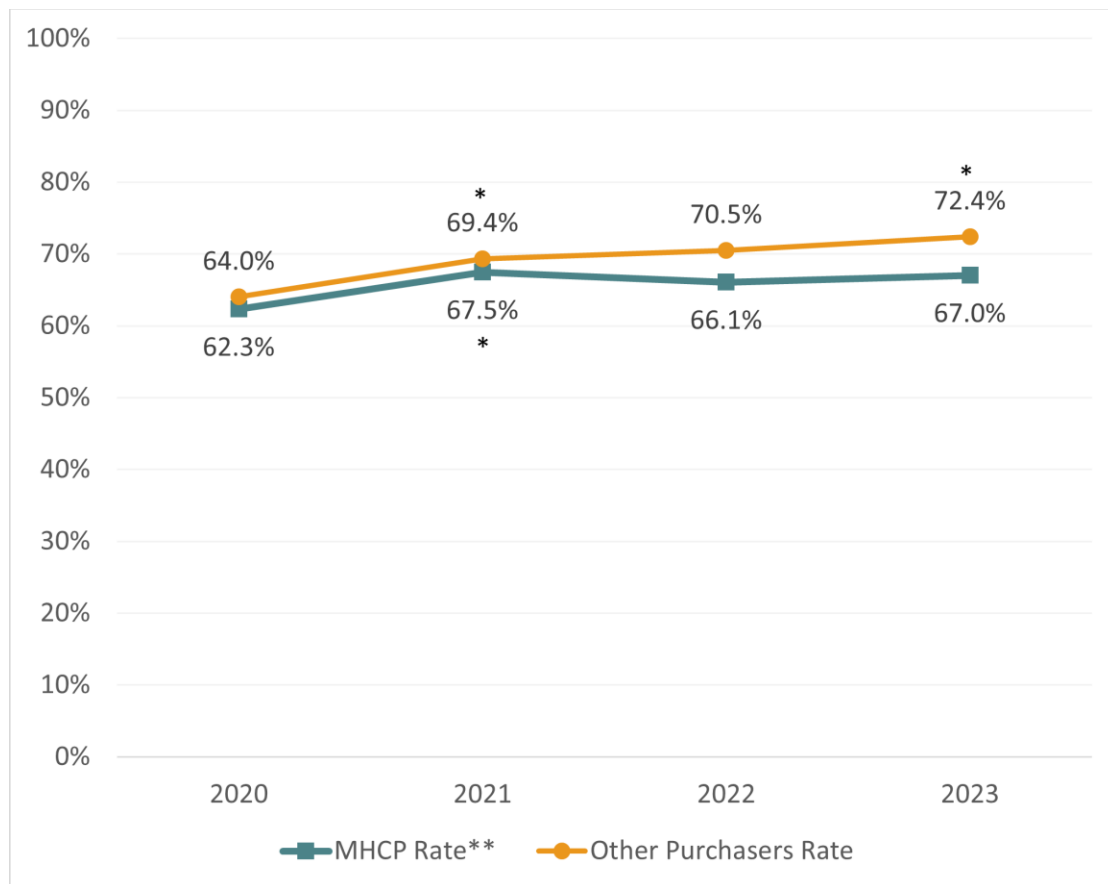
- **Controlling High Blood Pressure***: The percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.⁶
- **Optimal Diabetes Care**: The percentage of patients 18-75 years of age with diabetes (type 1 or 2) whose diabetes was optimally managed as defined as achieving ALL five of the following components:
 1. **HbA1c Control**: HbA1c less than 8.0 mg/mL
 2. **BP Control**: Blood pressure less than 140/90 mmHg
 3. **Daily Aspirin Use**: If patient has ischemic vascular disease, on a daily aspirin or antiplatelet, unless allowed contraindications or exceptions are present
 4. **Statin Use**: On a statin medication, unless allowed contraindications or exceptions are present
 5. **Tobacco-free**: Non-tobacco use
- **Optimal Vascular Care**: The percentage of patients 18-75 years of age with ischemic vascular disease (IVD) whose IVD was optimally managed as defined as achieving ALL four of the following components:
 1. **BP Control**: Blood pressure less than 140/90 mmHg
 2. **Daily Aspirin Use**: On a daily aspirin or antiplatelet, unless allowed contraindications or exceptions are present
 3. **Statin Use**: On a statin medication, unless allowed contraindications or exceptions are present
 4. **Tobacco-free**: Non-tobacco use
- **Optimal Asthma Control (Adults & Children)**: The percentage of adults (18-50 years of age) and children (5-17 years of age) who had a diagnosis of asthma and whose asthma was optimally controlled as defined by achieving both of the following:
 1. Asthma well-controlled as defined by the most recent asthma control tool result
 2. Patient not at risk of exacerbation (i.e., fewer than two emergency department visit and/or hospitalizations due to asthma in the last 12 months)

*HEDIS measure

CONTROLLING HIGH BLOOD PRESSURE

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

**For this measure, MHCP includes both MCO and FFS as separation of the two is not available.

NOTE: 2020 was the first available year of data using the current measure specifications

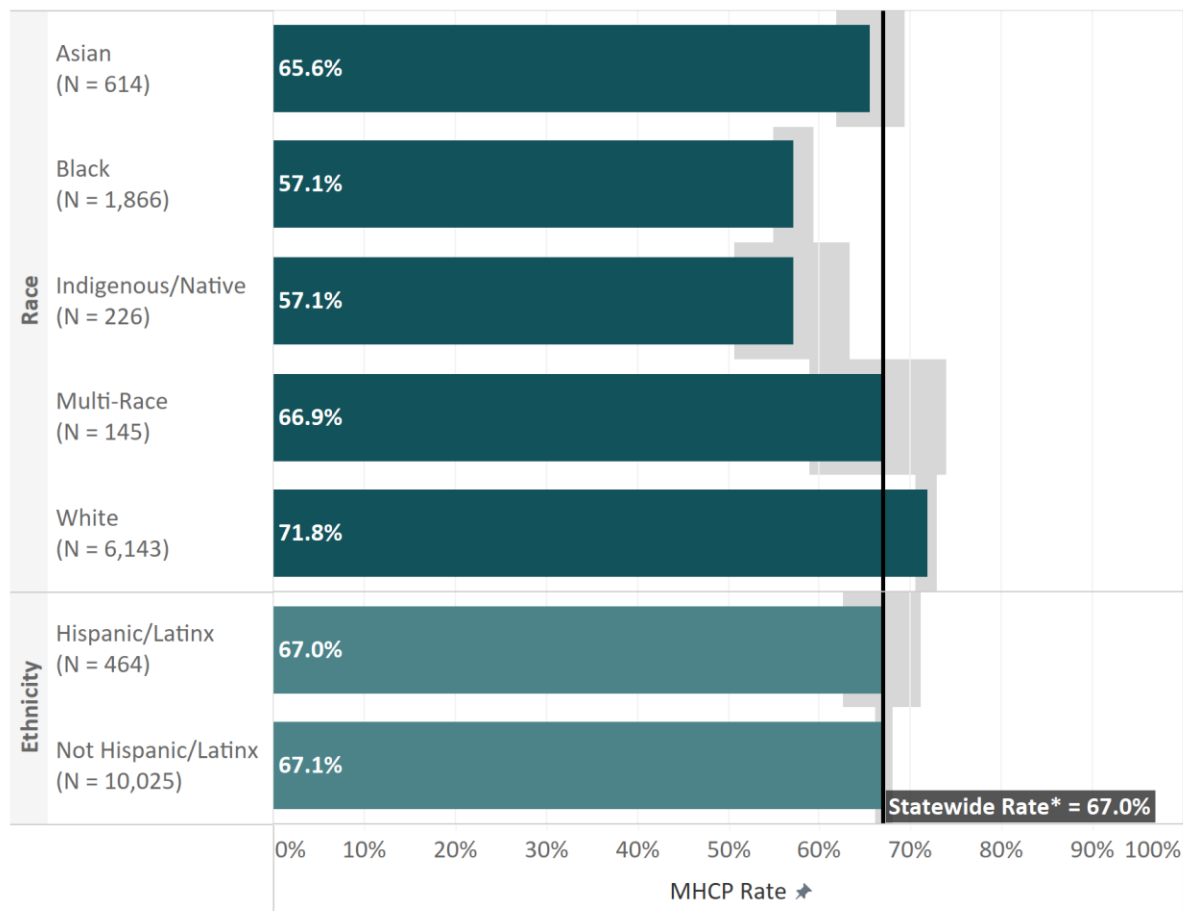
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Controlling High Blood Pressure rate for MHCP MCO patients remained stable.
- In 2023, there was a significant 5.4 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (67.0% and 72.4%, respectively).

CONTROLLING HIGH BLOOD PRESSURE

MHCP MCO Rates by Race/Ethnicity⁺

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander; this category had less than 60 patients for this measure, which is below the reporting threshold and so has been excluded from the chart above.

+ Stratification by Preferred Language and Country of Origin is not available for this measure. See Methodology appendix for more information.

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP population only. This measure does not allow for separation of managed care (MCO) and fee-for-service (FFS), so rate includes both.

Grey shading next to bars represents 95% confidence interval.

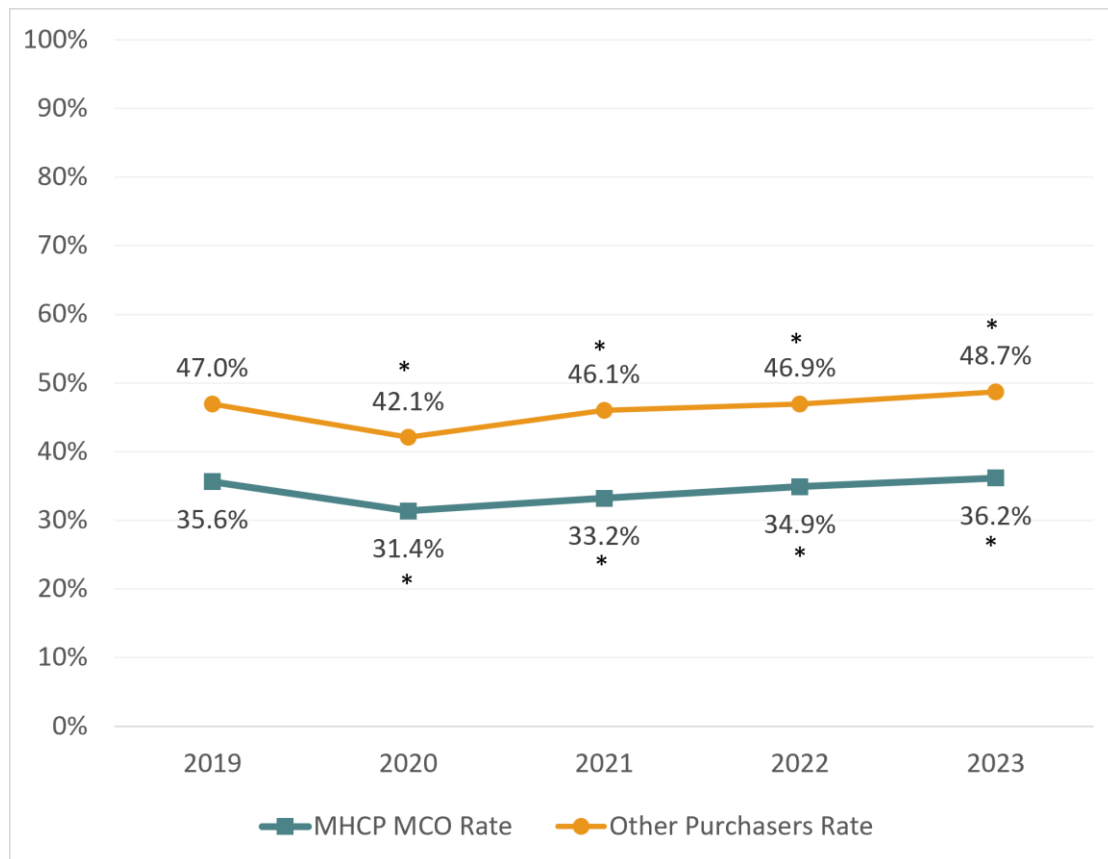
KEY TAKEAWAYS

Compared to the MHCP statewide rate, lower rates of blood pressure control were observed among patients who are Black or Indigenous/Native.

OPTIMAL DIABETES CARE

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2022 to 2023, the statewide Optimal Diabetes Care rate for MHCP MCO patients significantly increased by 1.3 percentage points.
- In 2023, there was a significant 12.5 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (36.2% and 48.7%, respectively).



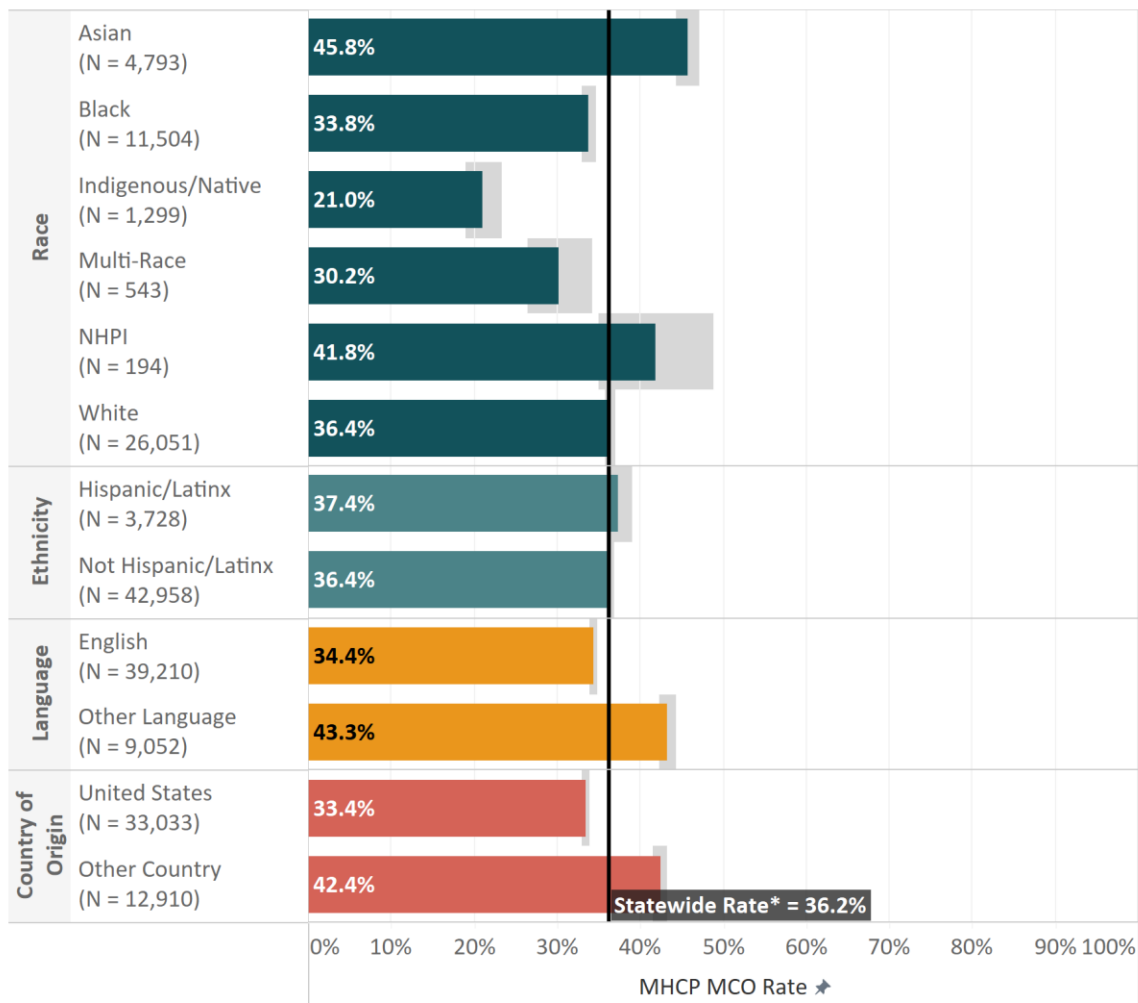
IMPROVEMENT SPOTLIGHT

Over the past five years, MCOs have been focusing improvement efforts on diabetes care as part of their performance improvement projects (PIPs). The steady increases in optimal care rates within the MHCP MCO population may be a result of these efforts.

