MINNESOTA HEALTH CARE DISPARITIES

By Insurance Type

Results for care delivered in 2022

MN Community MEASUREMENT

mn DEPARTMENT OF HUMAN SERVICES

RELEASED APRIL 2024

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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 Minnesotans, 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.

ABOUT THIS REPORT

For over 15 years, MN Community Measurement (MNCM) has collaborated with the Minnesota Department of Human Services (DHS) to measure health care quality by type of health insurance. This report continues to summarize the analysis and data from MNCM that compare results on key measures for Minnesotans who get their health insurance coverage through state programs. DHS uses these in a variety of ways, including to inform the state's health care purchasing strategies. This work helps to fulfill a legislative requirement (MN Statute 256B.072 § 1d) for DHS to establish a performance reporting and quality improvement system for medical groups and clinics providing health care services to patients enrolled in the managed care component of Minnesota Health Care Programs (MHCP) and compares indices of healthcare quality to patients enrolled in private health plans (Other Purchasers).[1]

When compared to the overall Minnesota population, patients enrolled in MHCP are of lower socioeconomic status and include a disproportionate number of persons of color, Indigenous/Native persons, persons with disabilities, and elderly adults. These enrollees often experience barriers or significant challenges to receiving optimal health care. Because of this, it may be harder for these individuals to receive care which meets best practices as often as patients insured with other types of insurance (e.g., commercial insurance).

This report summarizes health care quality for patients enrolled in Minnesota Health Care Programs Managed Care (MHCP MCO), makes comparisons by insurance type, and features statewide MHCP MCO results by race, Hispanic ethnicity, Country of Origin, and Preferred Language for measures where these data are available. The focus of this report is for the managed care components of Minnesota's Medical Assistance and MinnesotaCare programs. Throughout the report, MHCP results are compared to Other Purchasers. Other Purchasers include commercial (employer-based and individual health insurance coverage) and Medicare managed care data.

The data collected in this report were collected by MNCM in 2023 for 2022 dates of service.

As a companion to this report, medical group/clinic level results for the MHCP MCO population are provided in MNCM's Appendix Tables, which are available here: https://mncm.org/appendix-tables/

ACKNOWLEDGEMENTS

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.

OVERVIEW OF QUALITY MEASURES

This report includes 21 health care quality measures chosen by DHS and MNCM to identify and examine gaps in quality for patients enrolled in MHCP Managed Care with the goal of informing community efforts on improvement. The measures include:

PREVENTIVE HEALTH (3 measures)
Breast Cancer Screening*
Childhood Immunization Status (Combo 10)*
Colorectal Cancer Screening
CHRONIC CONDITIONS (5 measures)
Controlling High Blood Pressure*
Optimal Asthma Control – Adults
Optimal Asthma Control – Children
Optimal Diabetes Care, plus five components: 1) Blood Pressure Control; 2) Daily Aspirin Use; 3) HbA1c Control; 4) Statin Use; 5) Tobacco-free
Optimal Vascular Care, plus four components: 1) Blood Pressure Control; 2) Daily Aspirin Use; 3) Statin Use; 4) Tobacco-free
MENTAL HEALTH (13 measures)
Adolescent Mental Health and/or Depression Screening
Adolescent Depression: Follow-up PHQ-9/9M at Six Months
Adolescent Depression: Response at Six Months
Adolescent Depression: Remission at Six Months
Adolescent Depression: Follow-up PHQ-9/9M at 12 Months
Adolescent Depression: Response at 12 Months
Adolescent Depression: Remission at 12 Months
Adult Depression: Follow-up PHQ-9/9M at Six Months
Adult Depression: Response at Six Months
Adult Depression: Remission at Six Months
Adolescent Depression: Follow-up PHQ-9/9M at 12 Months
Adolescent Depression: Response at 12 Months
Adolescent Depression: Remission at 12 Months

*Healthcare Effectiveness Data and Information Set (HEDIS) measure. For more information on HEDIS measures, click here.

KEY FINDINGS

- Statewide MHCP MCO average rates decreased* in 2022 compared to 2021 for three measures: Childhood Immunization Status (Combo 10), Colorectal Cancer Screening, and Optimal Asthma Control – Children.

    o The Childhood Immunization Status measure had the largest decrease of 6.1 percentage points.

- Statewide MHCP MCO average rates increased* in 2022 compared to 2021 for two measures: Breast Cancer Screening and Optimal Diabetes Care.

    o The Breast Cancer Screening measure had the largest increase of 3.0 percentage points.

- In 2022, statewide MHCP MCO average rates were consistently lower* than the other purchasers' statewide rates for all measures.

    o The largest gap occurred in the Childhood Immunization Status measure, with a difference of 26.7 percentage points between the two populations.

    o Since 2018, these gaps have narrowed* for three measures: Optimal Asthma Control – Adults; Optimal Asthma Control – Children; Adolescent Mental Health and/or Depression Screening.

    o Since 2018, these gaps have widened* for four measures: Breast Cancer Screening; Childhood Immunization Status (Combo 10); Colorectal Cancer Screening; Controlling High Blood Pressure^.

- Statewide MHCP MCO average rates vary by race/ethnicity, country of origin and preferred language:

    o The rates for MHCP MCO patients who are Black are below* the MHCP MCO statewide averages on 14 out of the 21 measures found in this report.

    o The rates for MHCP MCO patients who are Indigenous/Native are below* the MHCP MCO statewide averages on six out of the 21 measures found in this report.

    o The rates for MHCP MCO patients from Somalia are below* the MHCP MCO statewide averages for four measures: Colorectal Cancer Screening; Optimal Asthma Control – Adults; Adult Depression: Follow-up PHQ-9/9M at Six Months; Adult Depression: Follow-up PHQ-9/9M at 12 Months.

    o The rates for MHCP MCO patients who prefer to speak Somali are below* the MHCP MCO statewide averages for four measures: Colorectal Cancer Screening; Optimal Asthma Control – Adults; Adult Depression: Follow-up PHQ-9/9M at Six Months; Adult Depression: Follow-up PHQ-9/9M at 12 Months.

*Statistically significant
^Since 2020 for the Controlling High Blood Pressure measure.

TABLE 1: COMPARISON OF 2022 MHCP MCO STATEWIDE RATES TO PREVIOUS YEAR

Table 1 displays MHCP MCO statewide results for the quality measures in comparison to the previous year.

QUALITY MEASURE	2022 MHCP MCO Statewide Rate	2021 MHCP MCO Statewide Rate	MHCP MCO Statewide Percentage Point Change (2022-2021)
PREVENTIVE HEALTH MEASURES			
Breast Cancer Screening	57.4% (N = 59,404)	54.4% (N = 48,376)	+3.0%*
Childhood Immunization Status (Combo 10)	34.9% (N = 3,634)	41.0% (N = 3,717)	-6.1%*
Colorectal Cancer Screening**	52.7% (N = 143,247)	58.3% (N = 117,919)	-5.6%*
CHRONIC CONDITIONS MEASURES			
Controlling High Blood Pressure	66.1% (N = 11,514)	67.5% (N = 10,821)	-1.4%
Optimal Diabetes Care	34.9% (N = 46,869)	33.2% (N = 48,670)	+1.7%*^
Optimal Vascular Care	43.3% (N = 17,642)	43.2% (N = 18,490)	+0.1%
Optimal Asthma Control – Adults	42.8% (N = 33,974)	43.1% (N = 35,127)	-0.3%
Optimal Asthma Control – Adults	42.8% (N = 33,974)	43.1% (N = 35,127)	-0.3%
MENTAL HEALTH MEASURES			
Adolescent Mental Health and/or Depression Screening	91.3% (N = 37,830)	91.1% (N = 40,264)	+0.2%
Adolescent Depression: Remission at Six Months	5.8% (N = 4,503)	6.2% (N = 3,298)	-0.4%
Adult Depression: Remission at Six Months	7.5% (N = 24,685)	7.6% (N = 21,732)	-0.1%

*Statistically significant difference (p < 0.05)   NA = Not applicable   N = Total number of patients (denominator)

^While there was a statistically significant increase in rate for this measure, there was a decrease in the number of patients included in the denominator.

** The eligible age range for the Colorectal Cancer Screening measure was expanded from 50-75 to 45-75 in 2022 to reflect updated USPSTF recommendations and to align with NCQA's measure.

TABLE 2: 2022 SUMMARY OF STATEWIDE RATE DIFFERENCES BY INSURANCE TYPE

Table 2 displays trends in the quality measures between MHCP MCO and Other Purchasers.

QUALITY MEASURE	2022 MHCP MCO Statewide Rate	2022 Other Purchasers Statewide Rate	2022 Rate Difference (MHCP - Other Purchasers)	Rate Difference Over Time^ (MHCP - Other Purchasers)
PREVENTIVE HEALTH MEASURES				
Breast Cancer Screening	57.4% (N = 59,404)	78.4% (N = 286,078)	-21.0%*	Gap widened* (2018-2022)
Childhood Immunization Status (Combo 10)	34.9% (N = 3,634)	61.7% (N = 2,887)	-26.7%*	Gap widened* (2018-2022)
Colorectal Cancer Screening**	52.7% (N = 143,247)	70.0% (N = 1,250,516)	-17.3%*	Gap widened* (2018-2022)
CHRONIC CONDITIONS MEASURES				
Controlling High Blood Pressure	66.1% (N = 11,514)	70.5% (N = 8,528)	-4.4%*	Gap widened* (2020-2022)[†]
Optimal Diabetes Care	34.9% (N = 46,869)	46.9% (N = 241,729)	-12.0%*	Gap stable (2018-2022)
Optimal Vascular Care	43.3% (N = 17,642)	57.6% (N = 142,830)	-14.3%*	Gap stable (2018-2022)
Optimal Asthma Control - Adults	42.8% (N = 33,974)	54.0% (N = 94,177)	-11.2%*	Gap narrowed* (2018-2022)
Optimal Asthma Control - Children	48.9% (N = 17,968)	56.6% (N = 34,711)	-7.7%*	Gap narrowed* (2018-2022)
MENTAL HEALTH MEASURES				
Adolescent Mental Health and/or Depression Screening	91.3% (N = 37,830)	93.1% (N = 104,822)	-1.8%*	Gap narrowed* (2018-2022)
Adolescent Depression: Remission at Six Months	5.8% (N = 4,503)	7.4% (N = 10,255)	-1.5%*	Gap stable (2019 – 2022)[†]
Adult Depression: Remission at Six Months	7.5% (N = 24,685)	10.8% (N = 75,340)	-3.4%*	Gap stable (2019-2022)[†]

*Statistically significant difference (p < 0.05)   ^ Based on last five years (2018-2022)

[†] First year of current measure specifications available

** The eligible age range for the Colorectal Cancer Screening measure was expanded from 50-75 to 45-75 in 2022 to reflect updated USPSTF recommendations and to align with NCQA's measure.

Table 3 compares the 2022 MHCP MCO rate of each racial/ethnicity group to the 2022 MHCP MCO statewide averages.

MEASURE	2022 MHCP MCO Statewide Average	Asian	Black	Indigenous/ Native	Multi-Race	Native Hawaiian/ Pacific Islander	White	Hispanic/ Latinx	Not Hispanic/ Latinx
PREVENTIVE HEALTH MEASURES									
Breast Cancer Screening	57.4%	●	▼	▼	●	●	▲	▲	●
Childhood Immunization Status (Combo 10)	34.9%	NR	▼	●	●	NR	●	▲	●
Colorectal Cancer Screening	52.7%	▲	▼	▼	▼	▼	▲	▼	●
CHRONIC CONDITIONS MEASURES									
Controlling High Blood Pressure	66.1%	▼	▼	●	●	NR	▲	●	●
Optimal Diabetes Care	34.9%	▲	▼	▼	▼	●	●	●	●
Optimal Vascular Care	43.3%	▲	▼	●	●	●	●	▲	●
Optimal Asthma Control - Adults	42.8%	▲	▼	▼	●	●	▲	●	●
Optimal Asthma Control - Children	48.9%	▲	●	▼	●	●	●	●	●
MENTAL HEALTH MEASURES									
Adolescent Mental Health and/or Depression Screening	91.3%	▲	▼	●	●	●	▲	●	●
Adolescent Depression: Remission at Six Months	5.8%	●	●	●	●	NR	●	●	●
Adult Depression: Remission at Six Months	7.5%	●	●	●	●	●	●	●	●

▲ Significant above statewide MHCP MCO statewide average

● Average

▼ Significantly below statewide MHCP MCO statewide average

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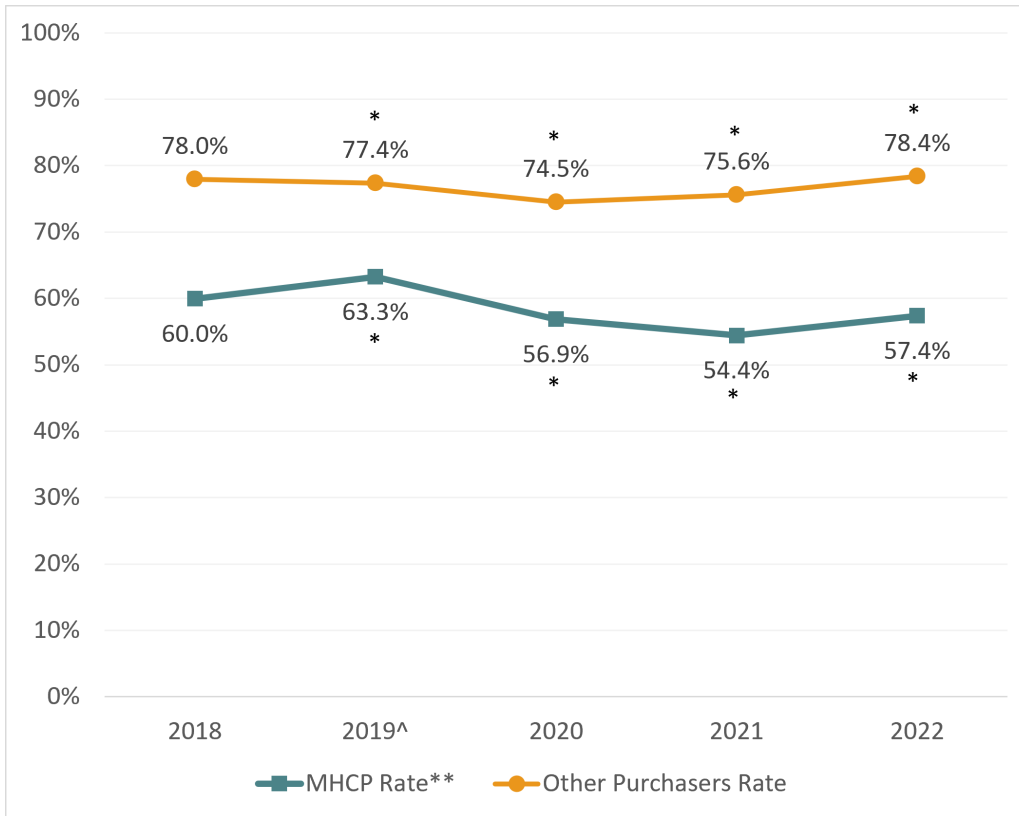
BREAST CANCER SCREENING

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.[2]

Data collected for this measure are from health plan claims (see Methodology appendix).

TREND IN BREAST CANCER SCREENING
2018 – 2022

Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

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

*Rate statistically significantly changed from previous year

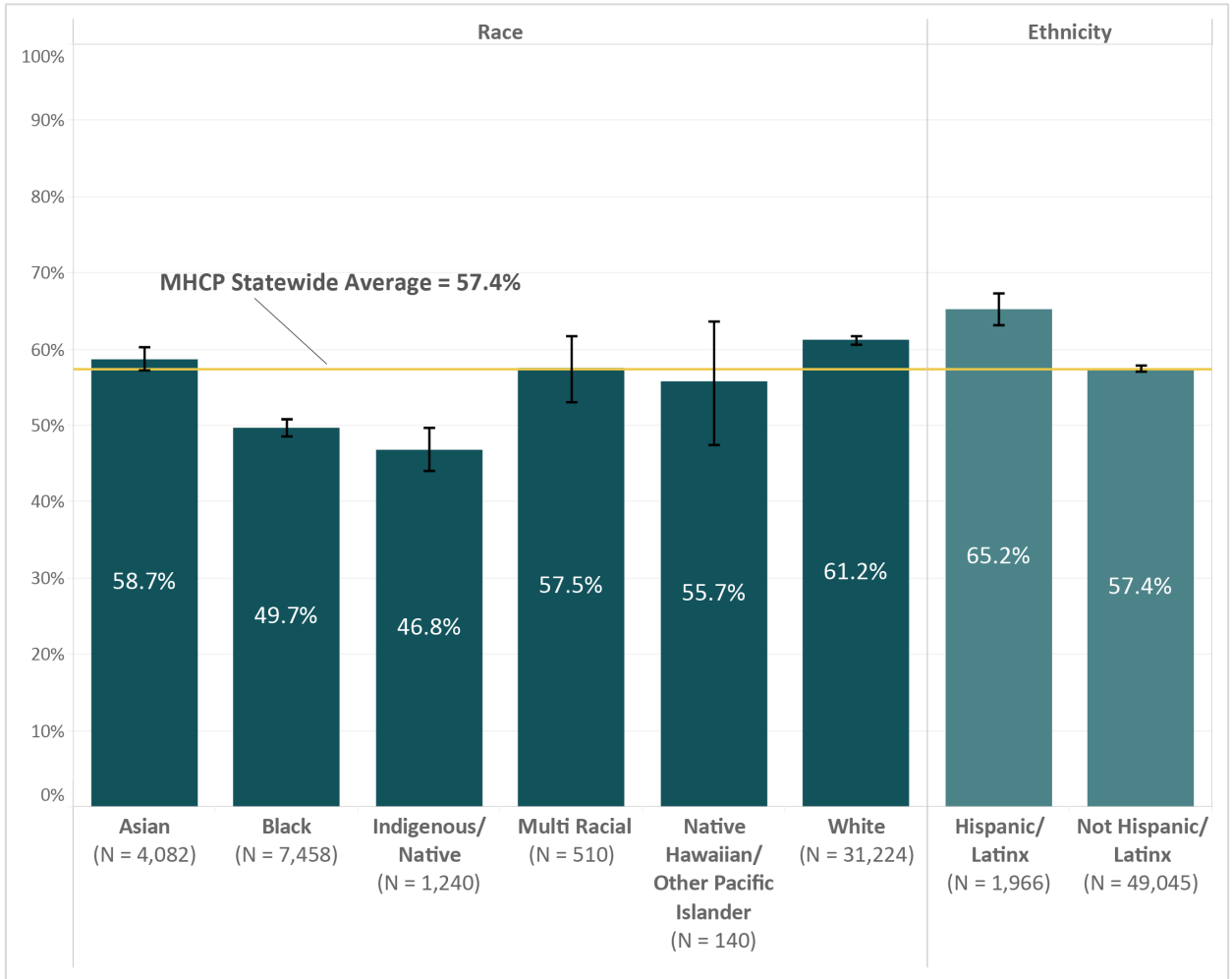**This measure does not allow for separation of MCO and FFS. MHCP here represents both MCO and FFS.

KEY TAKEAWAYS

- From 2021 to 2022, the MHCP statewide average for the Breast Cancer Screening measure statistically significantly increased by 3.0 percentage points.

- In 2022, the 21.0 percentage point gap between the MHCP statewide average and the Other Purchasers statewide average was statistically significant.

BREAST CANCER SCREENING (Continued)

MHCP* RATES BY RACE/ETHNICITY
2022 measurement year

MHCP Statewide Average = 57.4%

Race						Ethnicity	
Asian (N = 4,082): 58.7%	Black (N = 7,458): 49.7%	Indigenous/ Native (N = 1,240): 46.8%	Multi Racial (N = 510): 57.5%	Native Hawaiian/ Other Pacific Islander (N = 140): 55.7%	White (N = 31,224): 61.2%	Hispanic/ Latinx (N = 1,966): 65.2%	Not Hispanic/ Latinx (N = 49,045): 57.4%

⊺ Represents 95% confidence interval

KEY TAKEAWAYS

Race
Compared to the MHCP statewide average, the screening rate(s) for MHCP patients who are:

- White is statistically significantly higher.
- Black or Indigenous are statistically significantly lower.

Ethnicity
Compared to the MHCP statewide average, the screening rate for MHCP patients who are Hispanic/Latinx is statistically significantly higher.

*This measure does not allow for separation of MCO and FFS. MHCP here represents both MCO and FFS.

CHILDHOOD IMMUNIZATION STATUS (COMBO 10)

The percentage of children 2 years of age who had 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. [3]

Data collected for this measure are from health plan claims (see Methodology appendix).

TREND IN CHILDHOOD IMMUNIZATION STATUS
2018 – 2022
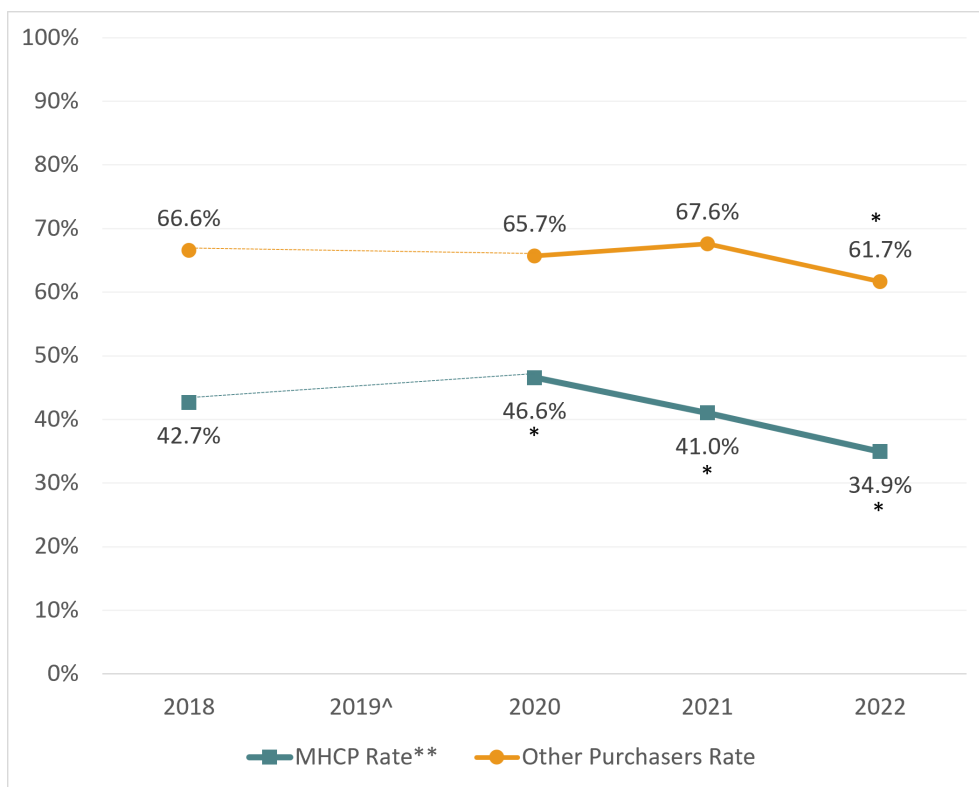
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

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

*Rate statistically significantly changed from previous year

**This measure does not allow for separation of MCO and FFS. MHCP here represents both MCO and FFS.

KEY TAKEAWAYS

- From 2021 to 2022, the MHCP statewide average for the Childhood Immunization Status (Combo 10) measure statistically significantly decreased by 6.1 percentage points.

- In 2022, the 26.7 percentage point gap between the MHCP statewide average and the Other Purchasers statewide average was statistically significant.

