2020 MINNESOTA HEALTH CARE DISPARITIES

by Insurance Type

RELEASED MARCH 2021

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MN Community MEASUREMENT

DEPARTMENT OF HUMAN SERVICES

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REPORT PREPARED BY
Jess Donovan, MPH, RN, BSN
Clinical Measurement Analyst

Direct question/comments to
support@mncm.org

WHO IS MN COMMUNITY MEASUREMENT?

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

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.

WHO IS THE MN DEPARTMENT OF HUMAN SERVICES?

The MN Department of Human Services (MN DHS) is the state Medicaid agency responsible for purchasing health care services for over 1 million Minnesotans, covering approximately 20% 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.

INTRODUCTION

In Minnesota, and in the U.S. as a whole, there are longstanding, well-documented disparities in key indicators of health and health care quality. Health care quality, cost and patient outcomes vary by where patients live, the type of health care they receive, their socioeconomic status, the type of health insurance coverage that they have, their race, ethnicity, language, country of origin, and other factors.

In 2020, both the COVID-19 pandemic and events such as the civil unrest surrounding the death of George Floyd served to highlight the urgency of improving health equity and created a renewed commitment and focus on health equity as a priority. One key step in formulating strategies to address inequities is data collection and analysis to better understand variation in outcomes and to assess the impact of interventions that are aimed at closing gaps in outcomes.

MN Community Measurement (MNCM) has collaborated with the Minnesota Department of Human Services (DHS) to measure health care quality by type of health insurance each year since 2007. This work helps to fulfill a legislative requirement 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). The data and analysis from MNCM that compare results on key measures for Minnesotans who get their health insurance coverage through state programs are used by DHS in a variety of ways, including to inform the state's health care purchasing strategies.

Compared to the overall Minnesota population, patients enrolled in MHCP are of lower socioeconomic status and include a disproportionate number of persons of color, American Indian or Alaska Natives, persons with disabilities, and elderly adults. MHCP enrollees often experience significant challenges that create barriers to receiving appropriate health care. As a result, they may not receive care that meets best practices as often as patients insured with other types of insurance.

As in previous years, this year's 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 and Hispanic ethnicity. This report focuses on 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. In addition, the report highlights high performing medical groups by measure for the MHCP MCO patient population.

The data presented in this report were collected by MNCM in 2020 for 2019 dates of service.

WHAT'S NEW

New to the report this year is the addition of MHCP MCO results by country of origin and preferred language for the measures calculated directly from clinical data collected by MNCM (these measures are also referred to as Direct Data Submission, or DDS, measures). Other changes in this year's report include the following:

- The five components of the Optimal Diabetes Care measure and the four components of the Optimal Vascular Care measure have been added with analyses by race/ethnicity, country of origin and preferred language.
- For the Adult Depression Remission at Six Months measure, trending is not available due to significant measure changes in the 2020 report year. For a complete summary of the changes to the depression measure, *click here*.
- In addition to the Adult Depression: Remission at Six Month measure, five more measures from the suite have been added – Follow-Up PHQ-9/PHQ-9M at Six Months, Response at Six Months, Follow-Up PHQ-9/PHQ-9M at 12 Months, Response at 12 Months and Remission at 12 Months.
- The 2020 report year was the first year that the Adolescent Depression Suite was publicly reported and the first year included in this report.
- Due to COVID-19 related impacts on the availability of audited HEDIS data from participating health plans, the following hybrid measures are not included in this year's report: Controlling High Blood Pressure, Childhood Immunization Status (Combo 10) and Immunizations for Adolescents (Combo 2).

OVERVIEW OF QUALITY MEASURES

This report includes 13 health care quality measures chosen by DHS and MNCM to address gaps in quality for patients enrolled in MHCP Managed Care and to focus community efforts on improvement. The measures include:

PREVENTIVE HEALTH

- **Breast Cancer Screening***
- **Colorectal Cancer Screening**

CHRONIC CONDITIONS

- **Optimal Diabetes Care**
  + five components (blood pressure control, daily aspirin, HbA1c control, statin use, tobacco-free)
- **Optimal Vascular Care**
  + four components (blood pressure control, daily aspirin, statin use, tobacco-free)
- **Optimal Asthma Control – Adults**
- **Optimal Asthma Control – Children**

MENTAL HEALTH

- **Adolescent Mental Health and/or Depression Screening**
- **Adult Depression Suite**
  - Follow-Up PHQ-9/PHQ-9M at Six Months/12 Months
  - Response at Six Months/12 Months
  - Remission at Six Months/12 Months
- **Adolescent Depression Suite**
  - Follow-Up PHQ-9/PHQ-9M at Six Months/12 Months
  - Response at Six Months/12 Months
  - Remission at Six Months/12 Months

*HEDIS measure

KEY FINDINGS

- Statewide MHCP results improved significantly since last year for four measures: Breast Cancer Screening; Colorectal Cancer Screening; Optimal Diabetes Care; and Adolescent Mental Health and/or Depression Screening. The Breast Cancer Screening measure had the largest percentage point change (increase of 3.3 percentage points).
- Statewide MHCP MCO rates are consistently and significantly lower than the Other Purchasers' statewide rates for all measures; however, the gap has significantly narrowed over time for the following measures: Colorectal Cancer Screening; Optimal Diabetes Care; Optimal Asthma Control – Adults; Optimal Asthma Control – Children; and Adolescent Mental Health and/or Depression Screening.
- MHCP Managed Care results vary by race/ethnicity. There continues to be significant room for improvement among groups:
  - MHCP MCO patients who are Indigenous/Native or Black are significantly below the MHCP MCO race averages on a majority of the measures.
  - Hispanic/Latinx patients are significantly above the MHCP MCO ethnicity average on two measures: Breast Cancer Screening and Optimal Vascular Care.

SUMMARY TABLES

TABLE 1: MHCP MCO STATEWIDE RATES FOR 2020 COMPARED TO PREVIOUS YEARS

Table 1 displays MHCP statewide results for the quality measures and compares them to the previous year.

QUALITY MEASURE	2020 MHCP MCO Statewide Rate	MHCP MCO Statewide Percentage Point Change *(2020 report year - 2019 report year)*	MHCP MCO Statewide Percentage Point Change Over Time *(2020 report year - First report year)*
PREVENTIVE HEALTH MEASURES			
Breast Cancer Screening	63.3%	3.3%**	0.6% (7 years)
Colorectal Cancer Screening	59.4%	2.8%**	12.0%** (10 years)
CHRONIC CONDITIONS MEASURES			
Optimal Diabetes Care	35.6%	1.1%**	2.0%** (5 years)
Optimal Vascular Care	47.3%	-0.2%	-5.0%** (5 years)
Optimal Asthma Control - Adults	44.9%	0.7%	3.2%** (6 years)
Optimal Asthma Control - Children	53.7%	-0.3%	0.7% (6 years)
MENTAL HEALTH MEASURES			
Adolescent Mental Health and/or Depression Screening	87.9%	1.7%**	12.2%** (3 years)
Adult Depression: Remission at Six Months	8.3%	NA	NA
Adolescent Depression: Remission at Six Months	6.5%	NA	NA

*Statistically significant difference ($p < 0.05$) † Significant measure changes in 2020 report year ^ First reported in 2020 report year NA = Not applicable

TABLE 2: SUMMARY OF STATEWIDE DIFFERENCES BY INSURANCE TYPE

Table 2 displays differences in the quality measures by insurance type.