OPTIMAL DIABETES CARE

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

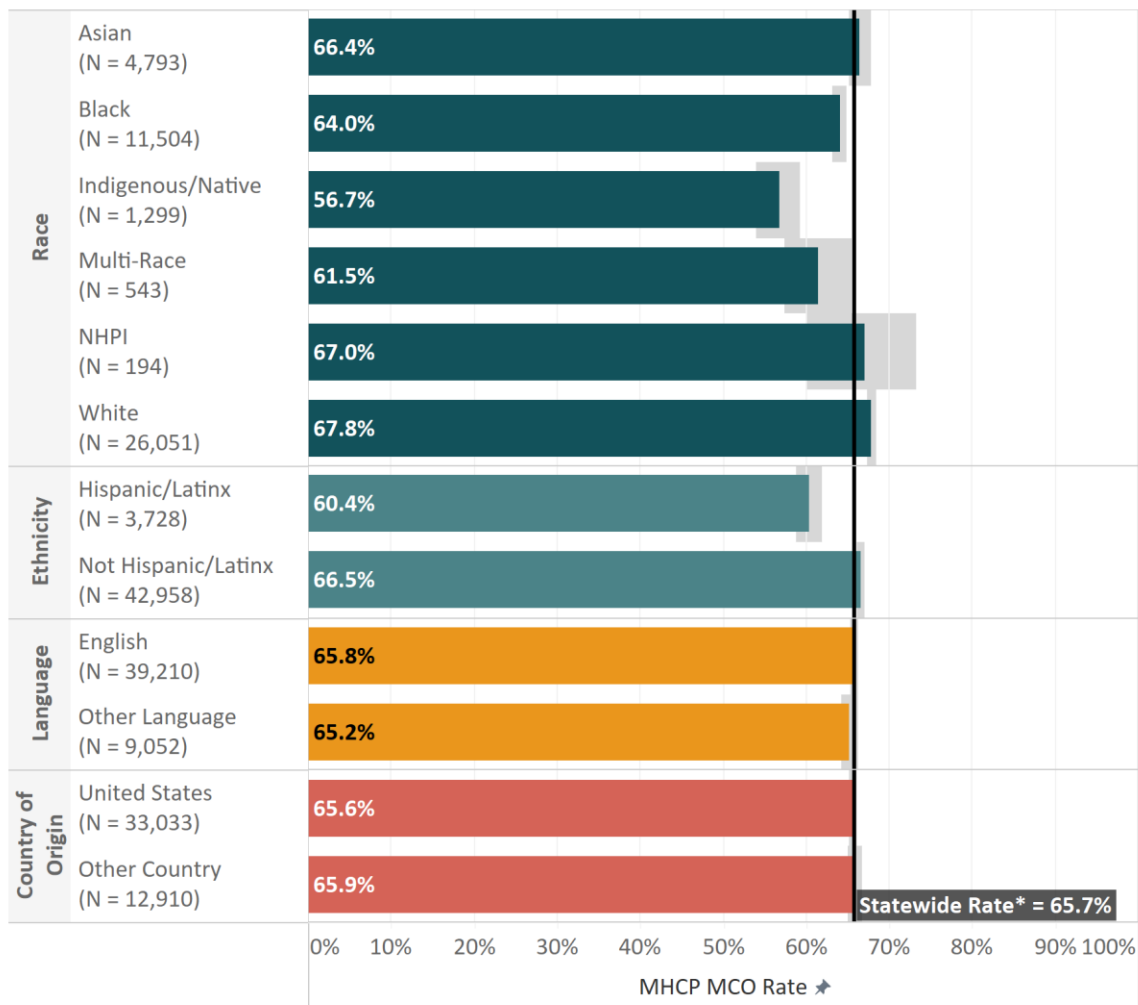
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of optimal care were observed among patients who are Black, Indigenous/Native or Multi-Race, as well as English-speakers and patients born in the United States.

OPTIMAL DIABETES CARE: HbA1c Control

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

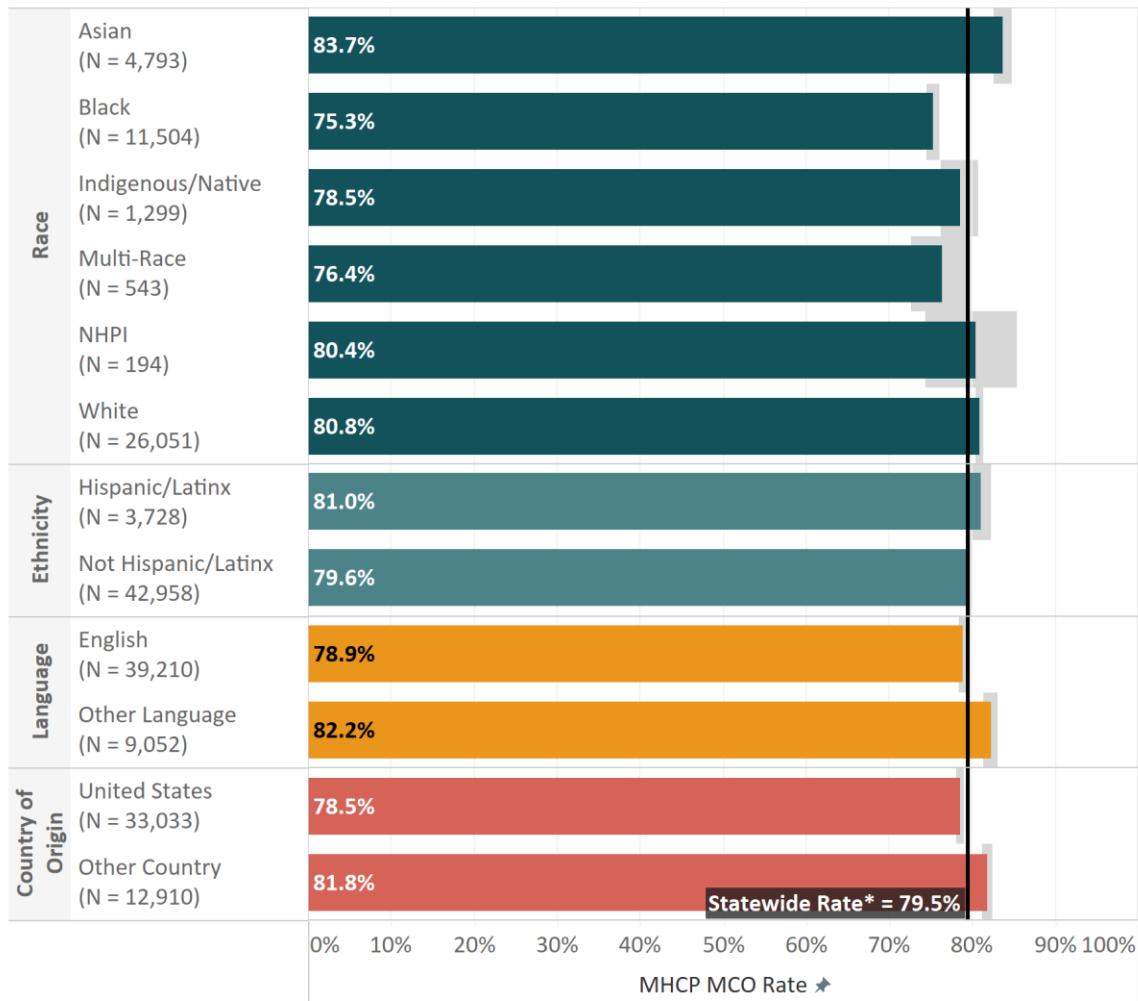
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of HbA1c control were observed among patients who are Black or Indigenous/Native, and Hispanic/Latinx patients.

OPTIMAL DIABETES CARE: BP Control

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

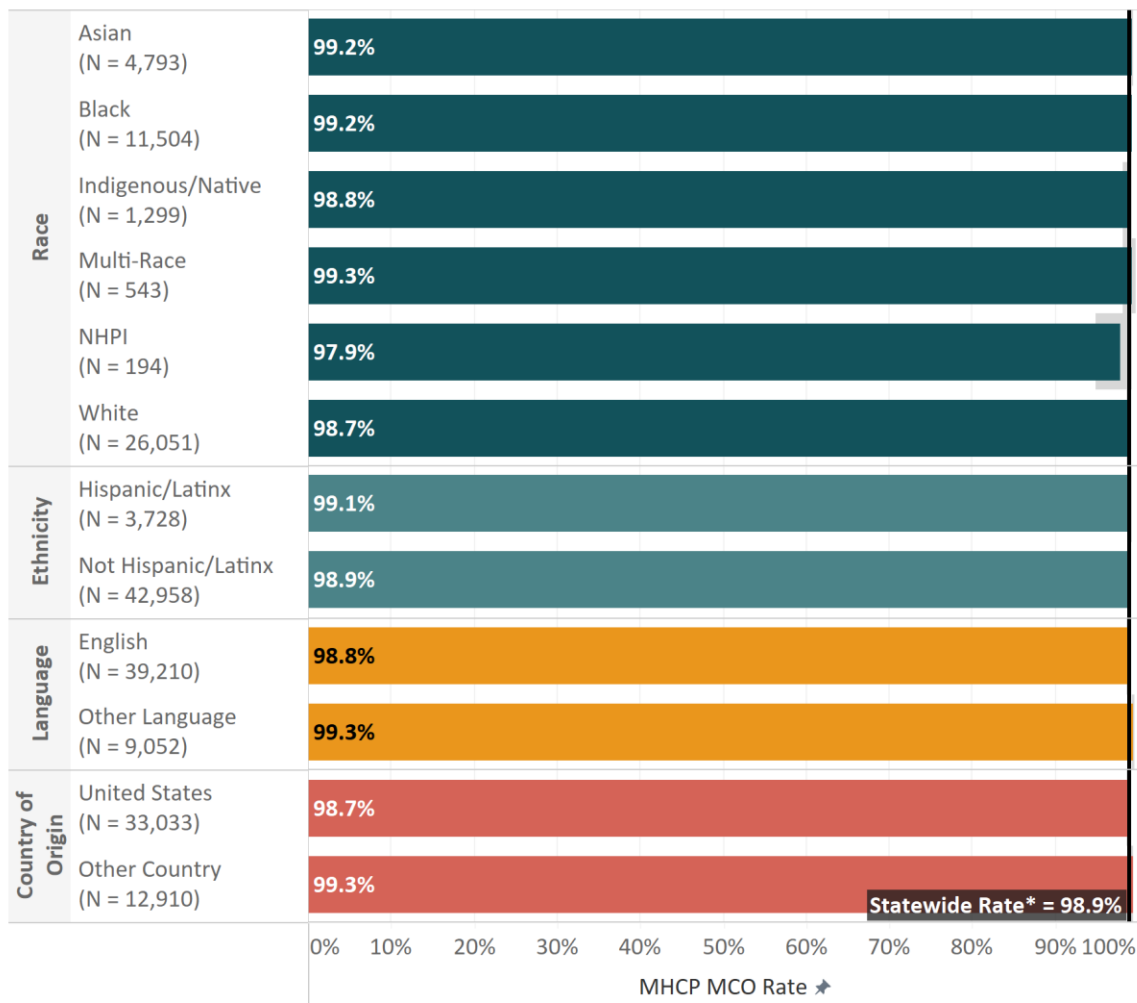
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of blood pressure control were observed among patients who are Black, and patients born in the United States.

OPTIMAL DIABETES CARE: Daily Aspirin Use

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

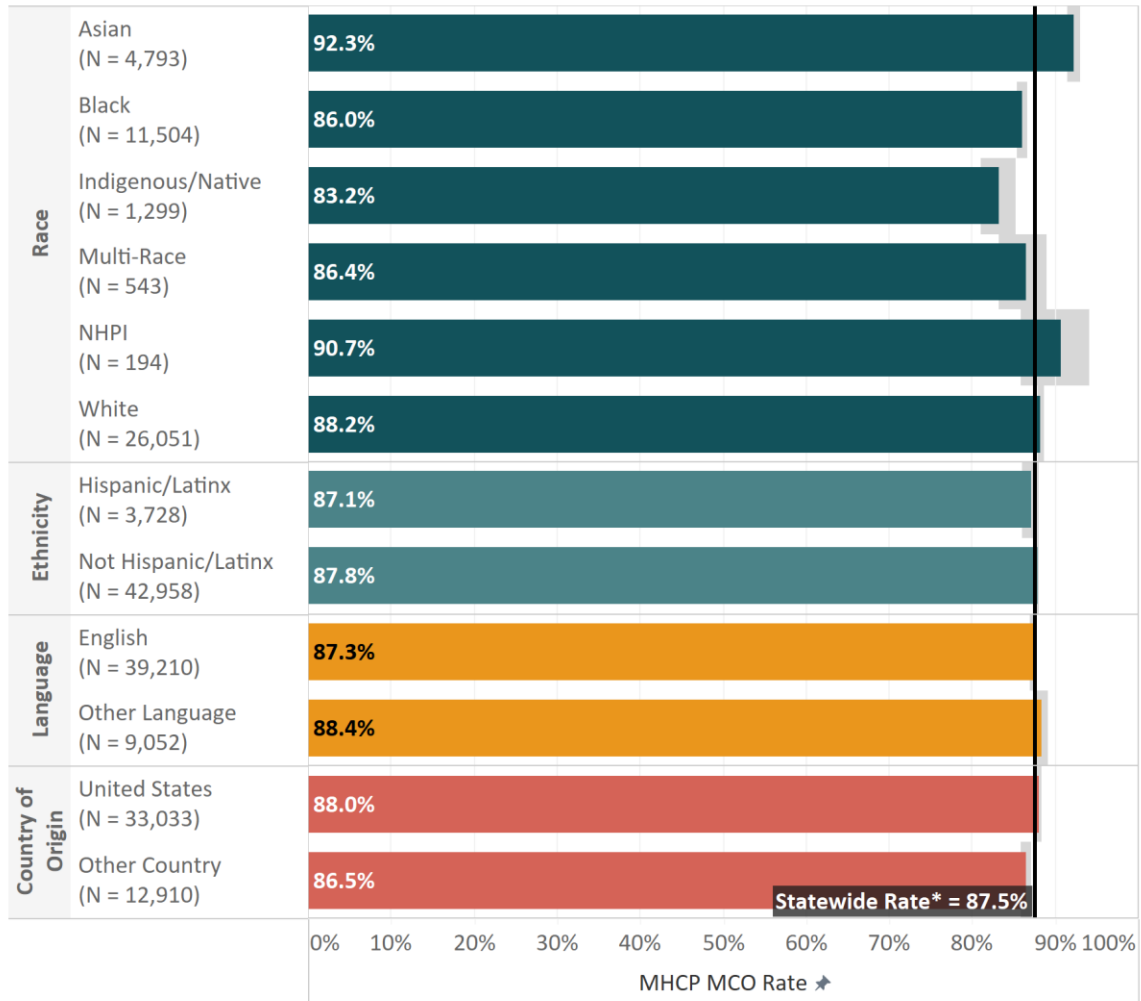
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, higher rates of aspirin use were observed among patients who are Black, non-English speakers, and patients born outside of the United States; all other groups had average rates.

OPTIMAL DIABETES CARE: Statin Use

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

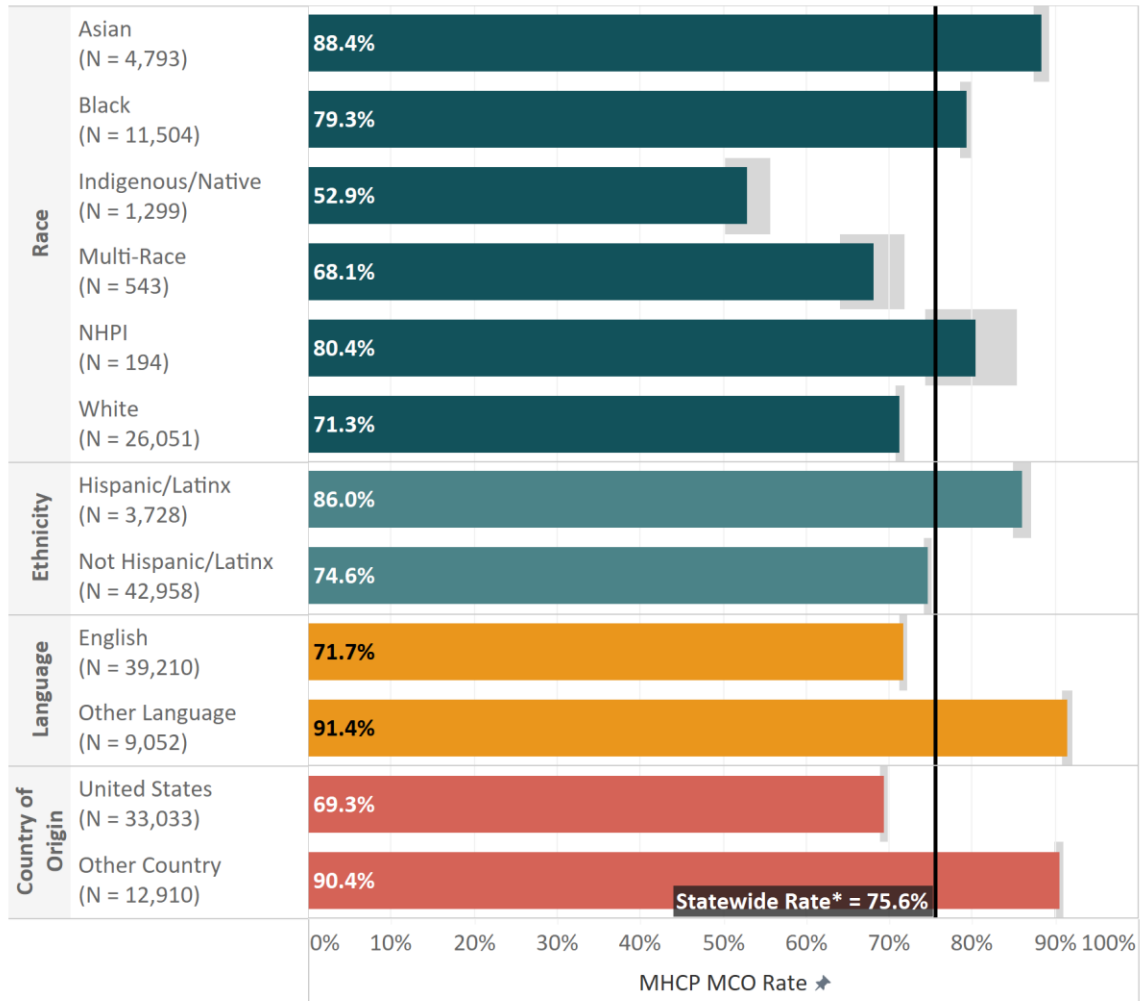
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of statin use were observed among patients who are Black or Indigenous/Native, as well as patients born outside of the United States.