CHILDHOOD IMMUNIZATION STATUS (COMBO 10) (Continued)

MHCP* RATES BY RACE/ETHNICITY
2022 measurement year
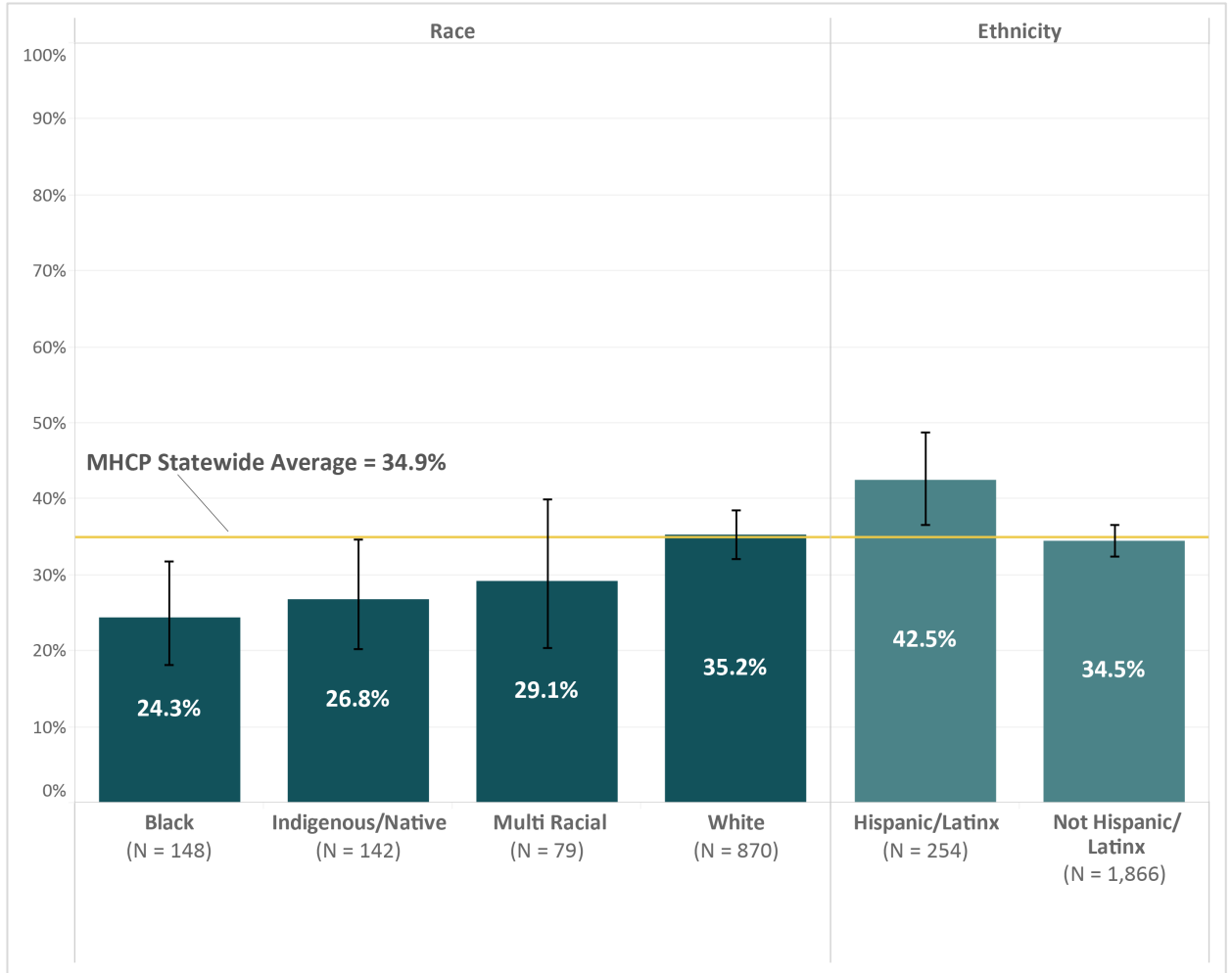
MHCP Statewide Average = 34.9%

Race				Ethnicity	
Black (N = 148)	Indigenous/Native (N = 142)	Multi Racial (N = 79)	White (N = 870)	Hispanic/Latinx (N = 254)	Not Hispanic/Latinx (N = 1,866)
24.3%	26.8%	29.1%	35.2%	42.5%	34.5%

⊺ Represents 95% confidence interval

KEY TAKEAWAYS

Race

Compared to the MHCP statewide average, the immunization rate for MHCP children who are Black is statistically significantly lower.

The Asian and Native Hawaiian/ Pacific Islander categories had less than 60 patients reported, which does not meet the reporting threshold for reliability.

*This measure does not allow for separation of MCO and FFS. MHCP here represents both MCO and FFS.

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 <u>OR</u>
- Flexible sigmoidoscopy during the measurement year or the four years prior <u>OR</u>
- CT colonography during the measurement year or the four years prior <u>OR</u>
- Fecal immunochemical test (FIT)-DNA during the measurement year or two years prior <u>OR</u>
- Guaiac-based fecal occult blood test (gFOBT) or FIT during the measurement year

Medical groups and clinics report data directly to MNCM for this measure based on electronic health records or paper-based medical charts (See Methodology Appendix).

TREND IN COLORECTAL CANCER SCREENING
2018 – 2022
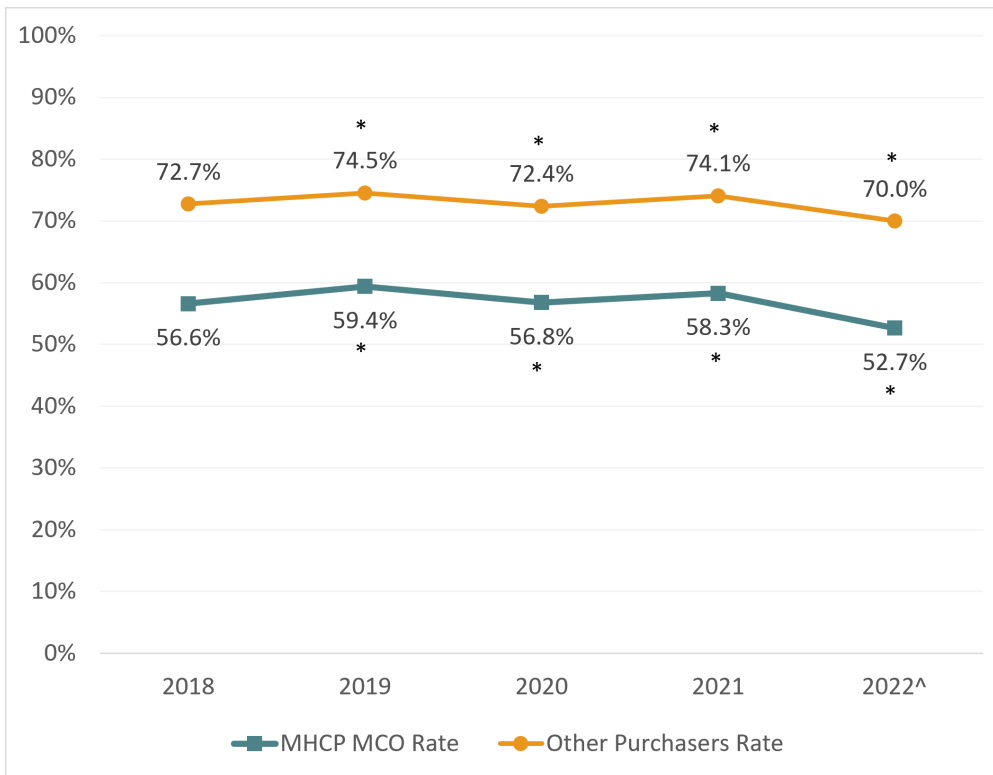
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

*Rate statistically significantly changed from previous year

^The eligible age range for the Colorectal Cancer Screening measure was expanded from 50-75 to 45-75 in 2022 to reflect updated USPSTF recommendations and to align with NCQA's measure.

KEY TAKEAWAYS

- From 2021 to 2022, the MHCP MCO statewide average for the Colorectal Cancer Screening measure statistically significantly decreased by 5.6 percentage points. This decrease may be partly due to the change in age range as noted above.

- In 2022, the 17.3 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

COLORECTAL CANCER SCREENING
(Continued)

In 2022, the eligible age range for the Colorectal Cancer Screening measure was expanded from 50-75 to 45-75 to reflect updated USPSTF recommendations and to align with NCQA's Colorectal Cancer Screening measure. With the significant decrease in rate, MNCM completed additional analyses to better understand the impact the age expansion had on the statewide rate.

MHCP MCO COLORECTAL CANCER SCREENING RATES BY AGE GROUP
2022 measurement year
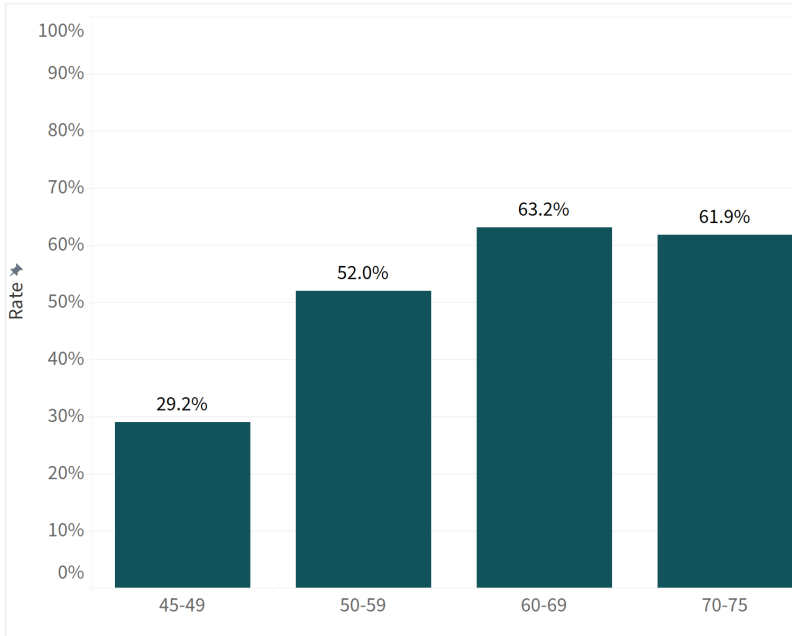
This chart provides a breakdown of Colorectal Cancer Screening rates for the MHCP MCO population by age group.

The 45-49 age group has the lowest rate of Colorectal Cancer Screening compared to any other age group.

MHCP MCO COLORECTAL CANCER SCREENING RATE COMPARISON
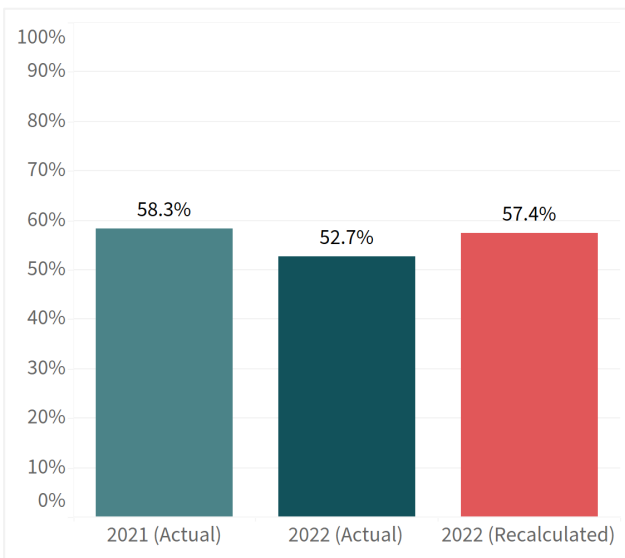
This chart compares the actual Colorectal Cancer Screening rate for the MHCP MCO population from 2021 and 2022 to a recalculated rate for 2022.

The recalculated rate removes the patients from the 45-49 age group from the denominator and recalculates the rate to match the 50-75 age range used for the 2021 rate.

Some of the decline in the rate in 2022 can be attributed to the expansion of the eligible age range. However, the recalculated rate is still significantly below the actual 2021 rate, suggesting that other factors are also contributing to the decline.

COLORECTAL CANCER SCREENING
(Continued)

MHCP MCO RATES BY RACE/ETHNICITY
2022 measurement year

Bar chart showing MHCP MCO screening rates by race/ethnicity for the 2022 measurement year. MHCP MCO Statewide Average = 52.7%.

Race:
- Asian (N = 11,146): 56.3%
- Black (N = 25,100): 44.0%
- Indigenous/Native (N = 2,232): 41.1%
- Multi Racial (N = 1,677): 48.7%
- Native Hawaiian/Pacific Islander (N = 297): 45.8%
- White (N = 91,508): 55.6%

Ethnicity:
- Hispanic/Latinx (N = 6,904): 49.9%
- Not Hispanic/Latinx (N = 128,948): 53.1%
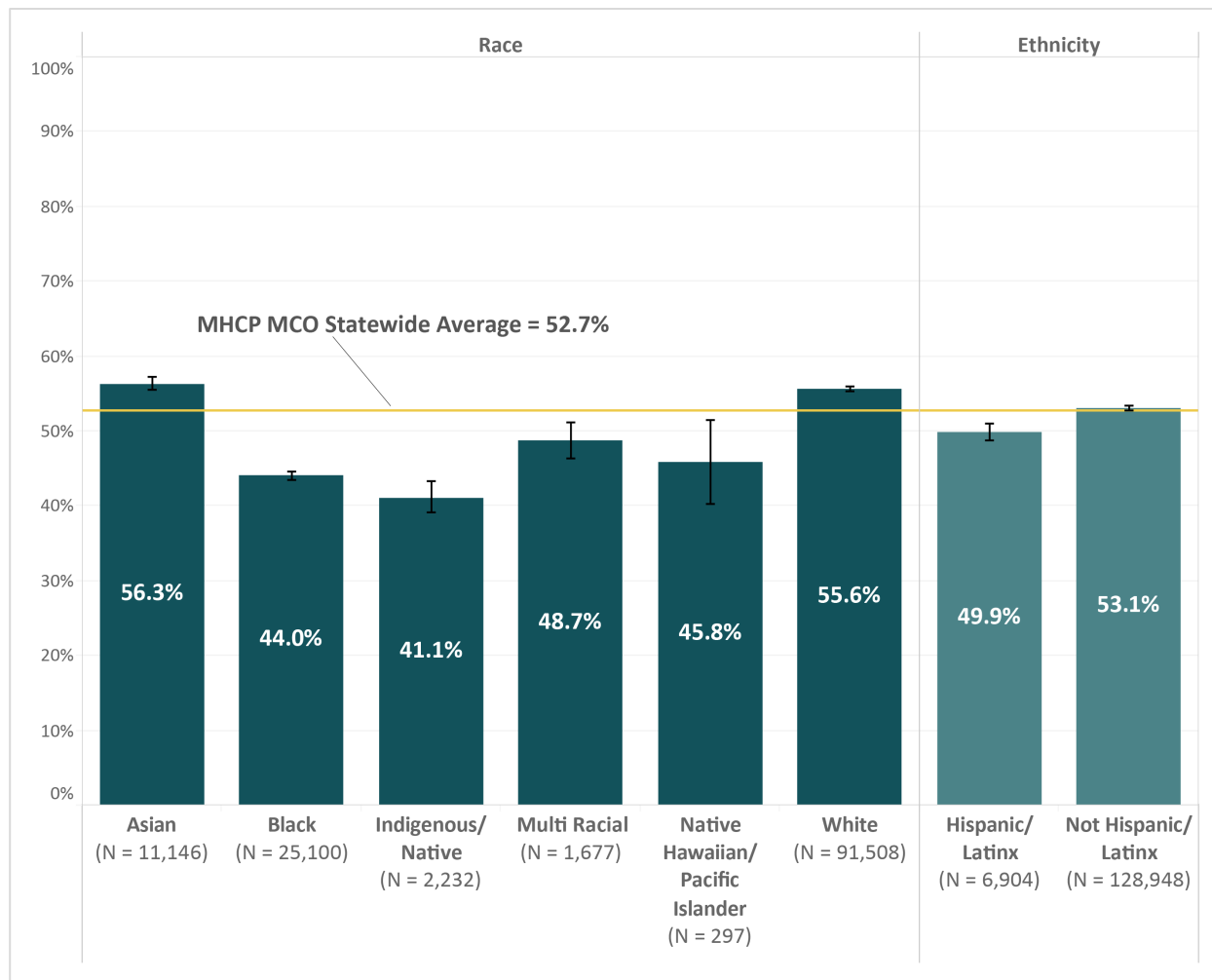
⬙ Represents 95% confidence interval

KEY TAKEAWAYS

Race

Compared to the MHCP statewide average, the screening rates for MHCP MCO patients who are:

- White or Asian are statistically significantly higher.

- Black, Indigenous/Native, Multi-Race or Native Hawaiian/Pacific Islander are statistically significantly lower.

Ethnicity

Compared to the MHCP MCO statewide average, the screening rate for MHCP MCO patients who are Hispanic/Latinx is statistically significantly lower.

COLORECTAL CANCER SCREENING

(Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2022 measurement year

MHCP MCO Statewide Average = 52.7%

Ethiopia (N = 1,885)	Laos (N = 2,370)	Mexico (N = 2,332)	Somalia (N = 6,679)	United States (N = 100,636)
47.2%	46.0%	50.6%	31.2%	54.4%
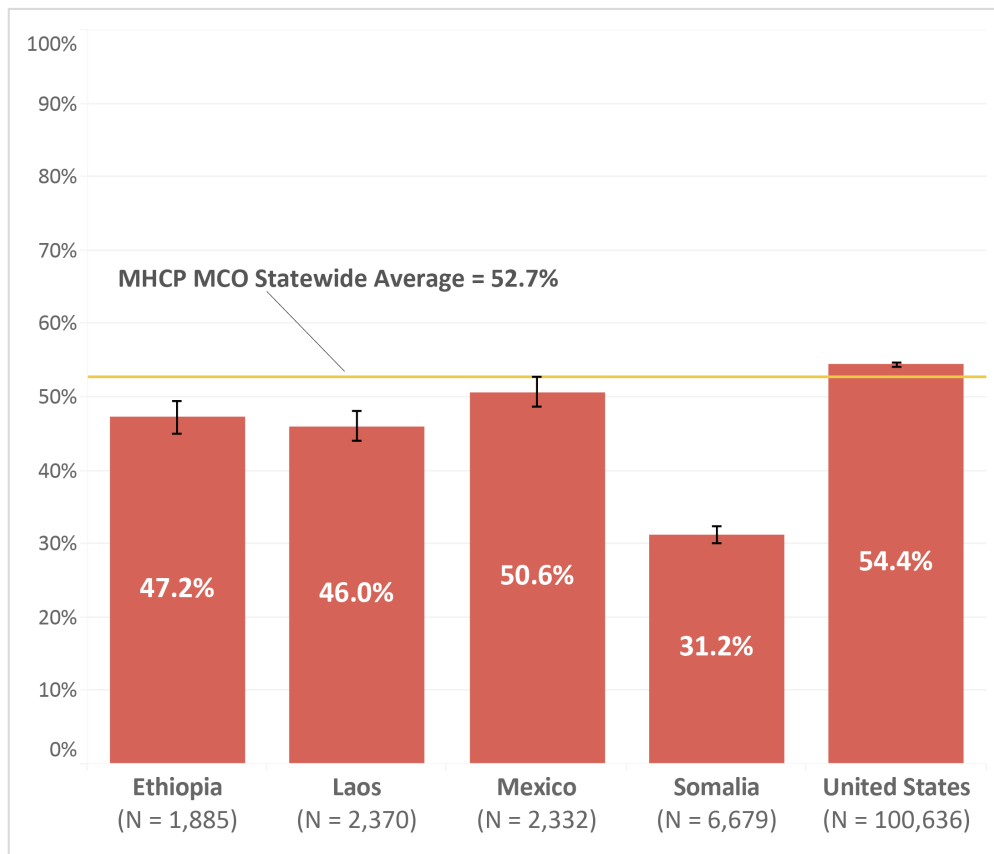
⊺ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients from Ethiopia, Laos, Mexico, Somalia or the United States make up 80 percent of the eligible MHCP MCO population for the Colorectal Cancer Screening measure.

- Compared to the MHCP MCO statewide average, the screening rate(s) for MHCP MCO patients who are from:

  - The United States is statistically significantly higher.

  - Ethiopia, Laos or Somalia are statistically significantly lower.

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

MHCP MCO Statewide Average = 52.7%

Language	Rate
English (N = 118,338)	53.7%
Hmong (N = 2,073)	45.1%
Somali (N = 6,034)	30.6%
Spanish (N = 3,925)	50.9%
Vietnamese (N = 2,101)	68.2%

⊺ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 92 percent of the eligible MHCP MCO population for the Colorectal Cancer Screening measure.

- Compared to the MHCP MCO statewide average, the screening rate(s) for MHCP MCO patients who speak:

  - English or Vietnamese are statistically significantly higher.
  - Hmong or Somali are statistically significantly lower.

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. [4]

Data collected for this measure are from health plan claims (see Methodology appendix).

TREND IN CONTROLLING HIGH BLOOD PRESSURE
2020 – 2022
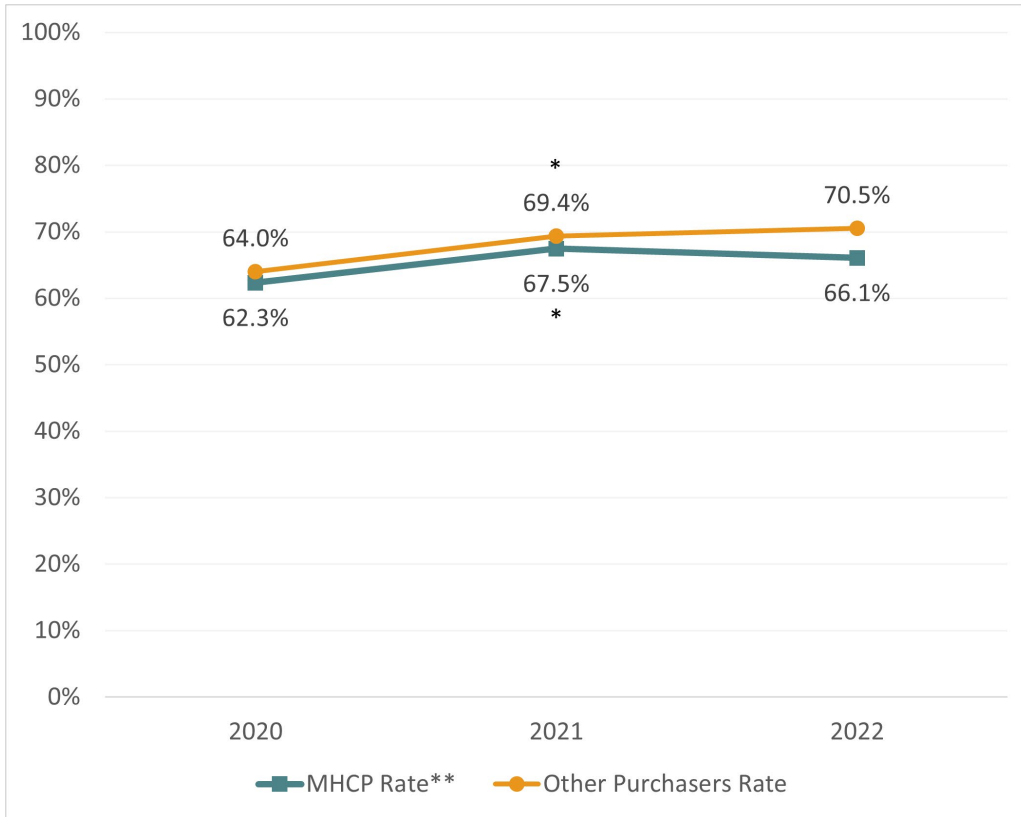
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

*Rate statistically significantly changed from previous year

**This measure does not allow for separation of MCO and FFS. MHCP here represents both MCO and FFS.

Note: 2020 was the first available year using the current measure specifications

KEY TAKEAWAYS

- From 2021 to 2022, the MHCP statewide average for the Controlling High Blood Pressure did not statistically significantly change.

