HEALTH CARE IN MINNESOTA:

Summary Report on Quality, Disparities, and Cost

For care delivered in 2024

MN Community MEASUREMENT

ABOUT
MN COMMUNITY MEASUREMENT

MN COMMUNITY MEASUREMENT (MNCM)

As an independent nonprofit dedicated to empowering health care decision makers with meaningful data, MN Community Measurement (MNCM) is a statewide resource for timely, comparable information on health care quality, disparities, and costs. While Minnesota has some of the best health indicators in the country, there continues to be wide variation in health care quality and wide disparities in outcomes for different population groups. Measuring and reporting on health care quality and cost helps consumers understand how care varies across providers, allows providers to identify improvement opportunities and see how their quality results compare to others, and helps health plans and other purchasers better understand and improve value for the money spent on health care.

ACKNOWLEDGEMENTS

This report is made possible by the engagement of numerous community partners, including medical groups, payers, and MNCM staff. 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 and to the many members of MNCM committees, workgroups, and staff providing ongoing guidance to shape this important work.

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ABOUT THIS REPORT

This report provides an overview of clinical quality, cost, and utilization measures reported by medical groups and payers for the 2024 measurement year. It offers a comprehensive analysis of health care in Minnesota, focusing on quality, disparities, and cost. The report includes key insights such as performance trends over time by measure, performance rates compared to achievable benchmark goals, regional variations in performance by three-digit zip code, and summaries of quality measures by race, ethnicity, preferred language, and country of origin. These actionable findings are designed to help community partners identify areas for improvement.

Additional information can be found in the Appendix section of this report.

EXECUTIVE SUMMARY

The *Health Care in Minnesota: Summary Report on Quality, Disparities, and Cost* by MN Community Measurement (MNCM) provides a comprehensive analysis of health care performance across the state for the 2024 measurement year. The report evaluates health care quality, disparities, and cost trends, offering valuable insights for community partners including medical groups, payers, policymakers, and community organizations.

KEY FINDINGS

Health Care Quality

- **Medical Group-Reported Measures:** Significant gaps remain in the Optimal Asthma Control measures, with thousands of patients needing improved care to meet statewide benchmarks.
- **Colorectal Cancer Screening:** Screening rates have increased for the newly eligible 45-49 age group. While the 2024 rate for all age groups has significantly increased compared to 2022, it remains significantly lower than 2021.
- **Payer-Reported Measures:** Breast Cancer Screening, Cervical Cancer Screening, Immunizations for Adolescents, Controlling High Blood Pressure, and Eye Exam for Patients with Diabetes saw significant increases, while Childhood Immunization rates continued to decline. Chlamydia Screening also had a significant decrease compared to 2023.
- **Childhood Immunization Status:** The Childhood Immunization Status (Combo 10) measure continues to show significant decreases in statewide rates since 2020.

Health Care Disparities

- **Racial and Ethnic Gaps:** Black, Indigenous, Multi-Race, and Hispanic/Latinx patients experienced the most disparities across multiple measures, particularly in Colorectal Cancer Screening.
- **Language and Country of Origin:** Patients speaking Somali and Spanish, as well as those from Laos, Mexico, and Somalia, had lower rates of preventive care and chronic disease management compared to statewide averages.

Health Care Costs and Utilization

- **Rising Costs:** The total cost of care increased by 7.3% in 2024. Cost for pharmacy use increased the most, by 8.9%, followed by professional fees, which increased by 8.3%.
- **Service Utilization:** All categories of medical services saw increased use, except for inpatient admissions. Women aged 36-64 had the highest number of claims, while men aged 18-35 had the lowest number of claims.

SECTION 1:
HEALTH CARE QUALITY
Measures reported by medical groups

The quality measures are split into two categories – measures reported by medical groups and measures reported by payers.

This section covers the measures reported by medical groups, and includes four sets of analyses:

- **Benchmark Analysis.** This analysis provides a summary of the performance rates for the measurement year and includes achievable benchmark goals by measure. The benchmark provided is intended to illustrate an achievable target based on actual performance observed in the market. This information can be used by medical groups to understand their current performance relative to statewide performance and establish improvement goals aligned with benchmarks for each measure.
- **Rates Over Time.** These tables provide rates for each of the measures over five years as well as an indicator of significant changes compared to the previous year. This information can be used by community partners to prioritize health care improvement efforts.
- **Rate Variation by Three-Digit ZIP Code Region.** These tables assess the rates of each of the three-digit ZIP code regions across Minnesota and compares them to a re-calculated statewide rate that includes only Minnesota residents (Minnesota Resident Average). This information can be used by community partners, including local public health departments, to inform strategies to improve health care at the local level and to prioritize resources and interventions in the areas most in need.
- **Age Analysis for Colorectal Cancer Screening.** This special analysis for the Colorectal Cancer Screening measure examines the impact of expanding the eligible age range from 50–75 to 45–75 in 2022, focusing on screening rates among the 45–49 age group following the U.S. Preventive Services Task Force (USPSTF) recommendation.

QUALITY MEASURES
Reported by medical groups

- Colorectal Cancer Screening
- Optimal Asthma Control – Adults
- Optimal Asthma Control – Children
- Optimal Diabetes Care, plus five components:
  - *HbA1c Control*
  - *BP Control*
  - *Daily Aspirin Use*
  - *Statin Use*
  - *Tobacco-free*
- Optimal Vascular Care, plus four components:
  - *BP Control*
  - *Daily Aspirin Use*
  - *Statin Use*
  - *Tobacco-free*
- 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*

* See measure notes

KEY FINDINGS

BENCHMARK ANALYSIS

- For both the adult and child/adolescent measures, the Optimal Asthma Control measures had the largest gaps between the respective statewide rates and the benchmark rates.
- For adults, the Optimal Diabetes Care measure had the smallest gap between the statewide rate and the benchmark rate (46.9% and 49.8%, respectively).
- For children/adolescents, the Adolescent Depression: Remission at 12 Months measure had the smallest gap between the statewide rate and the benchmark rate (8.0% and 11.9%, respectively).

RATES OVER TIME

- The Adult Depression: Follow-up at 12 Months measure had the largest ***increase*** in rate compared to 2023 (3.2 percentage points).
- The Adult Depression: PHQ-9/9M Utilization measure had the largest ***decrease*** in rate compared to 2023 (2.3 percentage points).
- While the rates for the Daily Aspirin components for both the Optimal Diabetes Care and Optimal Vascular Care measures have remained high, both measures have seen significant decreases in rates over the last two years.

RATE VARIATION BY THREE-DIGIT ZIP CODE REGION

- The northwest corner of Minnesota (565xx, 566xx, and 567xx regions) as well as the 561xx (Windom) region had significantly ***lower*** rates compared to the Minnesota Resident Average on at least three-quarters of the measures being analyzed.
- The 550xx (Stillwater) and 563xx (Minnetonka) regions had significantly ***higher*** rates compared to the Minnesota Resident Average on at least three-quarters of the measures being analyzed.
- The Optimal Asthma Control – Adults measure had the most regions (10) with significantly ***lower*** rates compared to the Minnesota Resident Average.
- The Colorectal Cancer Screening and the Adolescent Mental Health and/or Depression Screening measures had the most regions (7) with significantly ***higher*** rates compared to the Minnesota Resident Average.

AGE ANALYSIS FOR COLORECTAL CANCER SCREENING

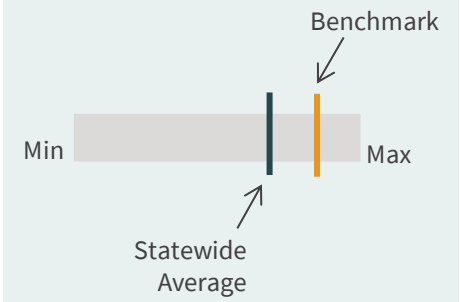
- Since the change in eligible age range in 2022, the Colorectal Cancer Screening measure has remained significantly below the 2021 rate. However, compared to 2023, the screening rate significantly increased by 1 percentage point in 2024.
- Additional age analysis revealed that the screening rate for the 45-49 age group has continued to increase since 2022. The 2024 rate for this age group was nearly 20 percentage points higher than the 2023 rate.

STATEWIDE RESULTS: Adults

	Quality Measure	2024 Statewide Average	2024 Benchmark	Gap	Maximum	Minimum	Variation
Preventive Health & Chronic Conditions	Colorectal Cancer Screening	71.5%	75.5%	69,268	81.3%	25.8%	
	Optimal Asthma Control	50.9%	68.1%	30,344	72.2%	0.0%	
	Optimal Diabetes Care	46.9%	49.8%	11,033	55.2%	22.8%	
	Optimal Vascular Care	54.5%	57.7%	8,980	61.1%	22.3%	
Depression Care	PHQ-9/9M Utilization	76.7%	88.7%	23,146	94.9%	20.1%	
	Follow-up at Six Months	53.2%	68.6%	15,834	78.9%	8.4%	
	Response at Six Months	18.3%	26.6%	8,416	34.4%	1.8%	
	Remission at Six Months	10.1%	16.4%	6,401	23.3%	1.8%	
	Follow-up at 12 Months	53.0%	66.3%	13,336	73.3%	11.9%	
	Response at 12 Months	19.4%	26.0%	6,725	32.2%	3.4%	
	Remission at 12 Months	10.8%	15.2%	4,543	19.3%	0.4%	

Benchmark: 90th percentile of medical groups or 90th percentile of patients, whichever is lower. This method prevents the benchmark from being too heavily influenced by only a few medical groups with small numbers of patients.
Needed Patients: The additional number of patients who would reach optimal status or goal if all medical groups' rates were at least at benchmark.

How to read chart



KEY TAKEAWAYS

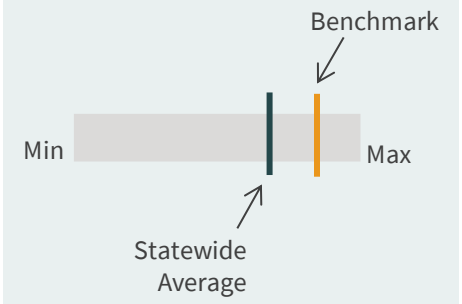
- Optimal Asthma Control had the largest gap between the statewide average and the benchmark. A little over 30,000 patients would need to be added to the numerator to reach the benchmark goal of 68.1%.
- Optimal Diabetes Care had the smallest gap needing just over 11,000 patients added to the numerator to reach the benchmark goal of 49.8%.

STATEWIDE RESULTS: Children/Adolescents

	Quality Measure	2024 Statewide Average	2024 Benchmark	Needed Patients	Minimum	Maximum	Variation
Preventive Health & Chronic Conditions	Adolescent Mental Health and/or Depression Screening	91.8%	97.3%	8,824	51.5%	99.5%	
	Optimal Asthma Control	53.0%	68.2%	9,311	0.0%	75.6%	
Depression Care	PHQ-9/9M Utilization	82.1%	88.8%	314	33.0%	100.0%	
	Follow-up at Six Months	48.2%	56.9%	678	13.3%	76.9%	
	Response at Six Months	15.2%	21.9%	551	2.2%	33.3%	
	Remission at Six Months	7.6%	12.5%	410	0.0%	18.0%	
	Follow-up at 12 Months	44.7%	53.9%	684	13.3%	68.8%	
	Response at 12 Months	15.8%	20.4%	363	1.8%	27.8%	
	Remission at 12 Months	8.0%	11.9%	328	0.0%	14.8%	

Benchmark: 90th percentile of medical groups or 90th percentile of patients, whichever is lower. This method prevents the benchmark from being too heavily influenced by only a few medical groups with small numbers of patients.
Needed Patients: The additional number of patients who would reach optimal status or goal if all medical groups' rates were at least at benchmark.

How to read chart



KEY TAKEAWAYS

- Optimal Asthma Control had the largest gap between the statewide average and the benchmark. A little over 9,000 patients would need to be added to the numerator to reach the benchmark goal of 68.2%.
- Remission at 12 Months had the smallest gap needing just over 300 patients added to the numerator to reach the benchmark goal of 11.9%.