OPTIMAL DIABETES CARE: Tobacco-free

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

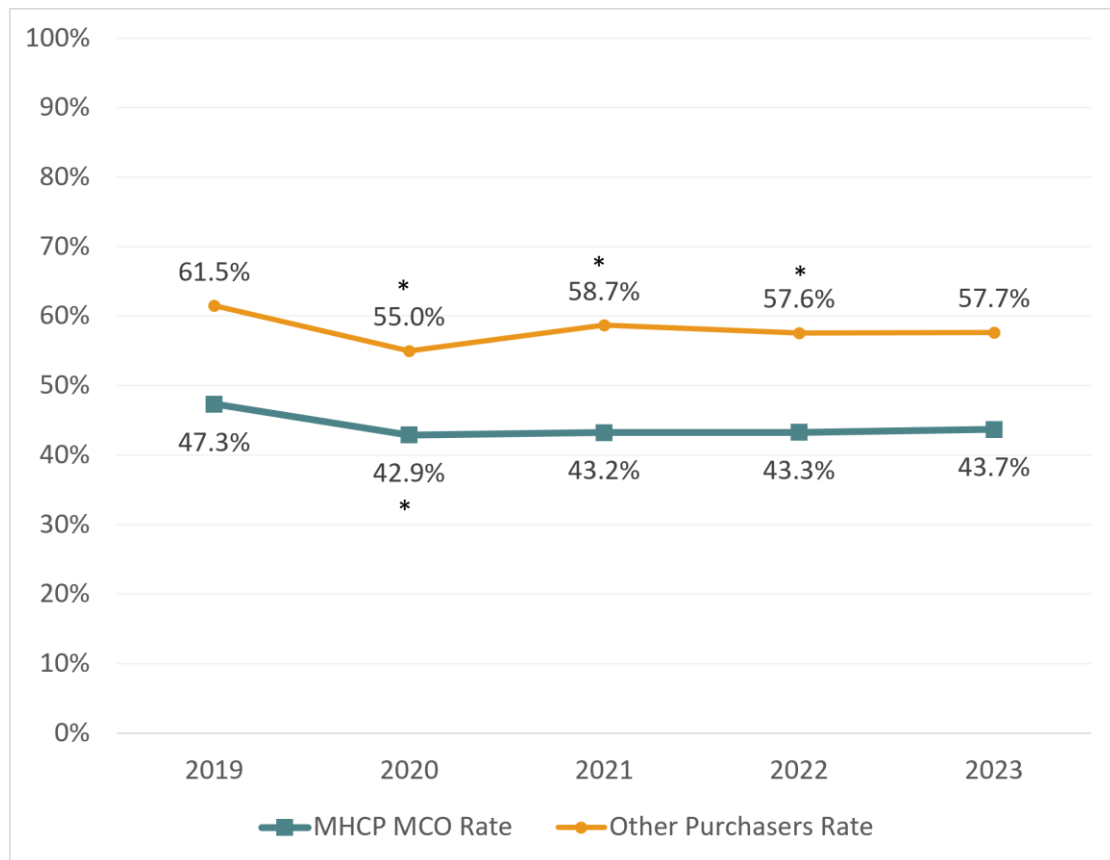
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of being tobacco-free were observed among patients who are Indigenous/Native, Multi-Race or White, non-Hispanic/Latinx patients, English-speakers, and patients born in the United States.

OPTIMAL VASCULAR CARE

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

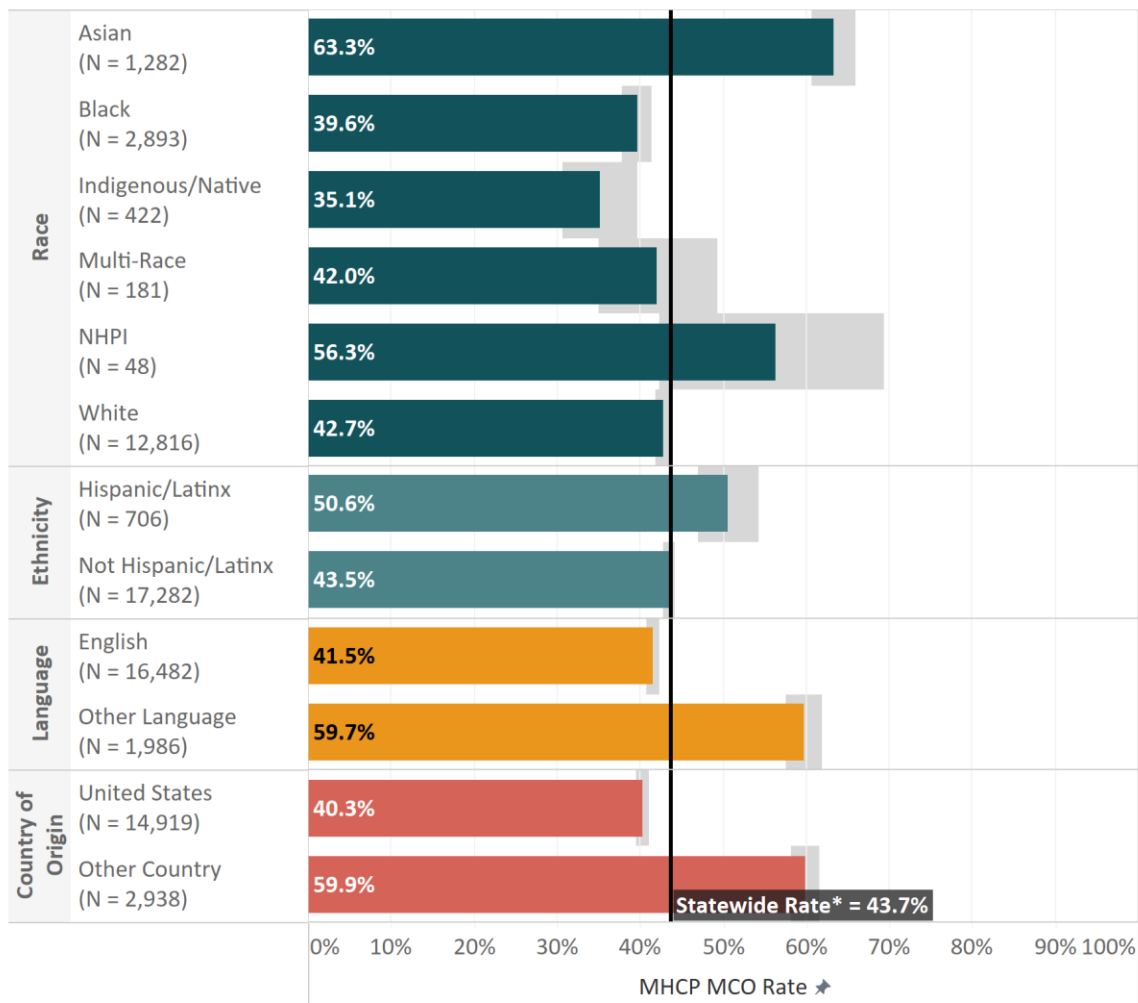
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Optimal Vascular Care rate for MHCP MCO patients remained stable.
- In 2023, there was a significant 14.0 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (43.7 and 57.7%, respectively).

OPTIMAL VASCULAR CARE

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

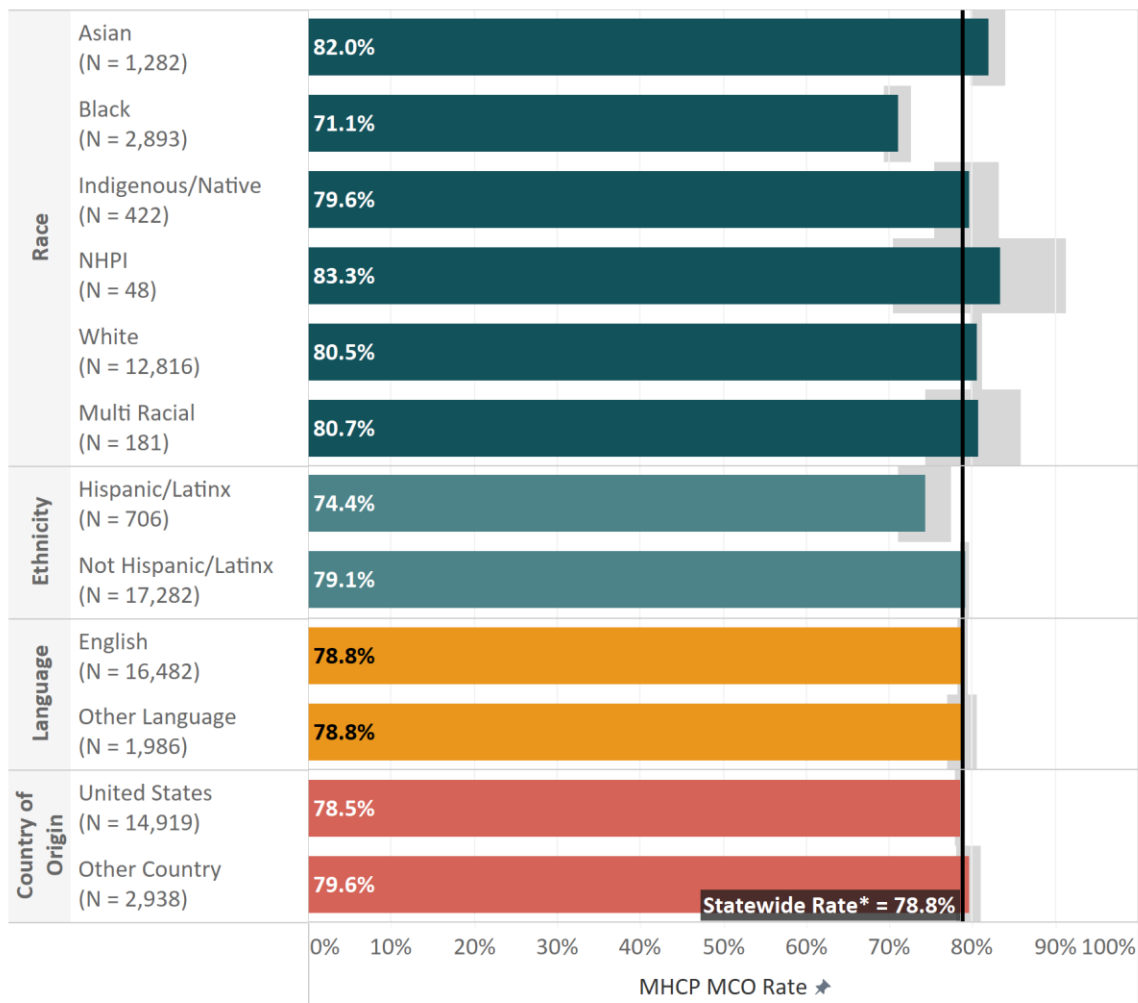
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of optimal care were observed among patients who are Black or Indigenous/Native, as well as English-speakers and patients born in the United States.

OPTIMAL VASCULAR CARE: BP Control

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

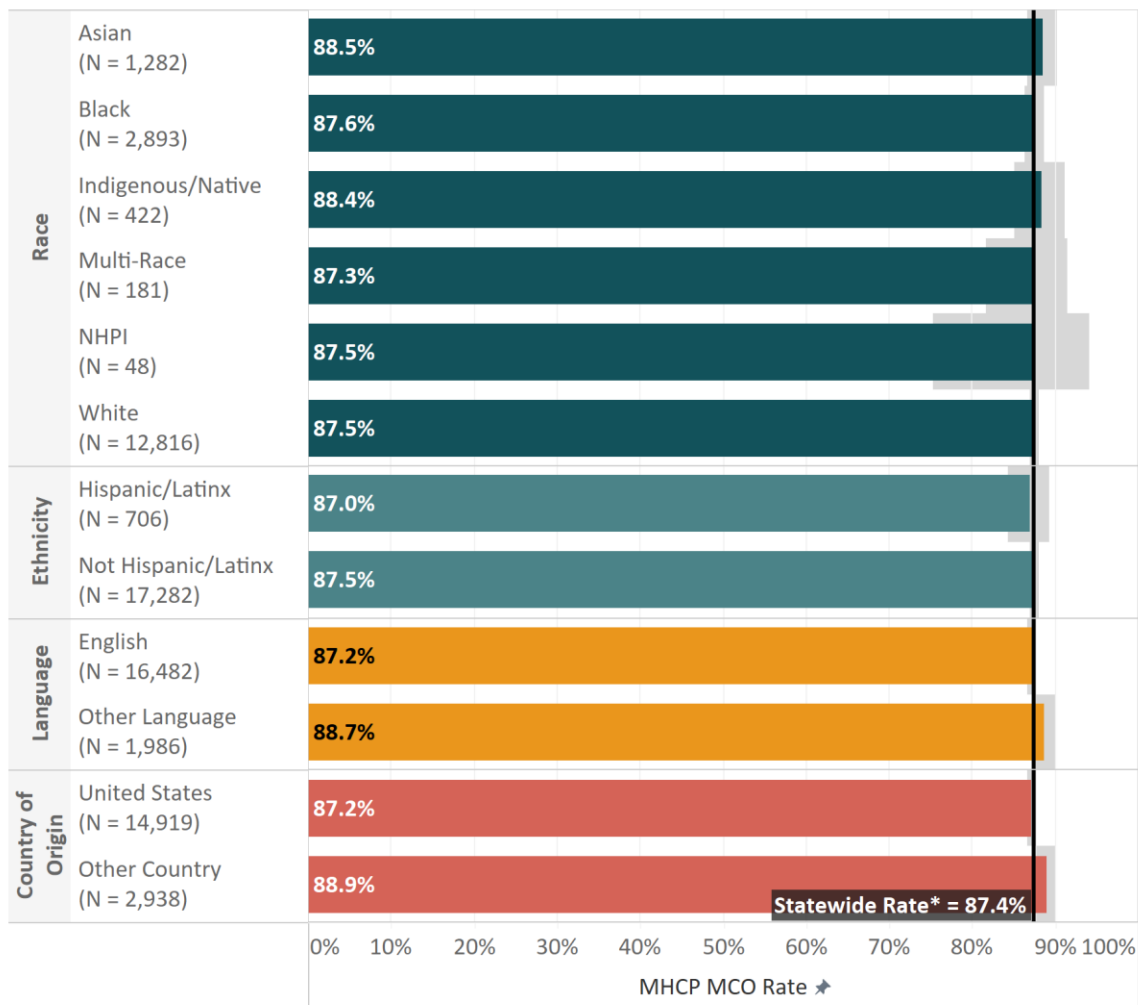
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of blood pressure control were observed among patients who are Black and Hispanic/Latinx patients.

OPTIMAL VASCULAR CARE: Daily Aspirin Use

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

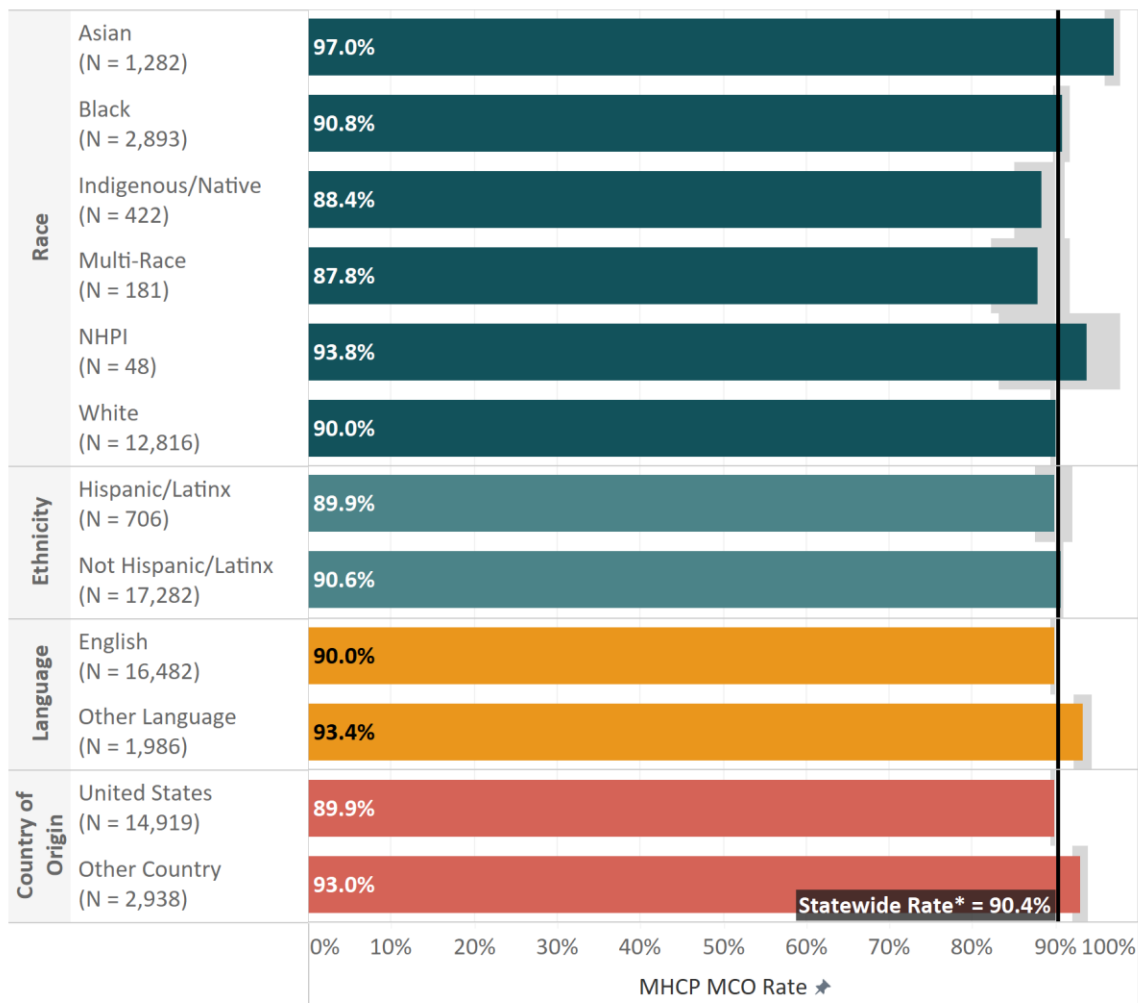
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, all groups had averages rates of aspirin use.