- In 2022, the 4.4 percentage point gap between the MHCP statewide average and the Other Purchasers statewide average was statistically significant.

CONTROLLING HIGH BLOOD PRESSURE

(Continued)

MHCP* RATES BY RACE/ETHNICITY
2022 measurement year
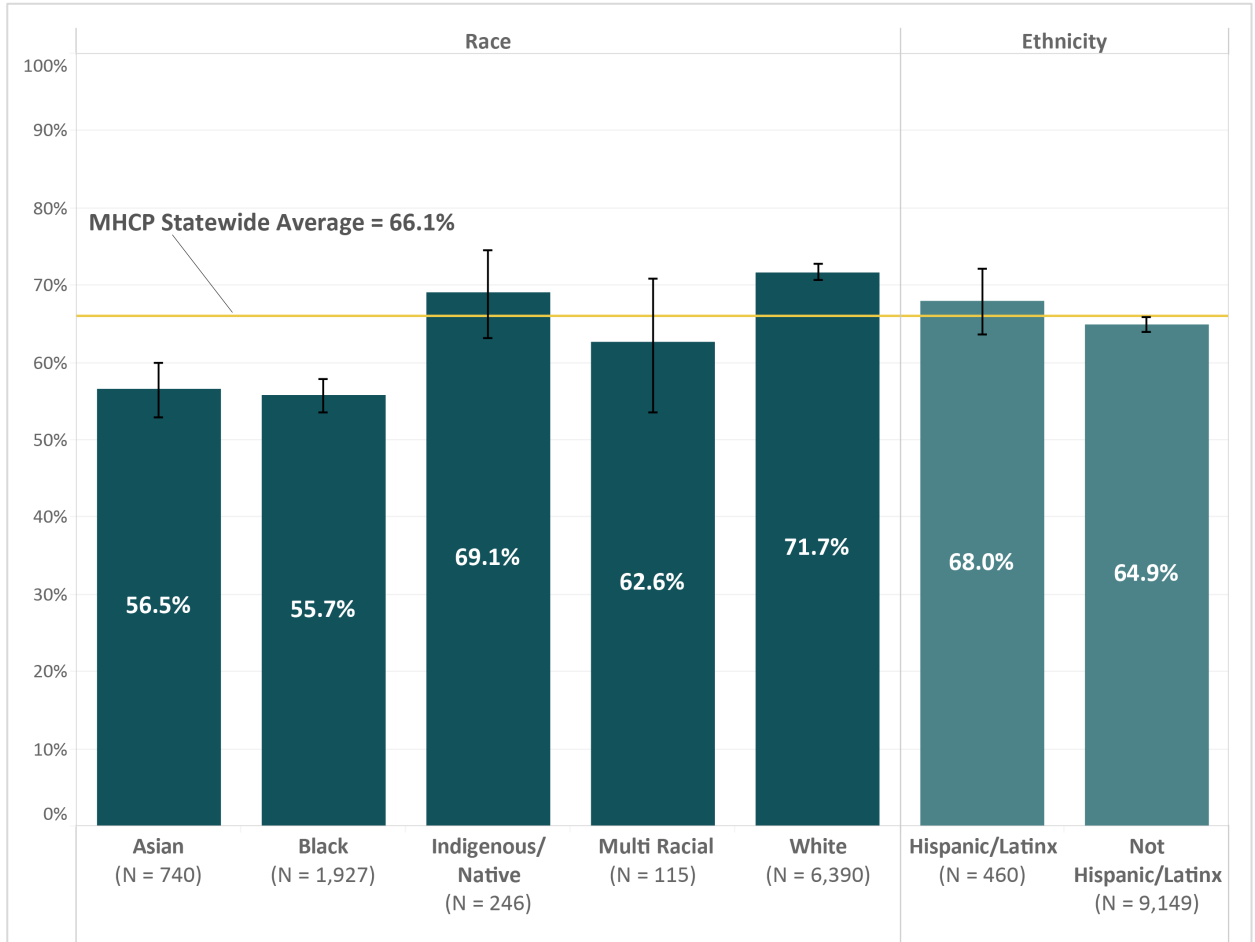
I Represents 95% confidence interval

KEY TAKEAWAYS

Race

Compared to the MHCP statewide average, the rate(s) for MHCP patients who are:

- White is statistically significantly higher.
- Asian or Black are statistically significantly lower.

The Native Hawaiian/ Pacific Islander category had less than 60 patients reported, which does not meet the reporting threshold for reliability.

*This measure does not allow for separation of MCO and FFS. MHCP here represents both MCO and FFS.

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 less than 8.0 mg/mL
2. Blood pressure less than 140/90 mmHg
3. On a statin medication, unless allowed contraindications or exceptions are present
4. Non-tobacco use
5. If patient has ischemic vascular disease, on a daily aspirin or antiplatelet, unless allowed contraindications or exceptions are present

Medical groups and clinics submitted data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

TREND IN OPTIMAL DIABETES CARE
2018 – 2022
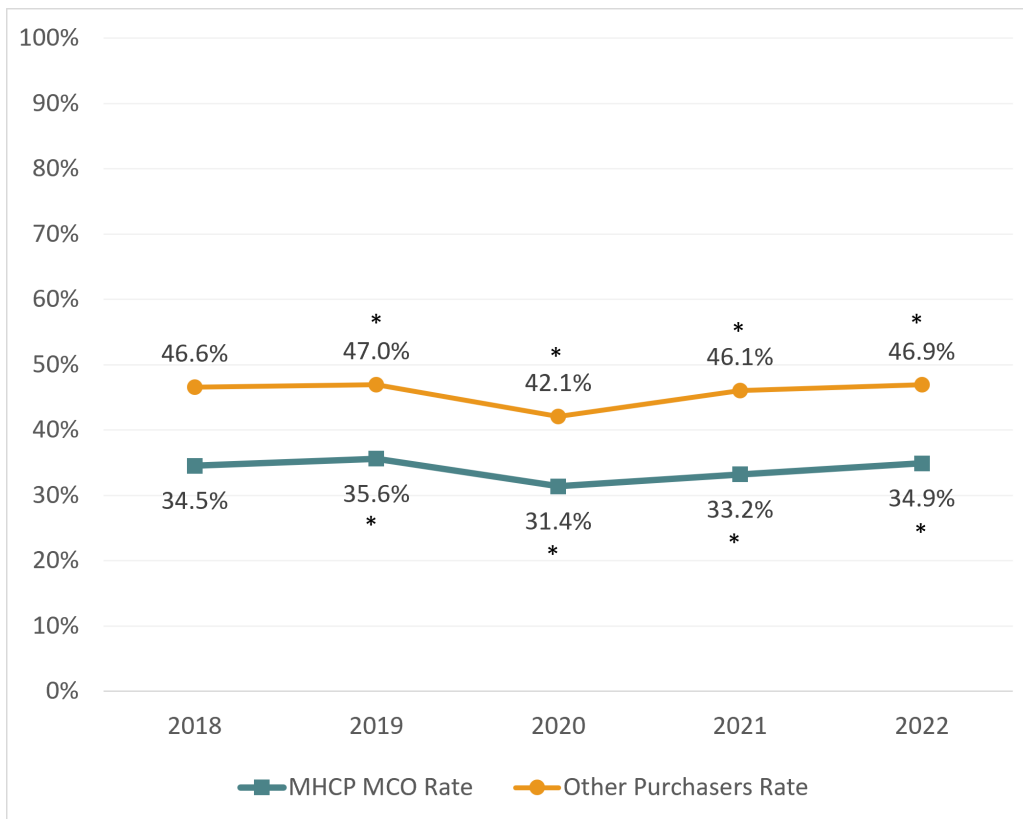
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2021 to 2022, the MHCP MCO statewide average for the Optimal Diabetes Care measure statistically significantly increased by 1.7 percentage points.

- In 2022, the 12.0 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

OPTIMAL DIABETES CARE (Continued)
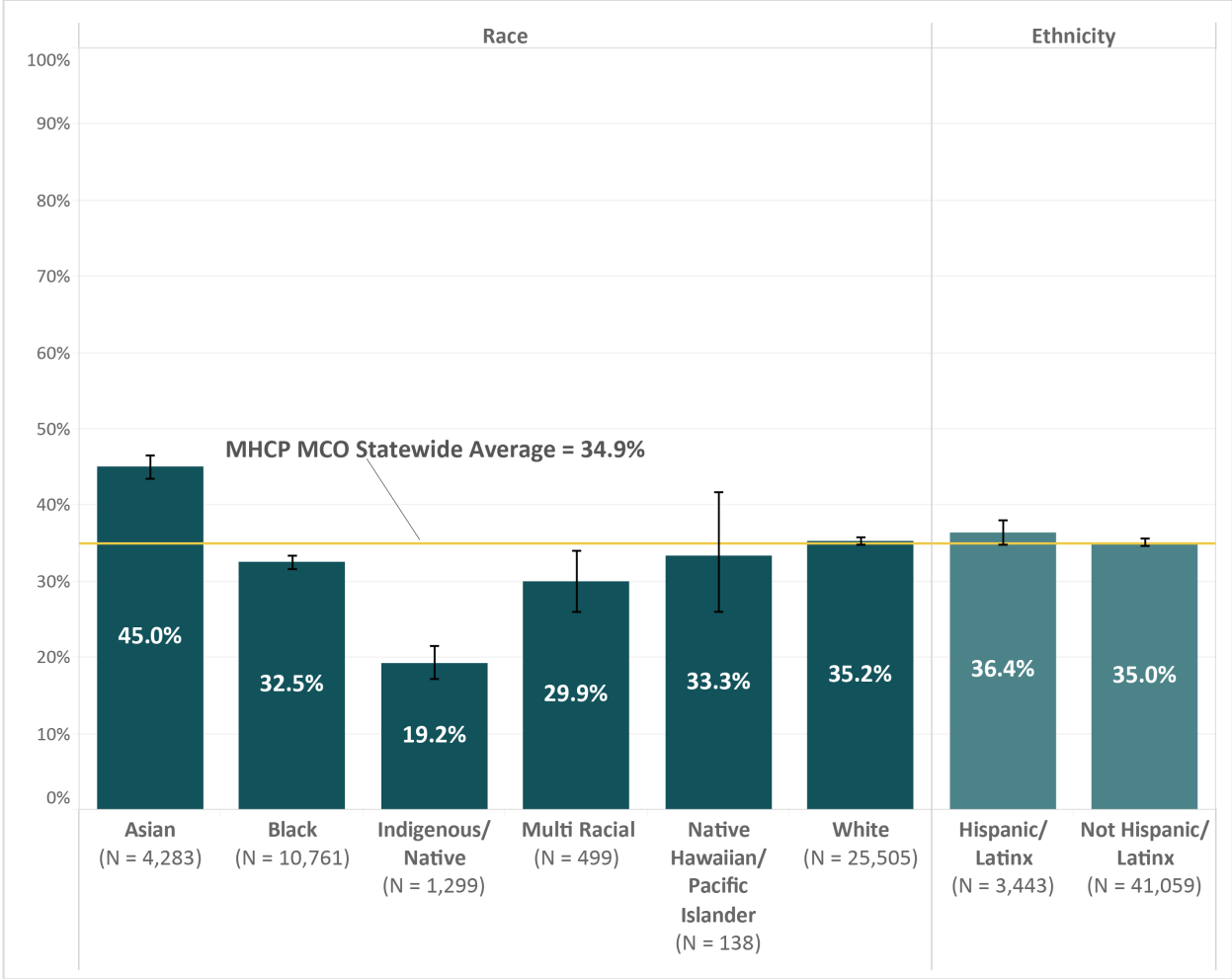
MHCP MCO RATES BY RACE/ETHNICITY
2022 measurement year

MHCP MCO Statewide Average = 34.9%

Race						Ethnicity	
Asian (N = 4,283)	Black (N = 10,761)	Indigenous/Native (N = 1,299)	Multi Racial (N = 499)	Native Hawaiian/Pacific Islander (N = 138)	White (N = 25,505)	Hispanic/Latinx (N = 3,443)	Not Hispanic/Latinx (N = 41,059)
45.0%	32.5%	19.2%	29.9%	33.3%	35.2%	36.4%	35.0%

⊥ Represents 95% confidence interval

KEY TAKEAWAYS
Race
Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who are:

- Asian is statistically significantly higher.
- Black, Indigenous/Native or Multi-Race are statistically significantly lower.

OPTIMAL DIABETES CARE (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN
2022 measurement year

MHCP MCO Statewide Average = 34.9%

Ethiopia (N = 755)	Laos (N = 1,019)	Mexico (N = 1,118)	Somalia (N = 2,791)	United States (N = 31,993)
43.3%	35.7%	38.6%	38.1%	32.0%
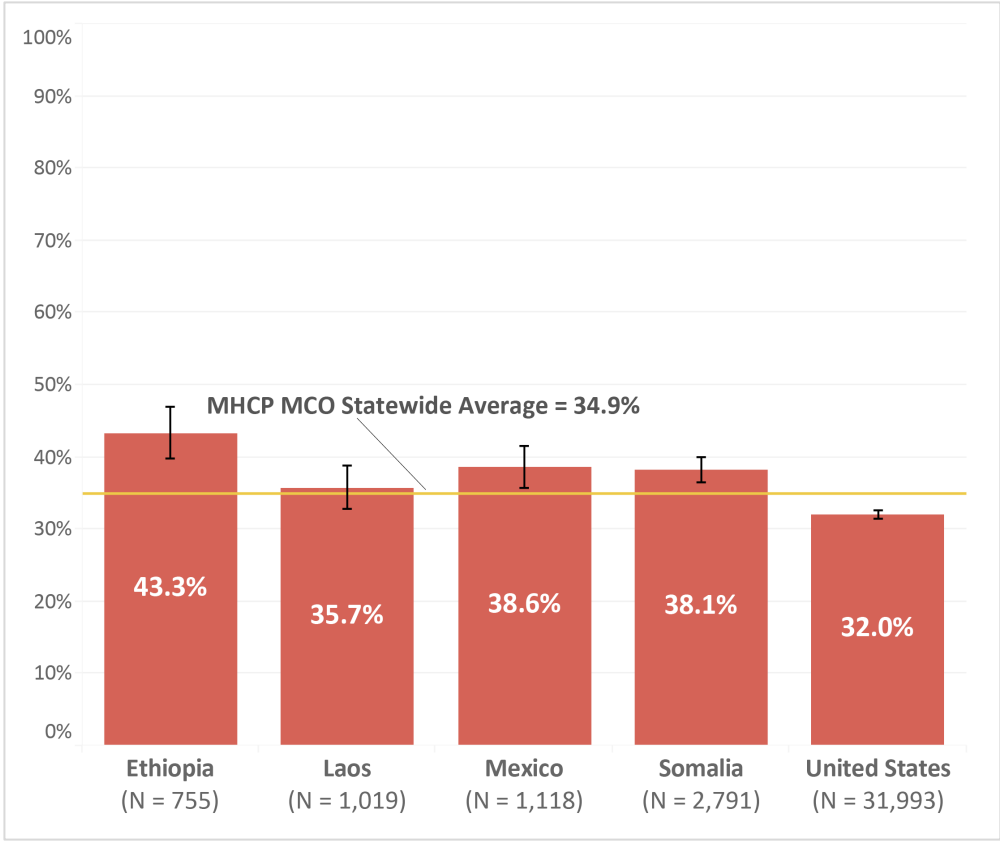
⊥ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients from Ethiopia, Laos, Mexico, Somalia or the United States make up 80 percent of the eligible MHCP MCO population for the Optimal Diabetes Care measure.

- Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who are from:

    - Ethiopia, Mexico or Somalia are statistically significantly higher.

    - The United States is statistically significantly lower.

OPTIMAL DIABETES CARE (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

MHCP MCO Statewide Average = 34.9%

English (N = 37,655)	Hmong (N = 937)	Somali (N = 2,394)	Spanish (N = 1,643)	Vietnamese (N = 583)
33.0%	32.9%	40.0%	41.3%	59.2%
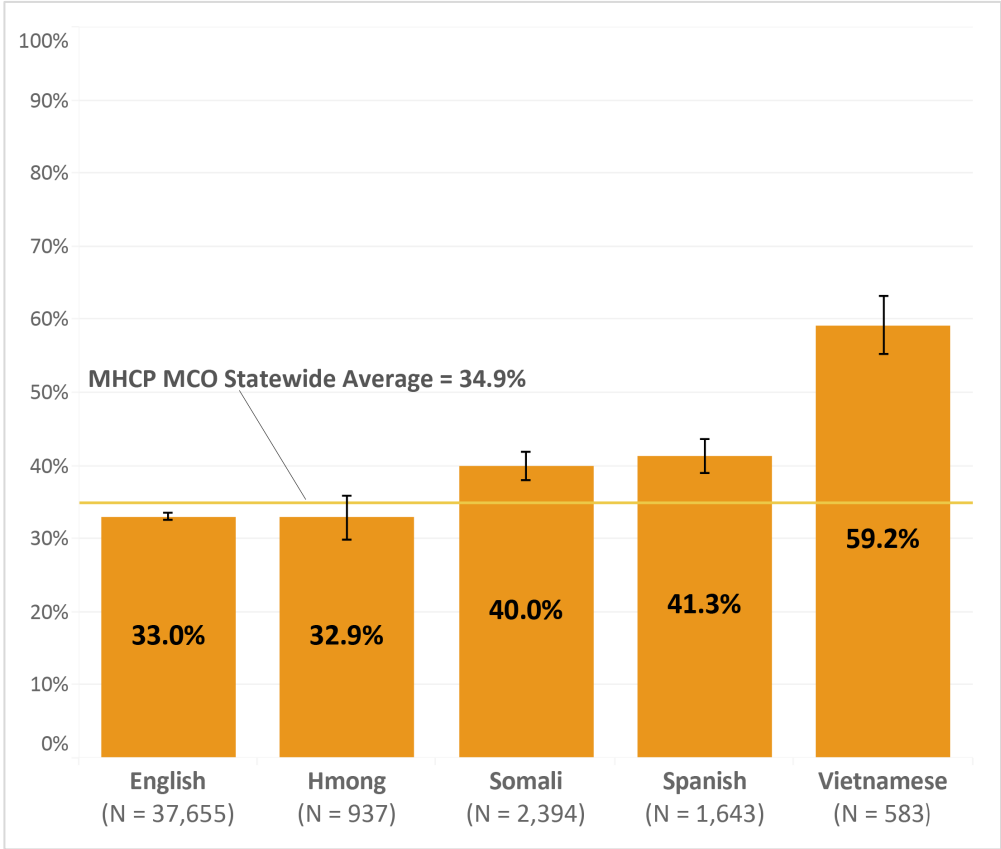
⌶ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 92 percent of the eligible MHCP MCO population for the Optimal Diabetes Care measure.

- Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who speak:

  - Somali, Spanish or Vietnamese are statistically significantly higher.

  - English is statistically significantly lower.

OPTIMAL DIABETES CARE: COMPONENTS

MHCP MCO RATES BY RACE
2022 measurement year
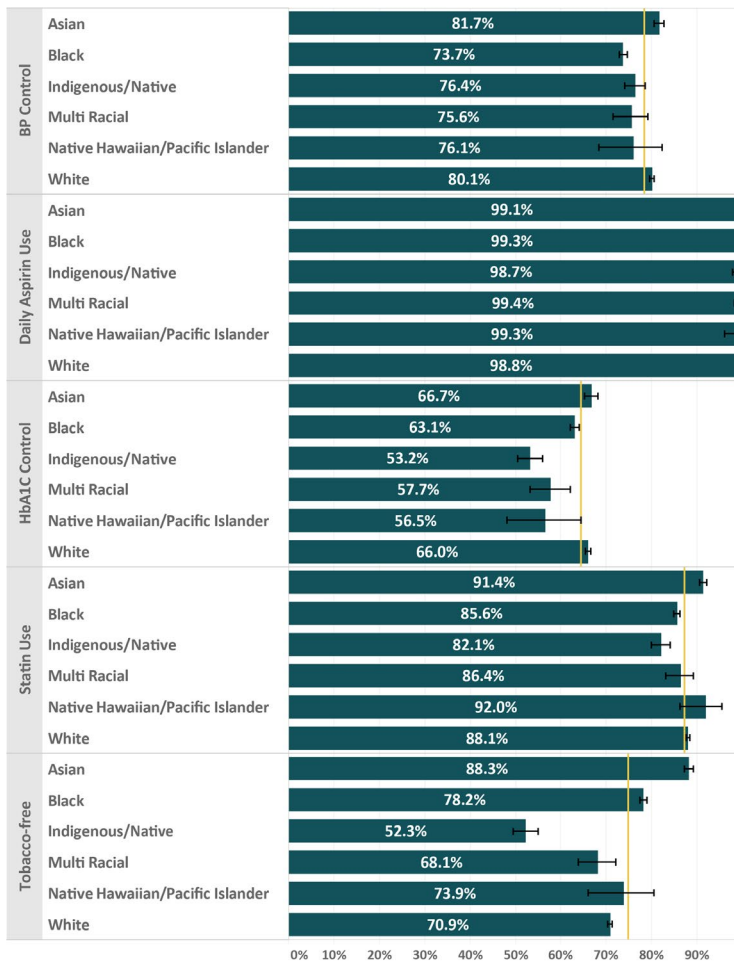
OVERALL MHCP MCO STATEWIDE AVERAGES
by component
(represented by yellow line)
- **BP Control:** 78.3%
- **Daily Aspirin:** 98.9%
- **HbA1c Control:** 64.4%
- **Statin Use:** 87.3%
- **Tobacco-free:** 74.8%

DENOMINATORS BY RACE
(Denominators are the same for each measure)
- **Asian:** 4,283
- **Black:** 10,761
- **Indigenous/ Native:** 1,299
- **Multi-Race:** 499
- **Native Hawaiian/ Pacific Islander:** 138
- **White:** 25,505

⊢——⊣ Represents 95% confidence interval

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for each of the components, MHCP MCO patients who are:

- Asian have statistically significantly higher rates for all components, except for Daily Aspirin Use, which is average.

- Black have statistically significantly lower rates of BP Control and Statin Use, but higher rates of Daily Aspirin Use and being Tobacco-free.

- Indigenous/Native have statistically significantly lower rates of HbA1c Control, Statin Use, and being Tobacco-free.

- Multi Racial have statistically significantly lower rates of HbA1c Control and being Tobacco-free.

- White have statistically significantly lower rates of being Tobacco-free, but higher rates of BP Control, HbA1c Control, and Statin Use.

OPTIMAL DIABETES CARE: COMPONENTS
(Continued)

MHCP MCO RATES BY ETHNICITY
2022 measurement year

	BP Control	Daily Aspirin Use	HbA1C Control	Statin Use	Tobacco-free
Hispanic/Latinx	79.3%	99.0%	58.9%	86.7%	85.1%
Not Hispanic/Latinx	78.5%	99.0%	65.1%	87.6%	73.8%

⊢——⊣ Represents 95% confidence interval

OVERALL MHCP MCO STATEWIDE AVERAGES
by component
(represented by yellow line)
- **BP Control:** 78.3%
- **Daily Aspirin:** 98.9%
- **HbA1c Control:** 64.4%
- **Statin Use:** 87.3%
- **Tobacco-free:** 74.8%

DENOMINATORS BY ETHNICITY
(Denominators are the same for each measure)
- **Hispanic/Latinx:**
- 3,443
- **Not Hispanic/Latinx:** 41,059

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for each of the components, MHCP MCO patients who are:

- Hispanic/Latinx have a statistically significantly lower rate of HbA1c Control, but a higher rate of being Tobacco-free.

- Not Hispanic/Latinx have a statistically significantly lower rate of Tobacco-free.