RATES OVER TIME: Adults

	Measure	2020	2021	2022	2023	2024
Preventive Health & Chronic Conditions	Colorectal Cancer Screening	70.6%	72.2% ▲	67.8% ▼	70.4% ▲	71.5% ▲
	Optimal Asthma Control	46.6%	50.3% ▲	50.3% ●	51.4% ▲	50.9% ●
	Optimal Diabetes Care (Composite)	40.6%	43.6% ▲	44.6% ▲	46.3% ▲	46.9% ▲
	HbA1c Control (Component)	67.2%	70.5% ▲	71.8% ▲	73.5% ▲	75.2% ▲
	Blood Pressure Control (Component)	76.0%	79.0% ▲	79.7% ▲	81.0% ▲	81.6% ▲
	Statin Use (Component)	87.4%	87.9% ▲	88.0% ●	88.0% ●	87.8% ▼
	Daily Aspirin Use (Component)	99.1%	99.1% ●	98.7% ▼	98.6% ▼	98.5% ▼
	Tobacco-free (Component)	84.0%	84.1% ●	84.6% ▲	84.9% ▲	84.0% ▼
	Optimal Vascular Care (Composite)	53.8%	56.5% ▲	55.3% ▼	55.4% ●	54.5% ▼
	Blood Pressure Control (Component)	76.9%	79.9% ▲	80.5% ▲	81.6% ▲	82.0% ▲
	Statin Use (Component)	90.9%	91.5% ▲	91.4% ●	91.7% ▲	91.4% ●
	Daily Aspirin Use (Component)	88.0%	89.8% ▲	87.3% ▼	86.3% ▼	85.8% ▼
	Tobacco-free (Component)	82.0%	82.4% ▲	82.4% ●	82.4% ●	81.3% ▼
Depression Care	PHQ-9/9M Utilization	68.7%	71.7% ▲	76.5% ▲	79.0% ▲	76.7% ▼
	Follow-up at Six Months	47.9%	45.3% ▼	47.3% ▲	51.1% ▲	53.2% ▲
	Response at Six Months	18.9%	18.1% ▼	17.9% ●	18.8% ▲	18.3% ▼
	Remission at Six Months	11.0%	10.3% ▼	10.1% ●	10.3% ●	10.1% ●
	Follow-up at 12 Months	39.6%	43.9% ▲	44.4% ●	49.7% ▲	53.0% ▲
	Response at 12 Months	16.5%	18.1% ▲	17.4% ▼	19.2% ▲	19.4% ●
	Remission at 12 Months	9.9%	10.6% ▲	10.1% ▼	11.0% ▲	10.8% ●

▲ Significantly higher than previous year
● Not significantly different than previous year (rate remained stable)
▼ Significantly lower than previous year

Notes & Considerations:

- MNCM urges caution in using 2020 data for comparison to other years and to draw general conclusions about quality of care.
- In MY2024, MNCM fully transitioned to a new data collection system. The statewide average for this year reflects only groups submitting data via the new system and may not be directly comparable to previous years' rates.

RATES OVER TIME: Children/Adolescents

Measure		2020	2021	2022	2023	2024
Preventive Health & Chronic Conditions	Adolescent Mental Health and/or Depression Screening	89.8%	91.2% ▲	92.0% ▲	92.8% ▲	91.8% ▼
	Optimal Asthma Control	56.0%	56.2% ●	53.5% ▼	53.9% ●	53.0% ▼
Depression Care	PHQ-9/9M Utilization	72.2%	75.5% ▲	81.6% ▲	81.8% ●	82.1% ●
	Follow-up at Six Months	45.5%	42.7% ▼	45.4% ▲	45.7% ●	48.2% ▲
	Response at Six Months	16.5%	14.3% ▼	14.2% ●	14.4% ●	15.2% ●
	Remission at Six Months	8.5%	7.4% ▼	7.0% ●	7.5% ●	7.6% ●
	Follow-up at 12 Months	35.6%	40.1% ▲	38.9% ●	41.9% ▲	44.7% ▲
	Response at 12 Months	13.2%	13.3% ●	13.6% ●	14.7% ●	15.8% ●
	Remission at 12 Months	7.0%	7.0% ●	6.9% ●	7.3% ●	8.0% ●

▲ Significantly higher than previous year
● Not significantly different than previous year (rate remained stable)
▼ Significantly lower than previous year

Notes & Considerations:

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SUMMARY OF RATE VARIATION BY THREE-DIGIT ZIP CODE: Adults

Three-Digit ZIP Code	Major City	CRC	OAC	ODC	OVC	Remiss 6M
Minnesota Resident Average*		**71.7%**	**53.4%**	**47.1%**	**55.3%**	**10.0%**
550xx	Stillwater	73.0% ▲	56.6% ▲	48.6% ▲	57.6% ▲	9.1% ▼
551xx	St. Paul	71.0% ▼	58.4% ▲	48.2% ▲	58.8% ▲	9.2% ▼
553xx	Minnetonka	73.1% ▲	57.4% ▲	49.9% ▲	58.5% ▲	9.9% ●
554xx	Minneapolis	69.0% ▼	55.2% ▲	44.5% ▼	54.5% ●	8.6% ▼
556xx	Two Harbors	68.9% ▼	24.3% ▼	40.9% ▼	56.2% ●	7.7% ●
557xx	Cloquet	72.9% ▲	51.1% ▼	45.9% ▼	52.5% ▼	12.5% ▲
558xx	Duluth	75.3% ▲	47.1% ▼	48.4% ●	53.8% ●	10.6% ●
559xx	Rochester	73.5% ▲	52.8% ●	50.1% ▲	52.2% ▼	14.2% ▲
560xx	Mankato	71.5% ●	49.9% ▼	46.7% ●	54.1% ●	10.1% ●
561xx	Windom	66.2% ▼	24.2% ▼	43.2% ▼	51.9% ▼	7.1% ▼
562xx	Willmar	71.9% ●	42.6% ▼	46.5% ●	53.0% ▼	12.3% ▲
563xx	St. Cloud	73.0% ▲	53.4% ●	46.3% ●	52.9% ▼	9.8% ●
564xx	Brainerd	73.7% ▲	40.7% ▼	46.2% ●	53.4% ▼	12.7% ▲
565xx	Detroit Lakes	70.5% ▼	38.7% ▼	44.8% ▼	50.0% ▼	11.3% ●
566xx	Bemidji	69.4% ▼	28.4% ▼	36.3% ▼	45.9% ▼	8.5% ●
567xx	Thief River Falls	70.7% ▼	19.4% ▼	44.6% ▼	49.4% ▼	4.6% ▼

▲ Significantly higher than Minnesota Resident Average
● Not significantly different than Minnesota Resident Average
▼ Significantly lower than Minnesota Resident Average
* Minnesota Resident Average is a recalculated statewide average that includes only patients with a Minnesota ZIP code as their residence.

Measure abbreviations:
CRC = Colorectal Cancer Screening
OAC = Optimal Asthma Control
ODC = Optimal Diabetes Care
OVC = Optimal Vascular Care
Remiss 6M = Depression Care: Remission at Six Months

View interactive maps by measure on MNCM's **Performance Hub**

SUMMARY OF RATE VARIATION BY THREE-DIGIT ZIP CODE: Children/Adolescents

Three-Digit ZIP Code	Major City	OAC	AMH	Remiss 6M
Minnesota Resident Average*		**54.2%**	**93.3%**	**7.4%**
550xx	Stillwater	55.7% ●	95.3% ▲	5.7% ●
551xx	St. Paul	59.2% ▲	95.0% ▲	6.2% ●
553xx	Minnetonka	59.4% ▲	93.8% ▲	6.4% ●
554xx	Minneapolis	57.7% ▲	91.7% ▼	6.1% ●
556xx	Two Harbors	34.0% ▼	82.2% ▼	6.1% ●
557xx	Cloquet	56.0% ●	94.4% ▲	8.2% ●
558xx	Duluth	54.9% ●	94.7% ▲	9.3% ●
559xx	Rochester	59.5% ▲	95.6% ▲	10.9% ▲
560xx	Mankato	46.7% ▼	92.5% ▼	8.7% ●
561xx	Windom	20.5% ▼	77.0% ▼	6.9% ●
562xx	Willmar	41.8% ▼	90.3% ▼	8.7% ●
563xx	St. Cloud	54.0% ●	93.7% ●	8.2% ●
564xx	Brainerd	40.4% ▼	95.3% ▲	7.9% ●
565xx	Detroit Lakes	46.3% ▼	89.1% ▼	8.8% ●
566xx	Bemidji	31.3% ▼	91.0% ▼	8.6% ●
567xx	Thief River Falls	16.1% ▼	73.5% ▼	NR

▲ Significantly higher than Minnesota Resident Average
● Not significantly different than Minnesota Resident Average
▼ Significantly lower than Minnesota Resident Average
NR Not reportable; region did not meet the reporting threshold of at least 30 patients
* Minnesota Resident Average is a recalculated statewide average that includes only patients with a Minnesota ZIP code as their residence.

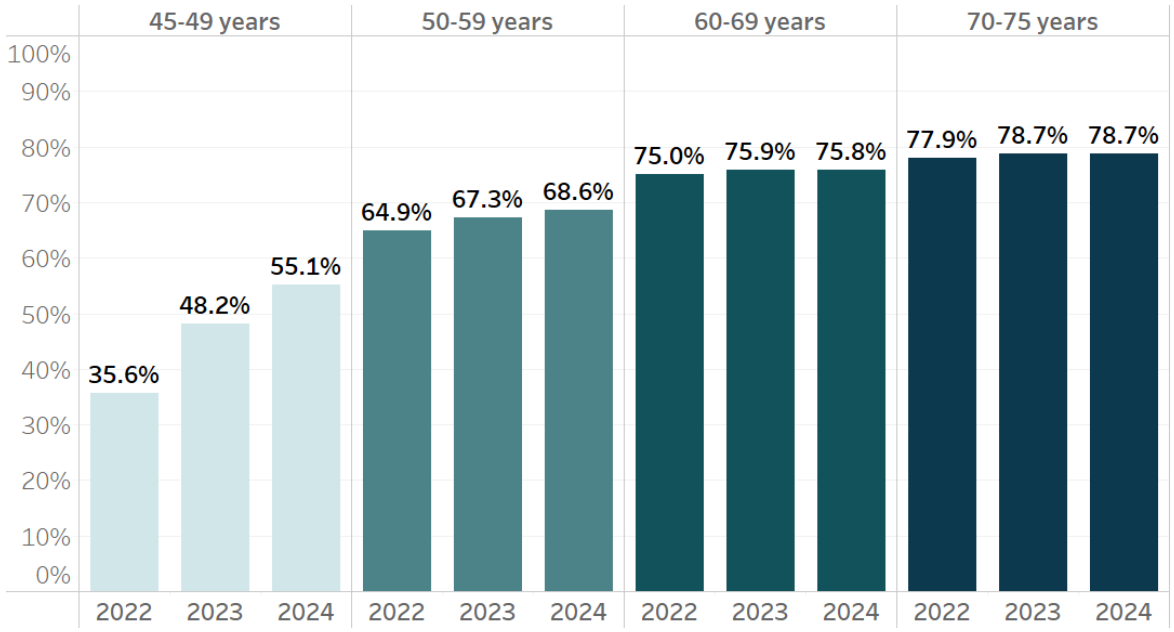
Measure abbreviations:
OAC = Optimal Asthma Control
AMH = Adolescent Mental Health and/or Depression Screening
Remiss 6M = Depression Care: Remission at Six Months

View interactive maps by measure on MNCM's **Performance Hub**

SCREENING RATES BY AGE
Colorectal Cancer Screening

In 2022, the U.S. Preventive Services Task Force (USPSTF) updated its colorectal cancer screening guidelines to recommend that adults at average risk for colorectal cancer begin screening at age 45 (previously age 50). In response to this change, the National Committee for Quality Assurance (NCQA), which stewards the Colorectal Cancer Screening measure, expanded the eligible age range from 50–75 to 45–75.

The graph below presents screening rates by age group, highlighting trends among adults aged 45–49 to monitor screening uptake following the 2022 guideline update.



KEY TAKEAWAY

While the 45–49 age group continues to have significantly lower screening rates than other age groups, rates within this group have increased consistently and significantly since 2022.

COMMUNITY INSIGHT

Uncovering Barriers to Progress in Optimal Diabetes Care

Gregg Simonson, PhD
Director, Strategy, Innovation and Partnerships
International Diabetes Center, HealthPartners Institute

While the Optimal Diabetes Care rates have been increasing over the past five years, progress has been slow, with statewide results consistently hovering around 45-46%. As a composite measure, examining performance on the individual component measures can help the community better understand which factors may be limiting improvement and identify opportunities for improvement.

Potential Drivers of Slow Progress

There are three components that may be limiting the progress of the Optimal Diabetes Care measure –

1) ***Tobacco-free component:*** The tobacco-free component has remained high and relatively stable over the past five years – around 84% – demonstrating the effectiveness of tobacco cessation programs and initiatives. However, there remains a subset of individuals with diabetes that continue to use tobacco and are unwilling to change their tobacco use habits and/or are treatment-resistant and do not respond positively to cessation programs.

2) ***Statin use component:*** While this component has also remained high and relatively stable over the past five years – around 87% – there is widespread misinformation on the Internet regarding this class of medication preventing some individuals with diabetes from taking statins.

3) ***HbA1c management component:*** This component remains the lowest performing metric. For individuals with type 2 diabetes, the progressive nature of the disease makes achieving and maintaining glycemic management targets difficult for some. Additionally, there are significant cost barriers around medication management for both diabetes and its associated comorbidities.

Strategies to Improve Diabetes Care

> *"Diabetes is a team sport with the individual with diabetes at the center of the team…"*

- ***Interdisciplinary collaboration:*** Research shows that including diabetes educators, care coordinators, community health workers, and medication therapy management (MTM) pharmacists as part of the diabetes care team for patients can significantly improve diabetes management. Expanding patient access to a full team such as this may help accelerate improvement in the Optimal Diabetes Care measure and improve diabetes outcomes overall. Additionally, improving reimbursement for care team members can help recognize the value that they bring to the team.

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COMMUNITY INSIGHT

Uncovering Barriers to Progress in Optimal Diabetes Care

Strategies to Improve Diabetes Care
(Continued)

- ***Improving access to new technologies:*** Continuous glucose monitoring (CGM) can significantly improve diabetes management, particularly for individuals with type 1 diabetes and those with type 2 diabetes who use insulin. As health care systems across Minnesota work to expand access to CGM, incorporating CGM metrics and reports into clinical workflows can help guide care teams in clinical decision-making and provide recommendations. By integrating CGM into the standard of care of patients with diabetes, there is greater potential to improve HbA1c management.