OPTIMAL VASCULAR CARE: Statin Use

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

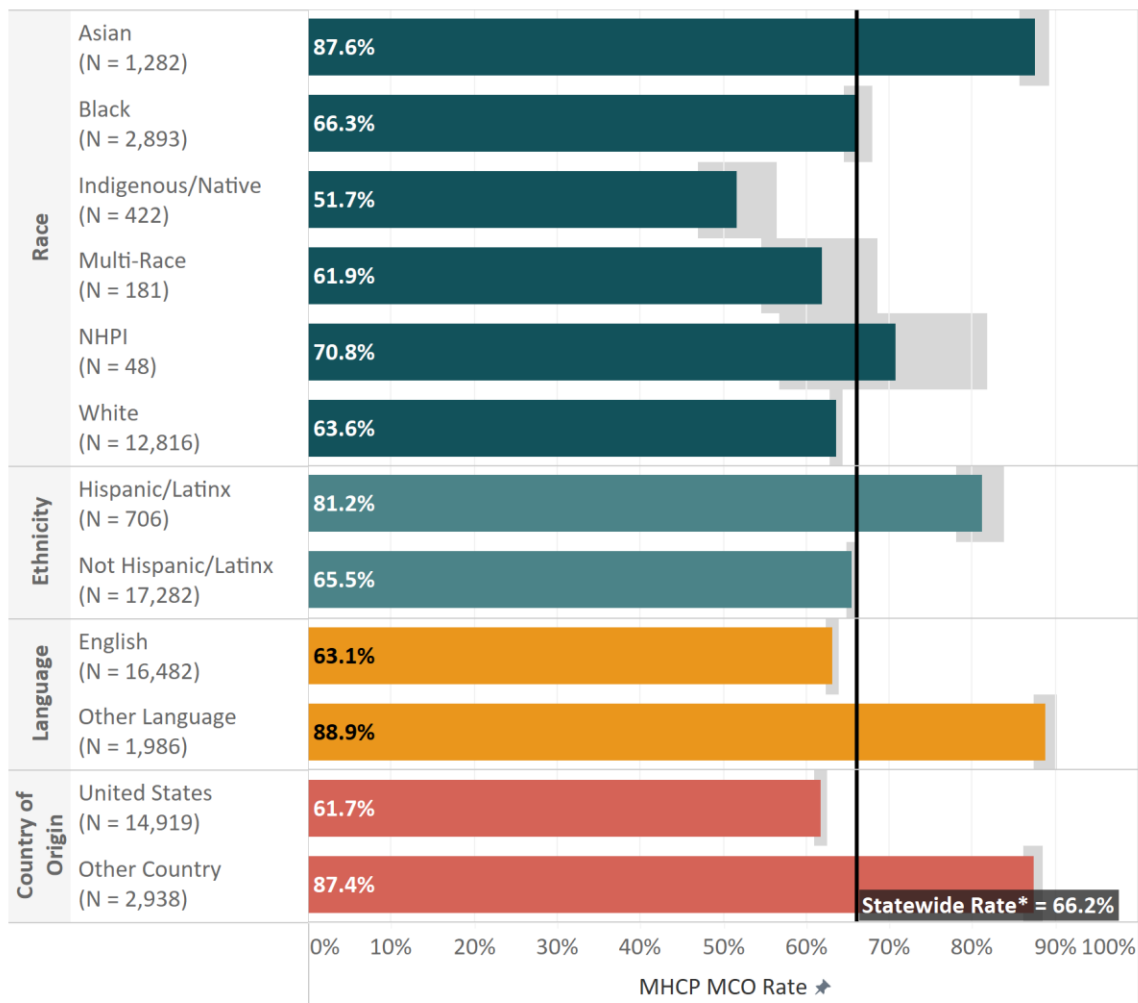
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, higher rates of statin use were observed among patients who are Asian, as well as non-English speakers and patients born outside of the United States.

OPTIMAL VASCULAR CARE: Tobacco-free

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

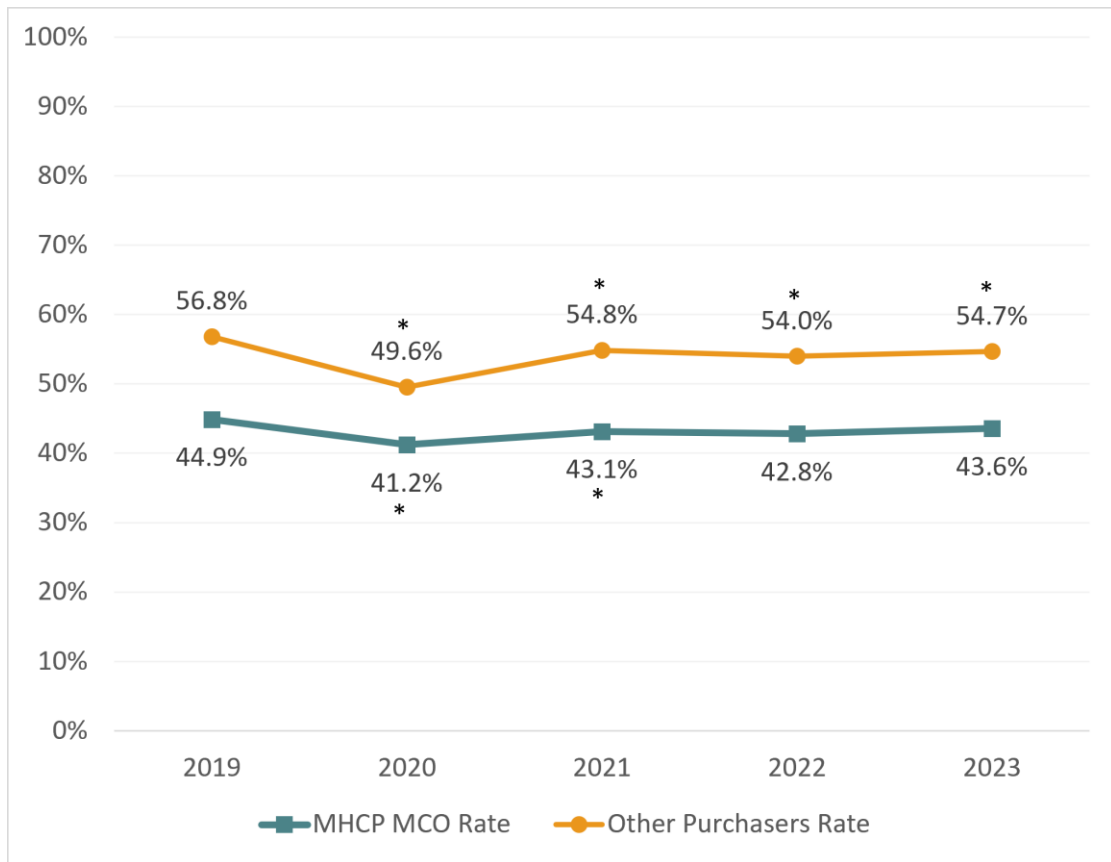
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of being tobacco-free were observed among patients who are Indigenous/Native or White, as well as English-speakers and patients born in the United States.

OPTIMAL ASTHMA CONTROL – ADULTS

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

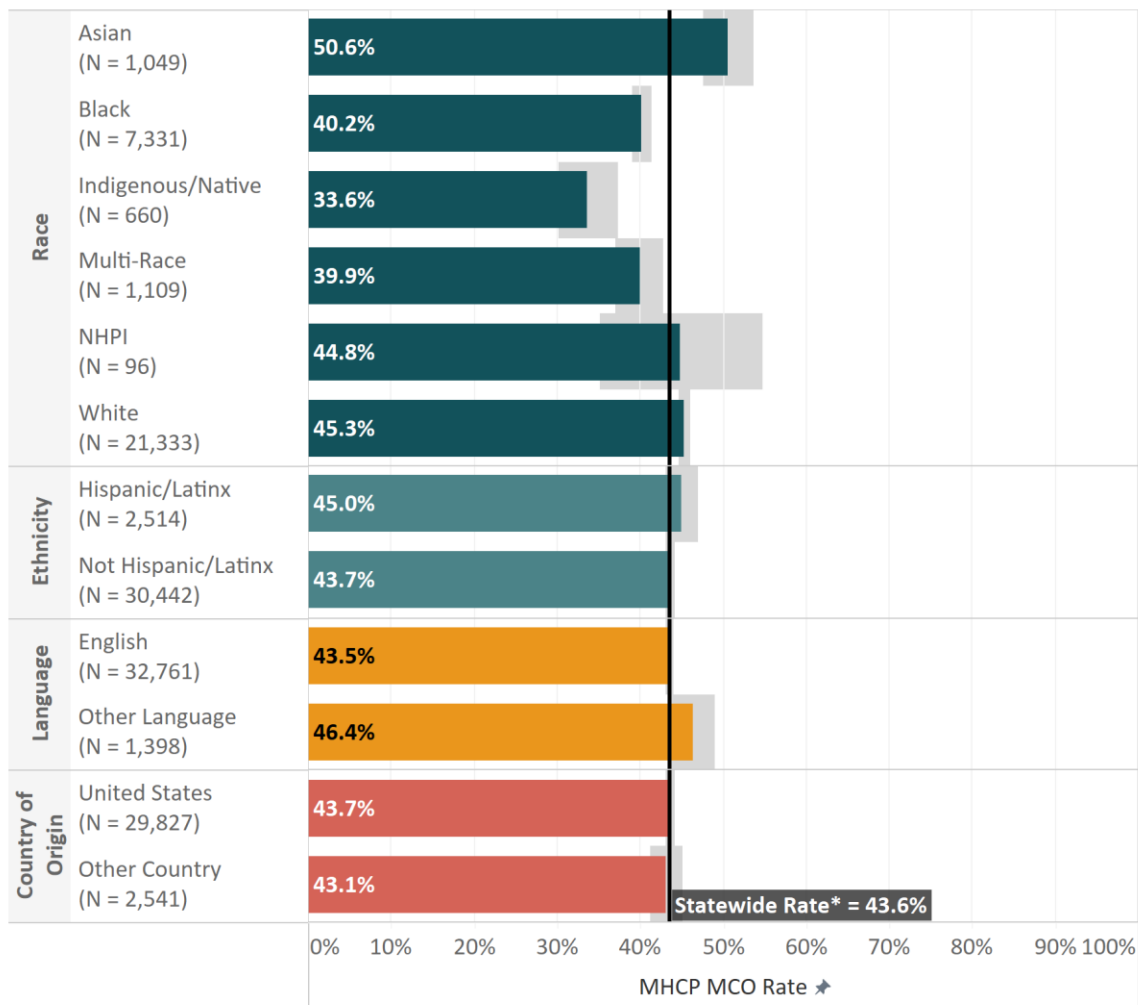
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Optimal Asthma Control – Adults rate for MHCP MCO patients remained stable.
- In 2023, there was a significant 11.1 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (43.6% and 54.7%, respectively).

OPTIMAL ASTHMA CONTROL – ADULTS

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

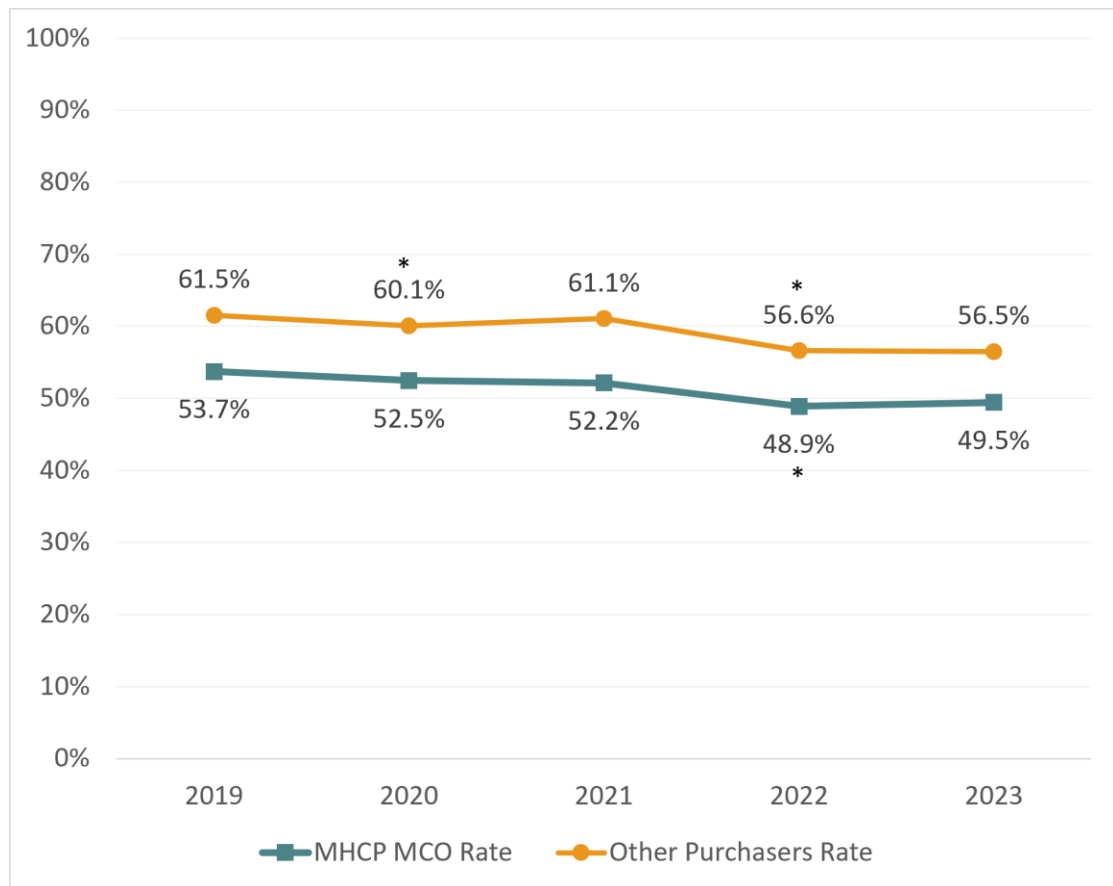
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of optimal control were observed among patients who are Black, Indigenous/Native or Multi-Race.

OPTIMAL ASTHMA CONTROL – CHILDREN

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

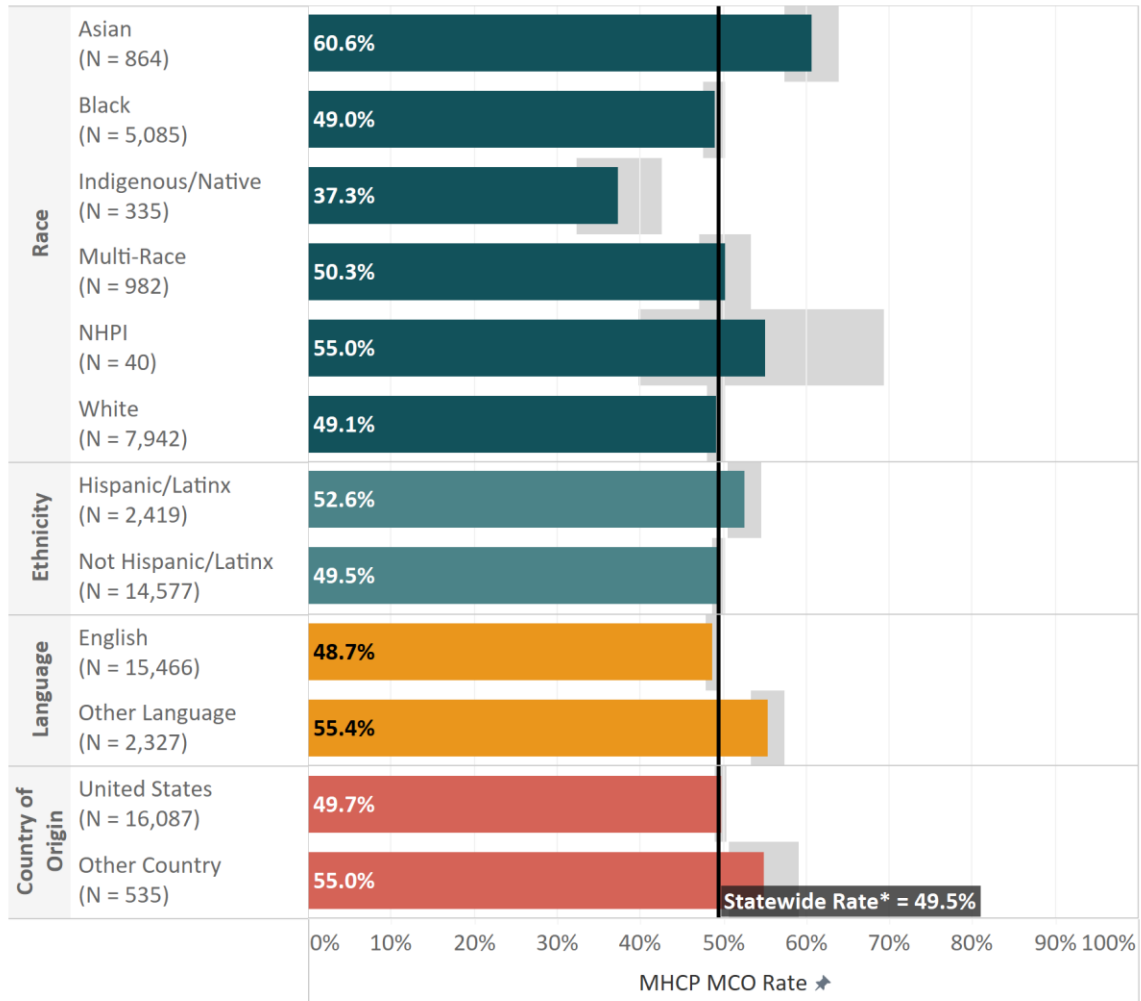
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Optimal Asthma Control – Children rate for MHCP MCO patients remained stable.
- In 2023, there was a significant 7.0 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (49.5% and 56.5%, respectively).