QUALITY MEASURE	2020 MHCP MCO Statewide Rate	2020 Other Purchasers Statewide Rate	2020 Rate Difference *(MHCP - Other Purchasers)*	Rate Difference Over Time *2020 report year vs. First report year (MHCP - Other Purchasers)*
PREVENTIVE HEALTH MEASURES				
Colorectal Cancer Screening	59.4% (N = 86,000)	74.5% (N = 1,134,536)	-15.1%*	Gap narrowed* (2011 - 2020)
CHRONIC CONDITIONS MEASURES				
Optimal Diabetes Care	35.6% (N = 32,301)	47.0% (N = 241,664)	-11.4%*	Gap narrowed* (2016 - 2020)
Optimal Vascular Care	47.3% (N = 12,230)	61.5% (N = 145,499)	-14.2%*	Gap narrowed (2016 - 2020)
Optimal Asthma Control - Adults	44.9% (N = 23,976)	56.8% (N = 98,584)	-11.9%*	Gap narrowed* (2015 - 2020)
Optimal Asthma Control - Children	53.7% (N = 17,731)	61.5% (N = 41,507)	-7.8%*	Gap narrowed* (2015 - 2020)
MENTAL HEALTH MEASURES				
Adolescent Mental Health and/or Depression Screening	87.9% (N = 31,294)	91.9% (N = 107,660)	-4.1%*	Gap narrowed* (2018 - 2020)
Adult Depression: Remission at Six Months†	8.3% (N = 20,993)	11.9% (N = 83,512)	-3.7%*	NA
Adolescent Depression: Remission at Six Months^	6.5% (N = 2,503)	8.5% (N = 7,615)	-2.1%*	NA

*Statistically significant difference ($p < 0.05$) † Significant measure changes in 2020 report year ^ First reported in 2020 report year NA = Not applicable

NOTE: Due to COVID-19 related impacts on the availability of audited HEDIS data from participating health plans, the Other Purchasers population for the Breast Cancer Screening measure only includes Commercial patients. As a result, this measure has been removed from table 2.

SUMMARY TABLES

TABLE 3: SUMMARY OF FINDINGS BY RACE/ETHNICITY

Table 3 compares the 2020 MHCP MCO rate of each racial/ethnicity group to the 2020 MHCP MCO race and ethnicity averages.

MEASURE	2020 MHCP MCO Race Average*	RACE										2020 MHCP MCO Ethnicity Average*	ETHNICITY		
		Asian	Black	Indigenous/ Native	Multi- Race	Native Hawaiian/ Other Pacific Islander	White	Chose Not to Disclose/ Declined	Patient Reported Race Unknown	Some Other Race	Unknown Race		Hispanic/ Latinx	Not Hispanic/ Latinx	Ethnicity Not Reported
PREVENTIVE HEALTH MEASURES															
Breast Cancer Screening	64.2%	▲	▼	▼	●	●	●	-	-	-	●	63.3%	▲	●	▼
Colorectal Cancer Screening	59.7%	▲	▼	▼	●	●	▲	▼	▼	●	-	59.7%	●	●	▼
CHRONIC CONDITIONS MEASURES															
Optimal Diabetes Care	35.6%	▲	▼	▼	▼	●	●	●	●	▲	-	35.8%	●	●	●
Optimal Vascular Care	47.2%	▲	●	▼	●	NR	●	▲	NR	●	-	47.5%	▲	●	NR
Optimal Asthma Control - Adults	45.2%	▼	▼	▼	●	●	▲	●	▼	●	-	45.2%	●	●	▼
Optimal Asthma Control - Children	53.4%	▼	●	▼	●	●	●	▼	▼	●	-	53.9%	●	●	●
MENTAL HEALTH MEASURES															
Adolescent Mental Health and/or Depression Screening	89.4%	●	▼	●	●	●	▲	●	▲	●	-	87.8%	▼	▲	●
Adult Depression: Follow-Up PHQ-9/PHQ-9M at Six Months	48.5%	●	▼	▼	▼	NR	▲	▼	▼	●	-	48.3%	▼	●	▼
Adult Depression: Response at Six Months	15.9%	●	▼	▼	●	NR	●	●	▼	●	-	15.8%	●	●	●
Adult Depression: Remission at Six Months	8.3%	●	▼	▼	●	NR	●	●	●	●	-	8.3%	●	●	●
Adolescent Depression: Follow-Up PHQ-9/PHQ-9M at Six Months	41.8%	●	▼	●	●	NR	●	●	NR	●	-	41.4%	●	●	NR
Adolescent Depression: Response at Six Months	13.1%	●	▼	●	●	NR	●	●	NR	●	-	13.3%	●	●	NR
Adolescent Depression: Remission at Six Months	6.3%	●	●	●	●	NR	●	●	NR	●	-	6.3%	●	●	NR

▲ Significant above statewide MHCP MCO race/ethnicity average ● Average ▼ Significantly below statewide MHCP MCO race/ethnicity average

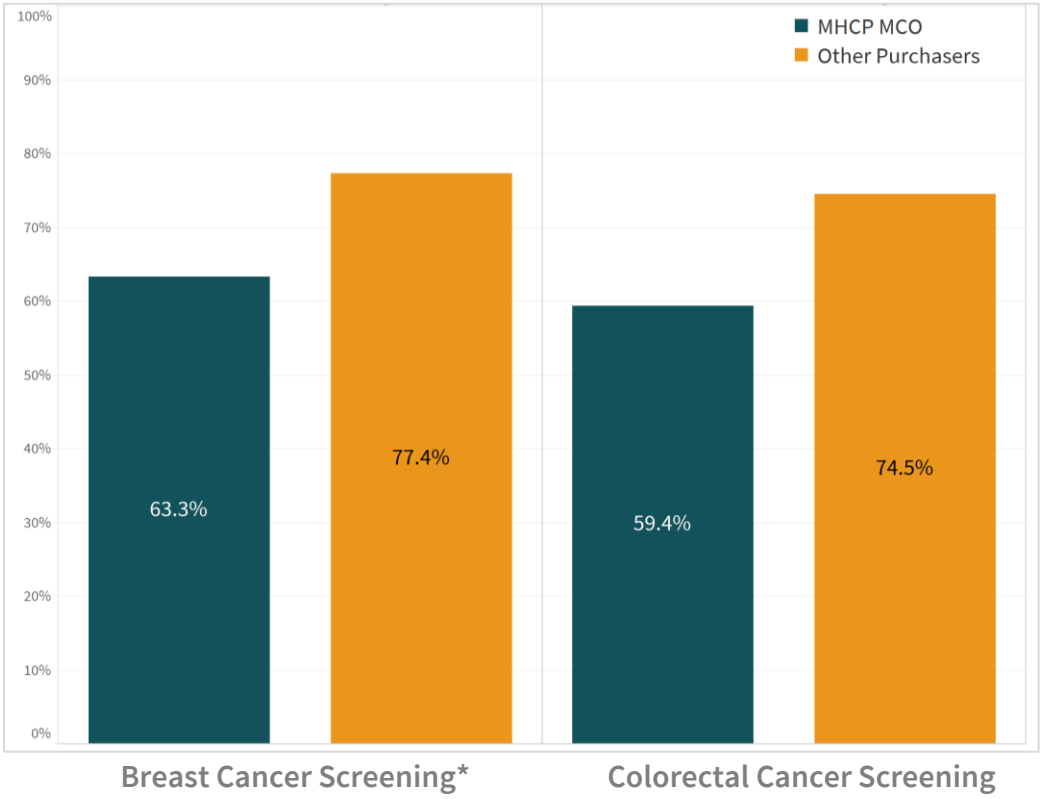
NR = Not reportable. Did not meet minimum reporting threshold of at least 30 patients - Race category not reported for HEDIS/DDS measure

*Statewide MHCP MCO rates were re-calculated for those with race/ethnicity information available.

PREVENTIVE HEALTH MEASURES

This section of the report focuses on preventive health measures segmented by insurance type. Preventive health services are an important focus for quality measurement to aid in preventing disease, helping people live healthier lives, and keeping health care costs down. Even though these services are covered by public and private insurance plans, millions of individuals do not get recommended preventive services.[1] Preventive health services can effectively reduce death, disability and disease, including breast and colorectal cancers.[1]

In this report, we are focused on two preventive health measures among MHCP managed care patients: 1) Breast Cancer Screening, and 2) Colorectal Cancer Screening.



For both Breast Cancer Screening and Colorectal Cancer Screening, there continues to be room for improvement, regardless of insurance type.

*Due to COVID-19 related impacts on the availability of audited HEDIS data from participating health plans, the Other Purchasers population for the Breast Cancer Screening measure only includes Commercial patients.