- ***Increasing provider education:*** Connecting primary care providers to the latest professional organization guidelines (e.g., American Diabetes Association Standards of Care) is essential to reduce clinical inertia. For example, advances in type 2 diabetes therapies including GLP-1 receptor agonists and SGLT2 inhibitors have the potential to do much more than lower HbA1c, including providing additional cardiorenal protection. However, these medications are currently underutilized in the management of type 2 diabetes. There are likely many reasons for this including lack of awareness of benefit, cost, side effects, etc. Regardless, ensuring that primary care providers are staying up-to-date on guidelines can help to address these barriers to treatment.

SECTION 2:
HEALTH CARE QUALITY
Measures reported by payers

This section covers the measures reported by payers, and includes two sets of analyses:

- **Benchmark Analysis.** This analysis provides a summary of the performance rates for the measurement year and includes achievable benchmark goals by measure. The benchmark provided is intended to illustrate an achievable target based on actual performance observed in the market. This information can be used by medical groups to understand their current performance relative to statewide performance and establish improvement goals aligned with benchmarks for each measure.
- **Rates Over Time.** These tables provide rates for each of the measures over five years as well as an indicator of significant changes compared to the previous year. This information can be used by community partners to prioritize health care improvement efforts.

QUALITY MEASURES
*Reported by payers**

- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status (Combo 10)
- Chlamydia Screening in Women
- Immunizations for Adolescents (Combo 2)
- Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis
- Controlling High Blood Pressure
- Eye Exam for Patients with Diabetes
- Osteoporosis Management in Women who had a Fracture

* See measure notes

KEY FINDINGS

Benchmark Analysis

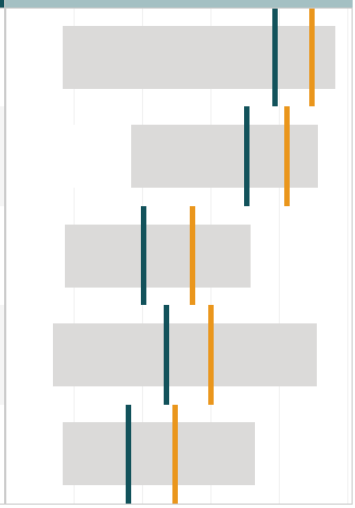
- For the preventive health measures, the Childhood Immunization Status (Combo 10) measure had the largest gap between the statewide rate and the benchmark rate, with 4,100 more patients with an up-to-date screening needed to achieve the benchmark.
- For the acute and chronic conditions measures, the Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis measure had the largest gap between the statewide rate and the benchmark rate, with over 4,000 more patients appropriately not being prescribed an antibiotic needed to achieve the benchmark.

Rates Over Time

- For the preventive health measures, the Breast Cancer Screening measure had the largest increase in rate compared to 2023 (2.9 percentage point increase).
- For the acute and chronic conditions measures, the largest increase from 2023 occurred in the Eye Exam for Patients with Diabetes measure (2.4 percentage point increase).
- The Childhood Immunization Status (Combo 10) has continued to significantly decrease over the last few years. A possible explanation for this decrease is a lower uptake in annual influenza immunization in recent years.

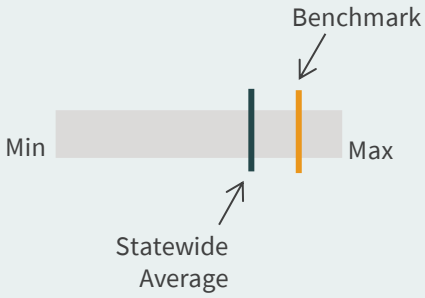
STATEWIDE RESULTS: Preventive Health

	Quality Measure	SW Average	Benchmark	Needed Patients	Minimum	Maximum	Variation
Preventive Health	Breast Cancer Screening	78.7%	89.4%	34,009	16.9%	96.4%	
	Cervical Cancer Screening	70.5%	82.2%	33,570	36.7%	91.5%	
	Childhood Immunization Status (Combo 10)	40.3%	54.5%	4,121	17.5%	71.6%	
	Chlamydia Screening in Women	47.0%	59.8%	11,648	13.9%	90.9%	
	Immunizations for Adolescents (Combo 2)	35.7%	49.4%	4,784	16.8%	72.8%	



Benchmark: 90th percentile of medical groups or 90th percentile of patients, whichever is lower. This method prevents the benchmark from being too heavily influenced by only a few medical groups with small numbers of patients.
Needed Patients: The additional number of patients who would reach optimal status or goal if all medical groups' rates were at least at benchmark.

How to read chart

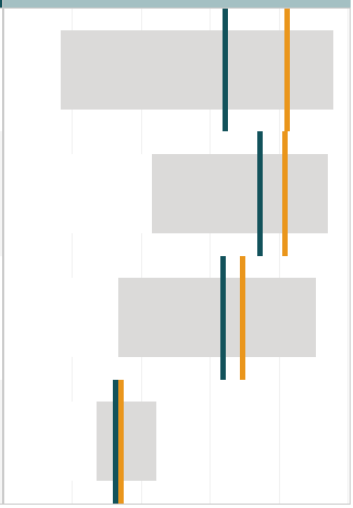


KEY TAKEAWAYS

- Childhood Immunization Status (Combo 10) had the largest gap between the statewide average and the benchmark measure. A little over 4,100 patients would need to be added to the numerator to reach the benchmark goal of 54.5%.
- Breast Cancer Screening had the smallest gap needing 34,009 patients added to the numerator to reach the benchmark goal of 89.4%.

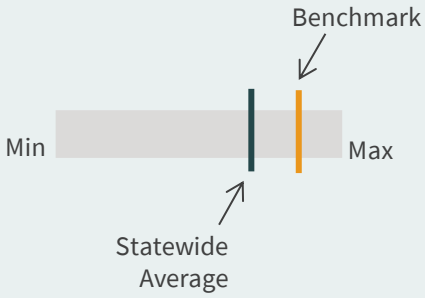
STATEWIDE RESULTS: Acute & Chronic Conditions

	Quality Measure	SW Average	Benchmark	Needed Patients	Minimum	Maximum	Variation
Acute & Chronic Conditions	Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis	64.4%	82.4%	4,052	16.7%	95.8%	
	Controlling High Blood Pressure	74.3%	81.8%	10,805	43.1%	94.3%	
	Eye Exam for Patients with Diabetes	63.6%	69.5%	10,778	33.3%	90.9%	
	Osteoporosis Management in Women who had a Fracture	32.6%	34.1%	40	27.1%	44.4%	



Benchmark: 90th percentile of medical groups or 90th percentile of patients, whichever is lower. This method prevents the benchmark from being too heavily influenced by only a few medical groups with small numbers of patients.
Needed Patients: The additional number of patients who would reach optimal status or goal if all medical groups' rates were at least at benchmark.

How to read chart



KEY TAKEAWAYS

- Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis had the largest gap between the statewide average and the benchmark for the measure. Over 4,000 patients would need to be added to the numerator to reach the benchmark goal of 82.4%.
- Osteoporosis Management in Women who had a Fracture had the smallest gap needing 40 patients added to the numerator to reach the benchmark goal of 34.1%.

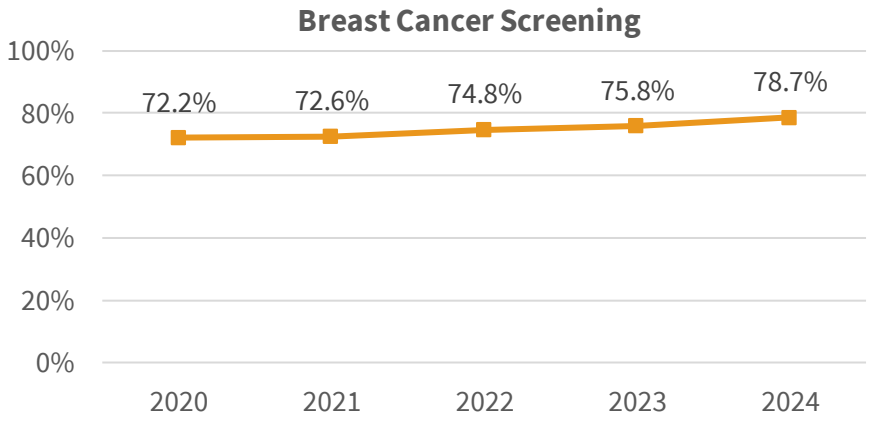
RATES OVER TIME

Measure	2020	2021	2022	2023	2024
Breast Cancer Screening	72.2%	72.6% ▲	74.8% ▲	75.8% ▲	78.7% ▲
Cervical Cancer Screening	64.5%	70.2% ▲	68.8% ●	68.0% ●	70.5% ▲
Childhood Immunization Status (Combo 10)	56.8%	53.0% ▼	48.1% ▼	44.4% ▼	40.3% ▼
Chlamydia Screening in Women	44.7%	47.7% ▲	48.7% ▲	48.4% ●	47.0% ▼
Immunizations for Adolescents (Combo 2)	33.3%	36.4% ▲	35.8% ▼	34.0% ▼	35.7% ▲
Avoidance of Antibiotic Treatment in Acute Bronchitis/Bronchiolitis	57.8%	59.3% ●	66.8% ▲	65.0% ▼	64.4% ●
Controlling High Blood Pressure	62.3%	70.2% ▲	71.0%	72.5% ▲	74.3% ▲
Eye Exam for Patients with Diabetes	56.4%	59.7% ▲	60.3% ▲	61.1% ▲	63.6% ▲
Osteoporosis Management in Women Who Had a Fracture	20.1%	29.9% ▲	28.3% ●	30.5% ●	32.6% ●

▲ Significantly higher than previous year
● Not significantly different than previous year (rate remained stable)
▼ Significantly lower than previous year

Notes & Considerations:

- We urge caution in using 2020 data for comparison to other years and to draw general conclusions about quality of care.



COMMUNITY INSIGHT

Community-Driven Progress in Breast Cancer Screening

Matt Flory
Associate Director – State Partnerships, American Cancer Society

Since 2020, the Breast Cancer Screening rates in Minnesota have been steadily increasing. These rates likely reflect a continued post-COVID "bounce back". Additionally, mammography and targeted initiatives across the state may have also helped drive these improvements. Still, despite these improvements, disparities remain. Mortality rates are highest among American Indian and African American women, and rural regions continue to experience higher mortality compared to metro areas.[1] Understanding where these disparities exist despite overall improvement is critical to ensure all populations have access to appropriate screening and that no one gets left behind.

Mobile Mammography

With the shift to hybrid and remote work, fewer workplace-based screening events have been available. In response, mobile units are now more often stationed at primary care clinics and community sites. Health systems throughout Minnesota have expanded its mobile capacity, which can improve access to screening, especially in rural areas.

Statewide Initiatives and Programs

There are many organizations and initiatives throughout the state working to improve access to care and reduce disparities, including:

- Breast Cancer GAPS Project
- Breast Cancer Champions
- American Indian Cancer Foundation
- MDH SAGE Program

1 Minnesota Department of Health. (2026). *Breast cancer screening: Data, disparities, and social determinants of health.* https://www.health.state.mn.us/data/mcrs/brcanreport.html

SECTION 3:
HEALTH CARE DISPARITIES

Stratification by Race, Ethnicity, Language, and Country of Origin (RELC) is available for measures reported by medical groups. This stratification provides a more granular view into where gaps in care exist, enabling community partners to implement data-driven strategies to reduce disparities.

There are three sets of analyses in this section for the medical group reported quality measures:

- **Stratification of statewide rates by Race/Ethnicity.** These snapshots provide an analysis for measures in which there is a significant gap between the rate of the race/ethnicity group and the statewide rate. The analysis describes how many additional patients within the race/ethnicity group would need to be added to the numerator to eliminate the disparity.
- **Stratification of statewide rates by Preferred Language.** The top five languages with the largest populations of patients across the measures are included. For the 2024 measurement year, the languages are: English, Hmong, Somali, Spanish, and Vietnamese.
- **Stratification of statewide rates by Country of Origin.** The top five countries with the largest populations of patients across the measures are included. For the 2024 measurement year, the countries are: India, Laos, Mexico, Somalia, and the United States.

RELC DATA COLLECTION

Best Practice

The RELC data featured in this section of the report was collected using best practices. Best practice is defined as the following:

- **Race/Ethnicity:** Patient can self-report the race/ethnicity in which they identify AND can select more than one race.
- **Preferred Language:** Patient can self-report their preferred language. A default language is not set for them.
- **Country of Origin:** Patient can self-report their country of origin. A default country is not set for them.

More information on RELC data collection can be found here.

KEY FINDINGS

RACE/ETHNICITY

- For most race/ethnicity groups, the largest gap between the group rate and the statewide average occurred in the Colorectal Cancer Screening measure.
- However, for the Indigenous/Native population, the largest gap was in the Optimal Diabetes Care measure (27.5% vs. 46.9%, respectively). For the Native Hawaiian/Pacific Islander population, the largest gap occurred in the Adult Depression: Follow-up at Six Months measure (36.2% vs. 53.2%, respectively).
- Black patients in Minnesota had the highest number of significant disparities (13 of 18 measures).