OPTIMAL DIABETES CARE: COMPONENTS
(Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN
2022 measurement year

OVERALL MHCP MCO STATEWIDE AVERAGES
by component
(represented by yellow line)
- **BP Control:** 78.3%
- **Daily Aspirin:** 98.9%
- **HbA1c Control:** 64.4%
- **Statin Use:** 87.3%
- **Tobacco-free:** 74.8%

DENOMINATORS BY COUNTRY
(Denominators are the same for each measure)
- **Ethiopia:** 755
- **Laos:** 1,019
- **Mexico:** 1,118
- **Somalia:** 2,791
- **United States:** 31,993

⊢——⊣ Represents 95% confidence interval

BP Control
Country	Rate
Ethiopia	81.1%
Laos	74.3%
Mexico	79.9%
Somalia	80.9%
United States	77.6%

Daily Aspirin Use
Country	Rate
Ethiopia	98.9%
Laos	98.9%
Mexico	99.4%
Somalia	99.7%
United States	98.8%

HbA1c Control
Country	Rate
Ethiopia	68.7%
Laos	55.4%
Mexico	59.5%
Somalia	62.5%
United States	63.9%

Statin Use
Country	Rate
Ethiopia	83.6%
Laos	88.8%
Mexico	86.0%
Somalia	82.9%
United States	87.6%

Tobacco-free
Country	Rate
Ethiopia	95.6%
Laos	95.2%
Mexico	92.8%
Somalia	91.9%
United States	68.4%

KEY TAKEAWAYS
Compared to the MHCP MCO statewide averages for each of the components, MHCP MCO patients who are from:

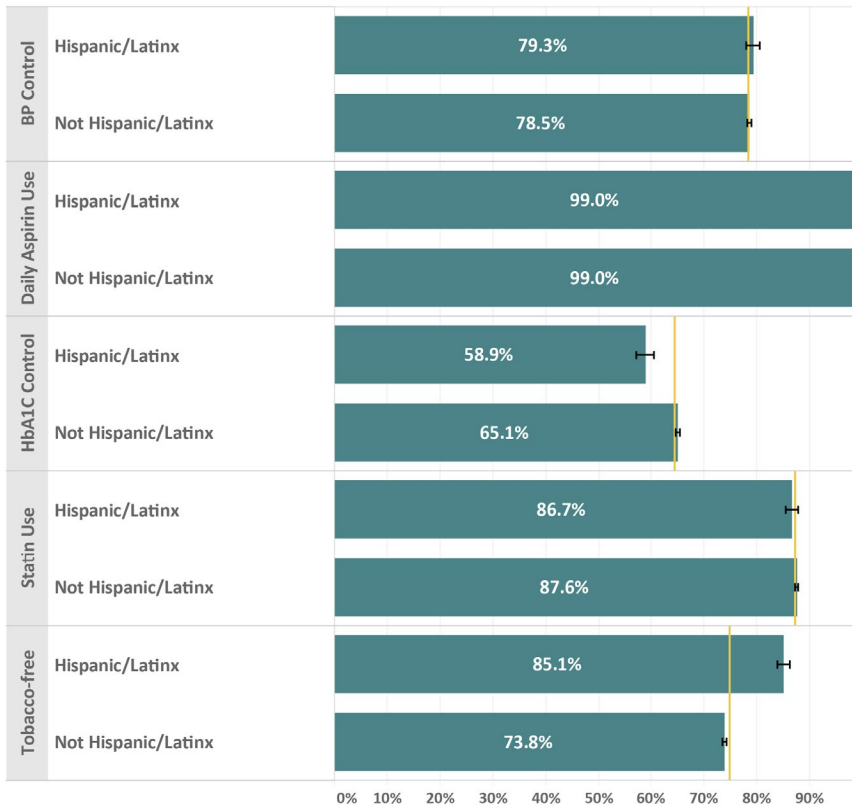- Ethiopia have a statistically significantly lower rate of Statin Use, but higher rates of HbA1c Control and being Tobacco-free.

- Laos have a statistically significantly lower rate of BP Control and HbA1c Control, but a higher rate of being Tobacco-free.

- Mexico have a statistically significantly lower rate of HbA1c Control, but a higher rate of being Tobacco-free.

- Somalia have a statistically significantly lower rate of Statin Use, but higher rates of BP Control, Daily Aspirin Use, and being Tobacco-free.

- United States have a statistically significantly lower rate of being Tobacco-free.

OPTIMAL DIABETES CARE: COMPONENTS
(Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

BP Control
- English: 77.6%
- Hmong: 74.3%
- Somali: 81.2%
- Spanish: 81.7%
- Vietnamese: 84.9%

Daily Aspirin Use
- English: 98.8%
- Hmong: 98.8%
- Somali: 99.7%
- Spanish: 99.3%
- Vietnamese: 99.1%

HbA1c Control
- English: 64.2%
- Hmong: 52.2%
- Somali: 61.9%
- Spanish: 62.3%
- Vietnamese: 80.8%

Statin Use
- English: 87.2%
- Hmong: 88.8%
- Somali: 84.0%
- Spanish: 86.3%
- Vietnamese: 94.5%

Tobacco-free
- English: 70.8%
- Hmong: 96.2%
- Somali: 94.3%
- Spanish: 93.2%
- Vietnamese: 88.9%

OVERALL MHCP MCO STATEWIDE AVERAGES
by component
(represented by yellow line)
- **BP Control:** 78.3%
- **Daily Aspirin:** 98.9%
- **HbA1c Control:** 64.4%
- **Statin Use:** 87.3%
- **Tobacco-free:** 74.8%

DENOMINATORS BY LANGUAGE
(Denominators are the same for each measure)
- **English:** 37,655
- **Hmong:** 937
- **Somali:** 2,394
- **Spanish:** 1,643
- **Vietnamese:** 583

⊢—⊣ Represents 95% confidence interval

KEY TAKEAWAYS
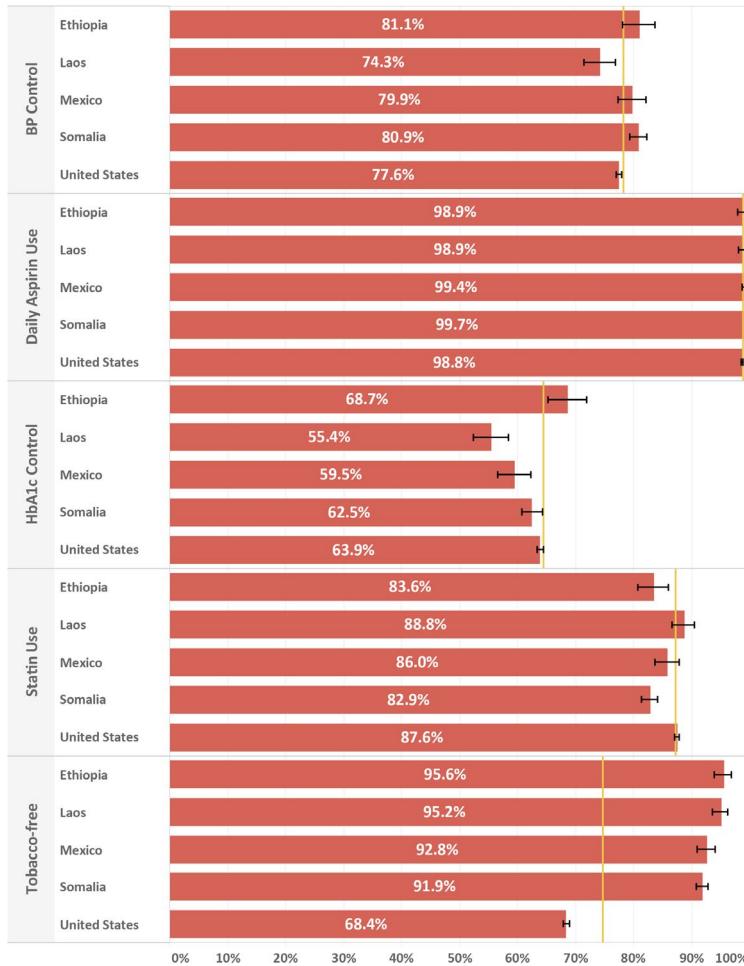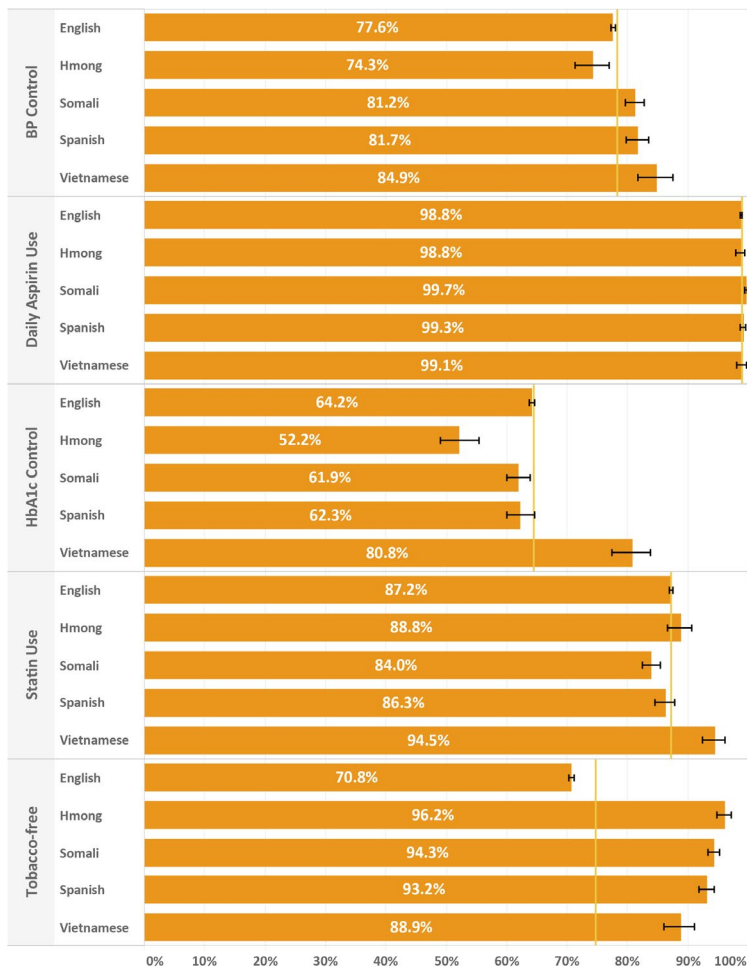Compared to the MHCP MCO statewide averages for the above components, MHCP MCO patients who speak:

- English have a statistically significantly lower rate of being Tobacco-free.

- Hmong have statistically significantly lower rates of BP Control and HbA1c Control, but higher rates of being Tobacco-free.

- Somali have statistically significantly lower rates of Statin Use and HbA1c Control, but higher rates of BP Control, Daily Aspirin Use, and being Tobacco-free.

- Spanish have statistically significantly higher rates of BP Control and being Tobacco-free.

- Vietnamese have statistically significantly higher rates for all components, except for Daily Aspirin Use, which is average.

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. Blood pressure less than 140/90 mmHg
2. On a statin medication, unless allowed contraindications or exceptions are present
3. Non-tobacco use
4. If patient has ischemic vascular disease, on a daily aspirin or antiplatelet, unless allowed contraindications or exceptions are present

Medical groups and clinics submitted data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

TREND IN OPTIMAL VASCULAR CARE
2018 – 2022
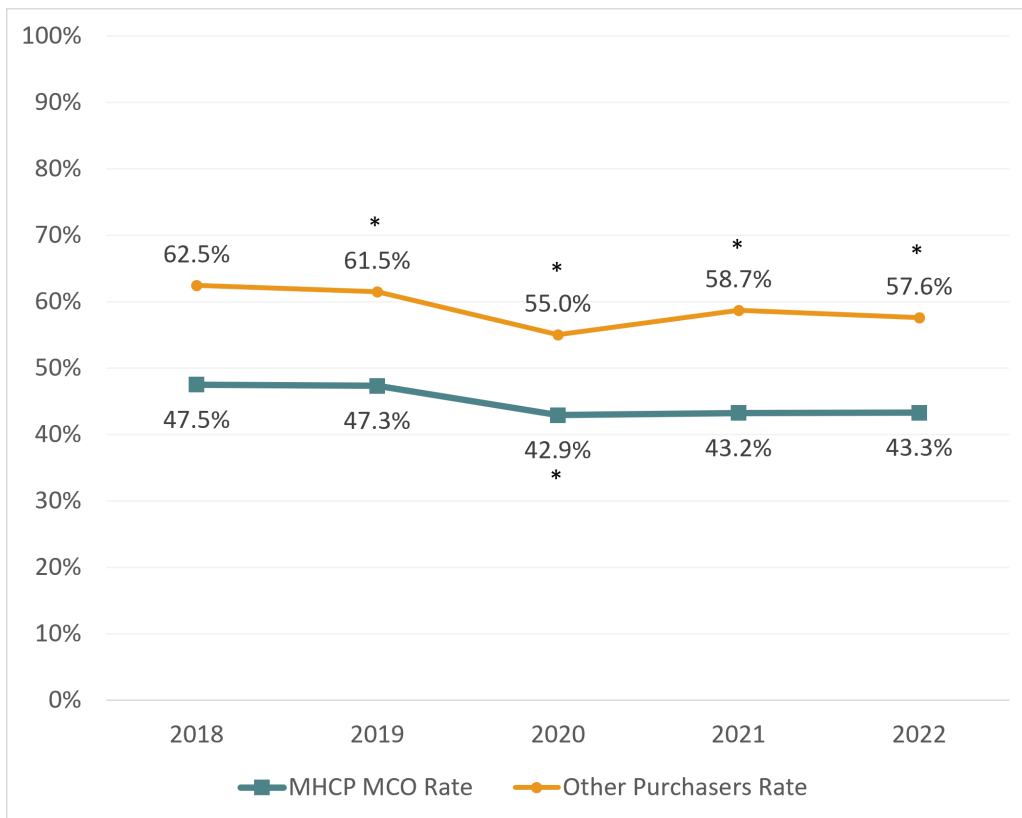
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS
- From 2021 to 2022, the MHCP MCO statewide average for the Optimal Vascular Care measure remained stable.
- In 2022, the 14.3 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

OPTIMAL VASCULAR CARE (Continued)
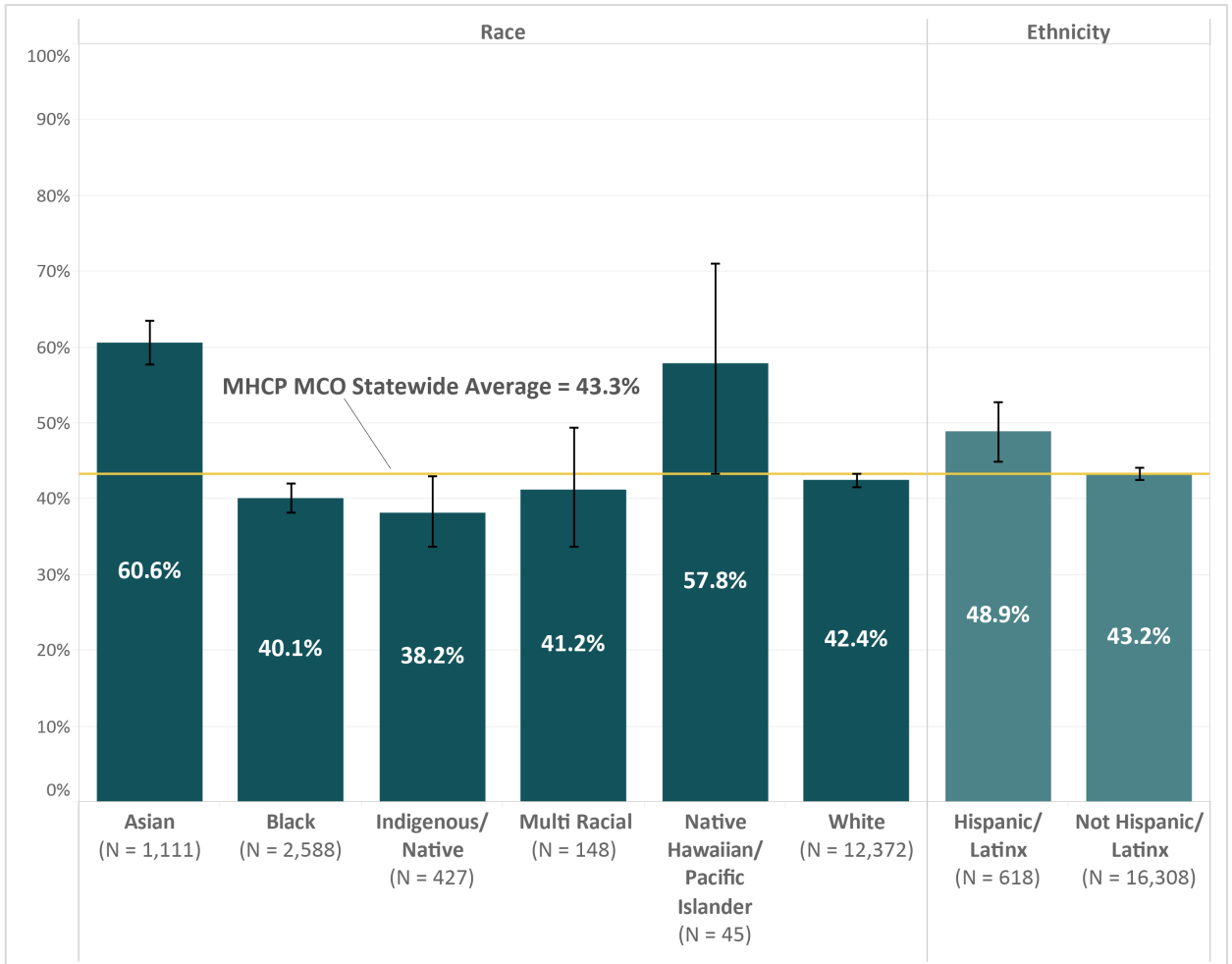
MHCP MCO RATES BY RACE/ETHNICITY
2022 measurement year

MHCP MCO Statewide Average = 43.3%

Race						Ethnicity	
Asian (N = 1,111)	Black (N = 2,588)	Indigenous/ Native (N = 427)	Multi Racial (N = 148)	Native Hawaiian/ Pacific Islander (N = 45)	White (N = 12,372)	Hispanic/ Latinx (N = 618)	Not Hispanic/ Latinx (N = 16,308)
60.6%	40.1%	38.2%	41.2%	57.8%	42.4%	48.9%	43.2%

⌶ Represents 95% confidence interval

KEY TAKEAWAYS

Race

Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who are:

- Asian is statistically significantly higher.
- Black is statistically significantly lower.

Ethnicity

Compared to the MHCP MCO statewide average, the optimal care rate for MHCP MCO patients who are Hispanic/Latinx is statistically significantly higher.

MHCP MCO RATES BY COUNTRY OF ORIGIN
2022 measurement year

MHCP MCO Statewide Average = 43.3%

Laos (N = 349)	Mexico (N = 157)	Somalia (N = 349)	United States (N = 14,303)	Vietnam (N = 144)
62.5%	56.1%	54.4%	40.3%	65.3%
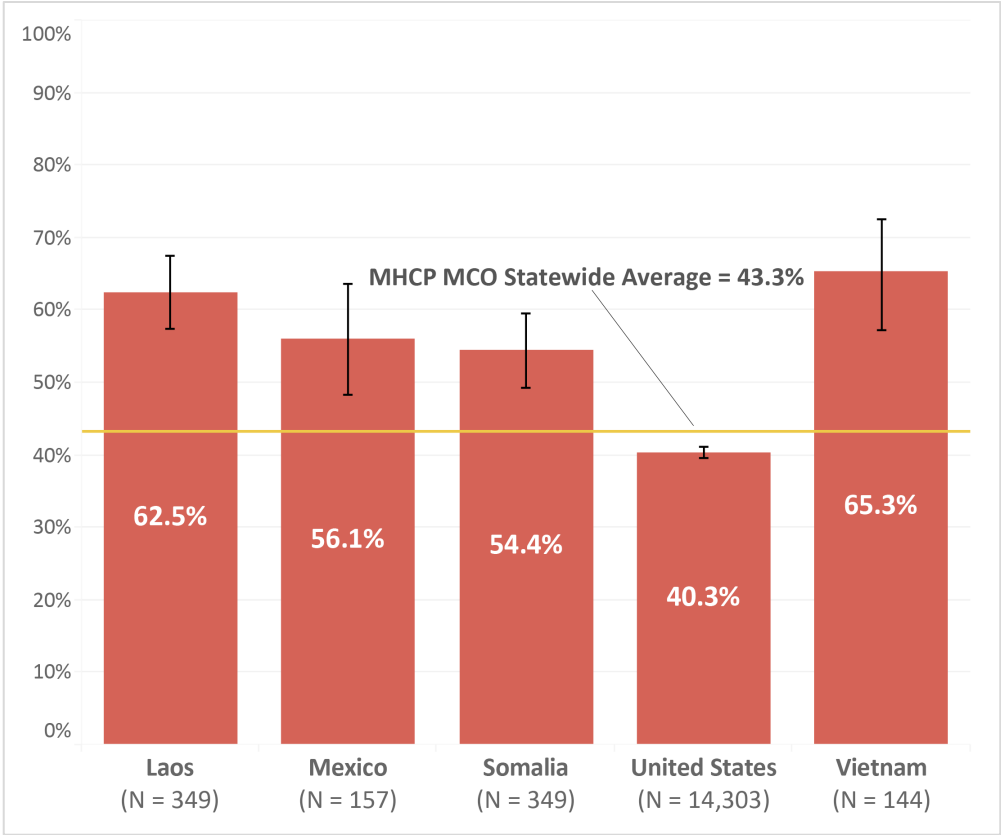
⌶ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients from Laos, Mexico, Somalia, the United States or Vietnam make up 87 percent of the eligible MHCP MCO population for the Optimal Vascular Care measure.

- Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients from:

  - Laos, Mexico, Somalia or Vietnam are statistically significantly higher.
  - The United States is statistically significantly lower.

OPTIMAL VASCULAR CARE (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year
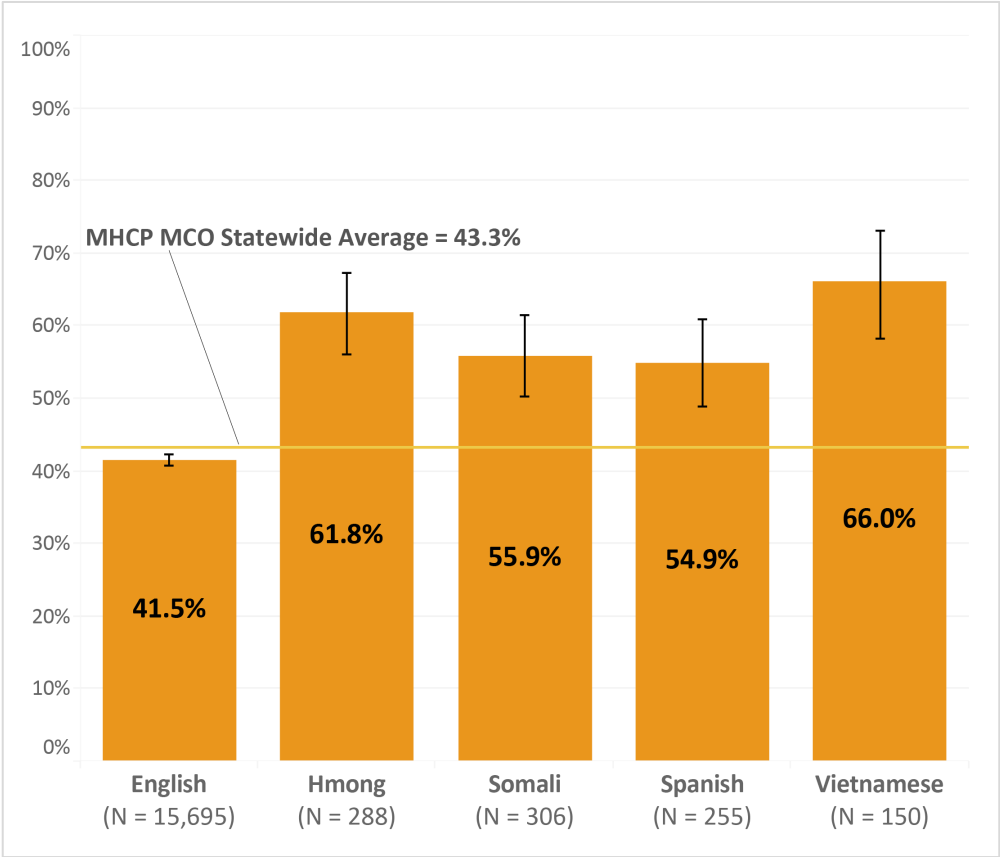
⊥ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 95 percent of the eligible MHCP MCO population for the Optimal Vascular Care measure.

- Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who speak:

  - Hmong, Somali, Spanish or Vietnamese are statistically significantly higher.

  - English is statistically significantly lower.

OPTIMAL VASCULAR CARE: COMPONENTS

MHCP MCO RATES BY RACE
2022 measurement year
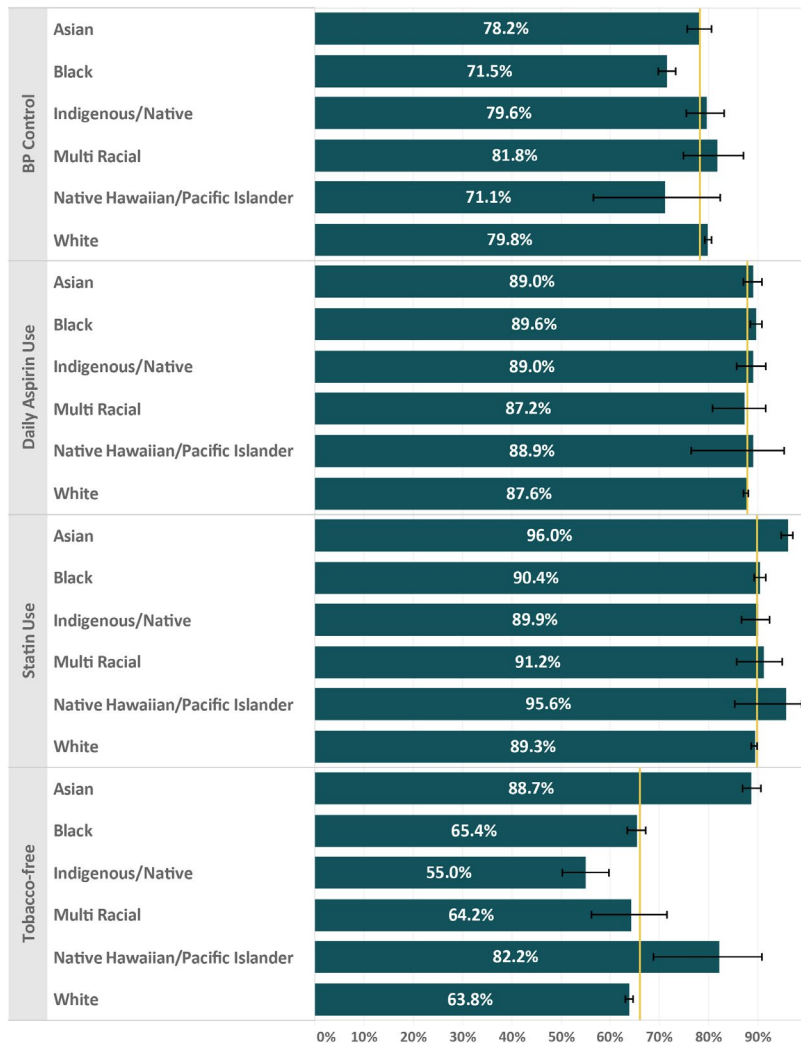
OVERALL MHCP MCO STATEWIDE AVERAGES
by component
(represented by yellow line)
- **BP Control:** 78.1%
- **Daily Aspirin:** 87.8%
- **Statin Use:** 89.8%
- **Tobacco-free:** 66.1%

DENOMINATORS BY RACE
(Denominators are the same for each measure)
- **Asian:** 1,111
- **Black:** 2,588
- **Indigenous/Native:** 427
- **Multi-Race:** 148
- **Native Hawaiian/Pacific Islander:** 45
- **White:** 12,372

⊢⎯⊣ Represents 95% confidence interval

Chart data

BP Control
- Asian: 78.2%
- Black: 71.5%
- Indigenous/Native: 79.6%
- Multi Racial: 81.8%
- Native Hawaiian/Pacific Islander: 71.1%
- White: 79.8%

Daily Aspirin Use
- Asian: 89.0%
- Black: 89.6%
- Indigenous/Native: 89.0%
- Multi Racial: 87.2%
- Native Hawaiian/Pacific Islander: 88.9%
- White: 87.6%

Statin Use
- Asian: 96.0%
- Black: 90.4%
- Indigenous/Native: 89.9%
- Multi Racial: 91.2%
- Native Hawaiian/Pacific Islander: 95.6%
- White: 89.3%

Tobacco-free
- Asian: 88.7%
- Black: 65.4%
- Indigenous/Native: 55.0%
- Multi Racial: 64.2%
- Native Hawaiian/Pacific Islander: 82.2%
- White: 63.8%

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for each of the components, MHCP MCO patients who are:

- Asian have statistically significantly higher rates of Statin Use and being Tobacco-free.

- Black have a statistically significantly lower rate of BP Control, but a higher rate of Daily Aspirin Use.

- Indigenous/Native have a statistically significantly lower rate of being Tobacco-free.

- Native Hawaiian/Pacific Islander have a statistically significantly higher rate of being Tobacco-free.

- White have a statistically significantly lower rate of being Tobacco-free, but a higher rate of BP Control.

OPTIMAL VASCULAR CARE: COMPONENTS
(Continued)

MHCP MCO RATES BY ETHNICITY
2022 measurement year
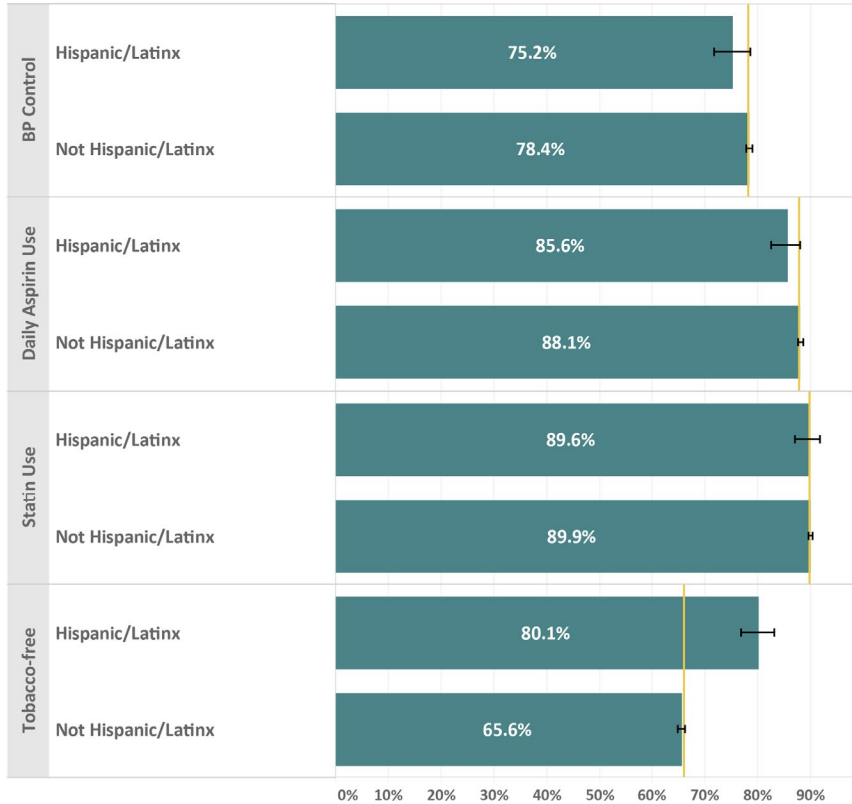
OVERALL MHCP MCO STATEWIDE AVERAGES
by component
(represented by yellow line)
- **BP Control:** 78.1%
- **Daily Aspirin:** 87.8%
- **Statin Use:** 89.8%
- **Tobacco-free:** 66.1%

DENOMINATORS BY ETHNICITY
(Denominators are the same for each measure)
- **Hispanic/Latinx:** 618
- **Not Hispanic/Latinx:** 16,308

⊢⟶⊣ Represents 95% confidence interval

KEY TAKEAWAYS
Compared to the MHCP MCO statewide average, MHCP MCO patients who are Hispanic/Latinx have a statistically significantly higher rate of being Tobacco-free.

OPTIMAL VASCULAR CARE: COMPONENTS

(Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2022 measurement year
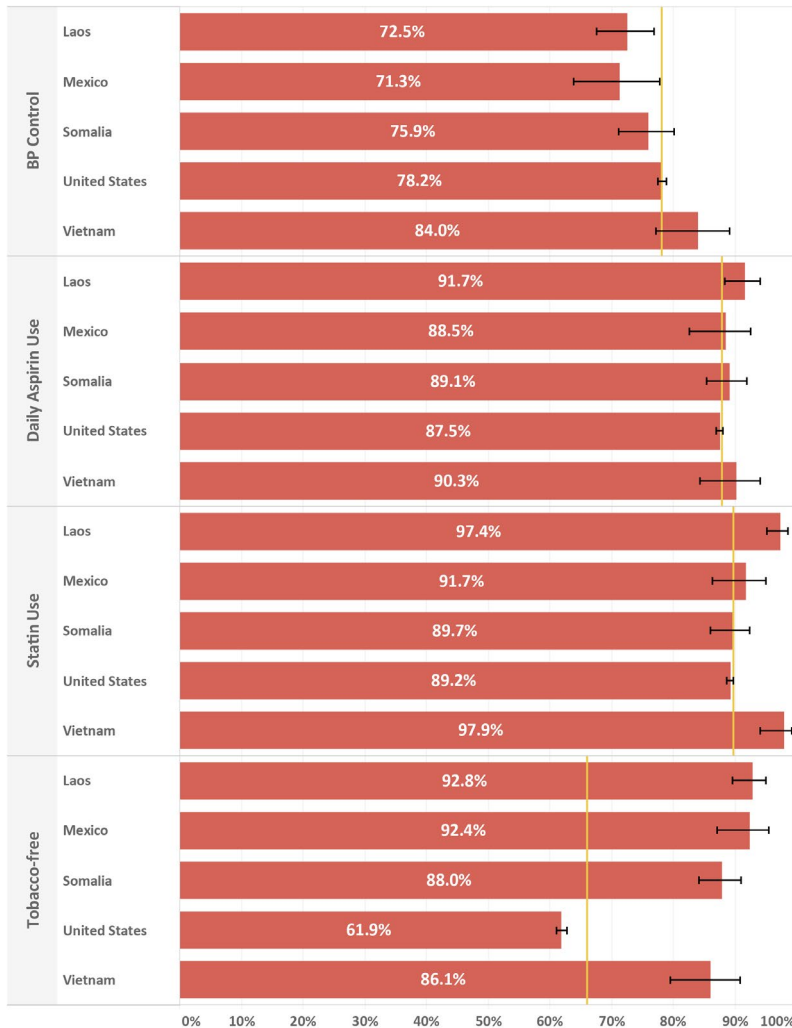
OVERALL MHCP MCO STATEWIDE AVERAGES
by component
(represented by yellow line)
- **BP Control:** 78.1%
- **Daily Aspirin:** 87.8%
- **Statin Use:** 89.8%
- **Tobacco-free:** 66.1%

DENOMINATORS BY RACE
(Denominators are the same for each measure)
- **Laos:** 349
- **Mexico:** 157
- **Somalia:** 349
- **United States:** 14,305
- **Vietnam:** 144

⊢—⊣ Represents 95% confidence interval

BP Control
Country	Rate
Laos	72.5%
Mexico	71.3%
Somalia	75.9%
United States	78.2%
Vietnam	84.0%

Daily Aspirin Use
Country	Rate
Laos	91.7%
Mexico	88.5%
Somalia	89.1%
United States	87.5%
Vietnam	90.3%

Statin Use
Country	Rate
Laos	97.4%
Mexico	91.7%
Somalia	89.7%
United States	89.2%
Vietnam	97.9%

Tobacco-free
| Country	Rate
Laos	92.8%
Mexico	92.4%
Somalia	88.0%
United States	61.9%
Vietnam	86.1%

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for each of the components, MHCP MCO patients who are from:

- Laos have a statistically significantly lower rate of BP Control, but higher rates of Daily Aspirin Use, Statin Use, and being Tobacco-free.

- Mexico have a statistically significantly higher rate of being Tobacco-free.

- Somalia have a statistically significantly higher rate of being Tobacco-free.

- United States have a statistically significantly lower rate of being Tobacco-free.

- Vietnam have statistically significantly higher rates of Statin Use and being Tobacco-free.

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

OVERALL MHCP MCO STATEWIDE AVERAGES
by component
(represented by yellow line)
- **BP Control:** 78.1%
- **Daily Aspirin:** 87.8%
- **Statin Use:** 89.8%
- **Tobacco-free:** 66.1%

DENOMINATORS BY LANGUAGE
(Denominators are the same for each measure)
- **English:** 15,695
- **Hmong:** 288
- **Somali:** 306
- **Spanish:** 255
- **Vietnamese:** 150

⊢⊣ Represents 95% confidence interval

Chart data:

Component	Language	Rate
BP Control	English	78.4%
BP Control	Hmong	72.2%
BP Control	Somali	75.2%
BP Control	Spanish	70.6%
BP Control	Vietnamese	83.3%
Daily Aspirin Use	English	87.7%
Daily Aspirin Use	Hmong	89.6%
Daily Aspirin Use	Somali	88.2%
Daily Aspirin Use	Spanish	88.6%
Daily Aspirin Use	Vietnamese	90.0%
Statin Use	English	89.4%
Statin Use	Hmong	96.5%
Statin Use	Somali	88.9%
Statin Use	Spanish	93.3%
Statin Use	Vietnamese	98.0%
Tobacco-free	English	63.2%
Tobacco-free	Hmong	95.5%
Tobacco-free	Somali	91.5%
Tobacco-free	Spanish	90.2%
Tobacco-free	Vietnamese	88.7%

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for the above components, MHCP MCO patients who speak:

- English have a statistically significantly lower rate of being Tobacco-free.
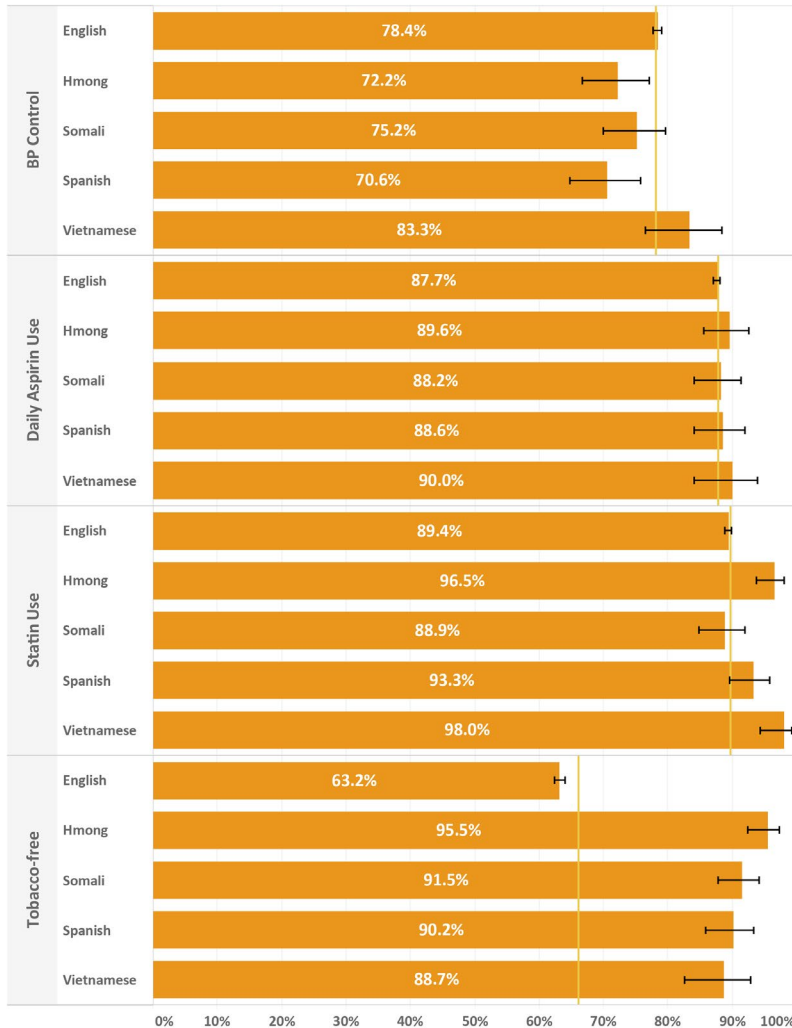
- Hmong have a statistically significantly lower rate of BP Control, but higher rates of Statin Use and being Tobacco-free.

- Somali have a statistically significantly higher rate of being Tobacco-free.

- Spanish have a statistically significantly lower rate of BP Control, but a higher rate of being Tobacco-free.

- Vietnamese have statistically significantly higher rates of Statin Use and being Tobacco-free.

OPTIMAL ASTHMA CONTROL - ADULTS

The percentage of adults (18-50 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)

Medical groups and clinics submitted data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

TREND IN OPTIMAL ASTHMA CONTROL - ADULTS
2018 – 2022
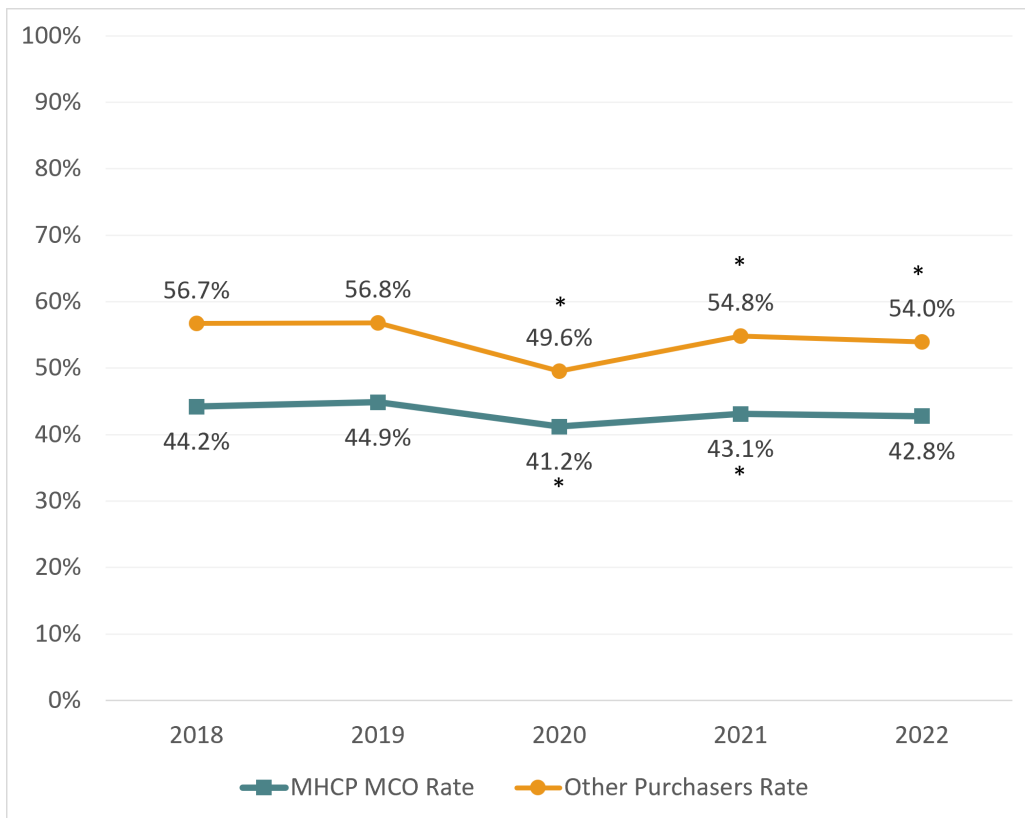
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2021 to 2022, the MHCP MCO statewide average for the Optimal Asthma Control – Adults measure remained stable.

- In 2022, the 11.2 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

OPTIMAL ASTHMA CONTROL – ADULTS (Continued)

MHCP MCO RATES BY RACE/ETHNICITY
2022 measurement year

MHCP MCO Statewide Average = 42.8%

Race						Ethnicity	
Asian (N = 1,062)	Black (N = 6,906)	Indigenous/Native (N = 709)	Multi Racial (N = 962)	Native Hawaiian/Pacific Islander (N = 89)	White (N = 21,691)	Hispanic/Latinx (N = 2,315)	Not Hispanic/Latinx (N = 30,257)
50.6%	38.4%	30.5%	40.4%	36.0%	44.8%	42.7%	43.0%
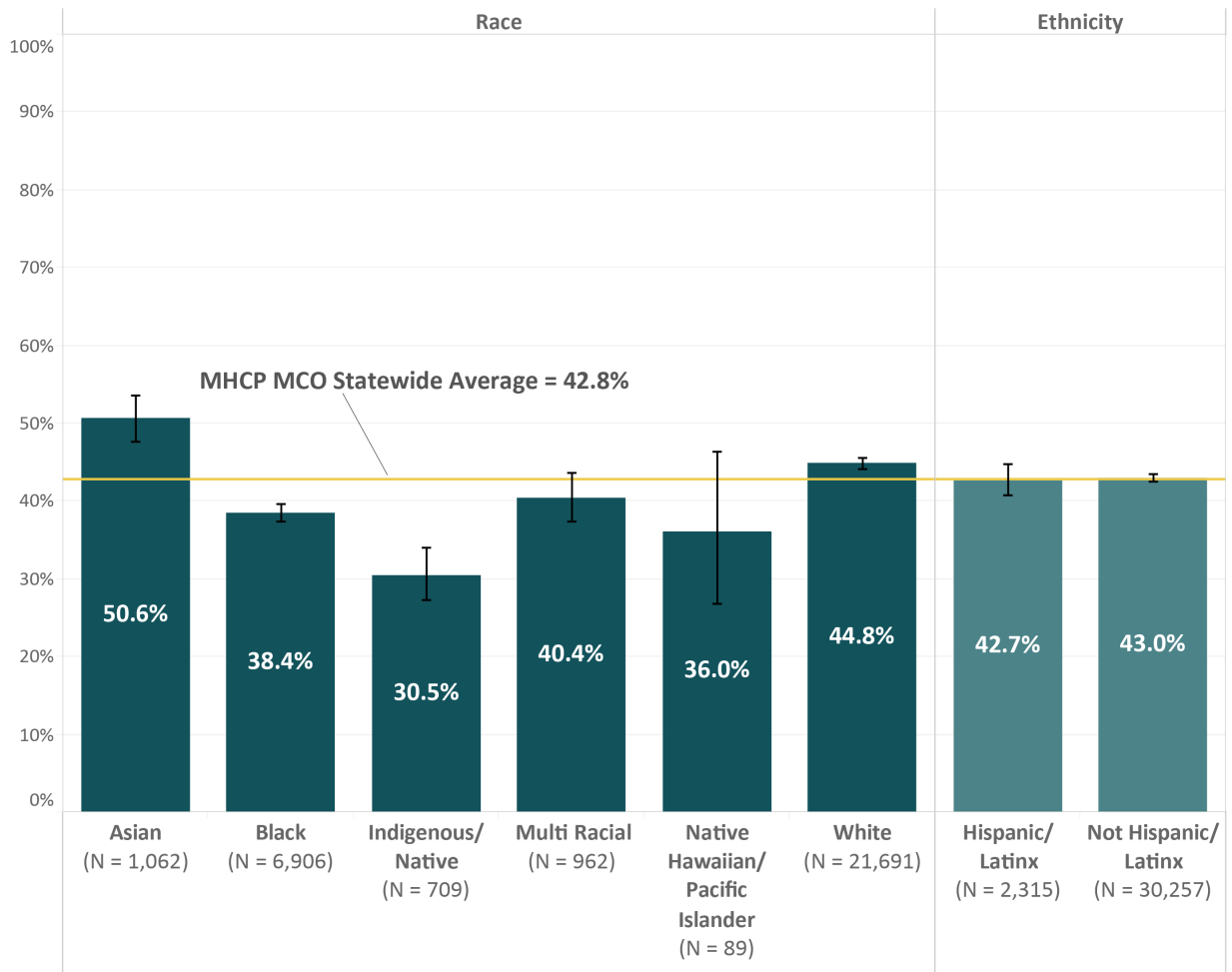
⌶ Represents 95% confidence interval

KEY TAKEAWAYS

Race

Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who are:

- Asian or White are statistically significantly higher.
- Black or Indigenous/Native are statistically significantly lower.