OPTIMAL ASTHMA CONTROL – CHILDREN

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of optimal control were observed among patients who are Indigenous/Native.

SECTION 4: MENTAL HEALTH

The National Alliance on Mental Illness (NAMI) estimates that approximately one in five adults and one in six children (ages 6-17) in the United States experience a mental health disorder each year.⁷ In 2020, around 8.4% of the adult population in the United States reported experiencing at least one depressive episode, positioning depression as a significant contributor to the overall mental health burden in the United States.⁸ The PHQ-9 tool can be used not only to screen for depression, but to also monitor depression symptoms, inform treatment, and improve patient outcomes, especially when paired with collaboration across the health care team.⁹

Nationally, the rates of response and remission remain low. NCQA adapted MNMCM's suite of depression measure and reported that in 2023, approximately 9.2% of Medicaid HMOs, 11.3% of Medicare HMOs, and 10.9% of commercial HMOs achieved a response to treatment in six months. Remission rates were also low, with 5.9 % of Medicaid HMOs, 7.6% of Medicare HMOs, and 6.3% of commercial HMOs achieving remission at six months.⁹

This section emphasizes two critical areas for advancing mental health: adolescent screening and follow-up care, response, and remission for both adults and adolescents.

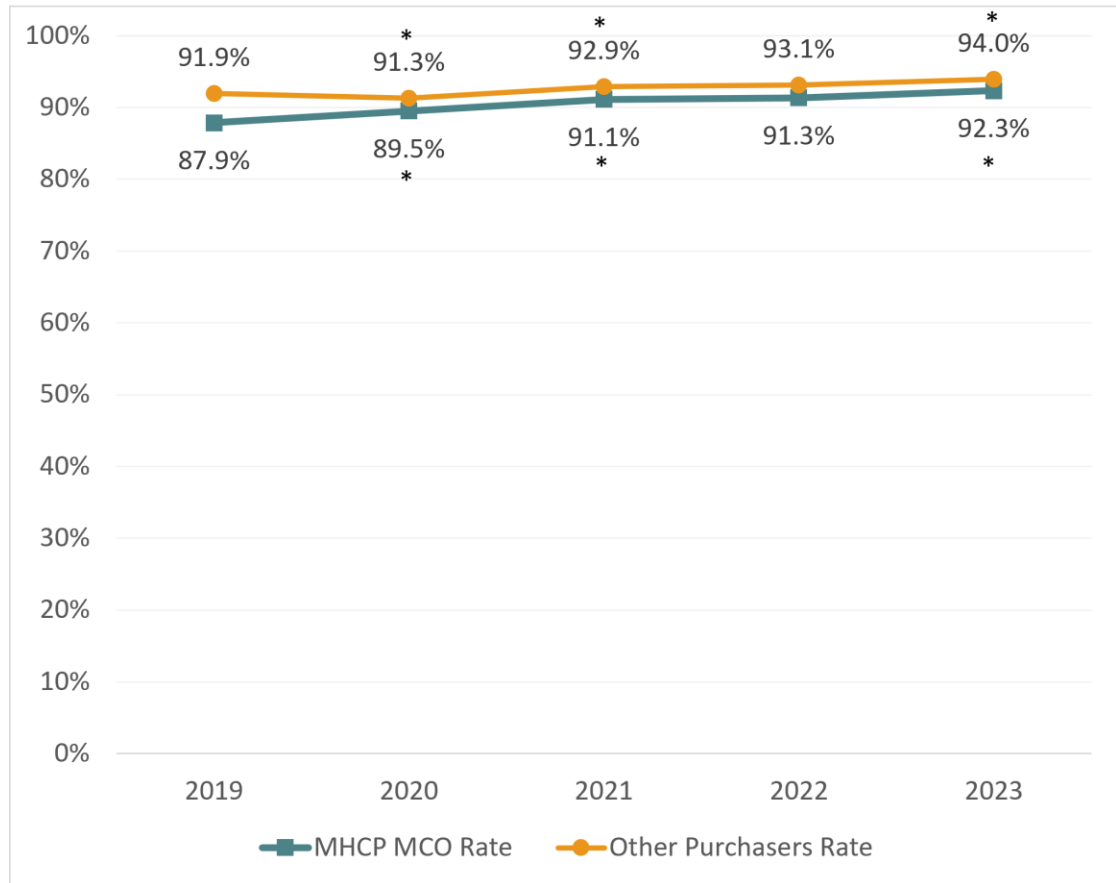
MEASURE DEFINITIONS

- **Adolescent Mental Health and/or Depression Screening:** The percentage of patients ages 12-17 who were screened for mental health and/or depression at using one of the specified tools during the measurement period.
- **Adolescent Depression Suite:** The percentage of adolescent patients (age 12-17) with depression who:
 - Have a completed PHQ-9/9M tool within 6/12 months after the index event (+/- 60 days). ([Follow-up PHQ-9/9M at Six/12 Months](#))
 - Demonstrated a response to treatment (at least 50 percent improvement on PHQ-9/9M tool) 6/12 months after the index event (+/- 60 days). ([Response at Six/12 Months](#))
 - Reached remission (PHQ-9/9M score less than 5) 6/12 months after the index event (+/- 60 days). ([Remission at Six/12 Months](#))
- **Adult Depression Suite:** The percentage of adult patients (age 18 years and older) with depression who:
 - Have a completed PHQ-9/9M tool within 6/12 months after the index event (+/- 60 days). ([Follow-up PHQ-9/9M at Six/12 Months](#))
 - Demonstrated a response to treatment (at least 50 percent improvement) 6/12 months after the index event (+/- 60 days). ([Response at Six/12 Months](#))
 - Reached remission (PHQ-9/9M score less than 5) 6/12 months after the index event (+/- 60 days). ([Remission at Six/12 Months](#))

ADOLESCENT MENTAL HEALTH SCREENING

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

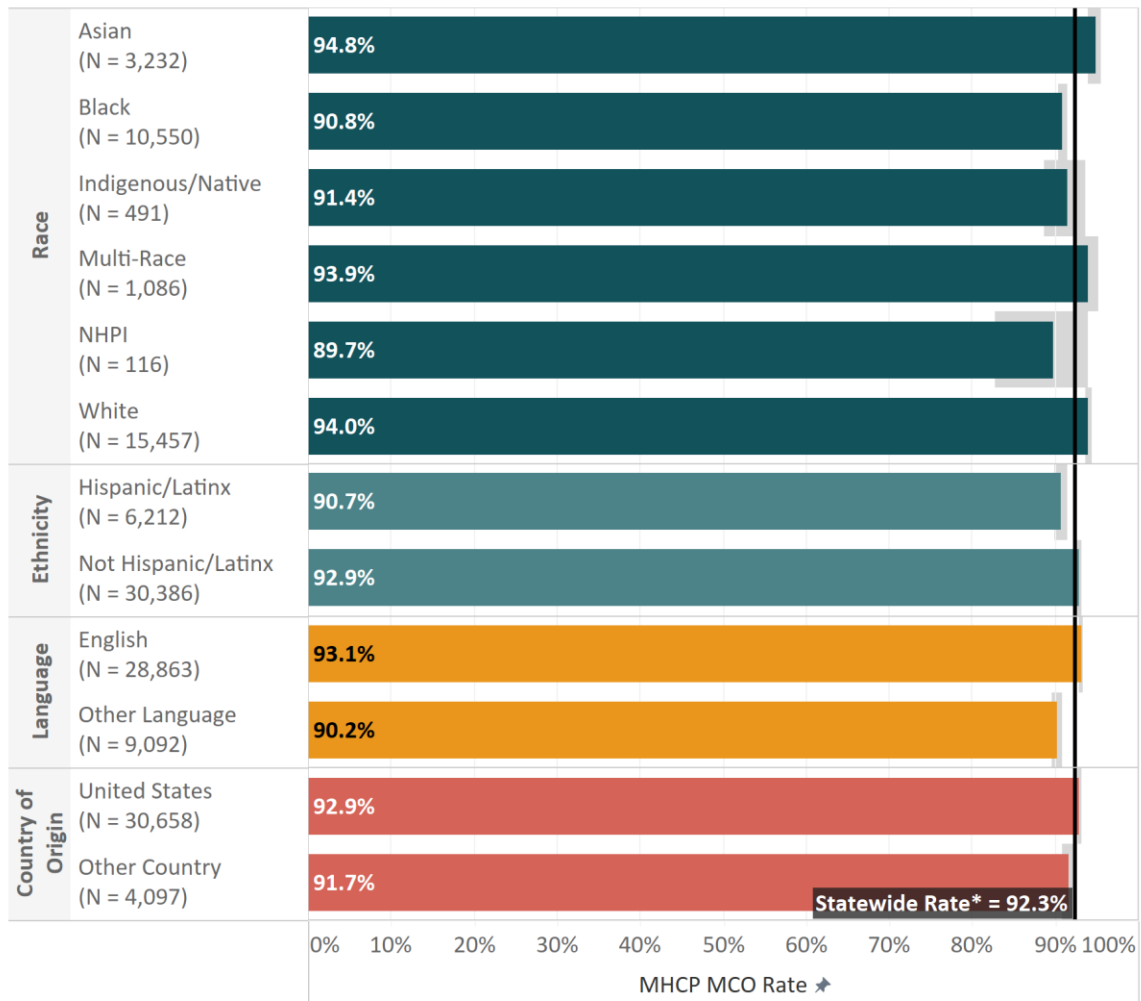
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Adolescent Mental Health Screening rate for MHCP MCO patients significantly increased by 1.0 percentage point.
- In 2023, there was a significant 1.7 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (92.3% and 94.0%, respectively).

ADOLESCENT MENTAL HEALTH SCREENING

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

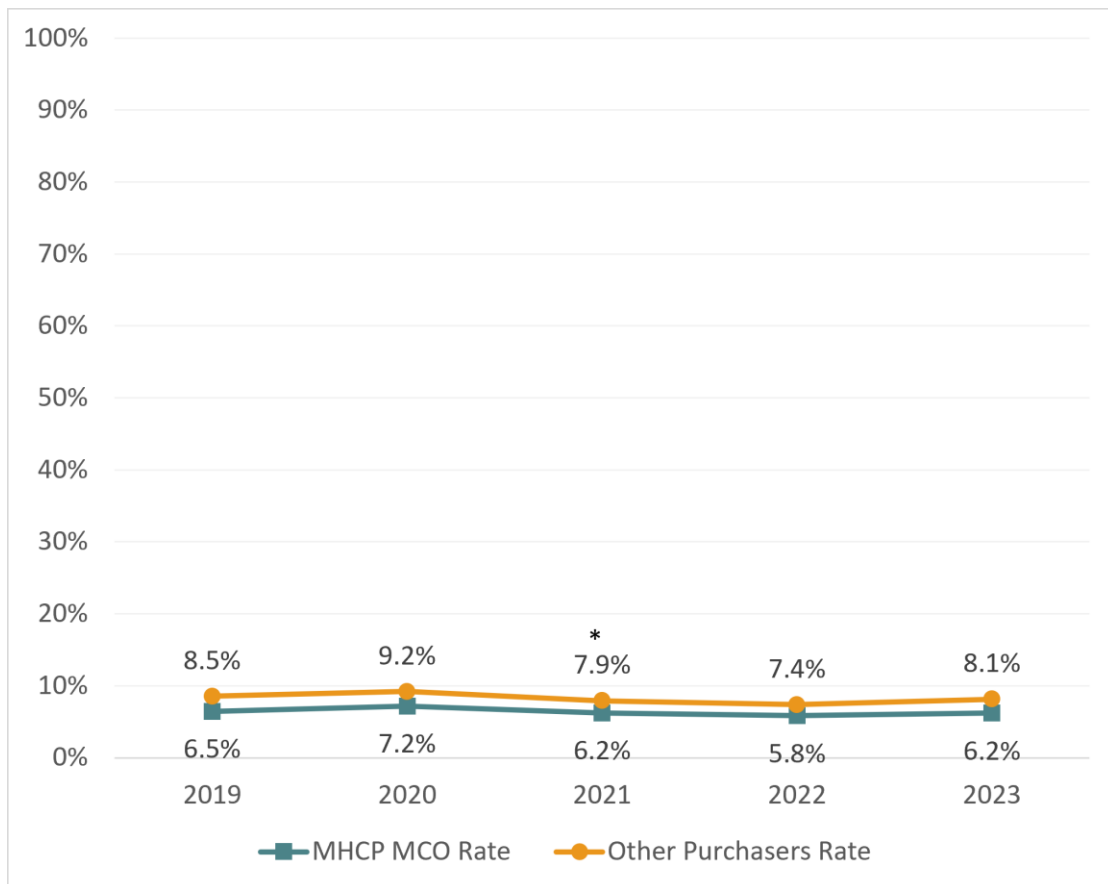
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, lower rates of screening were observed among patients who are Black, Hispanic/Latinx patients, and non-English speakers.

ADOLESCENT DEPRESSION: REMISSION AT SIX MONTHS

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

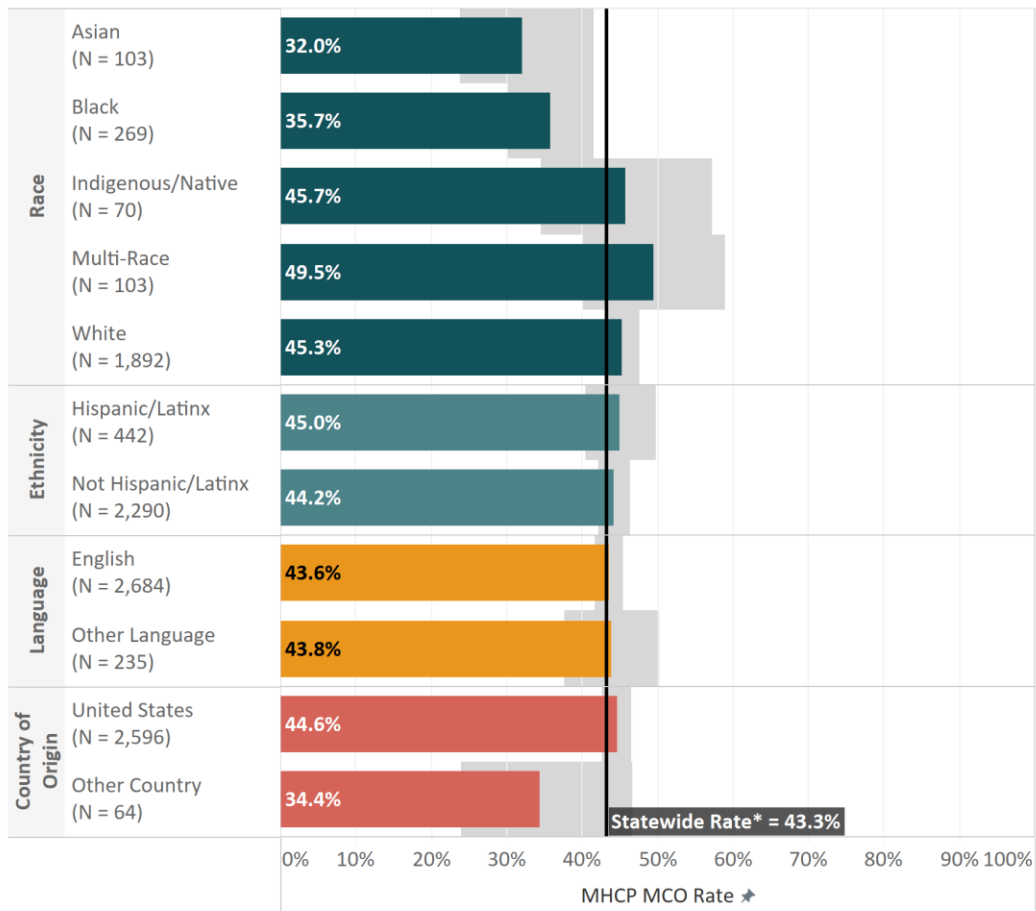
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Adolescent Depression: Remission at Six Months rate for MHCP MCO patients remained stable.
- In 2023, there was a significant 1.9 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (6.2% and 8.1%, respectively).

ADOLESCENT DEPRESSION: Follow-up at Six Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander; this category had less than 30 patients for this measure, which is below the reporting threshold and so has been excluded from the chart above.