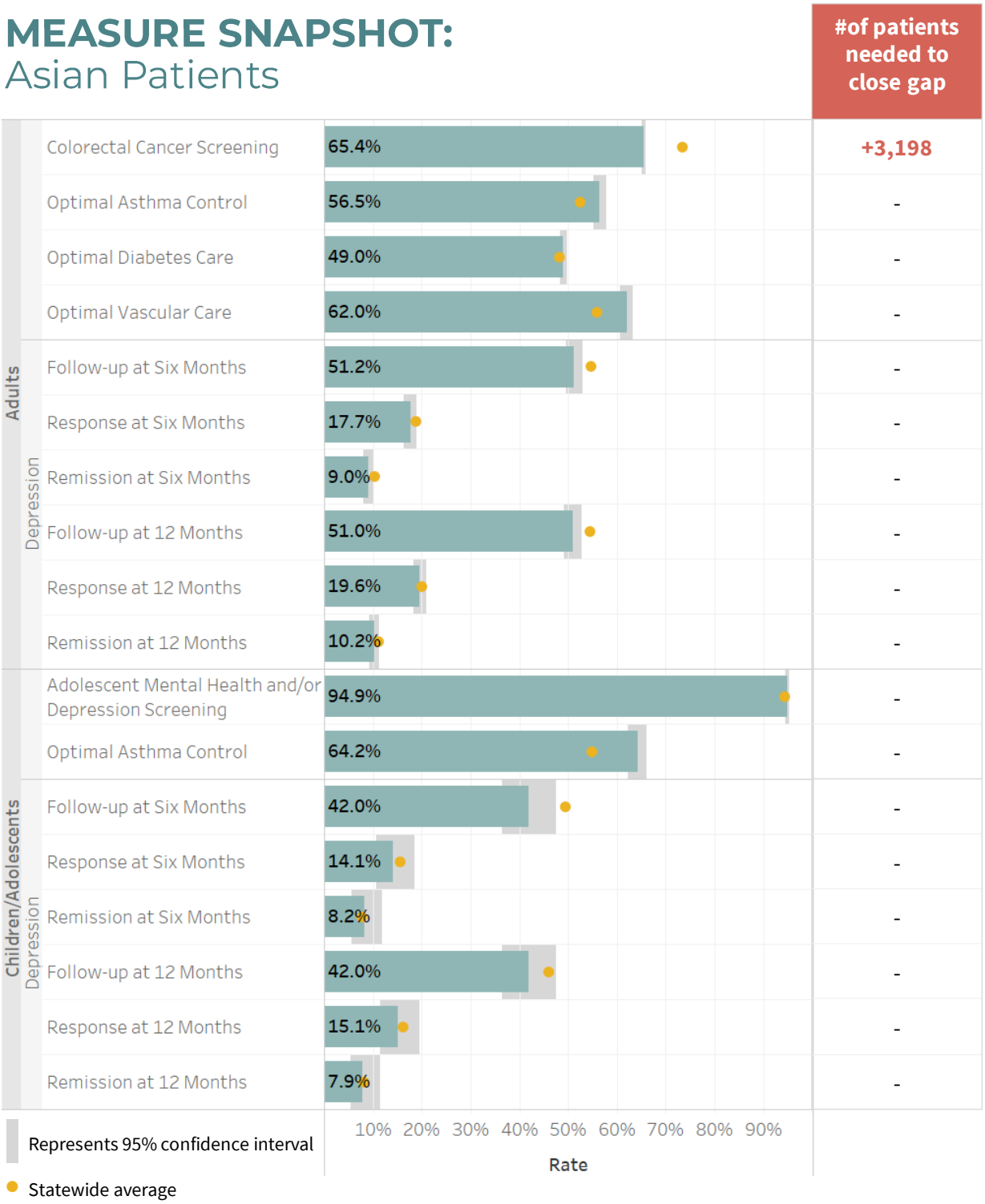
PREFERRED LANGUAGE

- Within the adult population –
    - Both patients who speak Spanish and patients who speak Somali had significantly lower rates compared to the statewide average on most measures (four measures and three measures, respectively).
    - Vietnamese-speakers had significantly higher rates compared to the statewide average on two of five measures.
- For the child/adolescent population –
    - Patients who speak Somali or Spanish had significantly lower rates of Adolescent Mental Health and/or Depression Screening, and Spanish-speakers also had lower rates of Optimal Asthma Control.
    - Hmong- and Vietnamese-speakers had significantly higher rates of Optimal Asthma Control.

COUNTRY OF ORIGIN

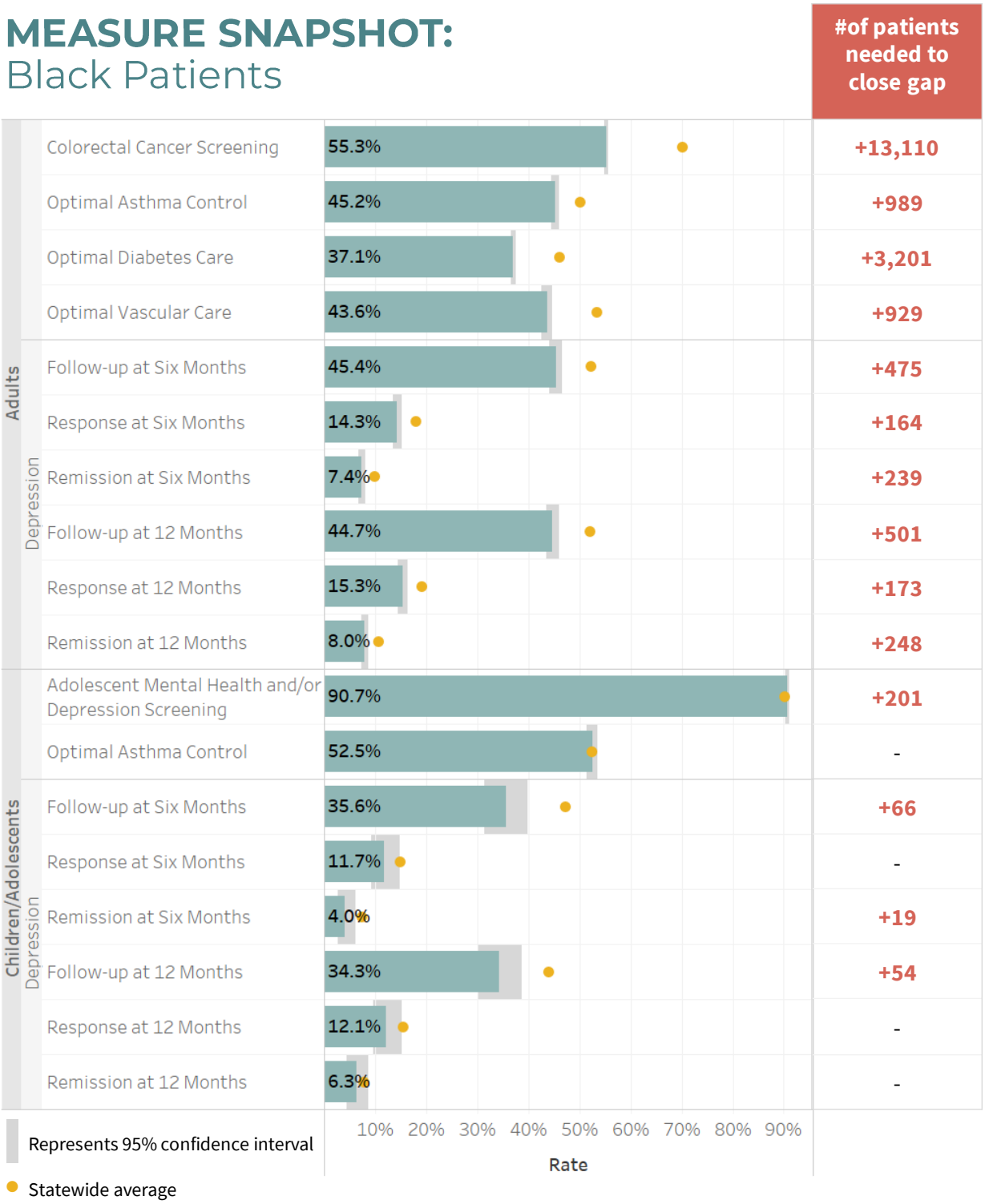
- Within the adult population –
    - Patients from Mexico or Somalia had significantly lower rates compared to the statewide average on most measures (four measures and three measures, respectively).
    - Patients from Laos also had significantly lower rates on three of five measures but did have significantly higher rates of Optimal Vascular Care.
    - Patients from India had significantly higher rates compared to the statewide average on three of five measures.
- For the child/adolescent population, patients from Mexico had significantly lower rates of Adolescent Mental Health and/or Depression Screening, while patients from India had significantly higher rates of screening.

MEASURE SNAPSHOT:
Asian Patients



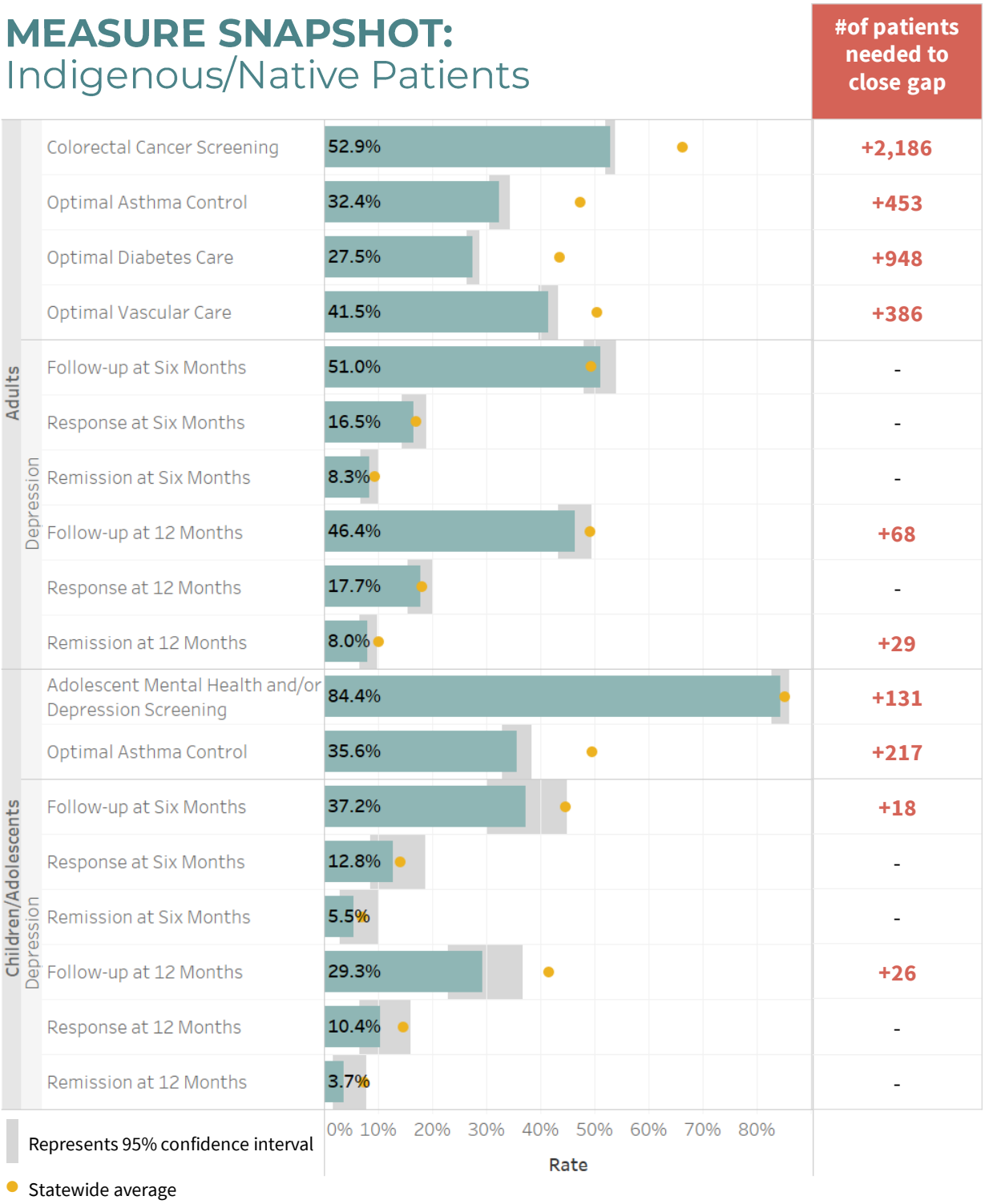
For Asian patients in Minnesota, a significant gap exists for one out of 18 measures compared to the statewide averages. The largest gap occurred in the Colorectal Cancer Screening measure, where over 3,000 more patients would need an updated screening to eliminate the disparity.