OPTIMAL ASTHMA CONTROL – ADULTS (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN
2022 measurement year

MHCP MCO Statewide Average = 42.8%

Burma (N = 116)	Kenya (N = 106)	Mexico (N = 191)	Somalia (N = 653)	United States (N = 29,373)
61.2%	34.9%	45.0%	36.6%	42.7%
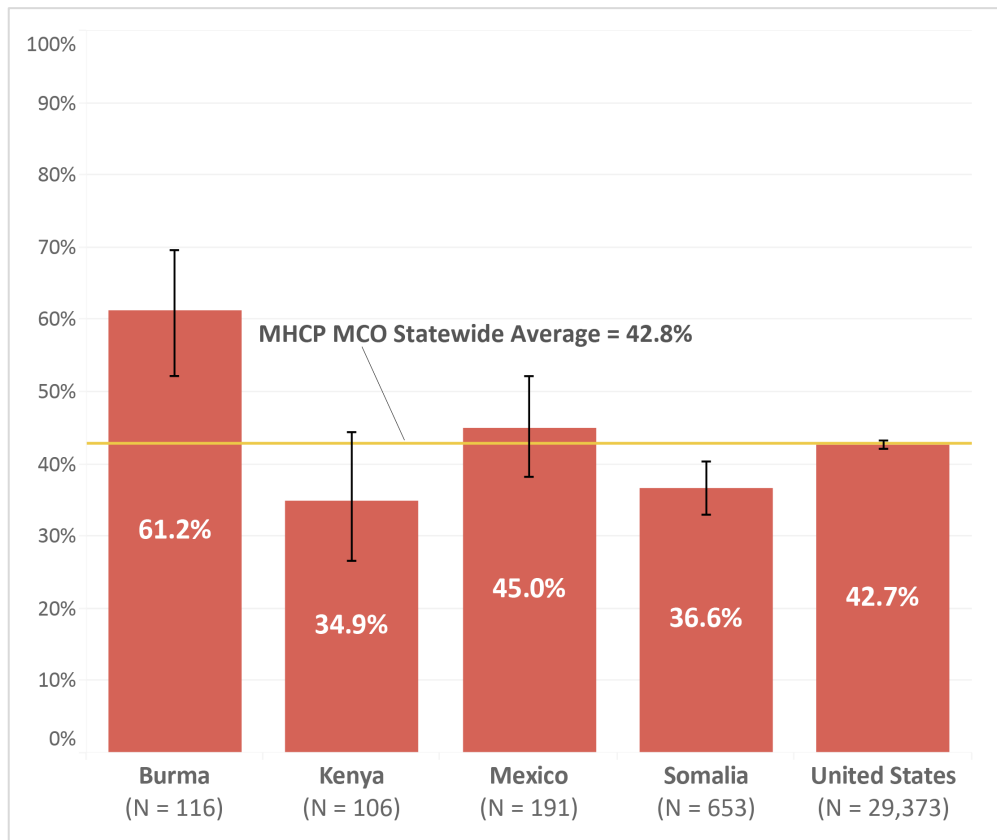
⌶ Represents 95% confidence interval

KEY TAKEAWAYS

- Adult patients from Burma, Kenya, Mexico, Somalia or the United States make up 90 percent of the eligible MHCP MCO population for the Optimal Asthma Control measure.

- Compared to the MHCP MCO statewide average, the optimal care rate for MHCP MCO patients from:

  - Burma is statistically significantly higher.

  - Somalia is statistically significantly lower.

OPTIMAL ASTHMA CONTROL – ADULTS (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

MHCP MCO Statewide Average = 42.8%

Arabic (N = 77)	English (N = 32,476)	Karen (N = 141)	Somali (N = 521)	Spanish (N = 358)
37.7%	43.0%	53.2%	35.7%	43.3%
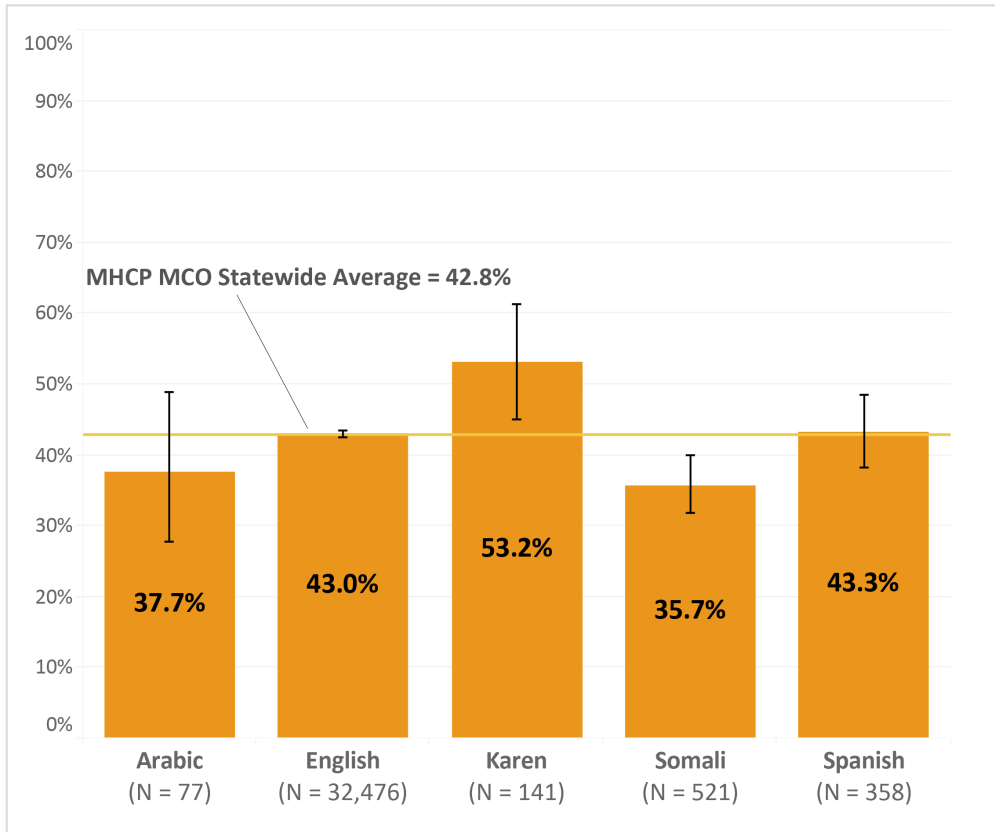
⊥ Represents 95% confidence interval

KEY TAKEAWAYS

- Adult patients who prefer to speak Arabic, English, Karen, Somali or Spanish make up 99 percent of the eligible MHCP MCO population for the Optimal Asthma Control measure.

- Compared to the MHCP MCO statewide average, the optimal control rate for MHCP MCO adults who speak:

  - Karen is statistically significantly higher.
  - Somali is statistically significantly lower.

OPTIMAL ASTHMA CONTROL – CHILDREN

The percentage of 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)

Medical groups and clinics submitted data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

TREND IN OPTIMAL ASTHMA CONTROL - CHILDREN
2018 – 2022
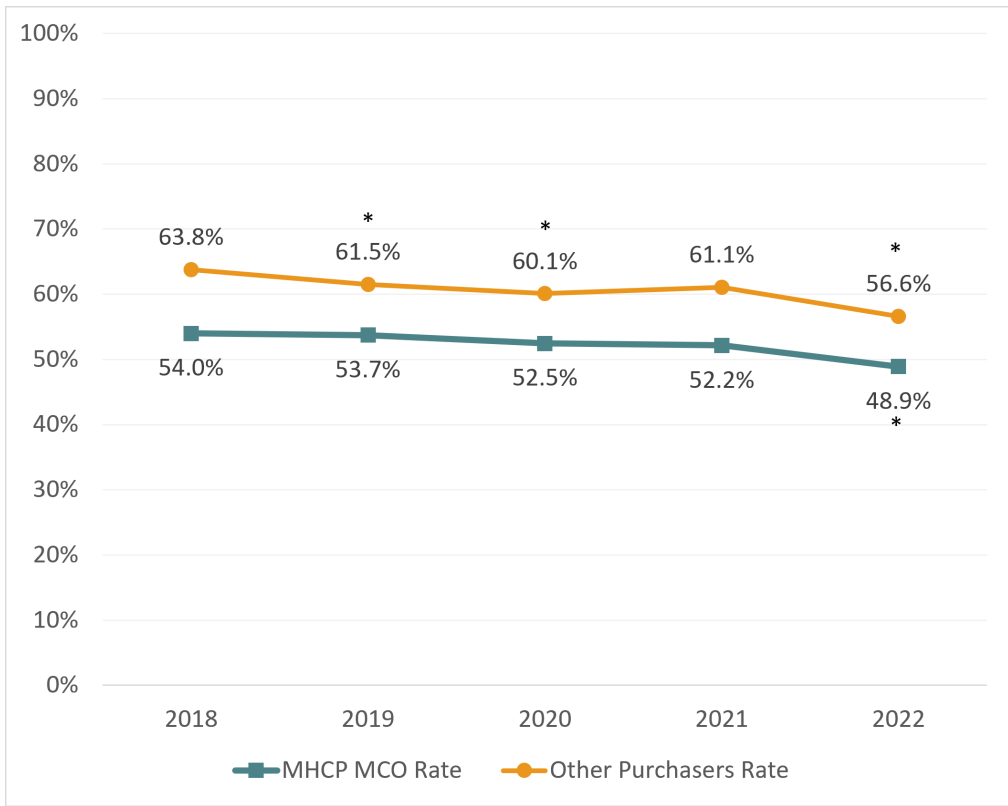
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS
- From 2021 to 2022, the MHCP MCO statewide average for the Optimal Asthma Control – Children statistically significantly decreased by 3.3 percentage points.

- In 2021, the 8.9 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

OPTIMAL ASTHMA CONTROL – CHILDREN (Continued)

MHCP MCO RATES BY RACE/ETHNICITY
2022 measurement year
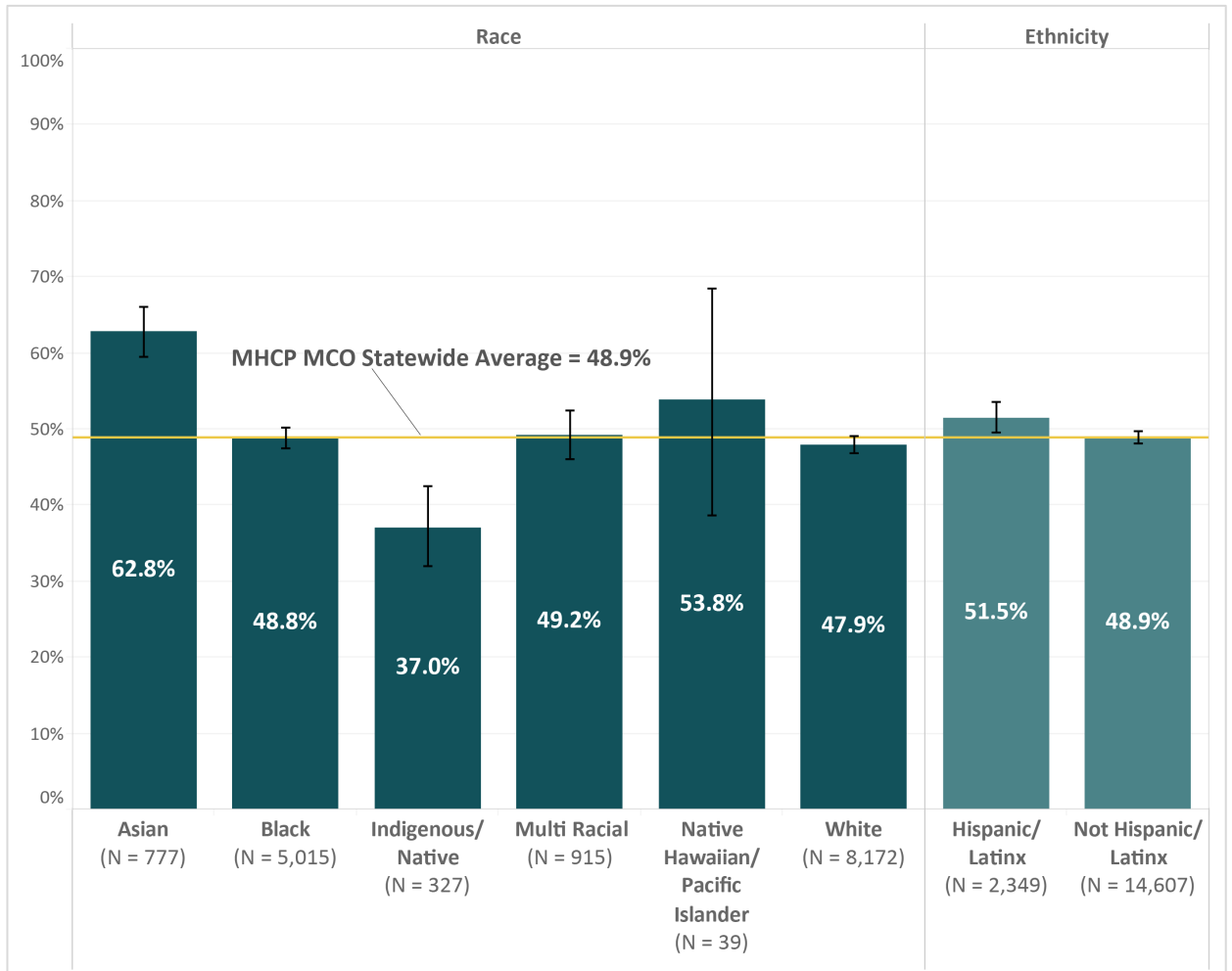
⊥ Represents 95% confidence interval

KEY TAKEAWAYS

Race

Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO children who are:

- Asian is statistically significantly higher.
- Indigenous/Native is statistically significantly lower.

OPTIMAL ASTHMA CONTROL – CHILDREN (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN
2022 measurement year
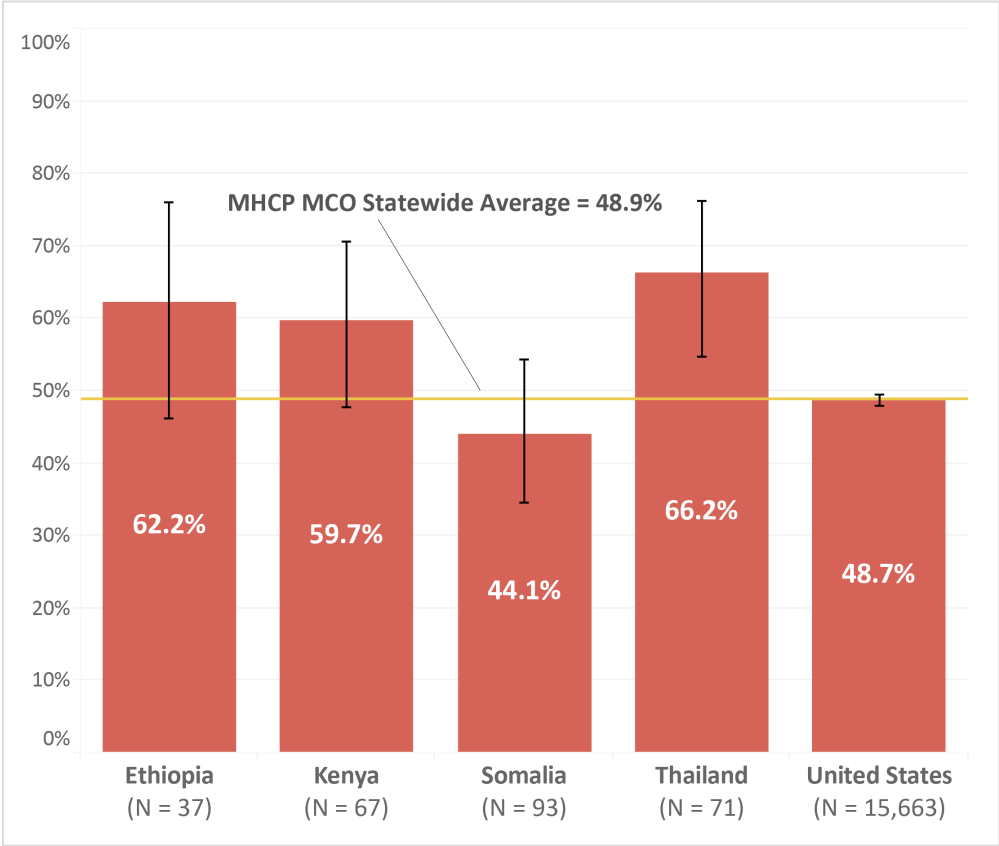
⊥ Represents 95% confidence interval

KEY TAKEAWAYS

- Child patients from Ethiopia, Kenya, Somalia, Thailand or the United States make up 89 percent of the eligible MHCP MCO population for the Optimal Asthma Control measure.

- Compared to the MHCP MCO statewide average, the optimal control rate for children from Thailand is statistically significantly higher.

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

MHCP MCO Statewide Average = 48.9%

Language	Rate
Arabic (N = 60)	51.7%
English (N = 15,460)	48.1%
Karen (N = 183)	61.2%
Somali (N = 867)	51.4%
Spanish (N = 1,007)	56.0%
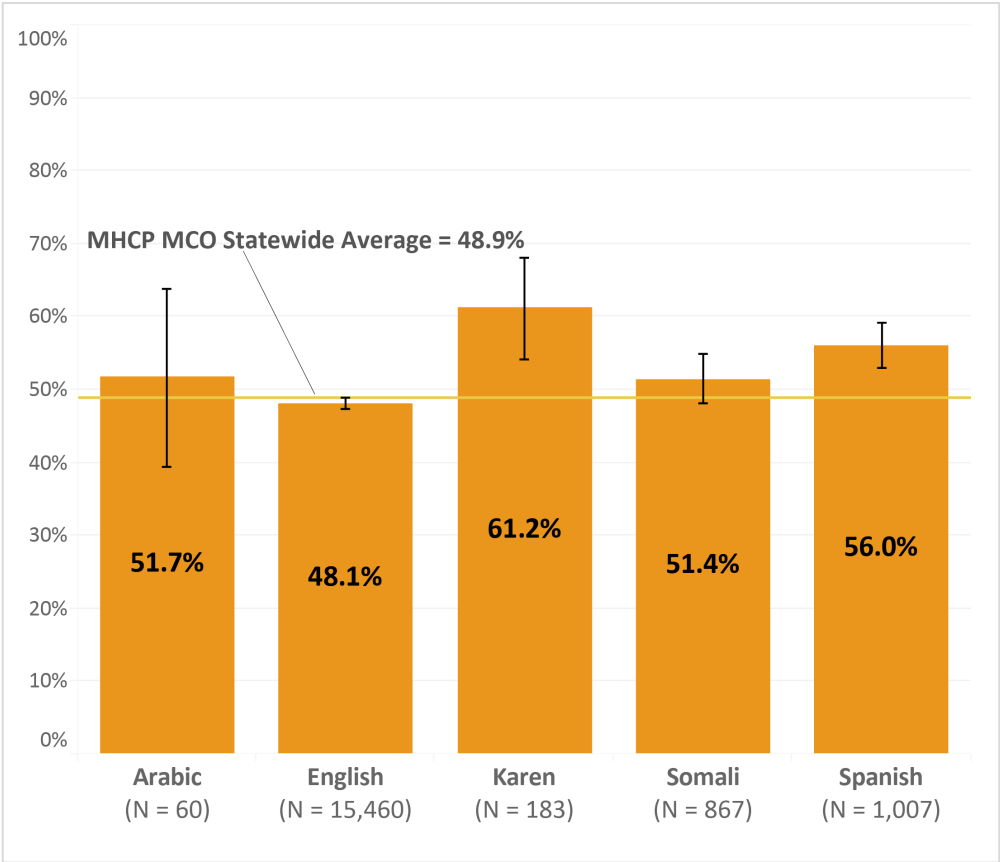
⌶ Represents 95% confidence interval

KEY TAKEAWAYS

- Child patients who prefer to speak Arabic, English, Karen, Somali or Spanish make up 98 percent of the eligible MHCP MCO population for the Optimal Asthma Control measure.

- Compared to the MHCP MCO statewide average, the optimal control rates for MHCP MCO children who speak Karen or Spanish are statistically significantly higher.

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.

Medical groups and clinics report data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

TREND IN ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING
2018 – 2022
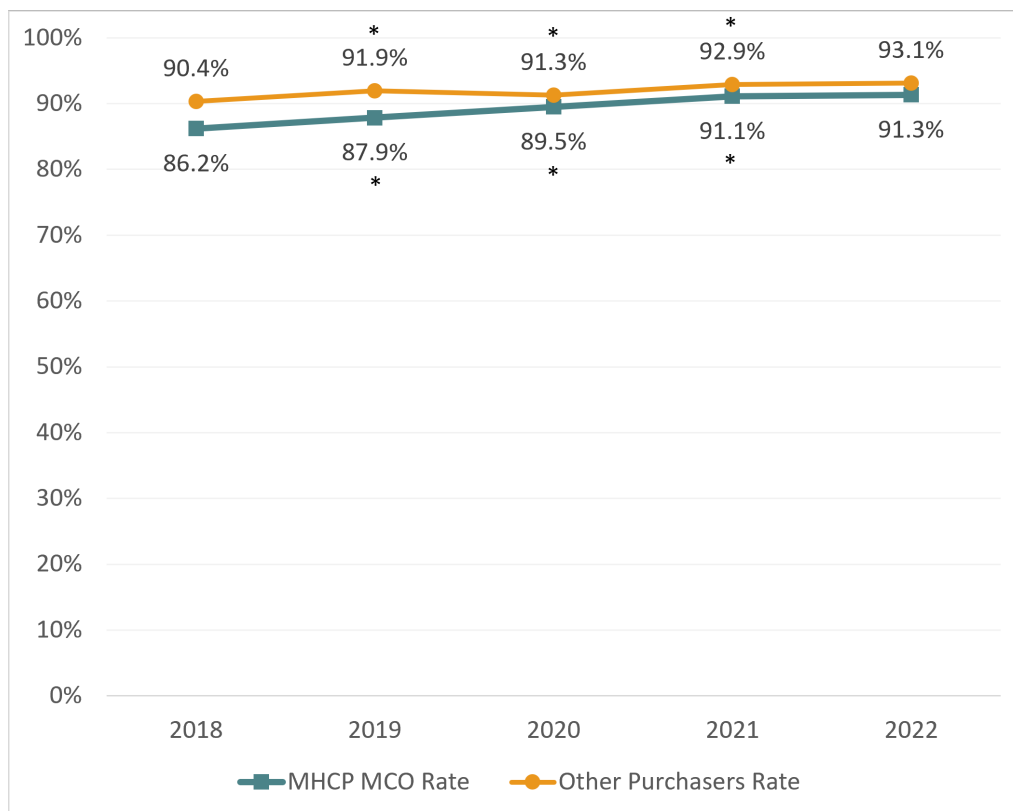
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

Year	MHCP MCO Rate	Other Purchasers Rate
2018	86.2%	90.4%
2019	87.9% *	91.9% *
2020	89.5% *	91.3% *
2021	91.1% *	92.9% *
2022	91.3%	93.1%

Legend: ■ MHCP MCO Rate ● Other Purchasers Rate

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

- From 2021 to 2022, the MHCP MCO statewide average for the Adolescent Mental Health and/ or Depression Screening measure did not statistically significantly change.