BREAST CANCER SCREENING

Breast cancer is the second most common cancer among women in the United States.[2] According to the Centers for Disease Control (CDC), while White and Black women get breast cancer at approximately the same rate, the death rate is higher among Black women.[2]

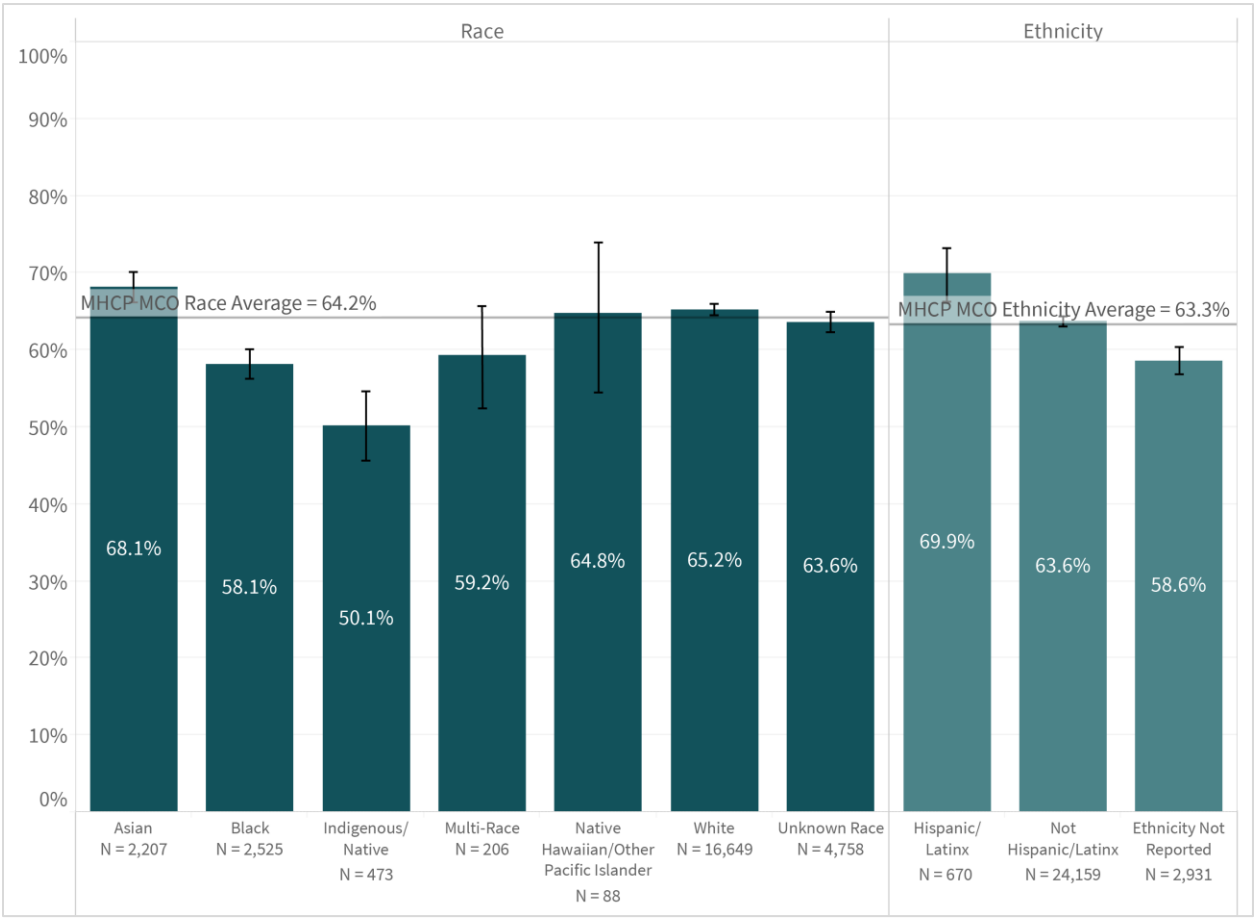
Measure Description

The percentage of women ages 50–74 who received a mammogram during the prior two years (the measurement year or prior year).

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

MHCP MCO RATES BY RACE/ETHNICITY

2020 report year (2019 dates of service)



The screening rates for MHCP MCO patients who are Asian are statistically significantly higher than the MHCP MCO race average. Black and Indigenous/Native MHCP MCO patients have statistically significantly lower rates of screening compared to the MHCP MCO race average.

MHCP MCO patients who are Hispanic/Latinx have a statistically significantly higher rate of screening compared to the MHCP MCO ethnicity average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

COLORECTAL CANCER SCREENING

Colorectal cancer is the third most common cancer diagnosed in both men and women in the United States (excluding skin cancers).[3] For 2021, the American Cancer Society estimates that there will be 104,270 new cases of colon cancer and 45,230 new cases of rectal cancer.[3] Fortunately, the death rate has been dropping for decades, likely because screenings allow for early detection of colorectal polyps, which can be removed before developing into cancer.[3]

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).

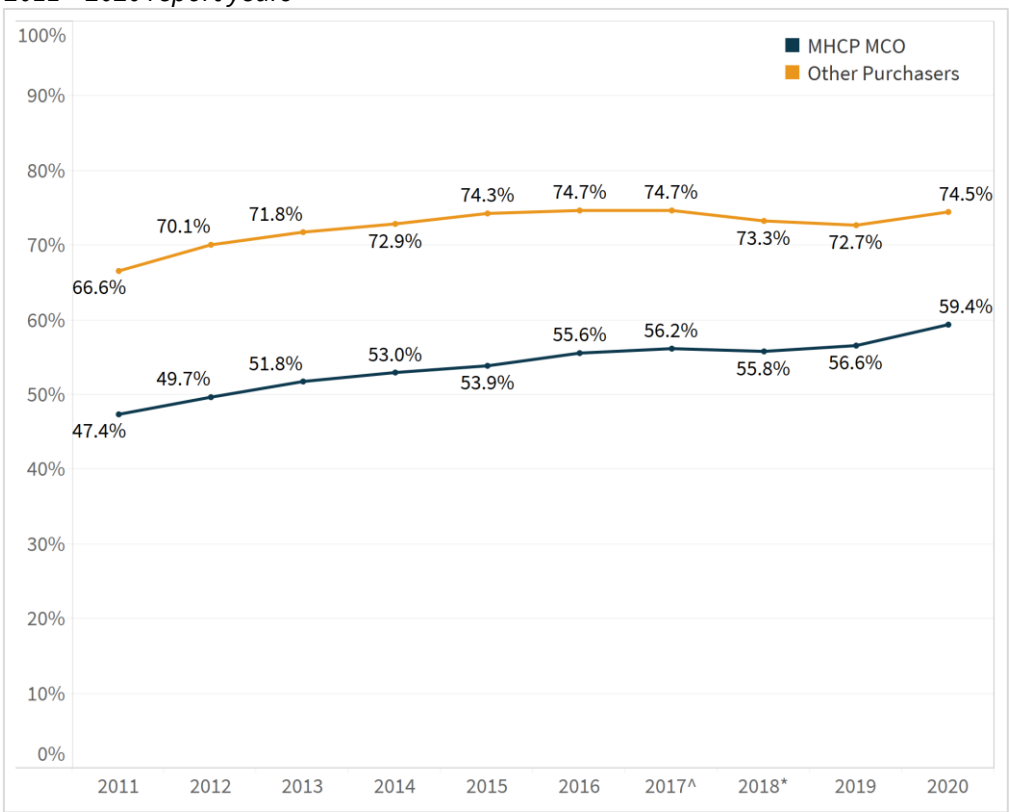
Measure Description

The percentage of adults ages 51 – 75 who are up-to-date with the appropriate screening for colorectal cancer. Appropriate screenings include one of the following:

- Colonoscopy during the measurement year or the nine years prior, or
- Flexible sigmoidoscopy during the measurement year or the four years prior, or
- CT colonography during the measurement year or the four years prior, or
- Fecal immunochemical test (FIT)-DNA during the measurement year or the two years prior, or
- Guaiac-based fecal occult blood test (gFOBT) or FIT during the measurement year

TREND IN COLORECTAL CANCER SCREENING

2011 – 2020 report years



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.