MEASURE SNAPSHOT: Black Patients



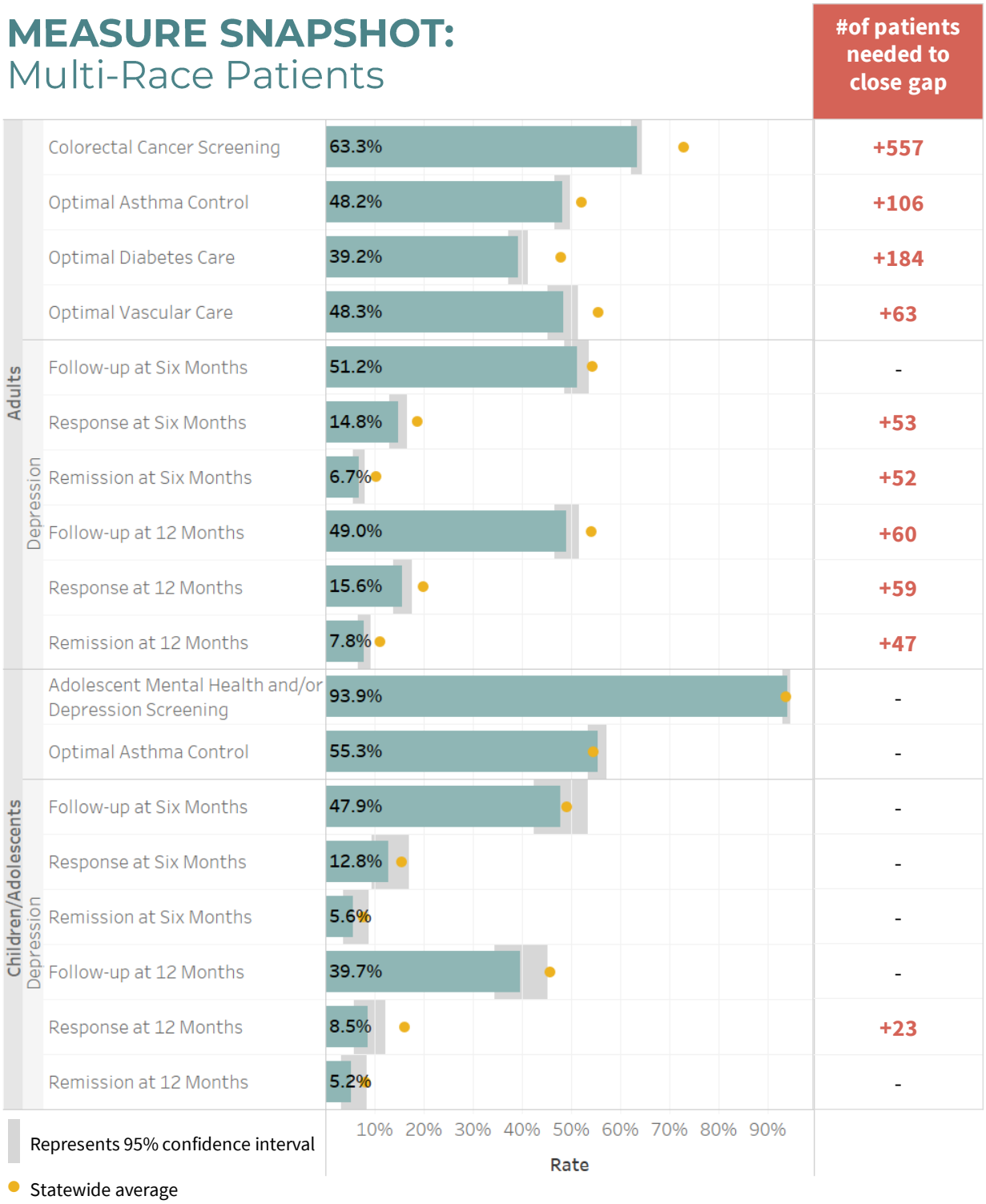
For Black patients in Minnesota, significant gaps exist for 14 out of 18 measures compared to the statewide averages. The largest gap occurred in the Colorectal Cancer Screening measure, with just over 13,000 more patients would need an updated screening to eliminate the disparity.

MEASURE SNAPSHOT:
Indigenous/Native Patients



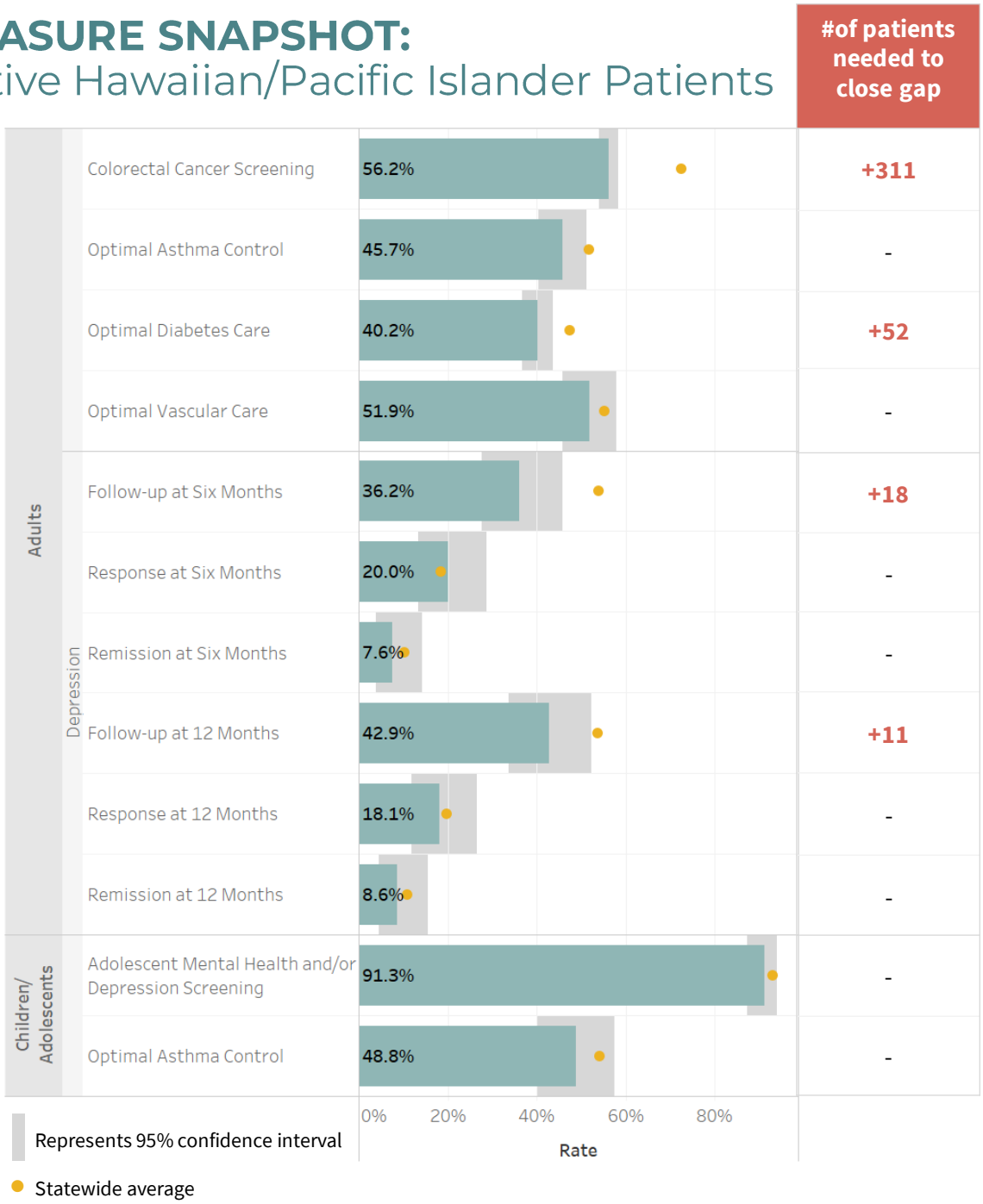
For Indigenous patients in Minnesota, significant gaps exist for ten out of 18 measures compared to the statewide averages. The largest gap occurred in the Optimal Diabetes Care measure, with over 900 more patients would need access to optimal care to eliminate the disparity.

MEASURE SNAPSHOT:
Multi-Race Patients



For Multi-Race patients in Minnesota, significant gaps exist for ten out of 18 measures compared to the statewide averages. The largest gap occurred in the Colorectal Cancer Screening measure, where over 500 more patients would need an updated screening to eliminate the disparity.

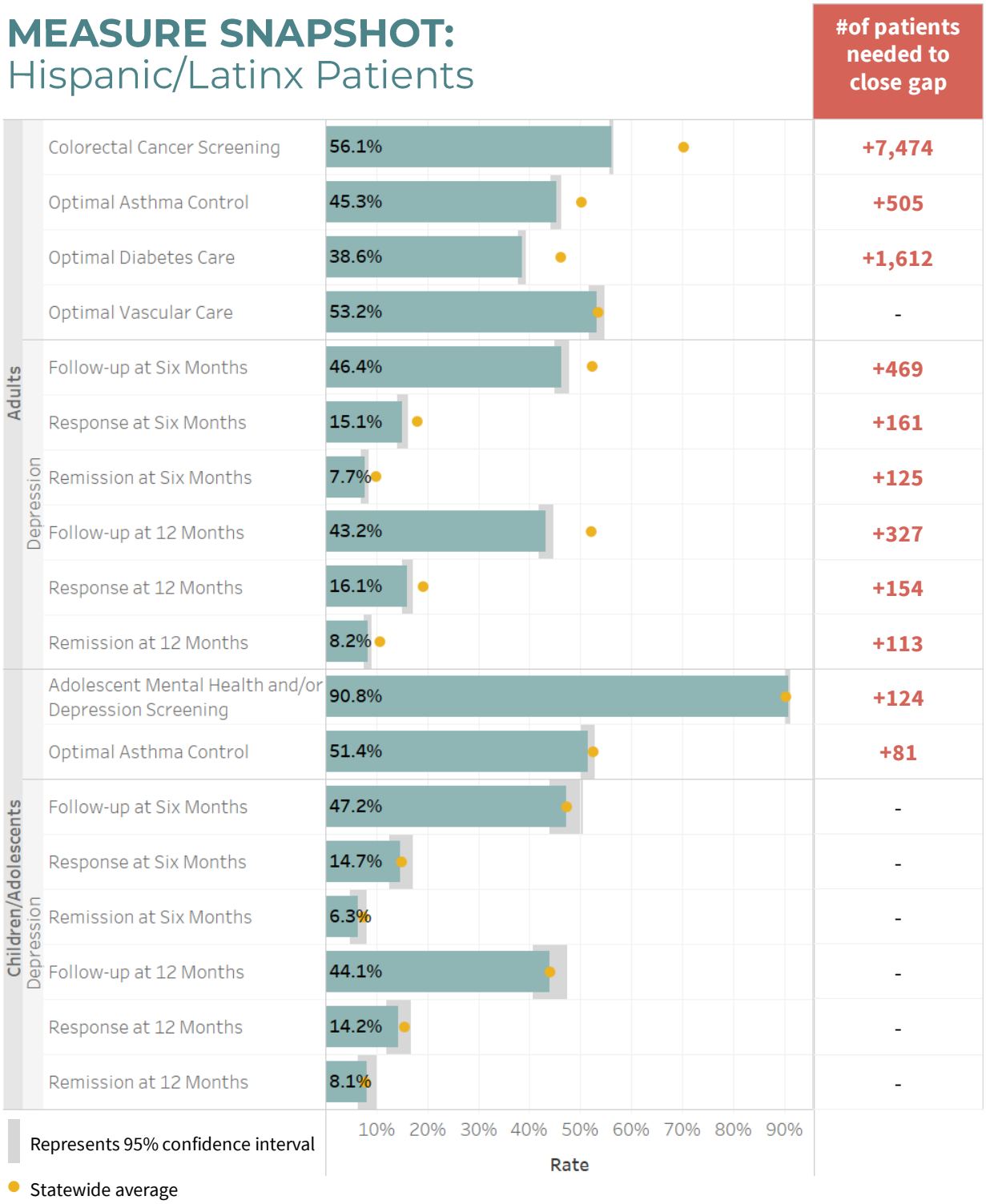
MEASURE SNAPSHOT:
Native Hawaiian/Pacific Islander Patients



For Native Hawaiian/Pacific Islander (NHPI) patients in Minnesota, significant gaps exist for four out of 12 measures compared to the statewide averages. The largest gap occurred in the Depression Care: Follow-up at Six Months for adults, with only 18 more patients needing follow-up to eliminate the disparity.

NOTE: NHPI patient counts for the adolescent depression measures did not meet the minimum reporting threshold of 30 patients; therefore, these measures are excluded from this chart.