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

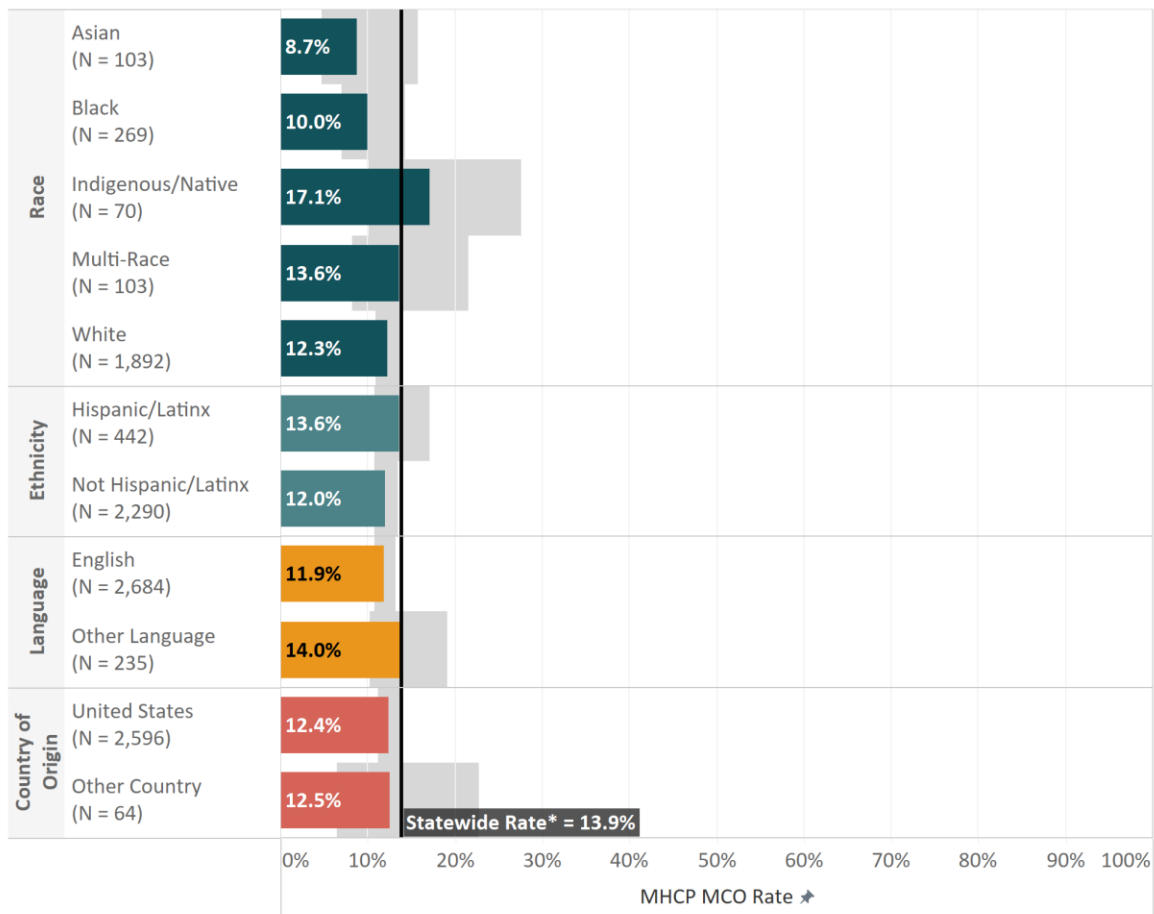
Compared to the MHCP MCO statewide rate, the rates of follow-up at six months for all groups were average.

ADOLESCENT DEPRESSION:

Response at Six Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander; this category had less than 30 patients for this measure, which is below the reporting threshold and so has been excluded from the chart above.

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

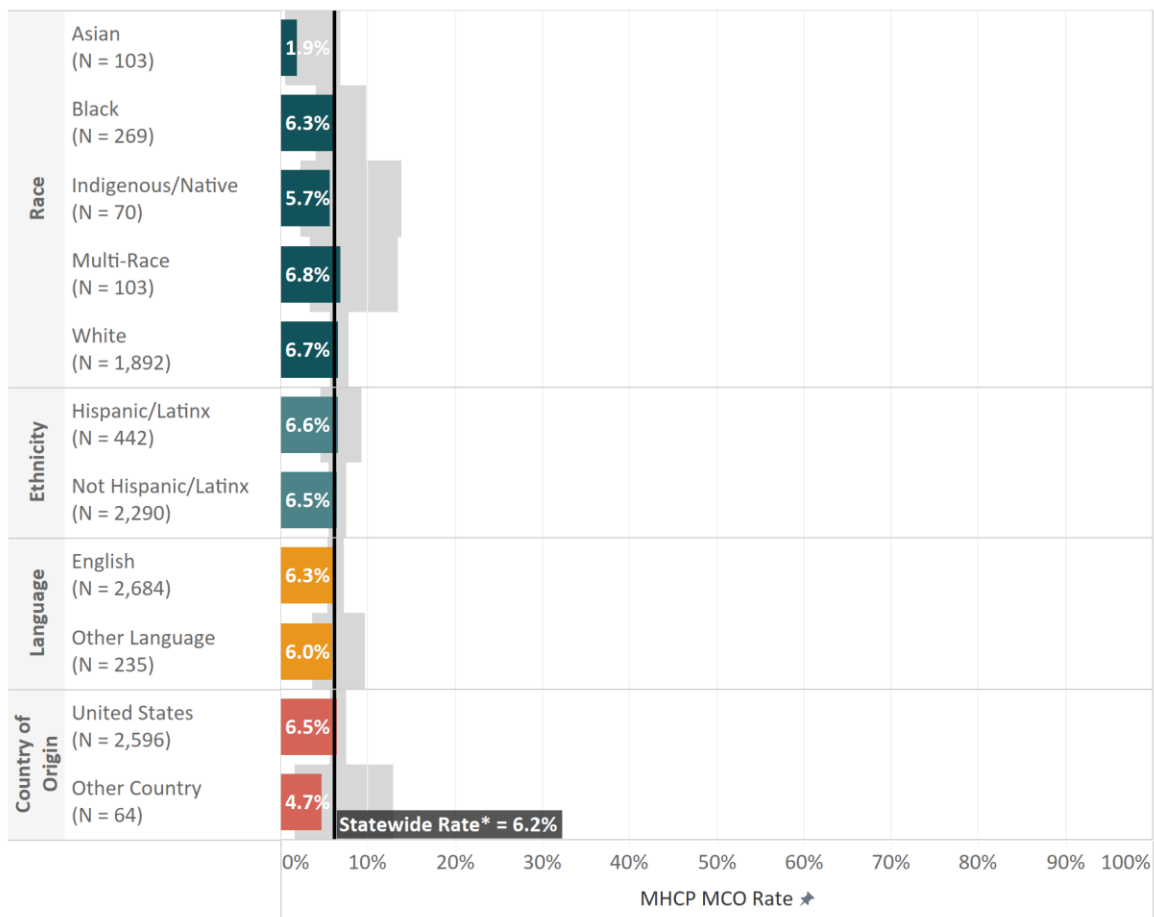
Compared to the MHCP MCO statewide rate, the rates of response at six months for all groups were average.

ADOLESCENT DEPRESSION:

Remission at Six Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander; this category had less than 30 patients for this measure, which is below the reporting threshold and so has been excluded from the chart above.

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

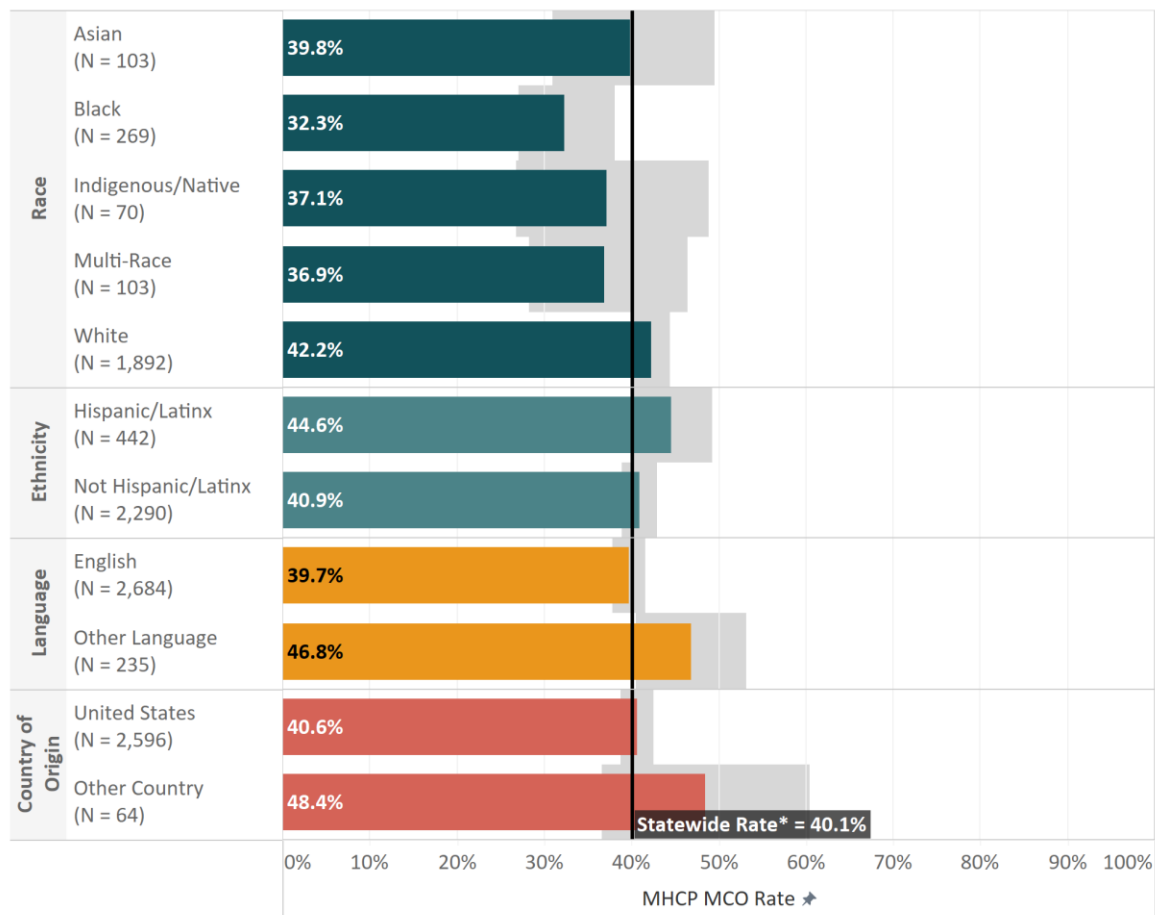
Compared to the MHCP MCO statewide rate, the rates of remission at six months for all groups were average.

ADOLESCENT DEPRESSION:

Follow-up at 12 Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander; this category had less than 30 patients for this measure, which is below the reporting threshold and so has been excluded from the chart above.

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Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

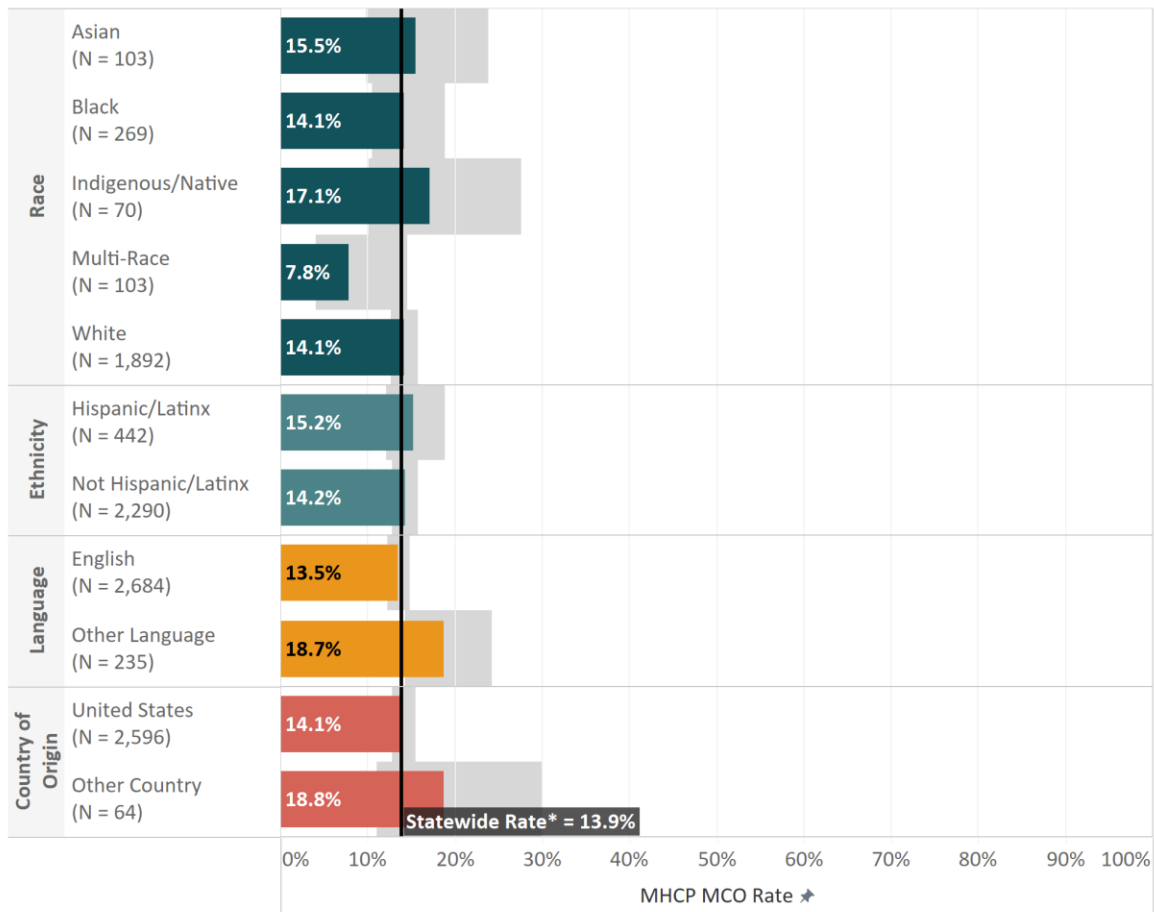
Compared to the MHCP MCO statewide rate, a lower rate of follow-up at 12 months was observed among patients who are Black.

ADOLESCENT DEPRESSION:

Response at 12 Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander; this category had less than 30 patients for this measure, which is below the reporting threshold and so has been excluded from the chart above.

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

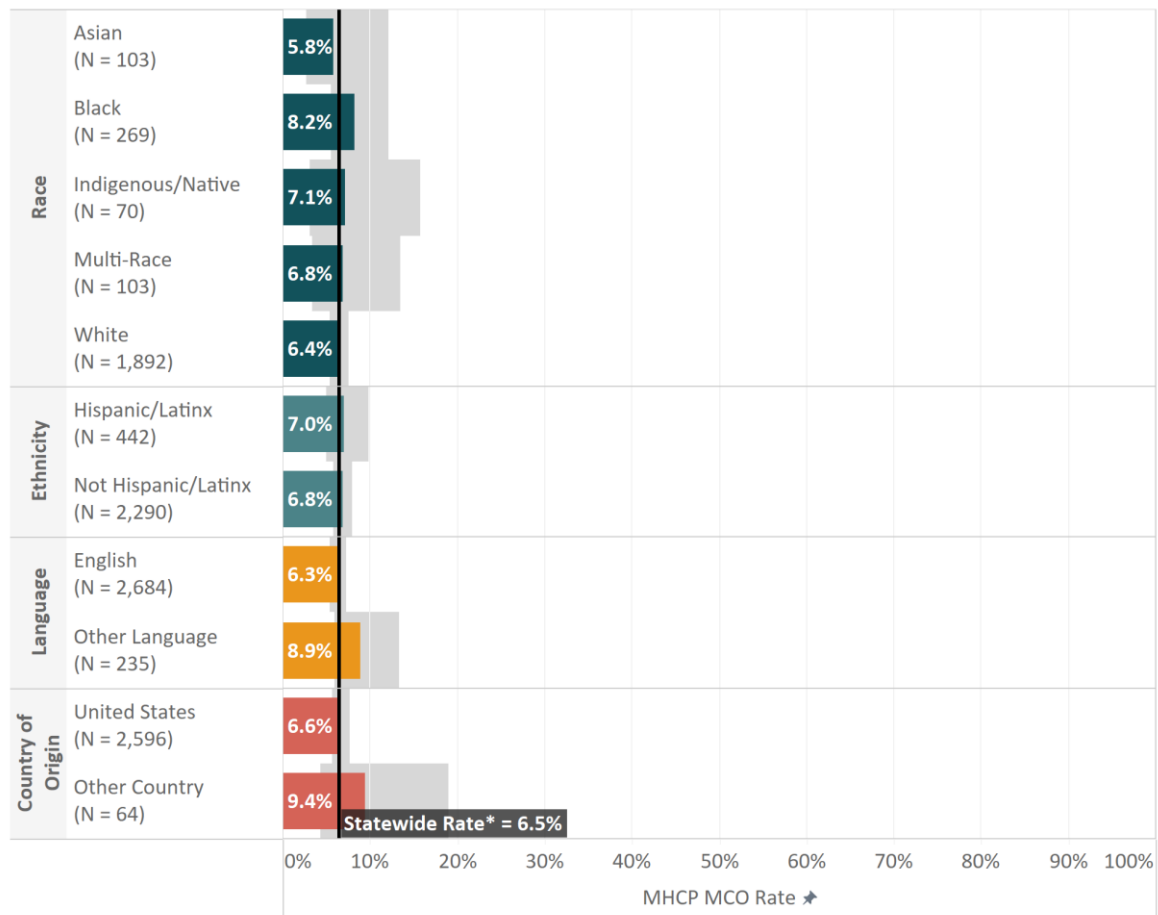
Compared to the MHCP MCO statewide rate, the rates of response at 12 months for all groups were average.

ADOLESCENT DEPRESSION:

Remission at 12 Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander; this category had less than 30 patients for this measure, which is below the reporting threshold and so has been excluded from the chart above.