^The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to a change in statewide rates for this measure.

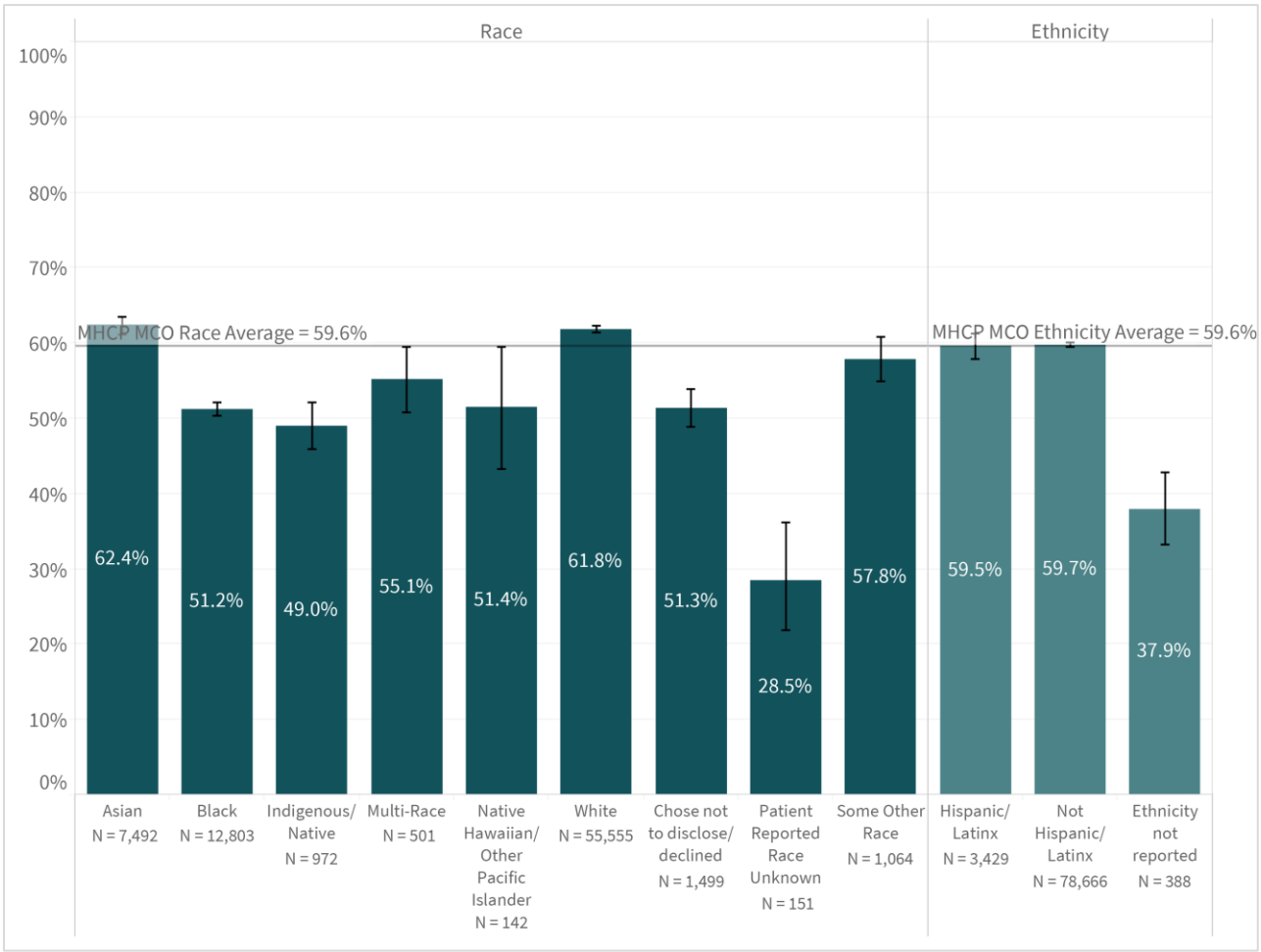
*Changes to the measure denominator definition resulted in significant drop in population for this measure and likely contributed to slight decrease in rate.

The Colorectal Cancer Screening rate for MHCP Managed Care (MCO) patients statistically significantly increased by 2.8 percentage points compared to the 2019 report year. While the gap in performance between patients insured by MHCP MCO and patients insured by Other Purchasers remains wide, it has statistically significantly narrowed since 2011.

COLORECTAL CANCER SCREENING

MHCP MCO RATES BY RACE/ETHNICITY

2020 report year (2019 dates of service)



The screening rates for MHCP MCO patients who are Asian or White are statistically significantly higher than the MHCP MCO race average. Black and Indigenous/Native MHCP MCO patients have statistically significantly lower rates of screening compared to the MHCP MCO race average.

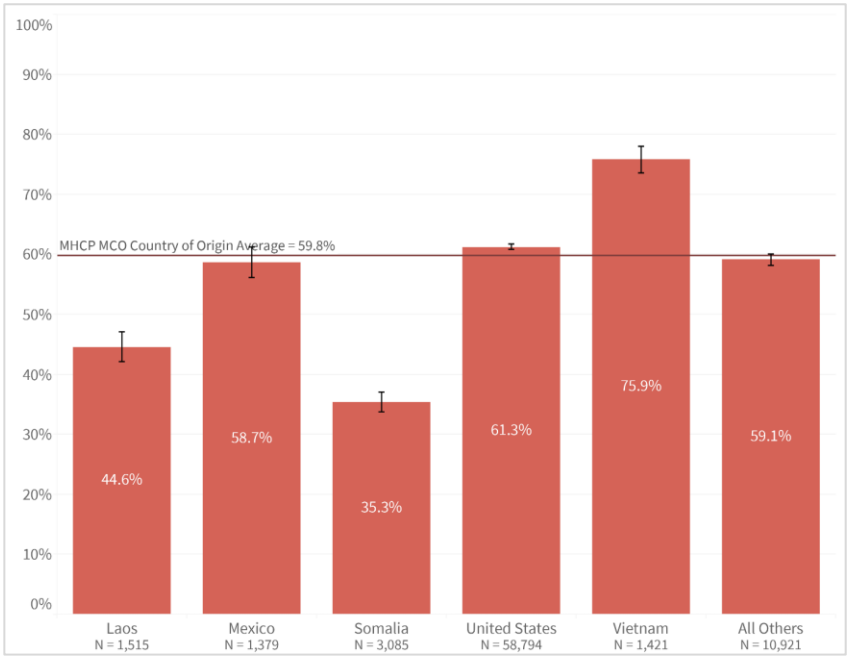
MHCP MCO patients who are either Hispanic/Latinx or Non-Hispanic/Latinx have average screening rates compared to the ethnicity average, while the screening rate for MHCP MCO patients who did not report their ethnicity is statistically significantly below the ethnicity average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.c

COLORECTAL CANCER SCREENING

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)

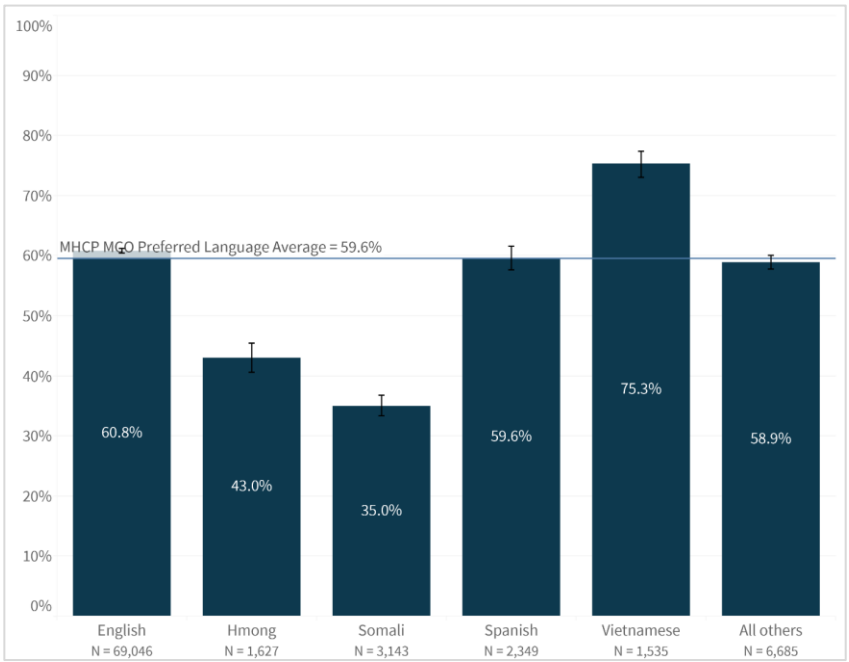


Patients from Laos, Mexico, Somalia, the United States or Vietnam make up the largest proportion of the eligible MHCP MCO population.