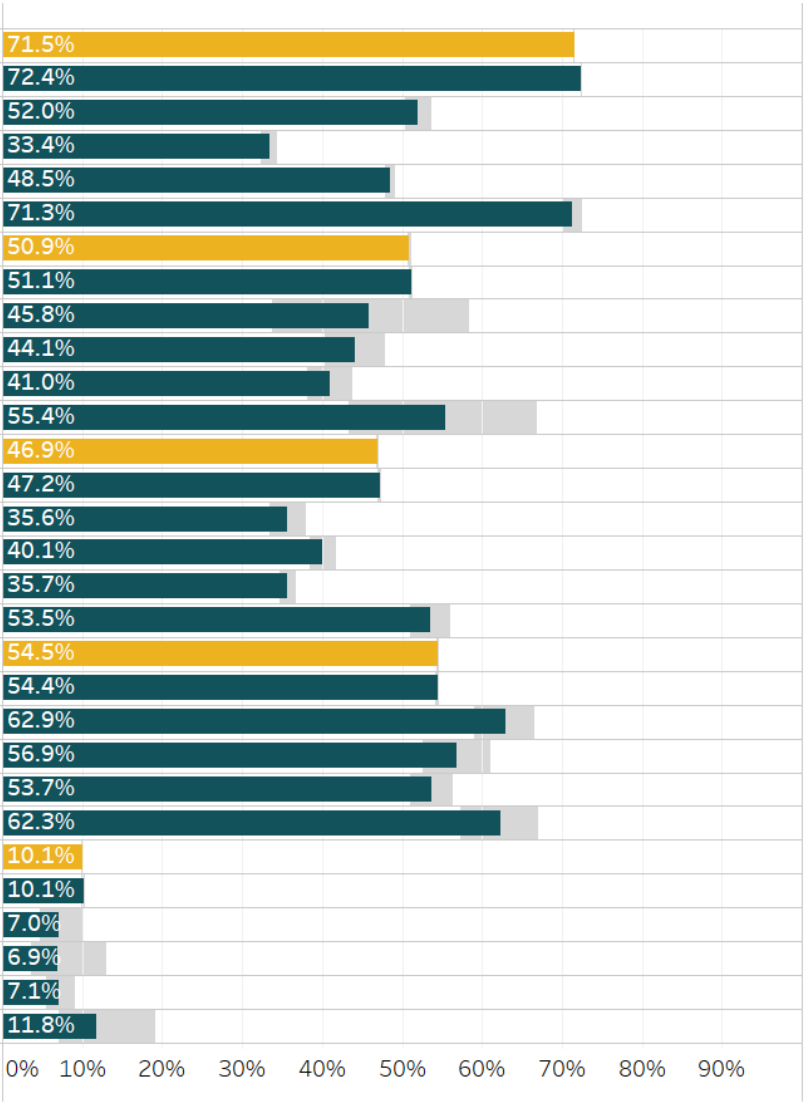
MEASURE SNAPSHOT:
Hispanic/Latinx Patients



For Hispanic/Latinx patients in Minnesota, significant gaps exist for 11 out of 18 measures compared to the statewide averages. The largest gap occurred in the Colorectal Cancer Screening measure, where over 7,000 more patients would need an updated screening to eliminate the disparity.

STATEWIDE RATES BY PREFERRED LANGUAGE
Adults

Measure	Language	Denominator
Colorectal Cancer Screening	STATEWIDE	1,663,408
	English	1,596,401
	Hmong	3,632
	Somali	8,356
	Spanish	22,862
	Vietnamese	5,447
Optimal Asthma Control	STATEWIDE	170,510
	English	167,324
	Hmong	59
	Somali	673
	Spanish	1,150
	Vietnamese	65
Optimal Diabetes Care	STATEWIDE	365,309
	English	313,880
	Hmong	1,723
	Somali	3,273
	Spanish	8,928
	Vietnamese	1,484
Optimal Vascular Care	STATEWIDE	224,982
	English	219,562
	Hmong	625
	Somali	524
	Spanish	1,287
	Vietnamese	379
Depression: Remission at 4-8 Months	STATEWIDE	100,190
	English	97,535
	Hmong	329
	Somali	116
	Spanish	799
	Vietnamese	110



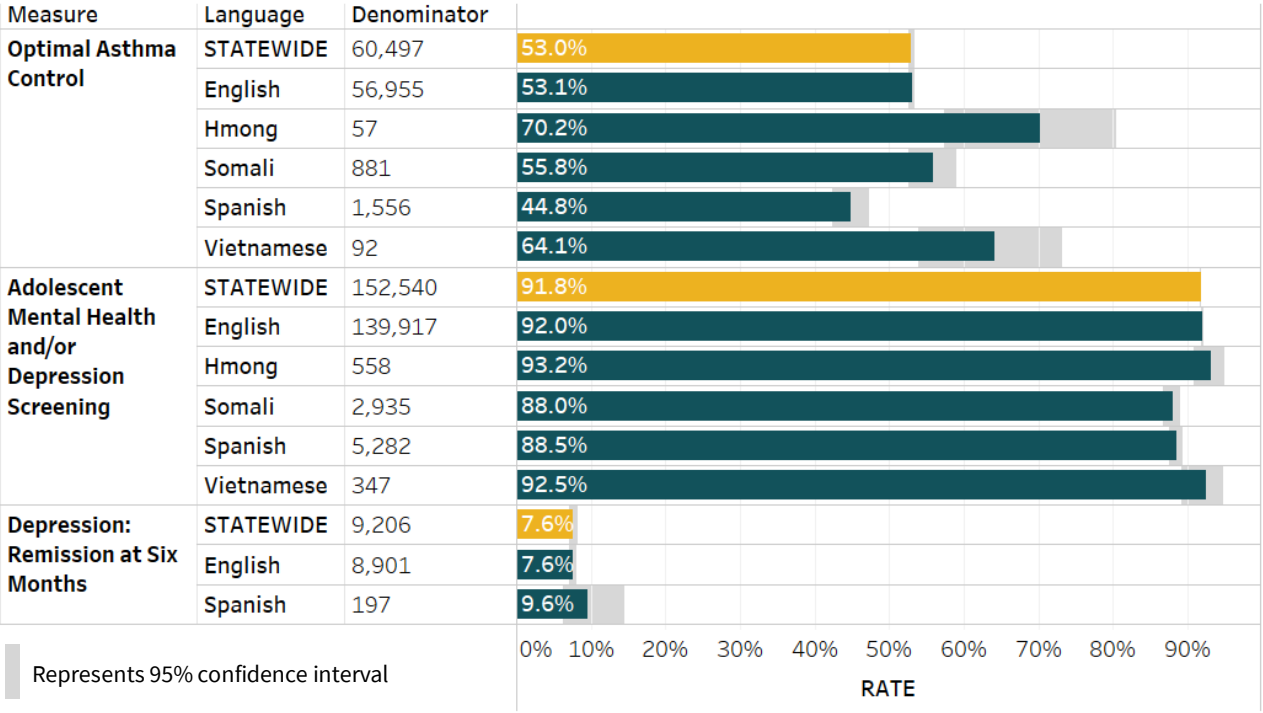
Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who speak Spanish had significantly lower rates than the statewide average on four of five measures, while Somali-speaking patients have lower rates on three measures.
- Hmong-speaking patients had lower rates on two measures but higher rates for Optimal Vascular Care compared with the statewide average.
- Vietnamese-speaking patients had significantly higher rates than the statewide average on two of the five measures.

STATEWIDE RATES BY PREFERRED LANGUAGE
Children/Adolescents

Measure	Language	Denominator	
Optimal Asthma Control	STATEWIDE	60,497	53.0%
	English	56,955	53.1%
	Hmong	57	70.2%
	Somali	881	55.8%
	Spanish	1,556	44.8%
	Vietnamese	92	64.1%
Adolescent Mental Health and/or Depression Screening	STATEWIDE	152,540	91.8%
	English	139,917	92.0%
	Hmong	558	93.2%
	Somali	2,935	88.0%
	Spanish	5,282	88.5%
	Vietnamese	347	92.5%
Depression: Remission at Six Months	STATEWIDE	9,206	7.6%
	English	8,901	7.6%
	Spanish	197	9.6%



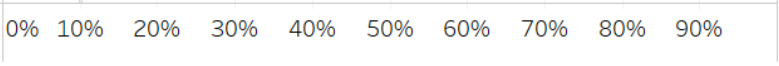
KEY TAKEAWAYS

- Patients who speak Spanish had significantly lower rates of Adolescent Mental Health and/or Depression Screening and Optimal Asthma Control in children compared to the statewide averages.
- Patients who speak Somali had significantly lower rates of Adolescents Mental Health and/or Depression Screening compared to the statewide average.
- Patients who speak Hmong or Vietnamese had significantly higher rates of Optimal Asthma Control in children compared to the statewide average.

NOTE: The number of patients who prefer to speak Hmong, Somali, or Vietnamese did not meet the public reporting threshold of at least 30 patients for the Depression: Remission at Six Months measure. As a result, the rates for these patients were removed from the chart.

STATEWIDE RATES BY COUNTRY OF ORIGIN
Adults

Measure	Country	Denominator	
Colorectal Cancer Screening	STATEWIDE	1,663,408	71.5%
	India	6,036	57.9%
	Laos	7,984	54.7%
	Mexico	16,493	52.4%
	Somalia	10,928	34.9%
	United States	1,461,220	73.4%
Optimal Asthma Control	STATEWIDE	170,510	50.9%
	India	473	56.2%
	Laos	129	51.2%
	Mexico	819	46.2%
	Somalia	1,061	45.6%
	United States	154,697	51.1%
Optimal Diabetes Care	STATEWIDE	365,309	46.9%
	India	2,502	51.8%
	Laos	3,220	40.7%
	Mexico	7,254	36.8%
	Somalia	4,540	38.2%
	United States	282,416	47.4%
Optimal Vascular Care	STATEWIDE	224,982	54.5%
	India	632	65.3%
	Laos	1,188	65.7%
	Mexico	980	55.5%
	Somalia	733	55.1%
	United States	208,219	54.5%
Depression: Remission at Six Months	STATEWIDE	100,190	10.1%
	India	197	5.6%
	Laos	449	6.5%
	Mexico	637	7.1%
	Somalia	267	9.4%
	United States	90,895	10.1%



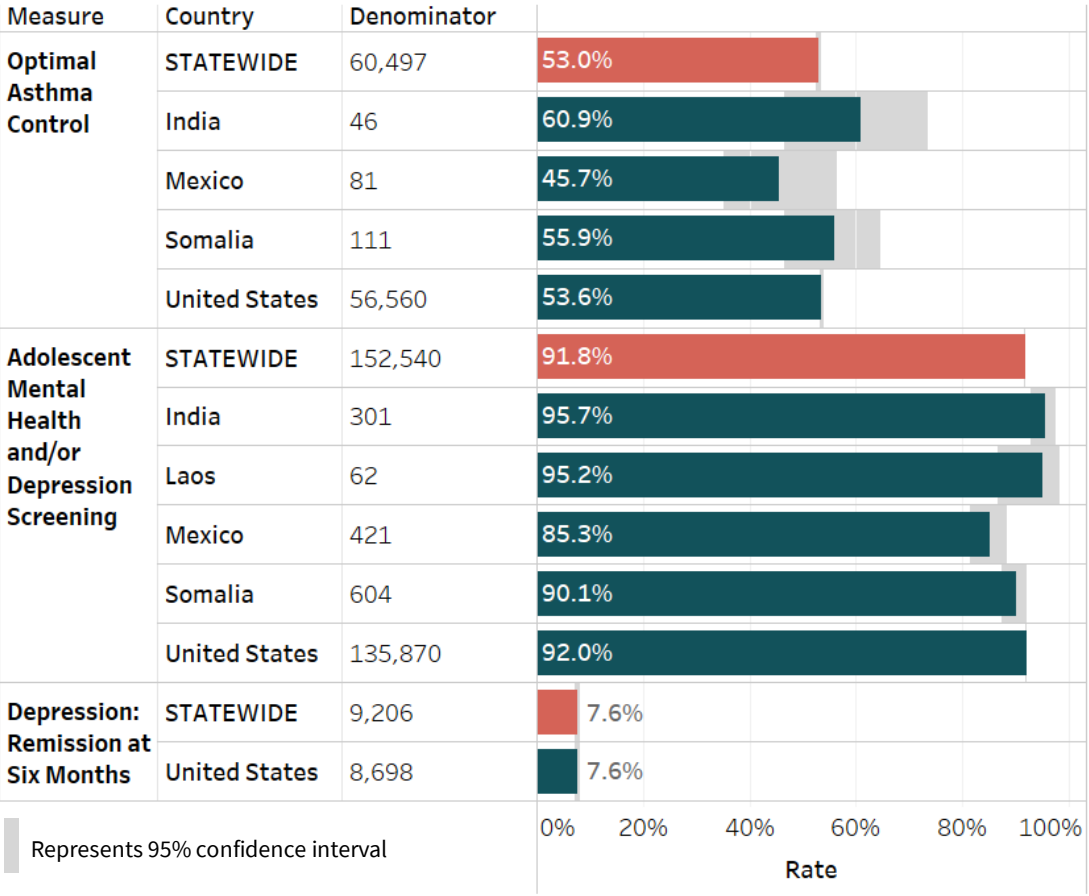
Represents 95% confidence interval

KEY TAKEAWAYS

- Patients from Mexico have significantly lower rates than the statewide average on four of five measures, while those from Somalia have lower rates on three measures.
- Patients from Laos have lower rates on three measures but higher rates for Optimal Vascular Care compared with the statewide average.
- Patients from India have significantly higher rates than the statewide average on three of the five measures.