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

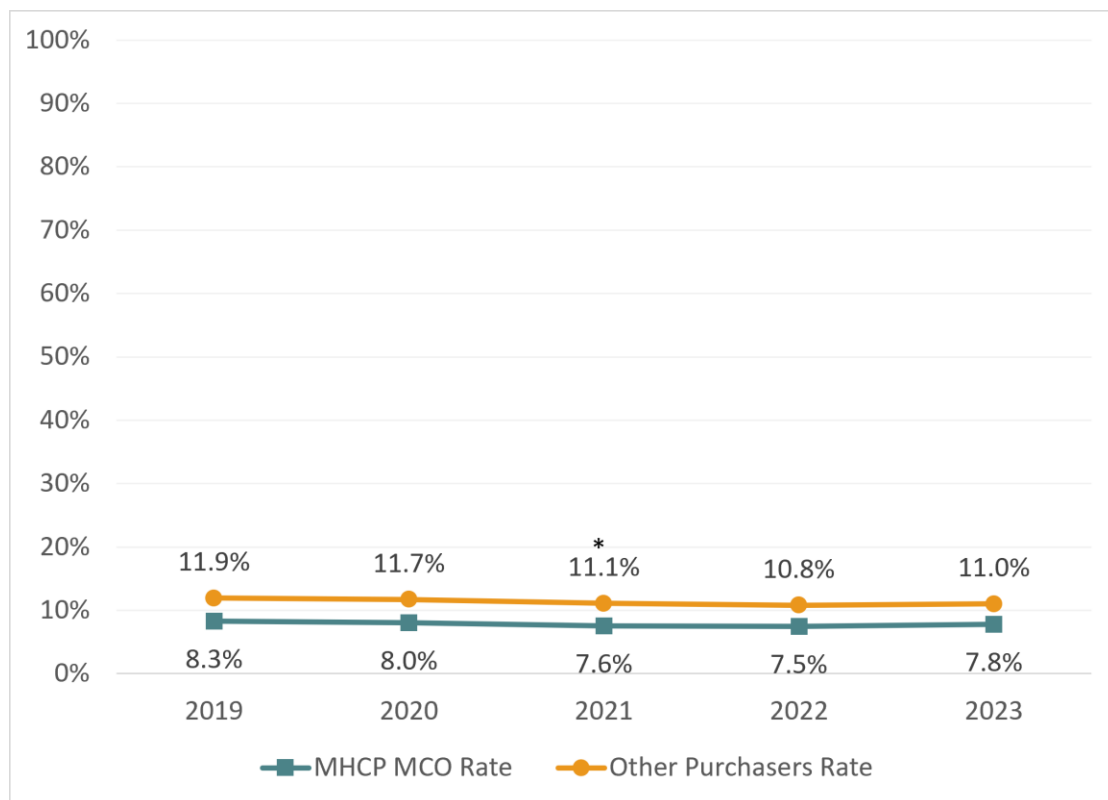
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, the rates of remission at 12 months for all groups were average.

ADULT DEPRESSION: REMISSION AT SIX MONTHS

Rates Over Time

2019-2023 measurement years



*Rate statistically significantly changed from previous year

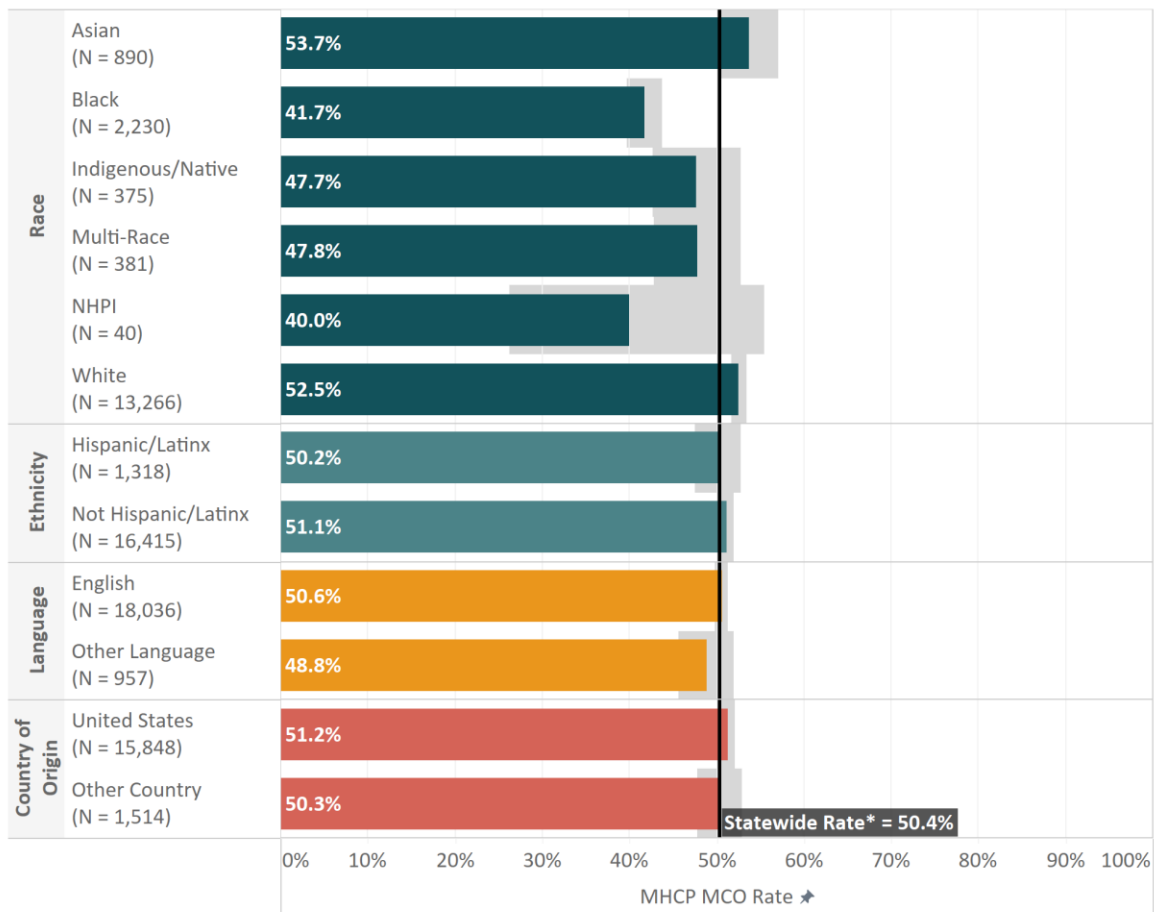
KEY TAKEAWAYS

- From 2022 to 2023, the statewide Adult Depression: Remission at Six Months rate for MHCP MCO patients remained stable.
- In 2023, there was a significant 3.2 percentage point gap between the statewide rates for MHCP MCO and Other Purchasers (7.8% and 11.0%, respectively).

ADULT DEPRESSION: Follow-up at Six Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

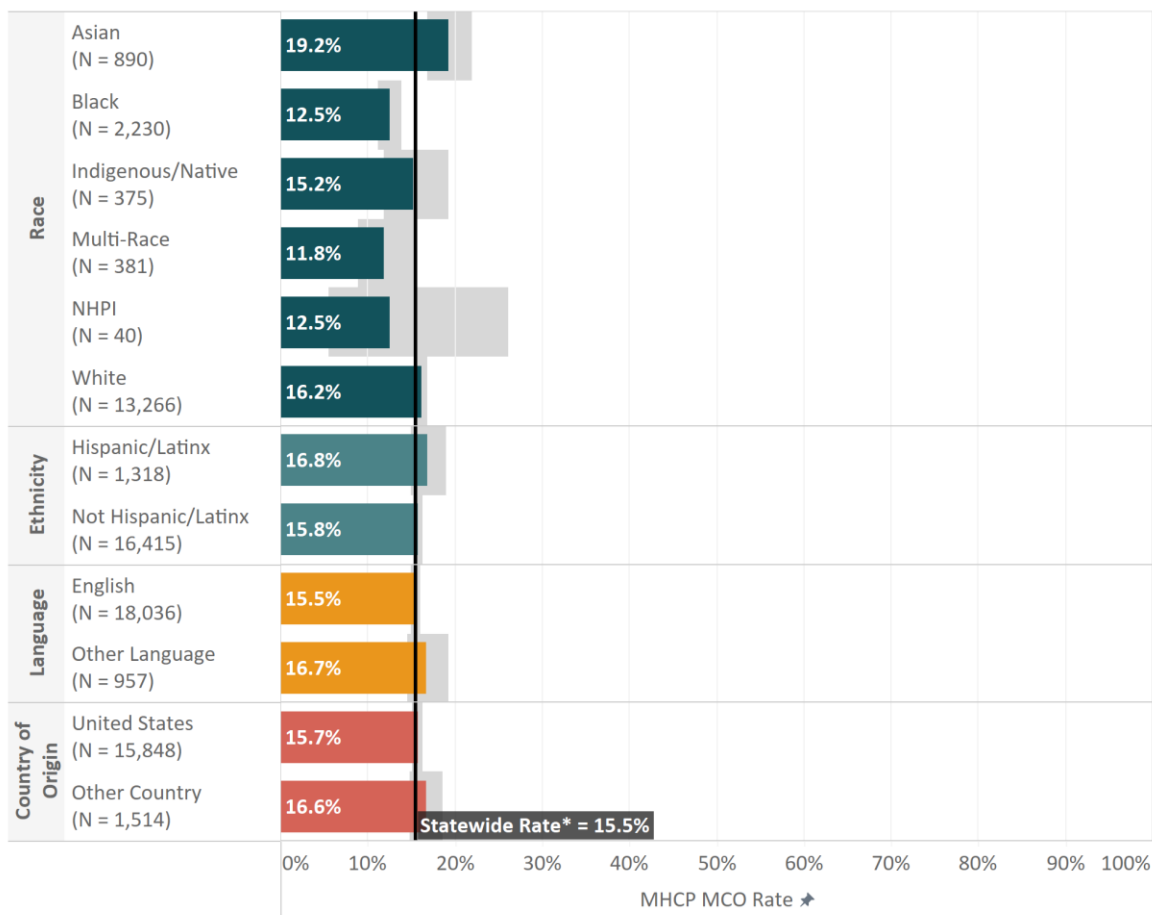
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, a lower rate of follow-up at six months was observed among patients who are Black.

ADULT DEPRESSION: Response at Six Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

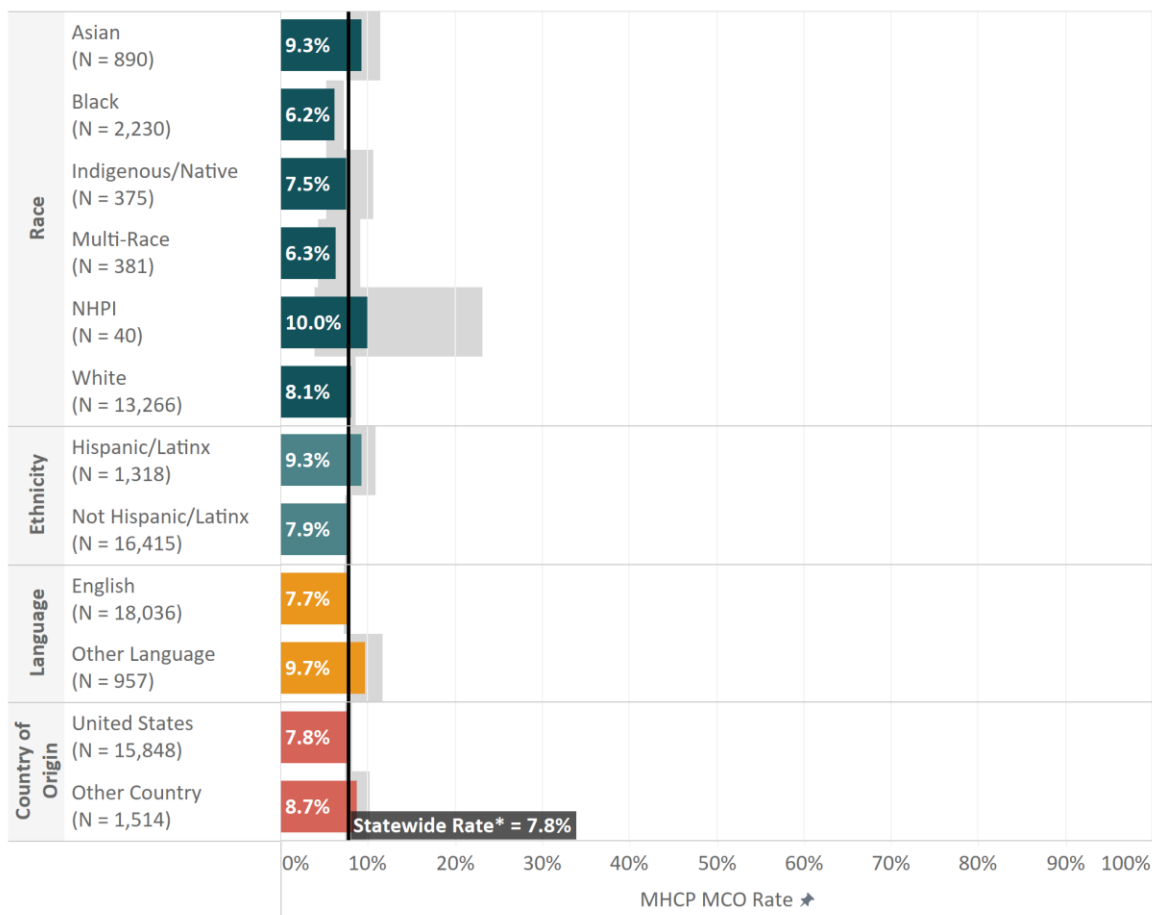
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, a lower rate of response at six months was observed among patients who are Black.

ADULT DEPRESSION: Remission at Six Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the "Statewide Rate" refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

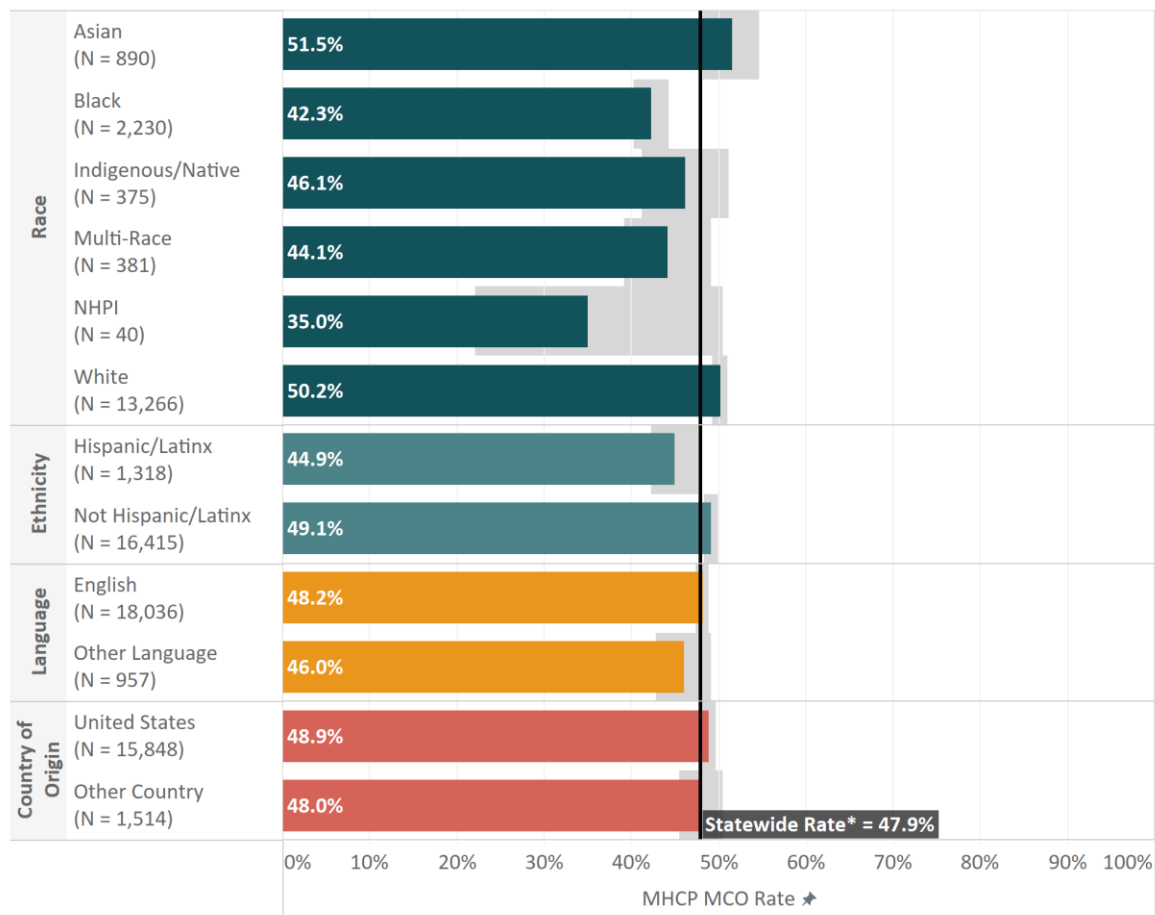
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, a lower rate of remission at six months was observed among patients who are Black.