Patients from Laos or Somalia have statistically significantly lower rates of colorectal cancer screening compared to the country of origin average, while patients from the United States or Vietnam have statistically significantly higher rates.

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year(2019 dates of service)



Patients who speak English, Hmong, Somali, Spanish or Vietnamese make up the largest proportion of the eligible MHCP MCO population.

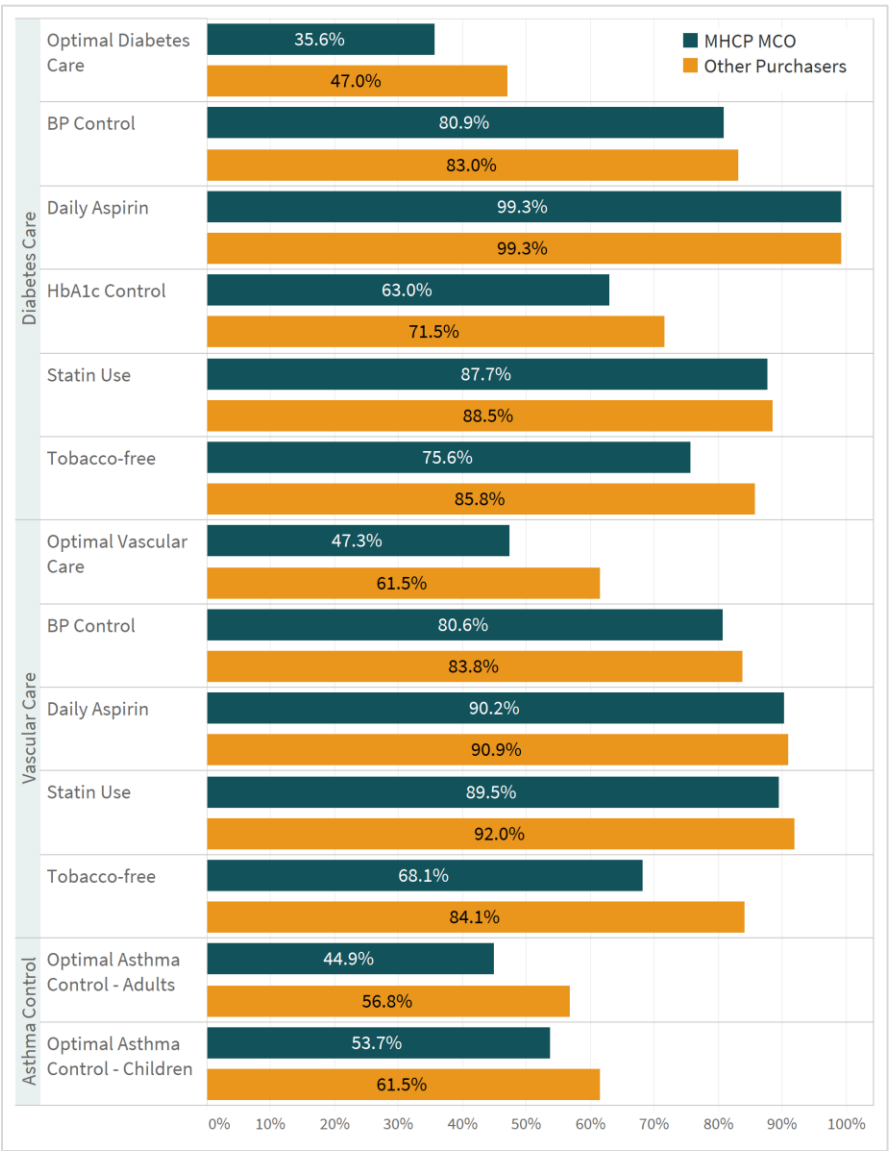
Patients who speak Hmong or Somali have statistically significantly lower rates of colorectal cancer screening compared to the preferred language average, while patients who speak English or Vietnamese have statistically significantly higher rates.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin or preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

CHRONIC CONDITIONS MEASURES

This section of the report focuses on chronic condition measures segmented by insurance type. Chronic disease is defined as a condition that lasts one year or more and requires ongoing medical attention or limits activities of daily living or both.[4] The Centers for Disease Control and Prevention (CDC) estimates that six in ten adults in the U.S. have a chronic disease and four in ten have two or more. [4] Additionally, chronic diseases are not only the leading causes of death and disability in the nation but are also the leading drivers of the $3.8 trillion spent on annual health care costs. [4] Chronic diseases are an important focus for measurement because of the large numbers of adults and children living with these conditions and known gaps in care related to optimal treatment.

In this report, we are focused on four chronic condition measures among MHCP managed care patients: 1) Optimal Diabetes Care, 2) Optimal Vascular Care, 3) Optimal Asthma Control – Adults, and 4) Optimal Asthma Control – Children. Additionally, the components of the Optimal Diabetes Care and Optimal Vascular Care measures have been added to this report as well.



For the four composite measures (i.e., Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Control – Adults and Optimal Asthma Control – Children), there continues to be room for improvement, regardless of insurance type. However, there are significant differences in performance rates by insurance type. In particular, the Optimal Vascular Care measure has the largest gap between insurance types, with a difference of 14.2 percentage points.

Within the Optimal Diabetes Care measure, the largest gap between payers exists within the tobacco-free component with a significant difference of 10.2 percentage points.

Similarly, within the Optimal Vascular Care measure, the largest gap between payers exists within the tobacco-free component as well with a significant difference of 16 percentage points.

OPTIMAL DIABETES CARE

Over 34 million people in the United States have diabetes and approximately 1.5 million people in the United States are diagnosed with diabetes each year.[5,6] Furthermore, an estimated $327 billion is spent annually on diagnosed diabetes.[5,6] Among those at risk for developing type 2 diabetes are those who are overweight/obese, are 45 years or older, have an immediate family member with type 2 diabetes, are physically active less than three times per week, had gestational diabetes or gave birth to a baby who weighted more than nine pounds or are Black, Hispanic/Latinx, Indigenous/Native, Pacific Islander or Asian.[5]

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).