STATEWIDE RATES BY COUNTRY OF ORIGIN
Children/Adolescents

Measure	Country	Denominator	Rate
Optimal Asthma Control	STATEWIDE	60,497	53.0%
	India	46	60.9%
	Mexico	81	45.7%
	Somalia	111	55.9%
	United States	56,560	53.6%
Adolescent Mental Health and/or Depression Screening	STATEWIDE	152,540	91.8%
	India	301	95.7%
	Laos	62	95.2%
	Mexico	421	85.3%
	Somalia	604	90.1%
	United States	135,870	92.0%
Depression: Remission at Six Months	STATEWIDE	9,206	7.6%
	United States	8,698	7.6%



KEY TAKEAWAYS

- Patients from Mexico had significantly lower rates of Adolescent Mental Health and/or Depression Screening compared to the statewide rate.
- Patients from India had significantly higher rates of Adolescent Mental Health and/or Depression Screening compared to the statewide rate.

NOTE: The number of patients from India, Laos, Mexico, and Somalia did not meet the public reporting threshold of at least 30 patients for the Depression: Remission at Six Months measure. As a result, the rates for these patients were removed from the chart.

COMMUNITY INSIGHT

Strengthening Access & Equity Through Federally Qualified Health Centers

Kevin Gilliam, MD
Medical Director
NorthPoint Health & Wellness Center

While Minnesota has consistently ranked among the top states for health care, significant disparities in access, quality, and outcomes persist across populations, highlighting ongoing gaps in achieving equitable care.

Notable Gaps in Care

- ***By race***: The gaps in care are particularly pronounced among Black adults where rates fall below the statewide average across all ten measures. The consistency and extent of these gaps likely point to broader systemic issues and other confounding factors that continue to impact care delivery and outcomes.
- ***By measure:*** The Colorectal Cancer Screening measure shows substantial gaps in care across multiple populations, highlighting the challenges associated with completing screening that require significant patient effort, care coordination, and follow-through.
- ***By language:*** The suite of depression measures illustrates how language barriers pose significant challenges in care delivery, emphasizing the importance of culturally and linguistically competent care to achieve equitable outcomes.

What is a Federally Qualified Health Center?

Federally Qualified Health Centers (FQHCs) are community-based health care organizations that provide primary care services to underserved populations . These centers play a critical role in delivering low-cost health care services, expanding access to care, and improving health outcomes within the communities they serve. One such organization is NorthPoint Health & Wellness, an FQHC that has served the North Minneapolis area since 1968, offering medical, dental, behavioral health, and human services.[1]

Barriers to Care Access & Engagement

Patients who rely on FQHCs for primary care face several common barriers to accessing and maintaining care. These include challenges with maintaining consistent insurance coverage, the cost of care competing with other financial priorities, and the time required to seek care amid other personal and work-related demands. Additionally, limited or lack of awareness of the importance of preventive screenings can further reduce engagement in recommended care.

(Continued on next page)

1 NorthPoint Health & Wellness Center. (n.d.). About NorthPoint. https://www.northpointhealth.org/about-us/who-we-are/about-northpoint

COMMUNITY INSIGHT

Strengthening Access & Equity Through Federally Qualified Health Centers

Strategies to Address Barriers

To address these barriers, FQHCs are implementing improvement efforts that center on increasing engagement, improving awareness, and streamlining access to services through their electronic medical records. These efforts include:

- ***Strategic marketing campaigns:*** These campaigns encourage patients to engage in primary care for ongoing health maintenance and directly address patient barriers, including limited awareness of preventive screenings and challenges navigating enrollment in Medicaid and other federal programs.
- ***Investment in technical infrastructure:*** Investing in technical infrastructure can better support care delivery. This includes enhancing automation of outreach efforts, optimizing technical workflows, and expanding use of patient portals. These tools help simplify appointment scheduling, improve communication between providers and patients, and increase patient awareness of recommended care, ultimately making it easier for patients to access and engage with care services.

SECTION 4:
HEALTH CARE COST

MNCM has one of the most robust public transparency efforts in the nation related to health care costs, which provides perspective on total cost of care (TCOC), resource use, and price as drivers of total cost. This report includes data from our analysis of 2024 health care costs for Minnesotans who had private health insurance.

The total cost of health care in Minnesota continues to increase. TCOC measures all medical and pharmacy costs for a patient. This information is important for all purchasers of health care because all Minnesotans benefit from reliable health care cost information delivered in a comparable, consistent manner.

TCOC is a combination of two factors: resource use (the amount and intensity of care) and prices

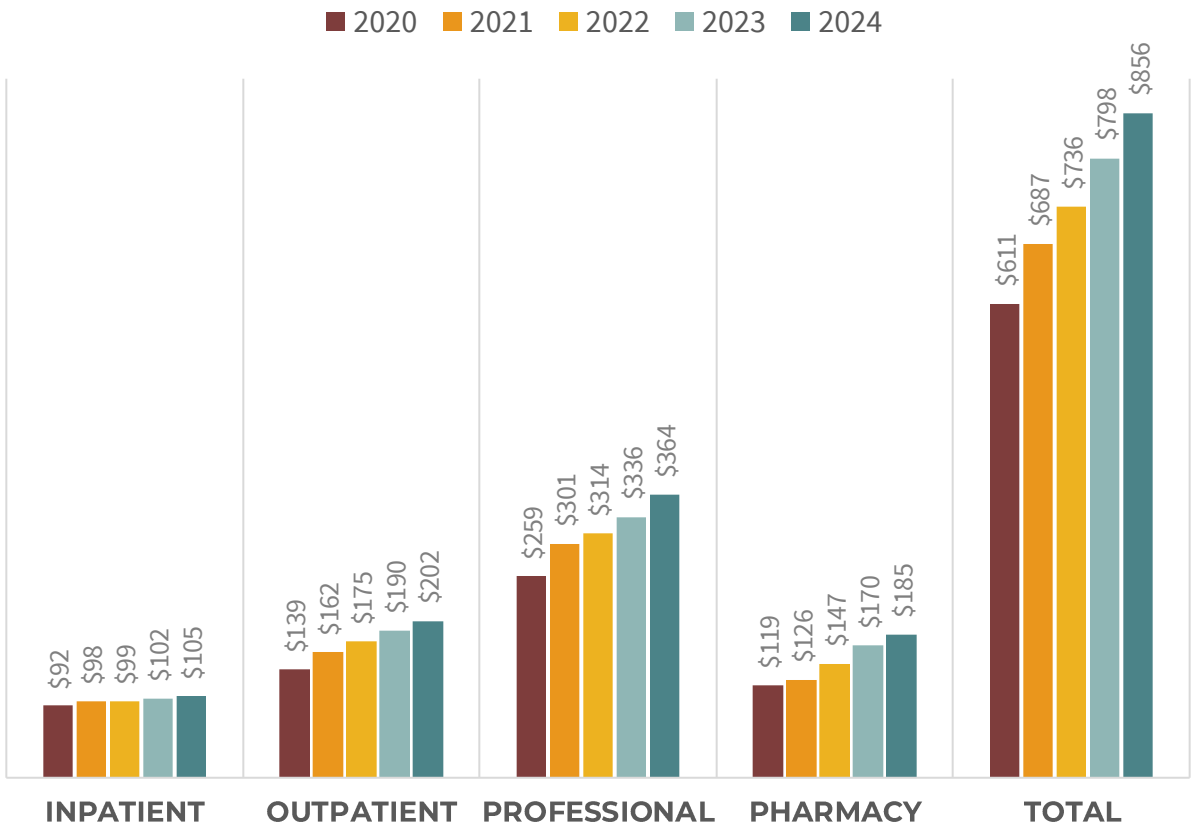
KEY TAKEAWAYS

- Total costs per attributed patient without adjustments for outliers increased by 7.3 percent in 2024. This represents an increase of $58 per patient per month. On an annual basis, the increase was $697 per person.
- Cost for pharmacy cost use increased the most, by 8.9 percent, followed by professional fees, which increased by 8.3 percent.
- All categories of medical services utilization increased compared to 2023, except for inpatient admissions.
- Women accessed health care at a higher rate than men when looking at health care claims. Specifically, women aged 36 to 64 had the highest number of claims, while men aged 18 to 35 had the lowest number of claims in 2024.

TOTAL COST OF CARE

Commercially Insured Patients

COST TREND BY SERVICE TYPE



KEY TAKEAWAYS

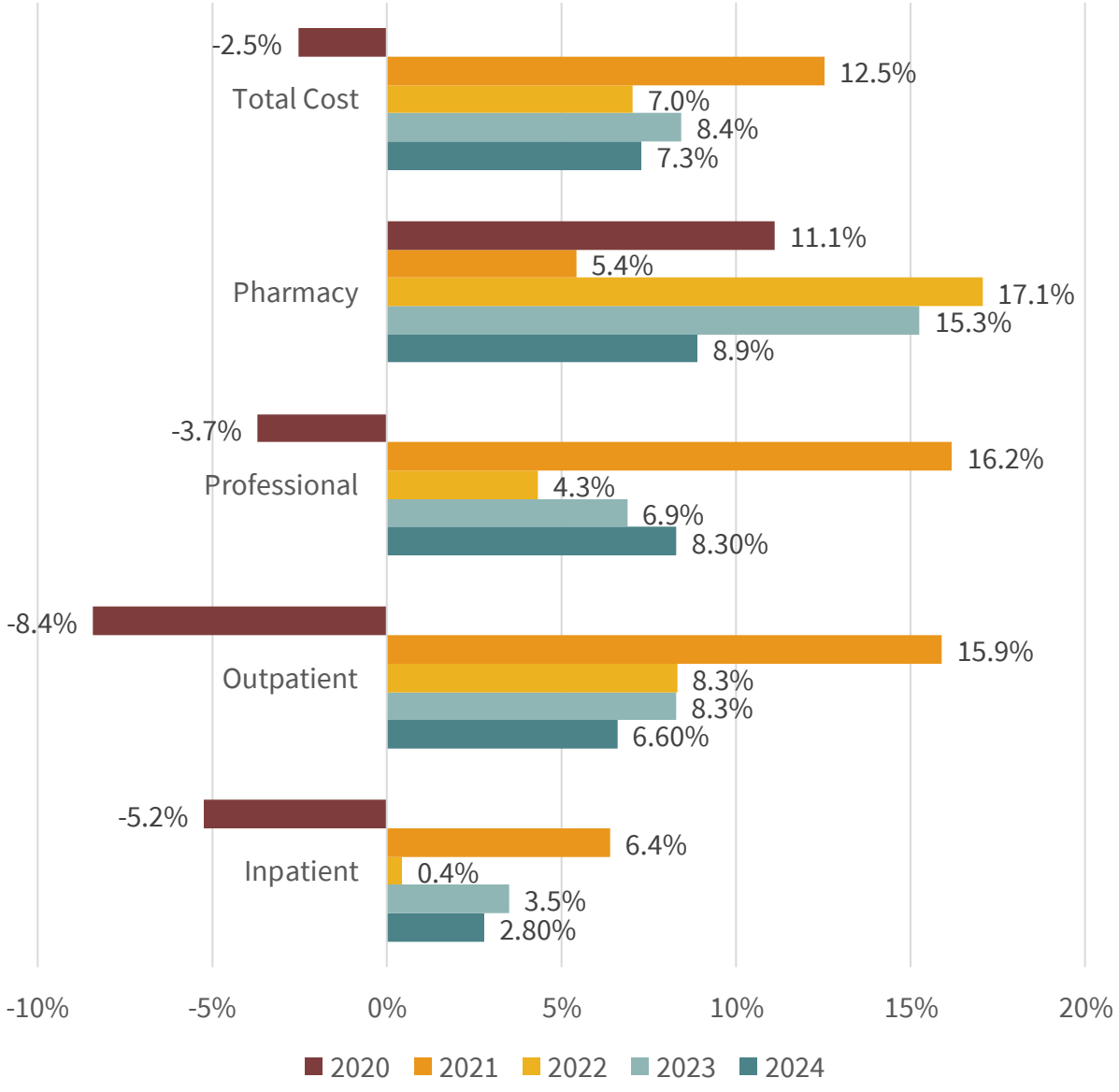
- In 2024, the average TCOC for commercially insured patients cared for by Minnesota primary care providers was $856 per month, an increase of $58 compared to 2023 and $120 compared to 2022.
- This chart includes all costs for patients who were attributed to a primary care provider, without adjustments for high-cost outliers.
- High-cost outliers are costs over $125,000 for any patient. This analysis includes 1,035,780 commercially insured patients aged 1-64 and $9.9 billion in claims.

NOTE: We urge caution in using 2020 data for comparison to other years and to draw general conclusions.

TOTAL COST OF CARE

Commercially Insured Patients

COST GROWTH TREND



KEY TAKEAWAYS

Statewide, TCOC increased by 7.3 percent in 2024. Cost for pharmacy use increased the most, by 8.9 percent, followed by professional fees, which increased by 8.3 percent.

NOTE: We urge caution in using 2020 data for comparison to other years and to draw general conclusions.

UTILIZATION

Commercially Insured Patients

Utilization metrics per 1,000 patients per year					
	2020	2021	2022	2023	2024
Emergency Room	147	163	175	180	183
Outpatient Surgery	112	134	144	152	152
Primary Care Visits	2,510	2,718	2,660	2,681	2,777
Lab	5,467	6,272	6,480	6,835	7,267
Radiology	862	996	1,048	1,112	1,172
Prescription Drugs *(count of 30-day prescriptions)*	15,666	16,880	17,617	18,501	18,904
Inpatient Admissions	47	47	45	45	44

How to interpret the "Per 1,000"

Utilization figures are listed in the commonly used "Per 1,000 Per Year" format. Or "What is the average number of events for 1,000 patients over a 12-month period?"