- In 2022, the 1.8 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING
(Continued)

MHCP MCO RATES BY RACE/ETHNICITY
2022 measurement year

	Race						Ethnicity	

MHCP MCO Statewide Average = 91.3%

Asian (N = 2,936)	Black (N = 10,023)	Indigenous/ Native (N = 469)	Multi Racial (N = 990)	Native Hawaiian/ Pacific Islander (N = 99)	White (N = 15,794)	Hispanic/ Latinx (N = 6,340)	Not Hispanic/ Latinx (N = 29,390)
93.2%	90.2%	91.3%	92.7%	91.9%	92.8%	90.6%	91.7%

⌶ Represents 95% confidence interval

KEY TAKEAWAYS

Race

Compared to the MHCP MCO statewide average, the screening rate(s) for MHCP MCO patients who are:

- Asian or White are statistically significantly higher.

- Black is statistically significantly lower.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING
(Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN
2022 measurement year

MHCP MCO Statewide Average = 91.3%

Country	Rate
Ethiopia (N = 501)	93.2%
Kenya (N = 563)	90.6%
Somalia (N = 580)	93.3%
Thailand (N = 326)	95.7%
United States (N = 29,424)	91.9%

⌶ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients from Ethiopia, Kenya, Somalia, Thailand or the United States make up 83 percent of the eligible MHCP MCO population for the Adolescent Mental Health and/or Depression measure.

- Compared to the MHCP MCO statewide average, the screening rate for MHCP MCO patients from Thailand is statistically significantly higher.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING
(Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

MHCP MCO Statewide Average = 91.3%

91.6%	91.6%	95.5%	90.5%	89.8%
English (N = 28,332)	**Hmong** (N = 405)	**Karen** (N = 462)	**Somali** (N = 2,888)	**Spanish** (N = 4,062)
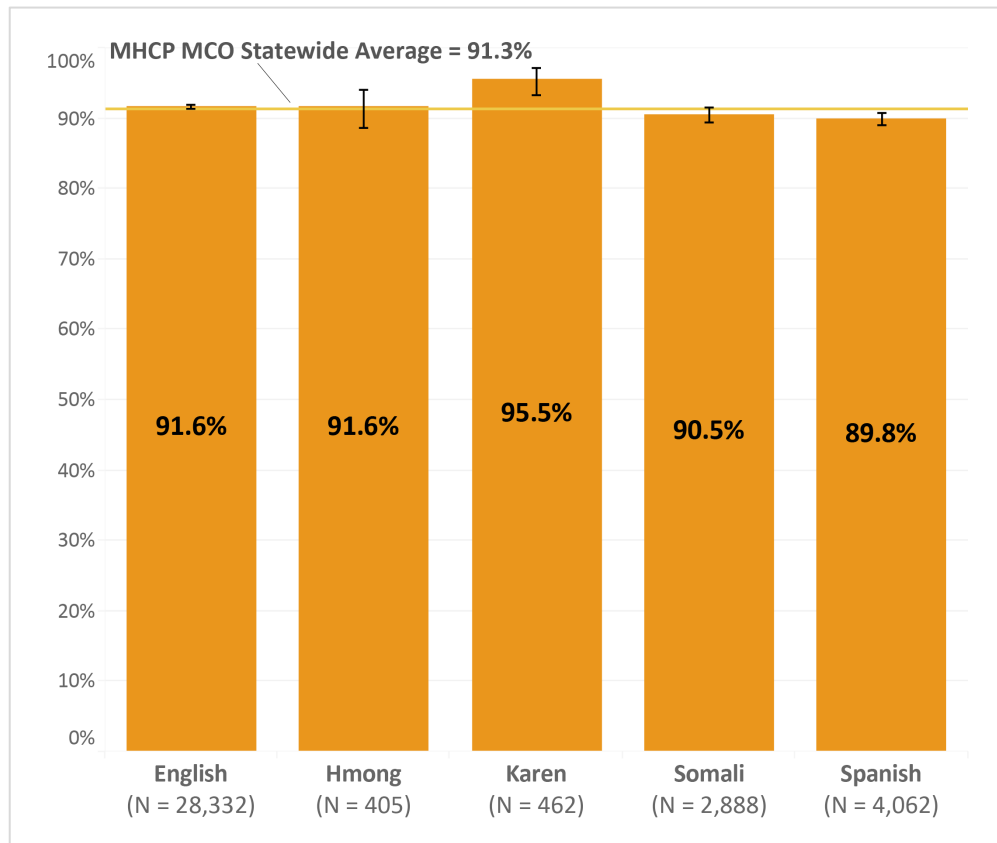
⌶ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak English, Hmong, Karen, Somali or Spanish make up 96 percent of the eligible MHCP MCO population for the Adolescent Mental Health and/or Depression Screening measure.

- Compared to the MHCP MCO statewide average, the screening rates for MHCP MCO patients who speak:

    - Karen is statistically significantly higher.

    - Spanish is statistically significantly lower.

ADOLESCENT DEPRESSION SUITE

Follow-up PHQ-9/9M at Six/12 Months: 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).

Response at Six/12 Months: The percentage of adolescent patients (age 12-17) with depression who demonstrated a response to treatment (at least 50 percent improvement) 6/12 months after the index event (+/- 60 days).

Remission at Six/12 Months: The percentage of adolescent patients (age 12-17) with depression who reached remission (PHQ-9/9M score less than 5) 6/12 months after the index event (+/- 60 days).

Medical groups and clinics report data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

ADOLESCENT DEPRESSION: REMISSION AT SIX MONTHS

2019-2022

Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

	2019	2020	2021	2022
Other Purchasers Rate	8.5%	9.2%	7.9% *	7.4%
MHCP MCO Rate	6.5%	7.2%	6.2%	5.8%

■ MHCP MCO Rate   ● Other Purchasers Rate

*Rate statistically significantly changed from previous year

Note: 2019 was the first available year using the current measure specifications

KEY TAKEAWAYS

- From 2021 to 2022, the MHCP MCO statewide average for the Adolescent Depression: Remission at Six Months measure remained stable.

- In 2022, the 3.4 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

ADOLESCENT DEPRESSION SUITE
(Continued)

MHCP MCO RATES BY RACE
2022 measurement year

Follow-up PHQ-9/9M at Six Months
Race	Rate
Asian	44.3%
Black	27.9%
Indigenous/Native	24.1%
Multi Racial	44.3%
White	45.6%

Response at Six Months
Race	Rate
Asian	13.6%
Black	9.2%
Indigenous/Native	6.3%
Multi Racial	12.1%
White	13.8%

Remission at Six Months
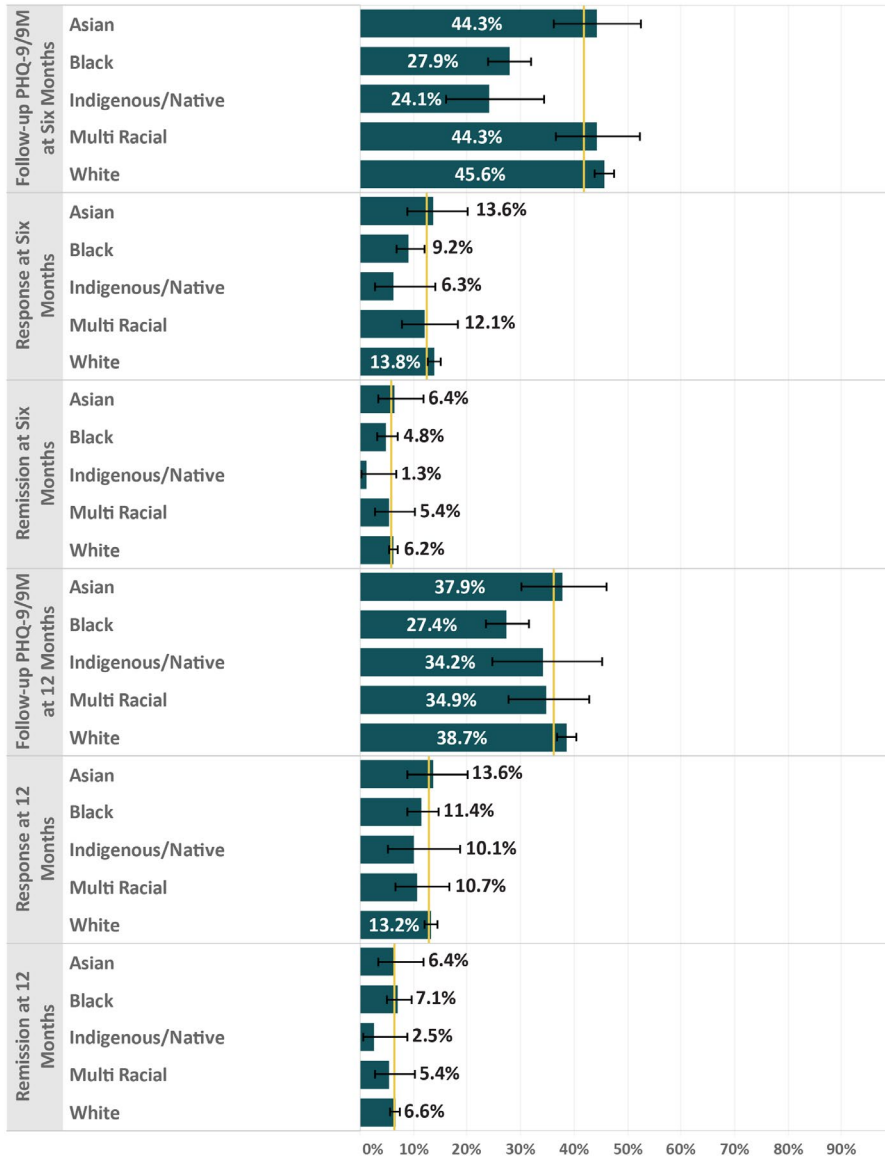| Race	Rate
Asian	6.4%
Black	4.8%
Indigenous/Native	1.3%
Multi Racial	5.4%
White	6.2%

Follow-up PHQ-9/9M at 12 Months
Race	Rate
Asian	37.9%
Black	27.4%
Indigenous/Native	34.2%
Multi Racial	34.9%
White	38.7%

Response at 12 Months
Race	Rate
Asian	13.6%
Black	11.4%
Indigenous/Native	10.1%
Multi Racial	10.7%
White	13.2%

Remission at 12 Months
Race	Rate
Asian	6.4%
Black	7.1%
Indigenous/Native	2.5%
Multi Racial	5.4%
White	6.6%

(x-axis: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90%)

OVERALL MHCP MCO STATEWIDE AVERAGES
by measure
(represented by yellow line)

Six Month Measures
- Follow-up: 41.9%
- Response: 12.5%
- Remission: 5.8%

12 Month Measures
- Follow-up: 36.3%
- Response: 12.8%
- Remission: 6.4%

DENOMINATORS BY RACE
(Denominators are the same for each measure)
- **Asian:** 140
- **Black:** 481
- **Indigenous/Native:** 79
- **Multi-Race:** 149
- **White:** 2,908

⊢──⊣ Represents 95% confidence interval

The Native Hawaiian/ Pacific Islander category had less than 30 patients reported, which does not meet the reporting threshold for reliability.

KEY TAKEAWAYS

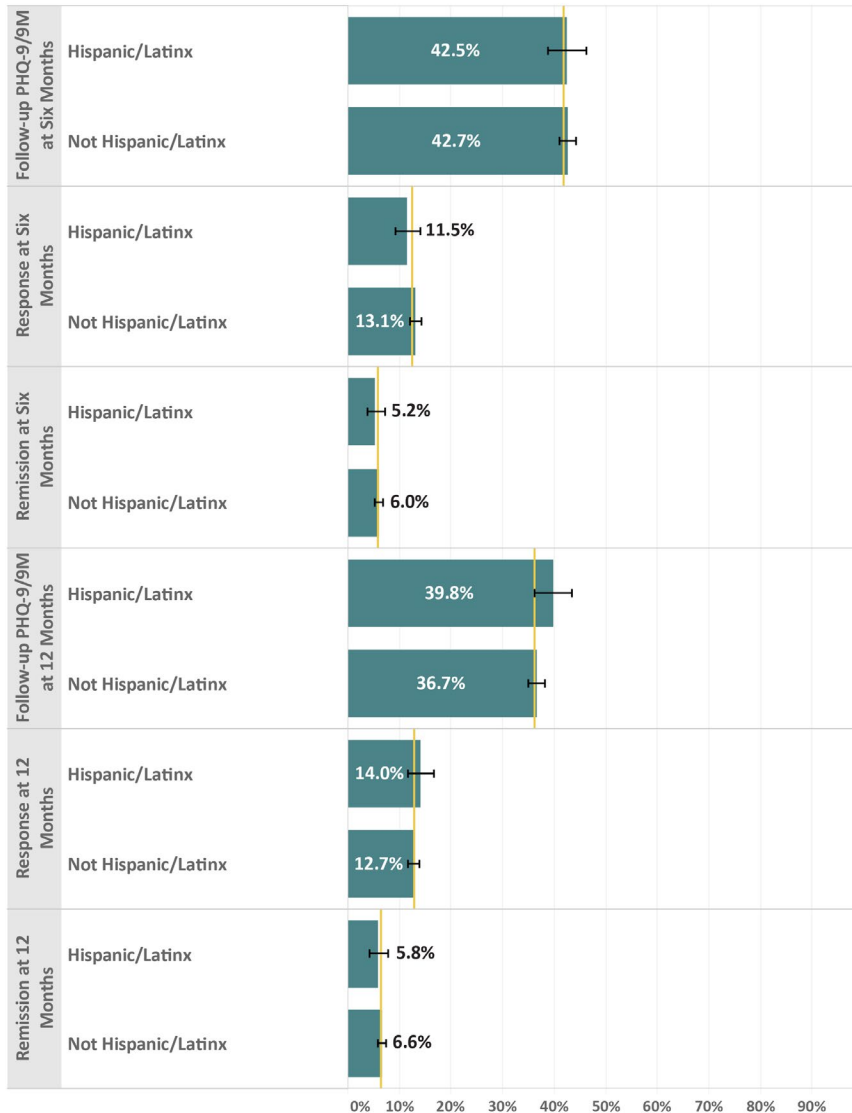Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients who are:

- Black have statistically significantly lower rates of Follow-up at Six Months and Follow-up at 12 Months.

- Indigenous/Native have a statistically significantly lower rate of Follow-up at Six Months.

- White have a statistically significantly higher rate of Follow-up at Six Months.

ADOLESCENT DEPRESSION SUITE

(Continued)

MHCP MCO RATES BY ETHNICITY
2022 measurement year

Follow-up PHQ-9/9M at Six Months
- Hispanic/Latinx: 42.5%
- Not Hispanic/Latinx: 42.7%

Response at Six Months
- Hispanic/Latinx: 11.5%
- Not Hispanic/Latinx: 13.1%

Remission at Six Months
- Hispanic/Latinx: 5.2%
- Not Hispanic/Latinx: 6.0%

Follow-up PHQ-9/9M at 12 Months
- Hispanic/Latinx: 39.8%
- Not Hispanic/Latinx: 36.7%

Response at 12 Months
- Hispanic/Latinx: 14.0%
- Not Hispanic/Latinx: 12.7%

Remission at 12 Months
- Hispanic/Latinx: 5.8%
- Not Hispanic/Latinx: 6.6%

(X-axis: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90%)

OVERALL MHCP MCO STATEWIDE AVERAGES
by measure
(represented by yellow line)

Six Month Measures
- Follow-up: 41.9%
- Response: 12.5%
- Remission: 5.8%

12 Month Measures
- Follow-up: 36.3%
- Response: 12.8%
- Remission: 6.4%

DENOMINATORS BY ETHNICITY
(Denominators are the same for each measure)
- **Hispanic/Latinx:** 671
- **Not Hispanic/Latinx:** 3,508

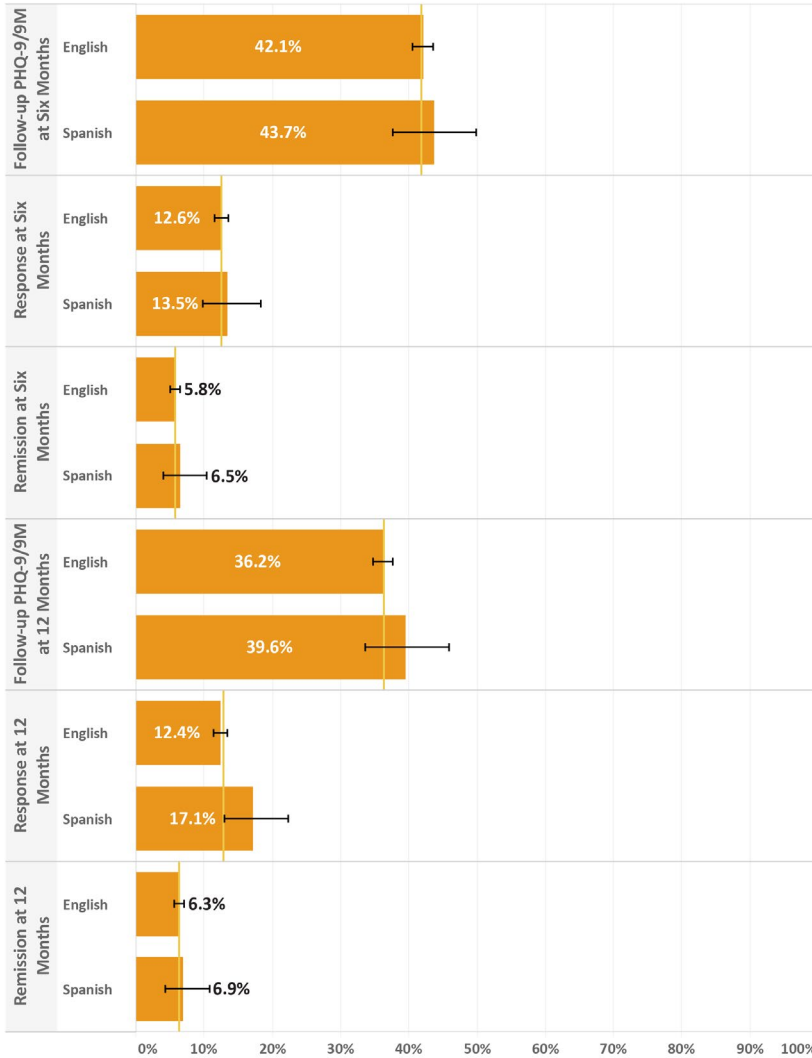⊢—⊣ Represents 95% confidence interval

KEY TAKEAWAYS
Compared to the MHCP MCO statewide averages for each measure, the rates for MHCP MCO patients who are Hispanic/Latinx and Not Hispanic/Latinx are not statistically different.

ADOLESCENT DEPRESSION SUITE
(Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

Follow-up PHQ-9/9M at Six Months
- English: 42.1%
- Spanish: 43.7%

Response at Six Months
- English: 12.6%
- Spanish: 13.5%

Remission at Six Months
- English: 5.8%
- Spanish: 6.5%

Follow-up PHQ-9/9M at 12 Months
- English: 36.2%
- Spanish: 39.6%

Response at 12 Months
- English: 12.4%
- Spanish: 17.1%

Remission at 12 Months
- English: 6.3%
- Spanish: 6.9%

OVERALL MHCP MCO STATEWIDE AVERAGES
by measure
(represented by yellow line)

Six Month Measures
- Follow-up: 41.9%
- Response: 12.5%
- Remission: 5.8%

12 Month Measures
- Follow-up: 36.3%
- Response: 12.8%
- Remission: 6.4%

DENOMINATORS BY LANGUAGE
(Denominators are the same for each measure)
- **English:** 4,108
- **Spanish:** 245

⊢⊣ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak English or Spanish make up 97 percent of the eligible MHCP MCO population for the Adolescent Depression measures.

- Compared to the MHCP MCO statewide averages for each measure, the rates for MHCP MCO patients who speak English or Spanish are not statistically different.

Note about Country of Origin: The United States was the only country with over 30 patients for the Adolescent Depression measures. As a result, this graph has been omitted.

ADULT DEPRESSION SUITE

Follow-up PHQ-9/9M at Six/12 Months: The percentage of adult patients (18 years and older) with depression who have a completed PHQ-9/9M tool within 6/12 months after the index event (+/- 60 days).

Response at Six/12 Months: The percentage of adult patients (18 years and older) with depression who demonstrated a response to treatment (at least 50 percent improvement) 6/12 months after the index event (+/- 60 days).

Remission at Six/12 Months: The percentage of adult patients (18 years and older) with depression who reached remission (PHQ-9/9M score less than 5) 6/12 months after the index event (+/- 60 days).