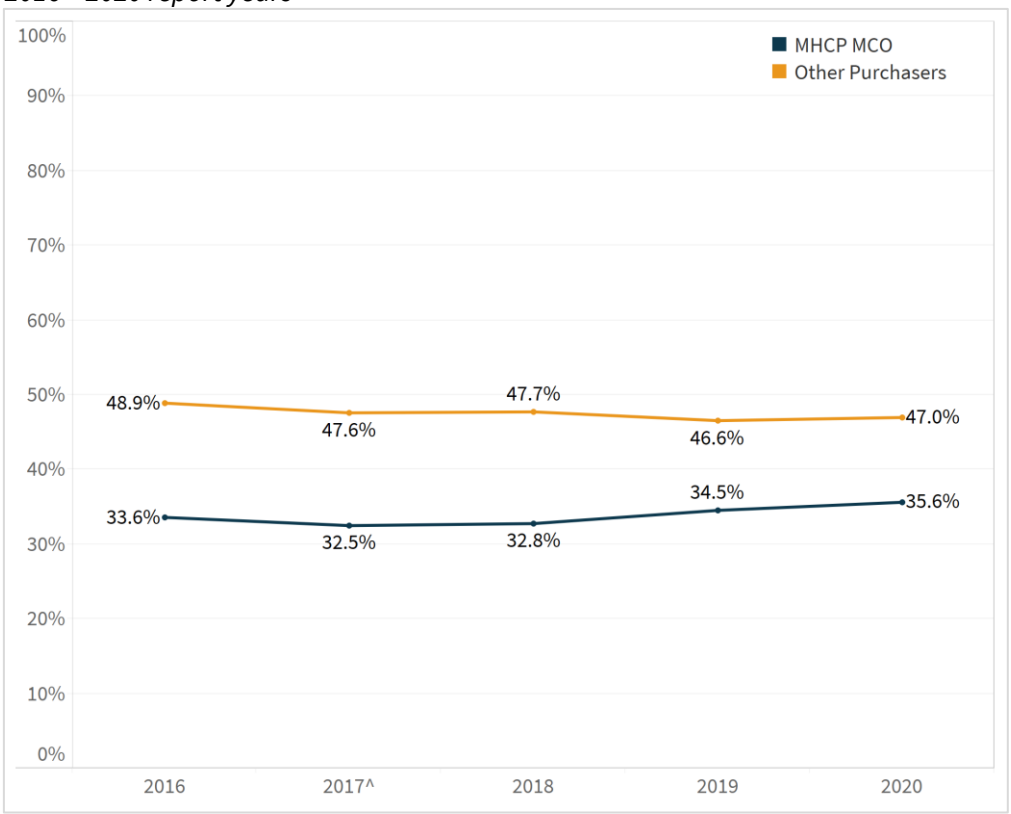
Measure Description

The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) and whose diabetes was optimally managed as defined by achieving ALL five of the following:

1. HbA1c less than 8.0 mg/dL
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. Patient with ischemic vascular disease on daily aspirin or anti-platelets, unless allowed contraindications or exceptions are present

TREND IN OPTIMAL DIABETES CARE

2016 – 2020 report years



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.

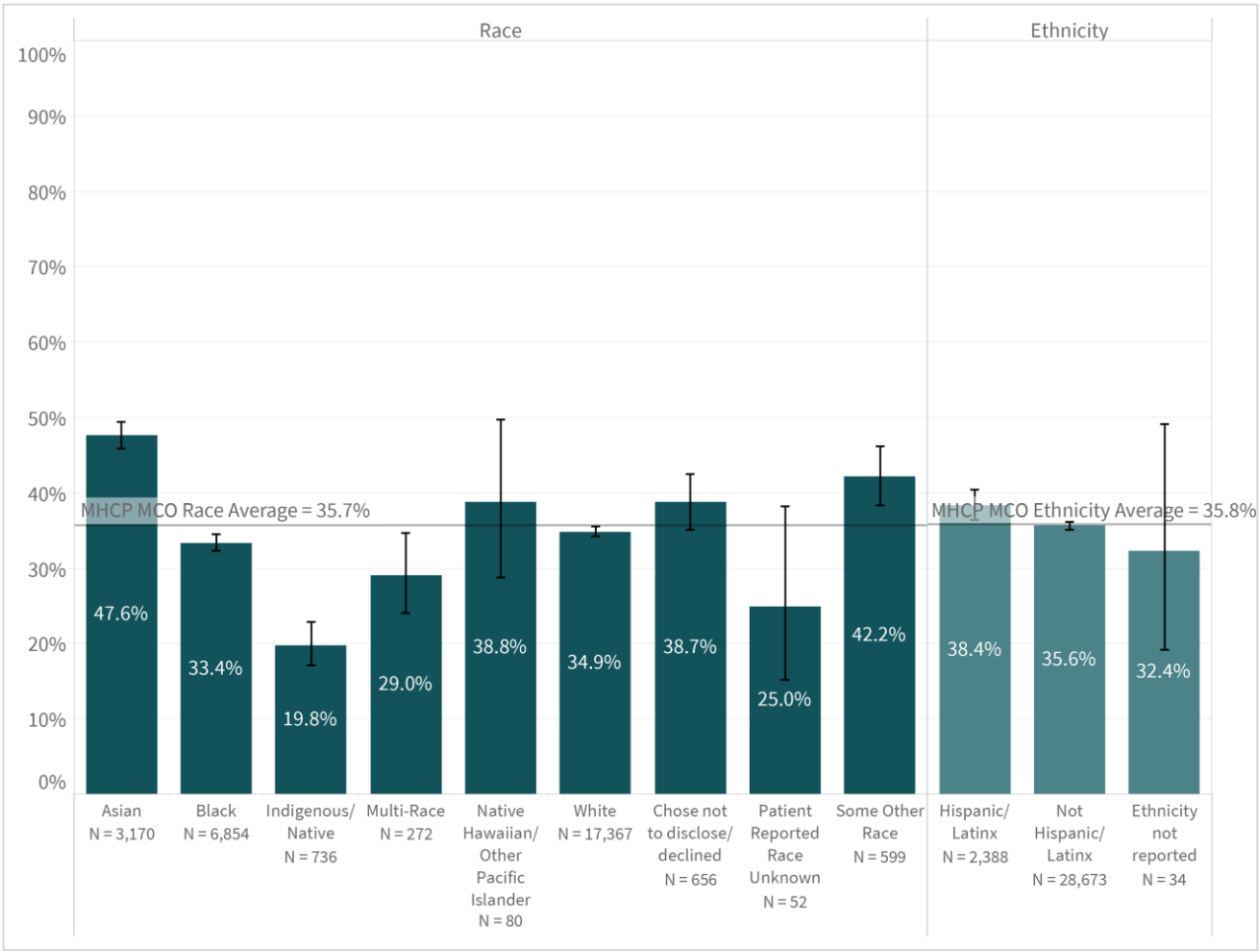
^The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to a change in statewide rates for this measure.

The Optimal Diabetes Care rate for MHCP MCO patients statistically significantly increased by 1.1 percentage points compared to the 2019 report year. While the gap in performance between patients insured by MHCP MCO and patients insured by Other Purchasers remains (11.5 percentage points), it has statistically significantly narrowed since 2016.

OPTIMAL DIABETES CARE

MHCP MCO RATES BY RACE/ETHNICITY

2020 report year (2019 dates of service)



The optimal care rate for MHCP MCO patients who are Asian is statistically significantly higher than the MHCP MCO race average. Black, Indigenous/Native and Multi-Race MHCP MCO patients have statistically significantly lower rates of optimal care compared to the MHCP MCO race average.

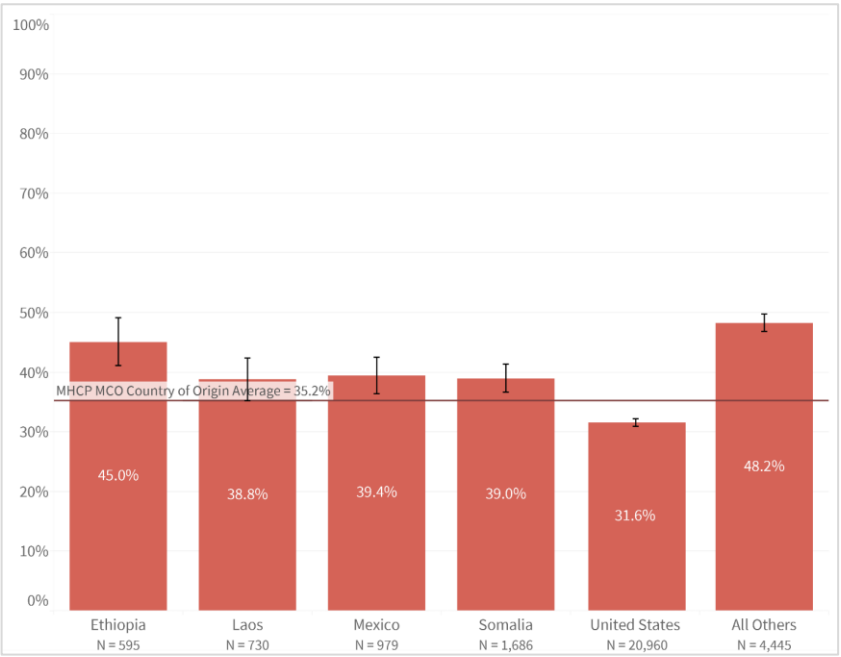
The optimal care rates for each of the ethnicity categories are average compared to the MHCP MCO ethnicity average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL DIABETES CARE