An inpatient admission rate of 45 means that for every 1,000 patients in a year, there are 45 admissions for inpatient hospital services. A prescription drugs rate of 18,501 means for 1,000 patients there were 18,501 prescriptions ordered and filled in a year, or an average of 1.54 prescriptions per patient per month.

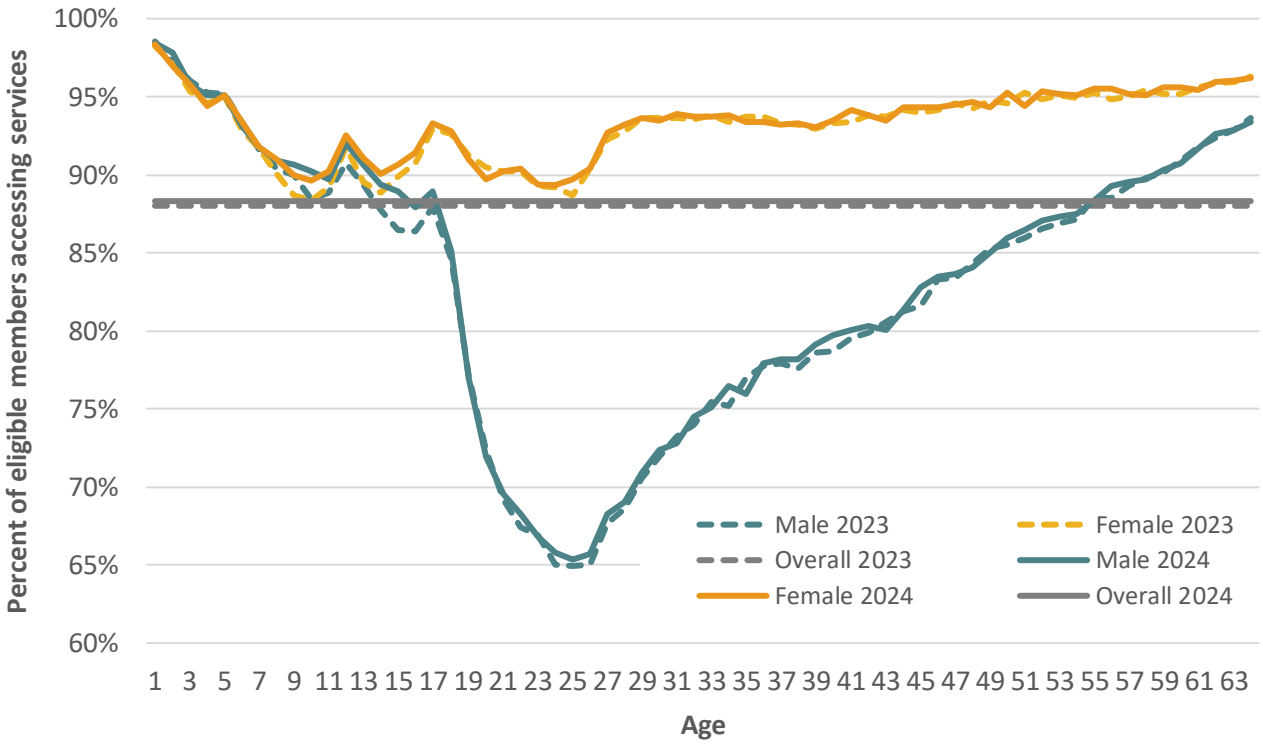
KEY TAKEAWAYS

- Total cost is driven by both the amount of resources used and the price of each resource. To further understand variation in resource use, MNCM's analysis includes the utilization of common categories of medical services, such as hospital admissions or radiology services. The table above shows the utilization of services over time.
- In 2024, all categories of medical services utilization increased compared to 2023, except for inpatient admissions. Radiology, lab, outpatient surgery, and prescription drugs saw an increase between five to six percent from 2023.

UTILIZATION

Commercially Insured Patients

PERCENTAGE OF HEALTH PLAN MEMBERS UTILIZING SERVICES 2023-2024



	2024			2023			Change (24-23)		
Age Group	Female	Male	Overall	Female	Male	Overall	Female	Male	Overall
1 to 17	92.5%	91.8%	92.1%	91.8%	91.0%	91.4%	0.8%	0.9%	0.8%
18 to 35	91.9%	71.8%	81.9%	91.8%	71.6%	81.7%	0.1%	0.3%	0.2%
36 to 64	94.7%	85.4%	90.1%	94.6%	85.2%	90.0%	0.1%	0.2%	0.1%
All	93.4%	83.1%	88.3%	93.2%	82.8%	88.0%	0.2%	0.4%	0.3%

KEY TAKEAWAYS

Every year there are individuals enrolled in health plans who, even though they have benefits for the full 12 months, do not have any health care claims. The trend for 2024 is similar to what the trend was for 2023. Women accessed health care at a slightly higher rate than men. Women aged 36 to 64 had the highest number of claims, while men aged 18 to 35 had the lowest number of claims.

COMMUNITY INSIGHT

Using Cost and Utilization Data to Drive Smarter, More Accountable Care

Alex Caldwell, MPH
Director – Center for Health Care Affordability,
Minnesota Department of Health

"Health care spending growth continues to outpace wage growth, raising real affordability concerns for Minnesota families, businesses, and public programs. For example, more Minnesotans are expressing concern about the affordability of their health insurance coverage. Nearly one in three Minnesotans (28.8%) reported in the 2025 Minnesota Health Access Survey that they are concerned their coverage will become too expensive – up from 17.5% in 2023. Publicly available data like these can help us better understand what is driving that growth and where targeted action can support a more affordable, high-value health care system."

Informing Smarter Payment & Policy Decisions

At a high level, the TCOC and utilization data helps purchasers, policymakers, and providers understand and visualize which service areas account for the greatest spending and utilization. These data can also identify services areas with the greatest annual growth in spending or utilization and highlight areas where deeper analysis may be needed to understand what is driving change (e.g., which procedures, prescriptions).

Increasing Transparency & Accountability

Purchasers, such as employers and public purchasers, can use the cost and utilization data to benchmark price and utilization markers. When paired with quality data, this information can help to inform plan design that encourages appropriate, timely, and cost-efficient care. The data can also equip leaders with oversight without prescribing specific solutions and create a shared truth of baseline knowledge about key drivers in health care costs.

Building Trust Through Public Reporting

Public reporting of the cost and utilization data illustrates the tradeoffs between higher spending and quality (or lack thereof) and highlights the types of health care services that contribute most to overall costs. Making these data publicly available can increase trust and strengthen public stewardship of affordability efforts.

Identifying Opportunities for Care Improvement

Current cost and utilization data help providers gain a high-level view of what may be driving cost growth in health care. However, more granular data on specific health care services, procedures, and medications would be needed to support care redesign or improvement. With more detailed data, providers could identify costly services or medications and examine variation in cost utilization, helping to uncover opportunities for greater standardization and efficiency of spending, price, or utilization in health care.

SECTION 5:
PATHWAYS TO ACTION

LEVERAGING DATA TO IMPROVE HEALTH CARE IN MINNESOTA

This report provides a data-driven foundation for health care partners—including providers, policymakers, payers, community organizations, and employers—to take strategic action. By leveraging this data, Minnesota can enhance health outcomes, reduce disparities, and make health care more affordable and efficient. Community partners can use this information in a variety of ways, which are described below.

COMMUNITY ORGANIZATIONS

- **Health Equity Initiatives:** Community-based organizations can leverage the report's insights on disparities in care to advocate for programs that promote equitable health outcomes. This information can be used to inform and develop community programs that focus on increasing access to screening, mental health services, and chronic disease management.
- **Education & Outreach:** The data can inform community education campaigns on preventive care, mental health, and chronic disease management.

EMPLOYERS & PURCHASERS OF HEALTH CARE

- **Benefit Design:** Employers can use cost and quality data to design benefits that offer the best value and outcomes for their workforce.
- **Workplace Wellness Initiatives:** The insights from this report can guide the development of employer-sponsored wellness programs that address prevalent health concerns such as diabetes, hypertension, and mental health.

PAYERS

- **Value-Based Incentives:** Payers can use performance data to structure value-based payment models, rewarding providers who achieve high-quality care benchmarks.
- **Member Outreach & Preventive Care Programs:** Payers can develop targeted interventions, such as wellness programs and preventive screening reminders, to improve health outcomes among their members.
- **Cost Containment Strategies:** By analyzing trends in total cost of care and utilization, payers can identify areas where efficiency improvements and cost reductions are possible.

POLICYMAKERS

- **Legislative Decisions:** Policymakers play a crucial role in shaping health care to ensure quality, affordability, and equity. The data and insights from this report can help them make informed decisions about legislation, funding, and public health strategies to improve healthcare outcomes in Minnesota.
- **Policy Changes:** Policymakers can utilize data on health care disparities and costs to guide the development of policies that ensure equitable access to quality care. This data can be leveraged to design targeted programs that address the needs of specific communities.

PROVIDERS & HEALTH SYSTEMS

- **Benchmarking & Performance Improvement:** Medical groups can compare their performance with statewide benchmarks to identify areas requiring quality improvement. This includes addressing gaps in asthma control, immunizations, colorectal cancer screening, mental health, and chronic disease management by implementing quality improvement initiatives to improve patient outcomes.
- **Targeted Care Interventions:** Providers can design care models and outreach strategies tailored to populations with the highest disparities. By utilizing stratified data on race, ethnicity, language, and country of origin, providers can collaborate with community organizations to create and implement culturally responsive interventions for populations facing the greatest health inequities.

PUBLIC HEALTH AGENCIES

- **Resource Allocation:** Public health agencies can direct funding and resources to areas and populations with the greatest health disparities.
- **Public Health Initiatives:** Public health agencies can develop and implement data-informed initiatives by understanding health care quality outcomes and how these outcomes vary across geographies within the state.
- **Public Health Campaigns:** This information can be used to inform educational campaigns targeting communities with lower screening rates or lower rates of optimal care.

RESEARCHERS

- **Health Care Trends:** Researchers in healthcare, public health, economics, and policy analysis can leverage this report's data to conduct studies that improve healthcare outcomes, inform policy decisions, and advance medical knowledge.
- **Inform Community and Academic Research Initiatives:** Researchers working with community organizations and academic institutions can use this report to guide research collaborations. Findings can be used as supporting data in grant applications for funding research on healthcare disparities, quality improvement, and cost control.

HOW COMMUNITY PARTNERS CAN ENGAGE WITH MNCM

MEASURE FEEDBACK & PRIORITIZATION

MNCM conducts its measure prioritization process every three years to gather and assess input on potential measure priorities, with the goal of identifying new measure topics or areas not already covered in MNCM's Slate of Measures. Annually, MNCM's Measurement and Reporting Committee (MARC) reviews the Slate of Measures and provides recommendations to the Board of Directors for approval. Importantly, MNCM values community input and encourages feedback on priority areas at any time throughout the year.

All comments can be submitted to MNCM via publiccomment@mncm.org. Submissions should include the commenter's name, title, organization, and the specific measure(s) the comments address.

COLLABORATE WITH US!

We believe collaboration is key to advancing health care quality, equity, and affordability. We invite our community partners to share insights, provide input on measurement priorities, and contribute to meaningful improvement initiatives.

Our reports and resources are designed to support your efforts, and we welcome the opportunity to explore how we can work together to drive positive change.

For questions or collaboration opportunities, please contact us at support@mncm.org.

APPENDIX A:
Measure Notes

- **Use of Spirometry Testing in the Assessment and Diagnosis of COPD:** The National Committee for Quality Assurance (NCQA) retired this measure for the 2024 measurement year.
- **Follow-Up Care for Children Prescribed ADHD Medication:** MNCM's Measurement and Reporting Committee (MARC) decided to transition from the Follow-Up Care for Children Prescribed ADHD Medication Initiation Phase to the Continuation and Maintenance Phase. MNCM will privately report the 2024 measurement year results.
- The measures reported by payers are adapted from the Healthcare Effectiveness Data Information Set (HEDIS®). HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

APPENDIX B:
MNCM Resources

MEASURE DEFINITIONS

Definitions for the measures included in this report can be here:

Measure Definitions

METHODOLOGY

The measures included in this report are collected from medical group electronic health records (EHR) and payer administrative claims. Information on the methodology for data collection, measure calculations, and risk adjustment here:

Methodology

CURRENT COMMUNITY REPORTS

View the most recent community reports released by MNCM here:

Current Reports

INFOGRAPHICS & BLOG POSTS

Beginning in 2025, MNCM began releasing a series of infographics and blog posts that correspond with monthly health awareness campaigns. These infographics provide a closer view of the statewide results by measure and can be found here:

Infographics

PAST COMMUNITY REPORTS

Past reports released by MNCM can be found here:

Past Reports

Performance Hub
from MN Community Measurement

MNCM's Performance Hub provides comprehensive analyses of health care quality and cost measures through an interactive platform. The Performance Hub includes information such as statewide rates and trends, medical group performance variable, statewide results by demographics, and statewide results by three-digit ZIP code region.

View the Performance Hub here:

Measures Reported by Medical Groups

Measures Reported by Payers

Cost & Utilization Measures