Medical groups and clinics report data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

ADULT DEPRESSION: REMISSION AT SIX MONTHS
2019-2022
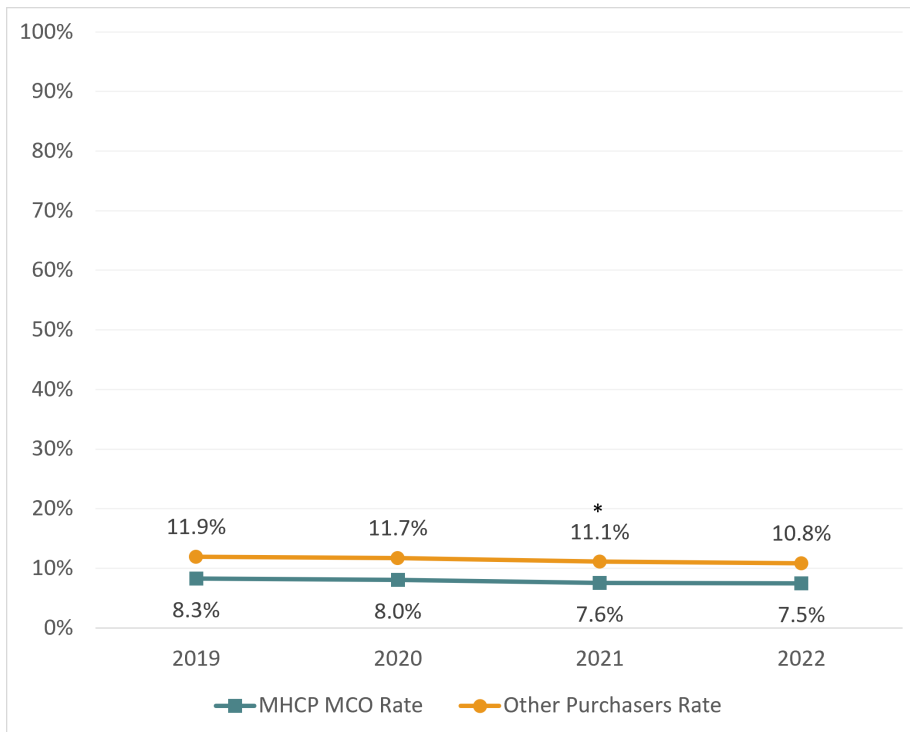
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

*Rate statistically significantly changed from previous year

Note: 2019 was the first available year using the current measure specifications
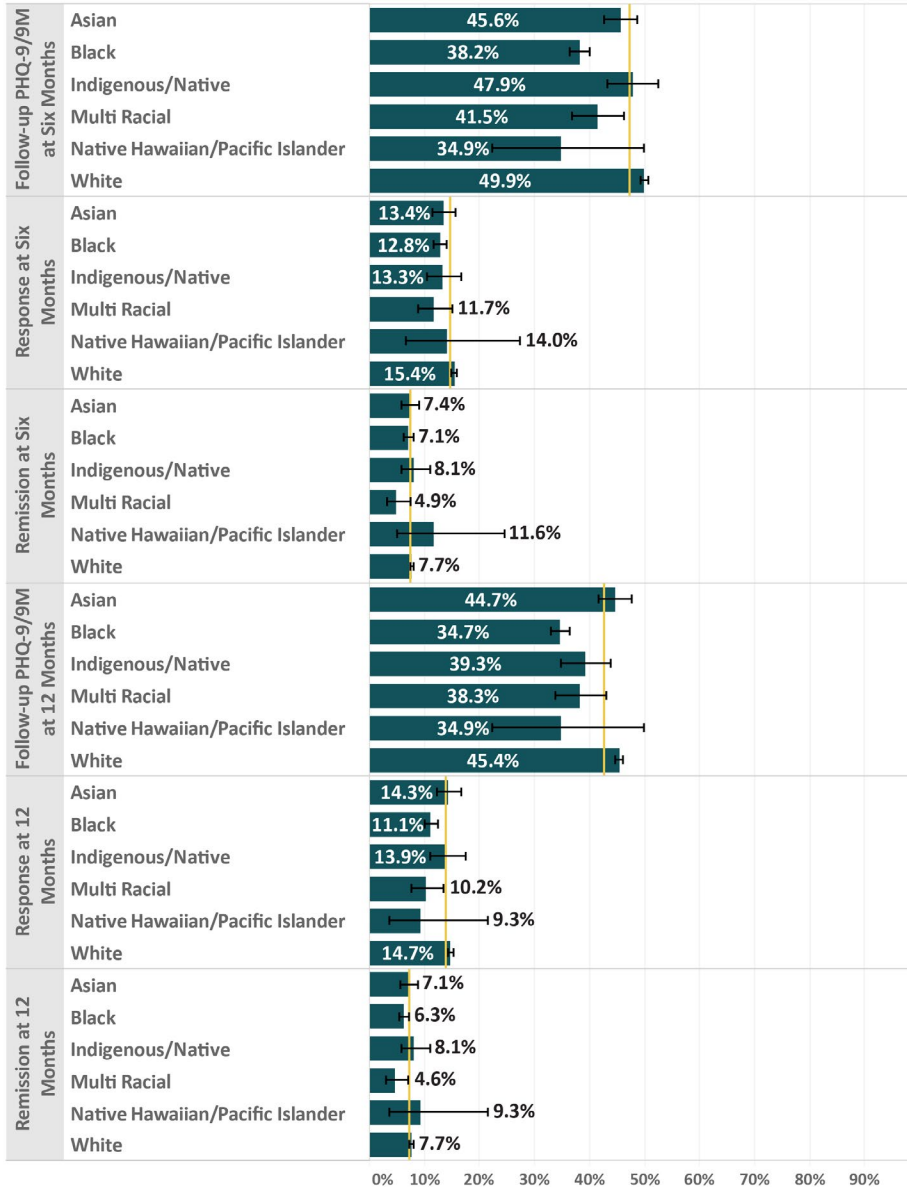
KEY TAKEAWAYS

- From 2021 to 2022, the MHCP MCO statewide average for the Adolescent Depression: Remission at Six Months measure remained stable.

- In 2022, the 3.4 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

ADULT DEPRESSION SUITE (Continued)

MHCP MCO RATES BY RACE
2022 measurement year

Follow-up PHQ-9/9M at Six Months
Race	Rate
Asian	45.6%
Black	38.2%
Indigenous/Native	47.9%
Multi Racial	41.5%
Native Hawaiian/Pacific Islander	34.9%
White	49.9%

Response at Six Months
Race	Rate
Asian	13.4%
Black	12.8%
Indigenous/Native	13.3%
Multi Racial	11.7%
Native Hawaiian/Pacific Islander	14.0%
White	15.4%

Remission at Six Months
Race	Rate
Asian	7.4%
Black	7.1%
Indigenous/Native	8.1%
Multi Racial	4.9%
Native Hawaiian/Pacific Islander	11.6%
White	7.7%

Follow-up PHQ-9/9M at 12 Months
Race	Rate
Asian	44.7%
Black	34.7%
Indigenous/Native	39.3%
Multi Racial	38.3%
Native Hawaiian/Pacific Islander	34.9%
White	45.4%

Response at 12 Months
Race	Rate
Asian	14.3%
Black	11.1%
Indigenous/Native	13.9%
Multi Racial	10.2%
Native Hawaiian/Pacific Islander	9.3%
White	14.7%

Remission at 12 Months
Race	Rate
Asian	7.1%
Black	6.3%
Indigenous/Native	8.1%
Multi Racial	4.6%
Native Hawaiian/Pacific Islander	9.3%
White	7.7%

x-axis: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90%

OVERALL MHCP MCO STATEWIDE AVERAGES
by measure
(represented by yellow line)

Six Month Measures
- Follow-up: 47.3%
- Response: 14.7%
- Remission: 7.5%

12 Month Measures
- Follow-up: 42.7%
- Response: 13.8%
- Remission: 7.3%

DENOMINATORS BY RACE
(Denominators are the same for each measure)
- **Asian:** 1,034
- **Black:** 2,783
- **Indigenous/Native:** 445
- **Multi-Race:** 412
- **Native Hawaiian/Pacific Islander:** 43
- **White:** 17,488
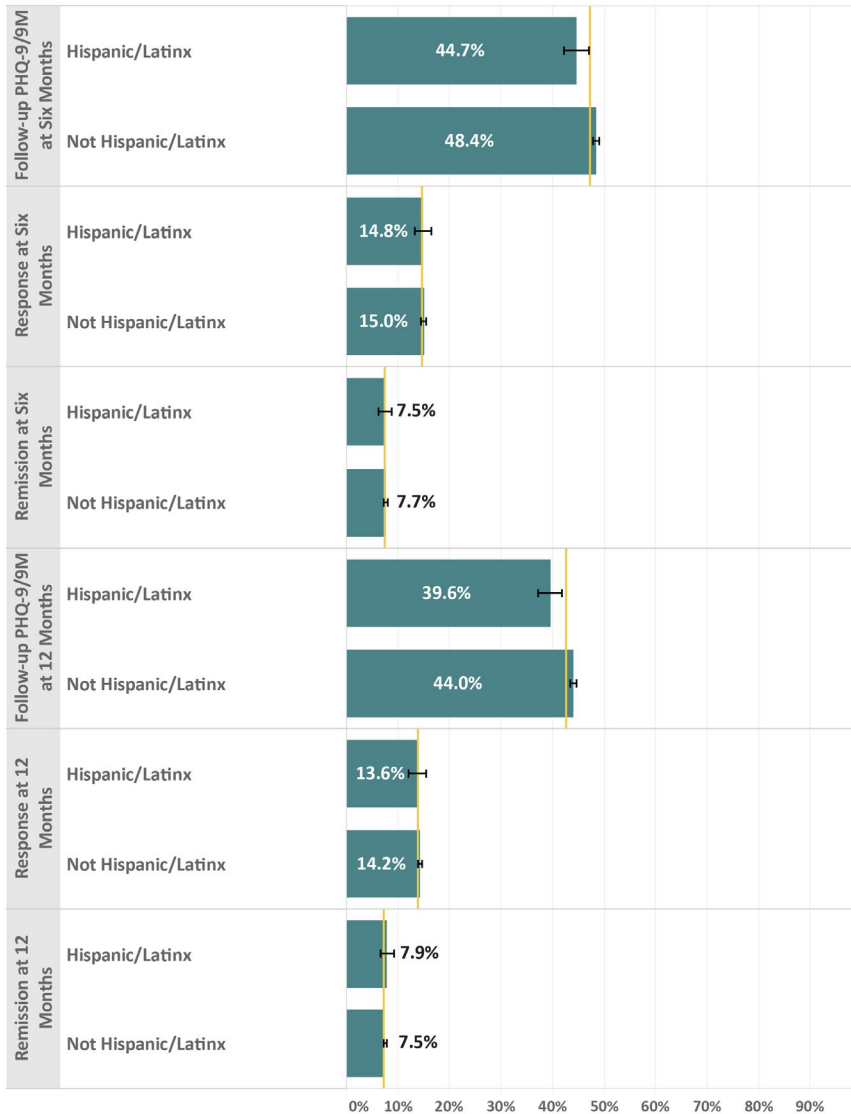
⊢—⊣ Represents 95% confidence interval

KEY TAKEAWAYS
Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients who are:

- Black have statistically significantly lower rates of Follow-up at Six Months, Response at Six Months, Follow-up at 12 Months, and Response at 12 Months.

- Multi Racial have a statistically significantly lower rate of Follow-up at Six Months.

- White have statistically significantly higher rates of Follow-up at Six Months and Follow-up at 12 Months.

ADULT DEPRESSION SUITE (Continued)

MHCP MCO RATES BY ETHNICITY
2022 measurement year

Follow-up PHQ-9/9M at Six Months
- Hispanic/Latinx: 44.7%
- Not Hispanic/Latinx: 48.4%

Response at Six Months
- Hispanic/Latinx: 14.8%
- Not Hispanic/Latinx: 15.0%

Remission at Six Months
- Hispanic/Latinx: 7.5%
- Not Hispanic/Latinx: 7.7%

Follow-up PHQ-9/9M at 12 Months
- Hispanic/Latinx: 39.6%
- Not Hispanic/Latinx: 44.0%

Response at 12 Months
- Hispanic/Latinx: 13.6%
- Not Hispanic/Latinx: 14.2%

Remission at 12 Months
- Hispanic/Latinx: 7.9%
- Not Hispanic/Latinx: 7.5%

(x-axis: 0% 10% 20% 30% 40% 50% 60% 70% 80% 90%)

OVERALL MHCP MCO STATEWIDE AVERAGES
by measure
(represented by yellow line)

Six Month Measures
- Follow-up: 47.3%
- Response: 14.7%
- Remission: 7.5%

12 Month Measures
- Follow-up: 42.7%
- Response: 13.8%
- Remission: 7.3%

DENOMINATORS BY ETHNICITY
(Denominators are the same for each measure)
- **Hispanic/Latinx:** 1,715
- **Not Hispanic/Latinx:** 21,194

⊢—⊣ Represents 95% confidence interval

KEY TAKEAWAYS
Compared to MHCP MCO statewide averages for each measure, MHCP MCO patients who are:

- Not Hispanic/Latinx have a statistically significantly higher rate of Follow-up at 12 Months.

- Hispanic/Latinx have a statistically significantly lower rate of Follow-up at 12 Months.

ADULT DEPRESSION SUITE (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN
2022 measurement year
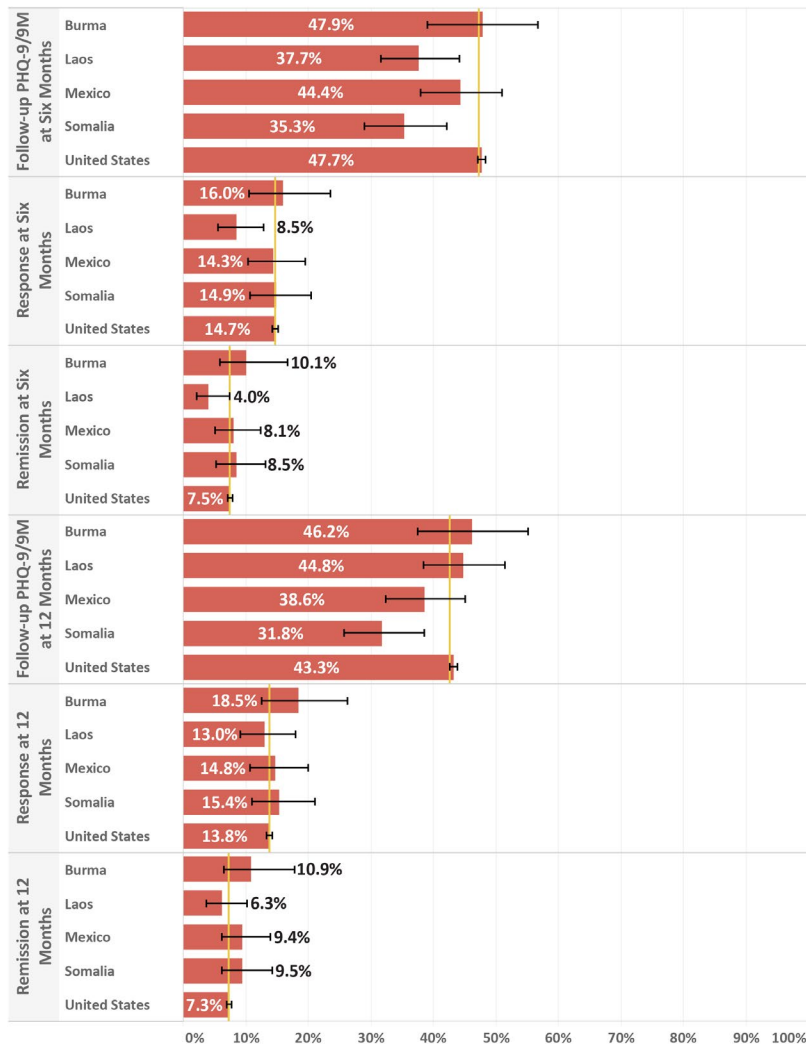
OVERALL MHCP MCO STATEWIDE AVERAGES
by measure
(represented by yellow line)

Six Month Measures
- Follow-up: 47.3%
- Response: 14.7%
- Remission: 7.5%

12 Month Measures
- Follow-up: 42.7%
- Response: 13.8%
- Remission: 7.3%

DENOMINATORS BY COUNTRY
(Denominators are the same for each measure)
- **Burma:** 119
- **Laos:** 223
- **Mexico:** 223
- **Somalia:** 201
- **United States:** 20,782

⊢ Represents 95% confidence interval

Chart data

Follow-up PHQ-9/9M at Six Months
- Burma: 47.9%
- Laos: 37.7%
- Mexico: 44.4%
- Somalia: 35.3%
- United States: 47.7%

Response at Six Months
- Burma: 16.0%
- Laos: 8.5%
- Mexico: 14.3%
- Somalia: 14.9%
- United States: 14.7%

Remission at Six Months
- Burma: 10.1%
- Laos: 4.0%
- Mexico: 8.1%
- Somalia: 8.5%
- United States: 7.5%

Follow-up PHQ-9/9M at 12 Months
- Burma: 46.2%
- Laos: 44.8%
- Mexico: 38.6%
- Somalia: 31.8%
- United States: 43.3%

Response at 12 Months
- Burma: 18.5%
- Laos: 13.0%
- Mexico: 14.8%
- Somalia: 15.4%
- United States: 13.8%

Remission at 12 Months
- Burma: 10.9%
- Laos: 6.3%
- Mexico: 9.4%
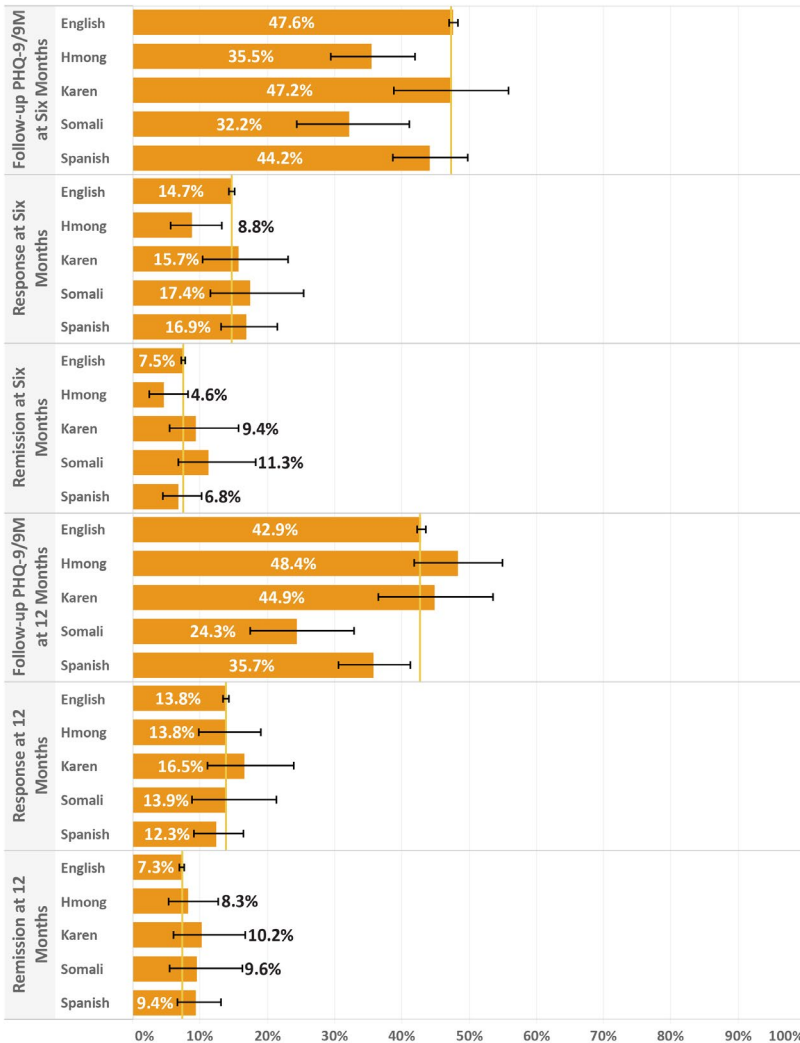- Somalia: 9.5%
- United States: 7.3%

KEY TAKEAWAYS

- Patients from Burma, Laos, Mexico, Somalia or the United States make up 87 percent of the eligible MHCP MCO population for the Adult Depression measures.

- Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients from:
  - Laos have statistically significantly lower rates of Follow-up at Six Months and Response at Six Months.
  - Somalia have statistically significantly lower rates of Follow-up at Six Months and Follow-up at 12 Months.

ADULT DEPRESSION SUITE (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE
2022 measurement year

Follow-up PHQ-9/9M at Six Months
Language	Rate
English	47.6%
Hmong	35.5%
Karen	47.2%
Somali	32.2%
Spanish	44.2%

Response at Six Months
Language	Rate
English	14.7%
Hmong	8.8%
Karen	15.7%
Somali	17.4%
Spanish	16.9%

Remission at Six Months
Language	Rate
English	7.5%
Hmong	4.6%
Karen	9.4%
Somali	11.3%
Spanish	6.8%

Follow-up PHQ-9/9M at 12 Months
Language	Rate
English	42.9%
Hmong	48.4%
Karen	44.9%
Somali	24.3%
Spanish	35.7%

Response at 12 Months
Language	Rate
English	13.8%
Hmong	13.8%
Karen	16.5%
Somali	13.9%
Spanish	12.3%

Remission at 12 Months
Language	Rate
English	7.3%
Hmong	8.3%
Karen	10.2%
Somali	9.6%
Spanish	9.4%

OVERALL MHCP MCO STATEWIDE AVERAGES
by measure
(represented by yellow line)

Six Month Measures
- Follow-up: 47.3%
- Response: 14.7%
- Remission: 7.5%

12 Month Measures
- Follow-up: 42.7%
- Response: 13.8%
- Remission: 7.3%

DENOMINATORS BY LANGUAGE
(Denominators are the same for each measure)
- **English:** 23,192
- **Hmong:** 217
- **Karen:** 127
- Somali: 115
- **Spanish:** 308

⊢⊣ Represents 95% confidence interval

KEY TAKEAWAYS
- Patients who prefer to speak English, Hmong, Karen, Somali or Spanish make up 97 percent of the eligible MHCP MCO population for the Adult Depression measures.
- Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients who speak:
    - Hmong have statistically significantly lower rates of Follow-up at Six Months and Response at Six Months.
    - Somali have statistically significantly lower rates of Follow-up at Six Months and Follow-up at 12 Months.
    - Spanish have a statistically significantly lower rate of Follow-up at 12 Months.

DEFINITIONS

GENERAL 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: 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

These measures are calculated using data submitted by medical groups/clinics. These data come from electronic health records or paper-based medical charts. See the Methodology Appendix for more information.

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. These measures include:

- Breast Cancer Screening
- Childhood Immunization Status (Combo 10)
- Controlling High Blood Pressure

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

Medical group: One or more clinic sites operated by a single organization.

DEFINITIONS (Continued)

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)

Patient Report Outcome – Performance Measure (PRO-PM): Measures built from a PROM.

The PRO-PM outcome measures in this report include:

- Optimal Asthma Control – Adults
- Optimal Asthma Control – Children
- Adult Depression Suite
- Adolescent Depression Suite

The PRO-PM process measures in this report include:

- Adolescent Mental Health and/or Depression Screening

DEFINITIONS (Continued)

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

Statewide rates: This includes patients meeting measurement criteria enrolled in managed care health plans including commercial, Medicaid managed care and Medicare managed care.

NOTES

Optimal Asthma Control

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

- Asthma Control Test (ACT)™ 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)
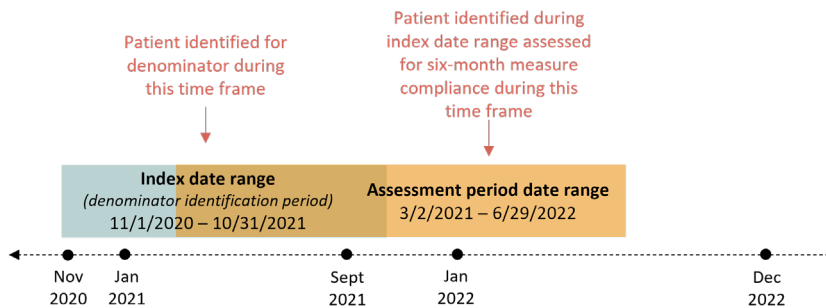
DEPRESSION MEASURES

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.

- **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.

NOTE: The diagnosis of depression does not have to be new for the patient to be included in the denominator.

The assessment period (shown 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.
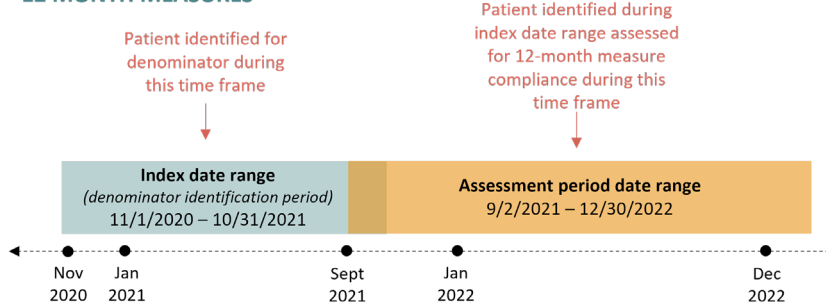
Example: A 23-year-old patient with depression was assessed at an encounter with an eligible provider on 12/2/2020 and had a PHQ-9 score of 20 (index event). Their six-month assessment period would be between 4/3/2021 and 8/1/2021. The patient would be considered numerator compliant for the six-month 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 (10/3/2021 to 1/31/2022) using the same criteria as above.

SOURCES

1   Minnesota Statutes, Performance Reporting and Quality Improvement 256B.072 § 1d (2022). Retrieved from https://www.revisor.mn.gov/statutes/cite/256B.072

2   National Committee for Quality Assurance. Breast Cancer Screening (BCS). HEDIS Measures and Technical Resources. Retrieved from https://www.ncqa.org/hedis/measures/breast-cancer-screening/

3   National Committee for Quality Assurance. Childhood Immunization Status (CIS). HEDIS Measures and Technical Resources. Retrieved from https://www.ncqa.org/hedis/measures/childhood-immunization-status/

4   National Committee for Quality Assurance. Controlling High Blood Pressure (CBP). HEDIS Measures and Technical Resources. Retrieved from https://www.ncqa.org/hedis/measures/controlling-high-blood-pressure/