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)

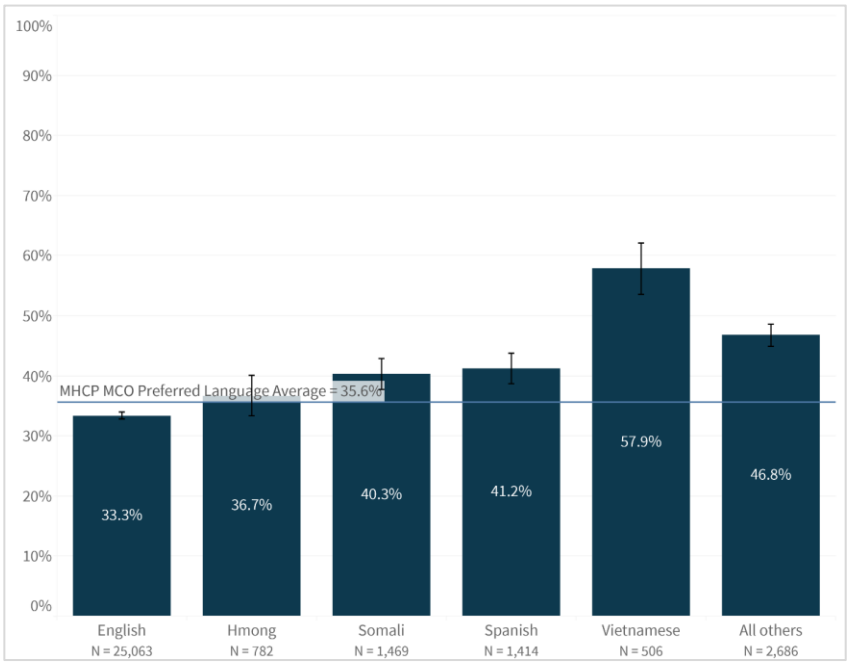


Patients from Ethiopia, Laos, Mexico, Somalia and the Unite States make up the largest proportion of the eligible MHCP MCO population.

Patients from the United States have statistically significantly lower rates of optimal diabetes care compared to the country of origin average, while patients from Ethiopia, Mexico or Somalia have statistically significantly higher rates.

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year(2019 dates of service)



Patients who speak English, Hmong, Somali, Spanish or Vietnamese make up the largest proportion of the eligible MHCP MCO population.

Patients who speak English have statistically significantly lower rates of optimal care compared to the preferred language average, while patients who speak Somali, Spanish or Vietnamese have statistically significantly higher rates.

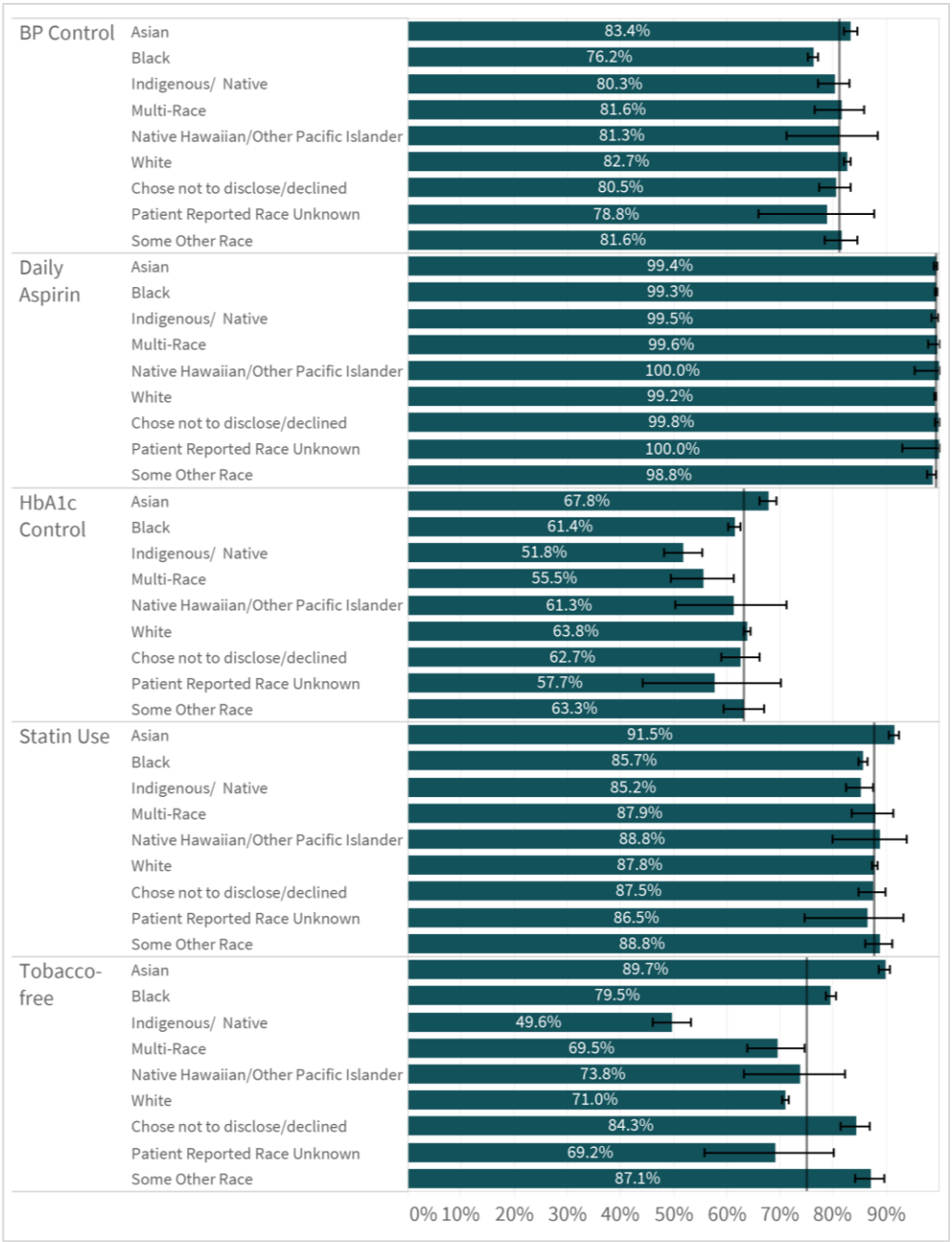
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin or preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL DIABETES CARE:

Focus on components

MHCP MCO RATES BY RACE

2020 report year (2019 dates of service)



OVERALL MHCP MCO RACE AVERAGES

by component
(represented by grey line)

- **BP Control:** 81.1%
- **Daily Aspirin:** 99.3%
- **HbA1c Control:** 63.3%
- **Statin Use:** 87.7%
- **Tobacco-free:** 75.0%