ADULT DEPRESSION: Follow-up at 12 Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

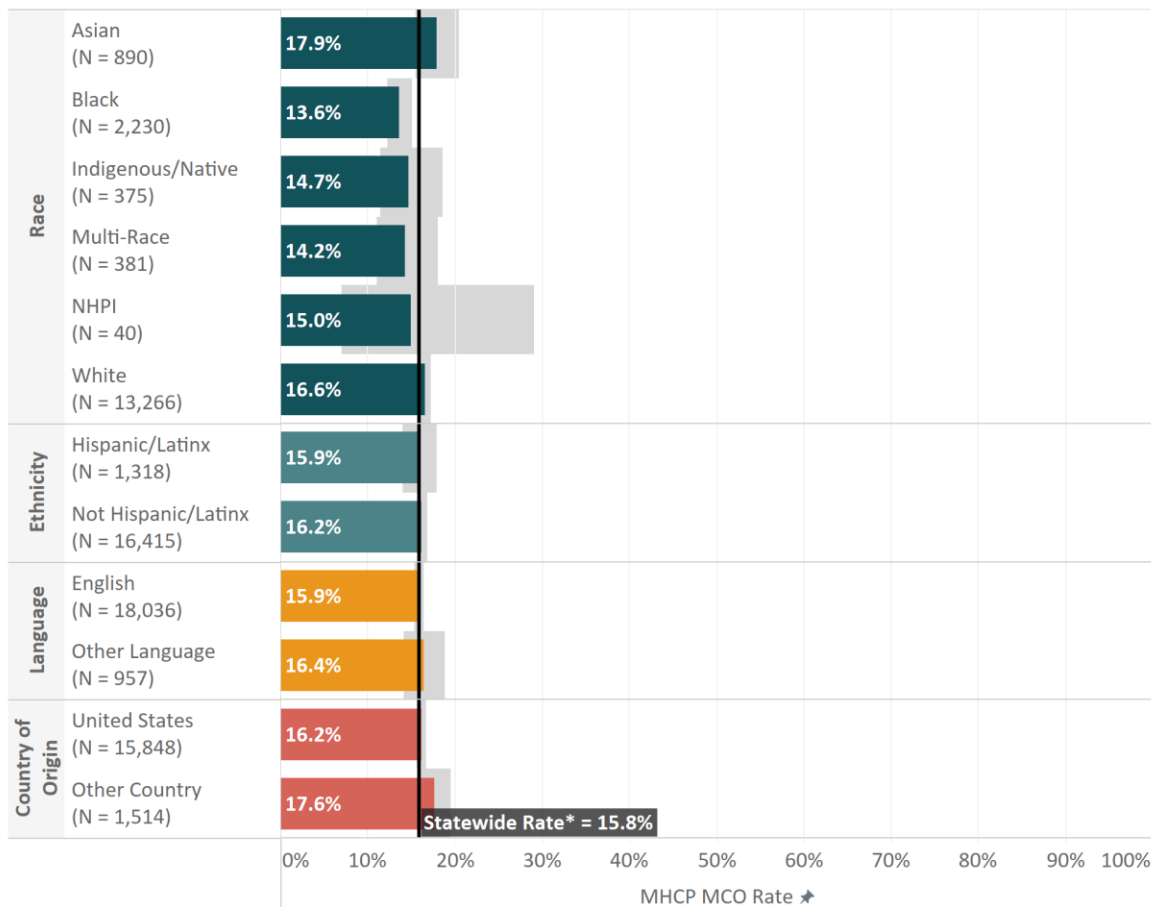
KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, a lower rate of follow-up at 12 months was observed among patients who are Black.

ADULT DEPRESSION: Response at 12 Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

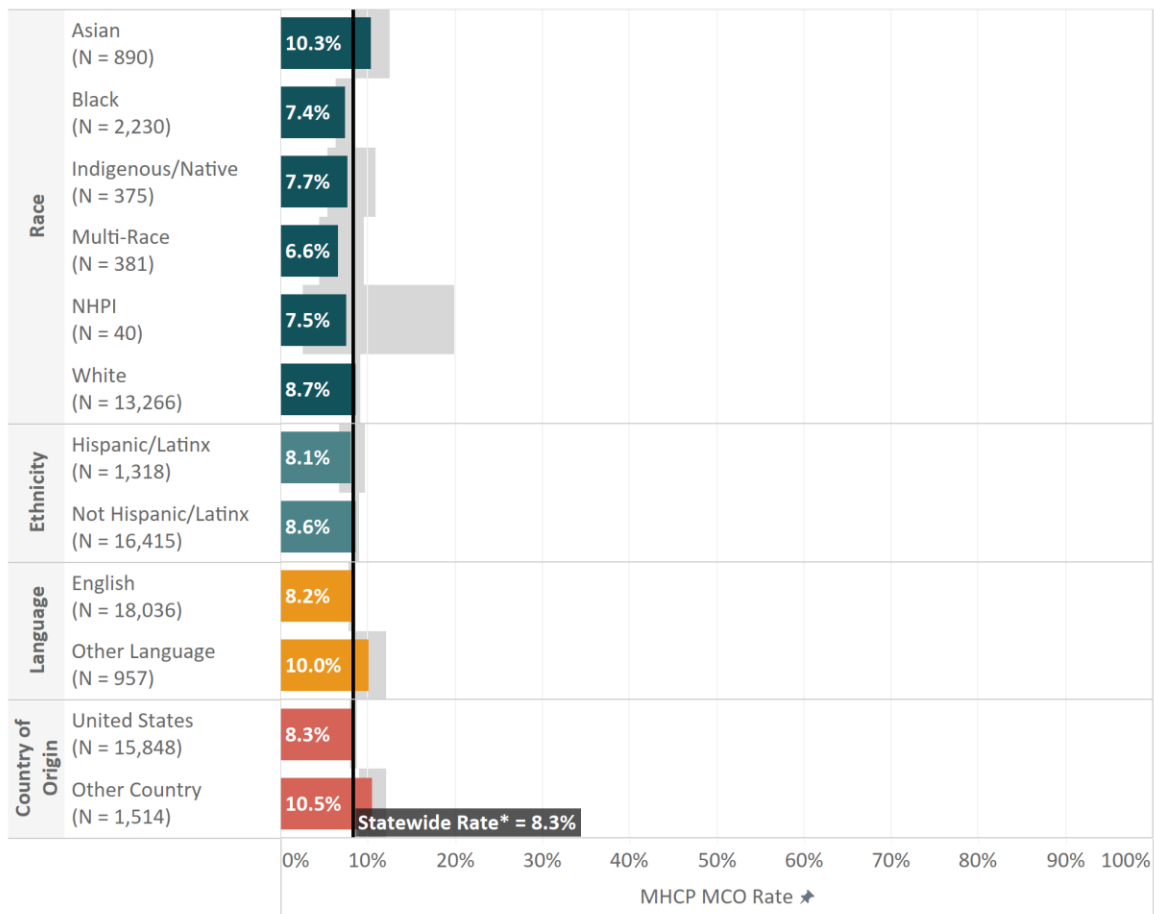
Compared to the MHCP MCO statewide rate, a lower rate of response at 12 months was observed among patients who are Black.

ADULT DEPRESSION:

Remission at 12 Months

MHCP MCO Rates by RELC

2023 measurement year



NHPI = Native Hawaiian/Pacific Islander

*For this chart, the “Statewide Rate” refers to the overall rate for the MHCP MCO population only.

Grey shading next to bars represents 95% confidence interval.

KEY TAKEAWAYS

Compared to the MHCP MCO statewide rate, a higher rate of remission at 12 months was observed among patients who were born outside of the United States; all other groups had average rates.

APPENDICES

Appendix A: Definitions
Appendix B: Methodology
Appendix C: Sources

APPENDIX A: DEFINITIONS

DEFINITIONS

- **95% confidence interval:** The degree of certainty in which the performance rate falls between the specified range of values.
- **Continuous enrollment criteria:** The minimum amount of time for a member/patient to be enrolled in a health plan to be eligible for a HEDIS measure. It ensures the health plan 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.
- **Composite measures:** A measure of two or more component measures, each of which individually reflects quality of care, combined into a single performance measure with a single score. The individual components are treated equally (not weighted). Every component must meet criteria to be counted in the numerator for the overall composite measure. The composite measures in this report include:
 - Optimal Diabetes Care
 - Optimal Vascular Care
 - Optimal Asthma Control – Adults
 - Optimal Asthma Control – Children
- **Clinical Data Submission measures:** These measures are calculated using data submitted by medical groups/clinics, which comes from electronic health records or paper-based medical charts. More information on this data collection method can be found in the Methodology section. These measures include:
 - Optimal Diabetes Care
 - Optimal Vascular Care
 - Adult Depression Suite
 - Adolescent Depression Suite
 - Optimal Asthma Control – Children
 - Optimal Asthma Control – Adults
 - Colorectal Cancer Screening
 - Adolescent Mental Health and/or Depression Screening
- **Healthcare Effectiveness Data and Information Set (HEDIS) measures:** A national set of performance measures used in the managed care industry and developed and maintain by the National Committee for Quality Assurance (NCQA). Clinical HEDIS measures use data from the administrative or hybrid data collection methodology. More information on this data collection method can be found in the Methodology section. These measures include:
 - Breast Cancer Screening
 - Childhood Immunization Status (Combo 10)
 - Controlling High Blood Pressure

DEFINITIONS CONTINUED

- **Insurance type:** Health care insurance type includes the following categories:
 - Commercial (employer-based and individual coverage)
 - State health care programs (Medical Assistance (Medicaid) and MinnesotaCare)
 - Medicare (federal health care programs for people ages 65 years and older and people who are disabled)
 - Uninsured
- **Measurement Year (MY):** The year in which health care services were delivered and the data was recorded.
- **Medical group:** One or more clinic sites operated by a single organization.
- **Minnesota Health Care Programs (MHCP):** These health care programs (i.e., Medical Assistance including dual eligible and MinnesotaCare) provide service under both fee-for-service and managed care delivery systems purchased by DHS. This report only includes performance rates for the managed care (MCO) programs (i.e., Medical Assistance and MinnesotaCare).
- **National Committee for Quality Assurance (NCQA):** A national, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations, as well as produces HEDIS measures.
- **Other Purchasers:** This includes commercial (employer-based insurance coverage) and/or Medicare managed care data.
- **Outcome measures:** These measures reflect the actual results of care. They are generally the most relevant measures for patients and the measures that providers most want to change. The outcome measures in this report include:
 - Controlling High Blood Pressure
 - Optimal Diabetes Care
 - Optimal Vascular Care
 - Optimal Asthma Control – Adults
 - Optimal Asthma Control – Children
 - Adult Depression: Remission and Response measures
 - Adolescent Depression: Remission and Response measures
- **Patient Reported Outcome (PRO):** Information reported by the patient.
- **Patient Report Outcome Measure (PROM):** A validated instrument or survey tool that collects data from a patient:
 - Optimal Asthma Control measures – Adults and Children: Asthma Control Test (ACT); Childhood Asthma Control Test (C-ACT); Asthma Control Questionnaire (ACQ); Asthma Therapy Assessment Questionnaire (ATAQ)
 - Adult and Adolescent Depression Suites: Patient Health Questionnaire – 9 item version (PHQ-9/PHQ-9M)

DEFINITIONS CONTINUED

- **Patient Report Outcome – Performance Measure (PRO-PM):** Measures built from a PROM. PRO-PM measures included in this report are:
 - Optimal Asthma Control – Adults (*outcome*)
 - Optimal Asthma Control – Children (*outcome*)
 - Adolescent Mental Health and/or Depression Screening (*process*)
 - Adult Depression Suite (*outcome*)
 - Adolescent Depression Suite (*outcome*)
- **Process measures:** A measure that shows whether steps proven to benefit patients are followed correctly. They measure whether an action was completed (e.g., having a medical exam or test, writing a prescription, or administering a drug). The process measures in this report include:
 - Breast Cancer Screening
 - Childhood Immunization Status (Combo 10)
 - Colorectal Cancer Screening
 - Adolescent Mental Health and/or Depression Screening

MEASURE NOTES

Optimal Asthma Control

The following is the scoring used for numerator compliance for the well-controlled component:

- Asthma Control Test (ACT)TM result greater than or equal to 20 (patients 12 years of age and older)
- Childhood Asthma Control Test (C-ACT)[©] result greater than or equal to 20 (patients 11 years of age and younger)
- Asthma Control Questionnaire (ACQ)[©] result less than or equal to 0.75 (patients 17 years of age and older)
- Asthma Therapy Assessment Questionnaire (ATAQ)[©] result equal to 0 – Pediatric (5 to 17 years of age) or Adult (18 years of age and older).

Adolescent Mental Health and/or Depression Screening

The following are the accepted screening tools for numerator compliance for the measure:

- Patient Health Questionnaire – 9 item version (PHQ-9)
- PHQ-9M Modified for Teens and Adolescents
- Kutcher Depression Scale (KADS)
- Beck Depression Inventory II (BDI-II)
- Beck Depression Inventory Fast Screen (BDI-FS)
- Child Depression Inventory (CDI)
- Child Depression Inventory II (CDI-2)
- Patient Health Questionnaire – 2 item version (PHQ-2)
- Pediatric Symptom Checklist – 17 item version (PSC-17) - parent version
- Pediatric Symptom Checklist – 35 item (PSC-35) - parent version
- Pediatric Symptom Checklist – 35 item Youth Self-Report (PSC Y-SR)
- Global Appraisal of Individual Needs screens for mental health and substance abuse (GAIN-SS)

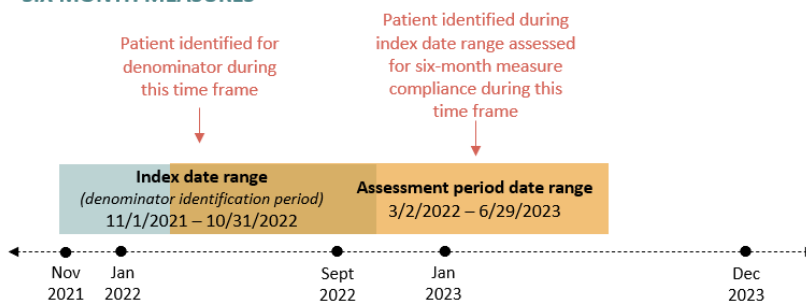
DEPRESSION MEASURES

The depression measures are unique in that the time period for identifying eligible patients for the denominators do not follow the typical measurement period that the other quality measures do. The depression measures are longitudinal in design, meaning patients are followed through a period of time and assessed for the desired outcome. A patient is first identified for the denominator during the denominator identification period (shown below), which primarily occurs two years prior to when the data are submitted. Patients are identified as being eligible for the denominator by the following:

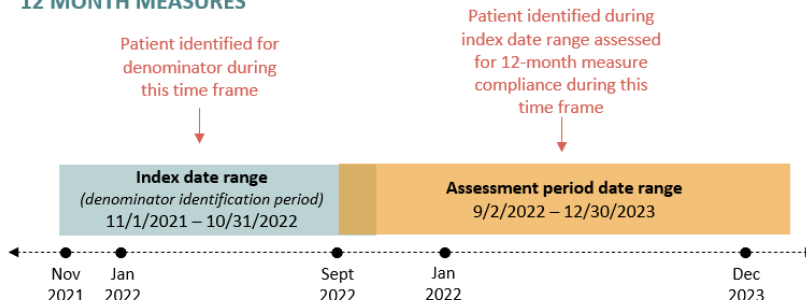
- **Depression diagnosis:** The patient had an encounter with an eligible provider in an eligible specialty, coded with one of the diagnosis indicating Major Depression/Dysthymia during the denominator identification period. The diagnosis of depression does not have to be new for the patient to be included in the denominator.
- **PHQ-9/9M score greater than 9:** The patient completed a PHQ-9/PHQ-9M tool and the score was greater than 9 during the denominator identification period.
- **Age:** The patient was 12 years or older at the time of the encounter.

The assessment period (below) is the time in which those patients identified in the denominator identification period are assessed for the desired outcome and primarily occurs in the year prior to data submission.

SIX MONTH MEASURES



12 MONTH MEASURES



Example: A 23-year-old patient with depression was assessed at an encounter with an eligible provider on 12/2/2021 and had a PHQ-9 score of 20 (index event). Their six-month assessment period would be between 4/3/2022 and 8/1/2022. The patient would be considered numerator compliant for the six-month measures if the following was achieved during the assessment period:

- Follow-up PHQ-9/PHQ-9M: Patient was screened using PHQ-9/9M tool
- Response: Most recent PHQ-9/9M score was 10 or below (score reduced by 50% or more)
- Remission: Most recent PHQ-9/9M score was less than 5

The patient is then assessed 12 months after the index event (10/3/2022 to 1/31/2023) using the same criteria as above.

APPENDIX B: METHODOLOGY

The measures in this report are collected from two separate data sources: clinics and health plans. Measures reported by medical groups (or, PIPE measures) use data from clinics, which enables reporting of results by clinic location as well as by medical group. In contrast, measures reported by health plans (or, the Healthcare Effectiveness Data and Information Set (HEDIS) measures) use data from health plans, which enables reporting of results by medical group only.

PIPE MEASURES

MNCM's PIPE system is a method of data collection in which medical groups and clinics directly submit data to MNCCM. Most of the measures that utilize this data are developed and maintained by MNCCM.

DATA COLLECTION

Data submission requirements are specified by MN Community Measurement in our 2023 Measurement Year (MY) PIPE Data File Field 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 MNCCM's Knowledge Base in the "PIPE Resources" section.

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 MNCCM's Knowledge Base. All appropriate Health Insurance Portability and Accountability (HIPAA) requirements are followed.

DATA VALIDATION

After clinical quality data is submitted, MNCCM 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, MNCCM 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.

PIPE MEASURES CONTINUED

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.
 - 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.

PIPE MEASURES CONTINUED

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

MNCM's PIPE system identifies the eligible population for each measure for medical groups.

NUMERATOR SPECIFICATIONS

For 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 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 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 PIPE measures.

PIPE MEASURES CONTINUED

Best Practices for RELC Data Collection

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:

- Patients self-report their race , ethnicity, country of origin and preferred language
- 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).
- 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 PIPE

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

HEDIS MEASURES

The Healthcare Effectiveness Data and Information Set (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.

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.

HEDIS MEASURES CONTINUED

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.

APPENDIX C: SOURCES

- 1 Minnesota Department of Human Services (n.d.). Medicaid Matters: We're all healthier when we're all covered [PDF]. Retrieved from <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8665A-ENG>
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- 8 National Alliance on Mental Illness. (2017). Depression. Retrieved from <https://www.nami.org/about-mental-illness/mental-health-conditions/depression/>
- 9 National Committee for Quality Assurance. Depression Remission or Response for Adolescents and Adults (DRR-E). Retrieved from <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/measures-list/depression-remission-or-response-for-adolescents-and-adults-drr-e/>