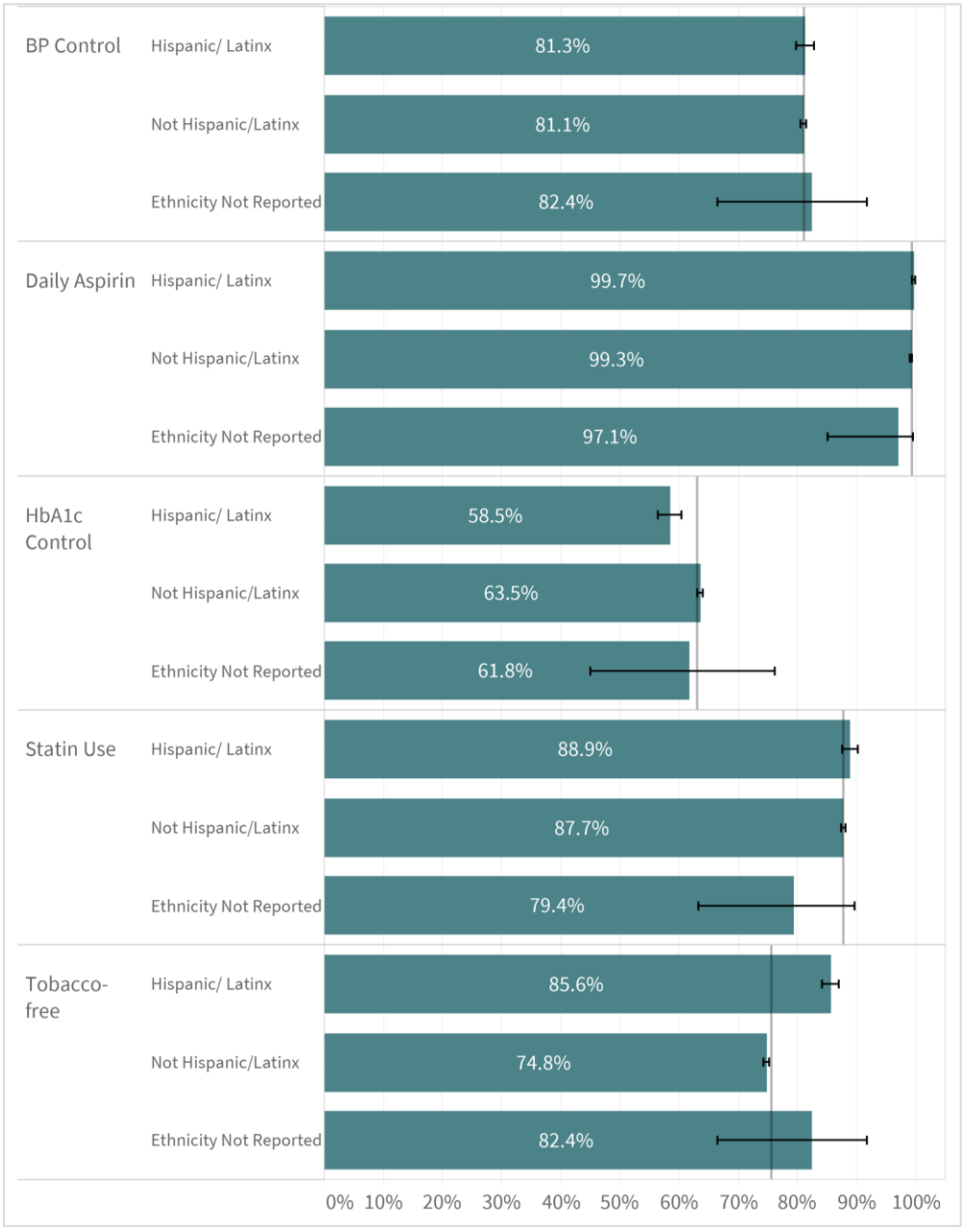
Among eligible MHCP MCO patients with diabetes, those who are Black have statistically significantly lower rates of blood pressure control, HbA1c control and statin use compared to the respective overall MHCP MCO race averages. However, these patients have statistically higher rates of being tobacco-free.

Among eligible MHCP MCO patients with diabetes, those who are Asian have statistically significantly higher rates of BP control, HbA1c control, statin use and being tobacco-free compared to the respective overall MHCP MCO race averages.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL DIABETES CARE:

Focus on components



OVERALL MHCP MCO ETHNICITY AVERAGES
by component
(represented by grey line)

- **BP Control:** 81.1%
- **Daily Aspirin:** 99.3%
- **HbA1c Control:** 63.1%
- **Statin Use:** 87.7%
- **Tobacco-free:** 75.6%

Among eligible MHCP MCO patients with diabetes, those who are of Hispanic/Latinx ethnicity have statistically significantly lower rates of HbA1c control, but statistically significantly higher rates of being tobacco-free.

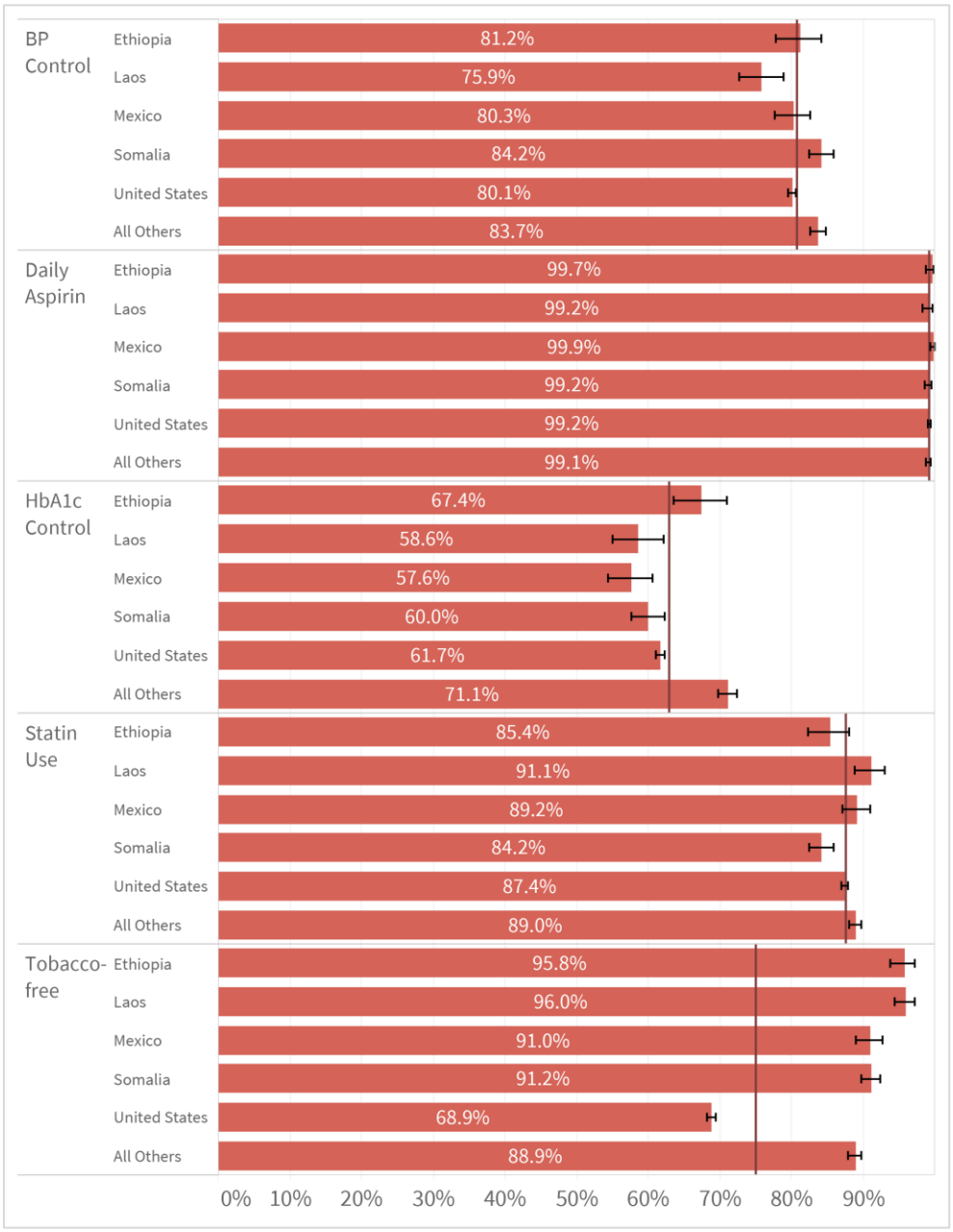
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL DIABETES CARE:

Focus on components

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)



OVERALL MHCP MCO COUNTRY OF ORIGIN AVERAGES

by component
(represented by dark red line)

- **BP Control:** 80.8%
- **Daily Aspirin:** 99.2%
- **HbA1c Control:** 62.9%
- **Statin Use:** 87.6%
- **Tobacco-free:** 75.1%

MHCP MCO patients from the United States have statistically significantly lower rates of HbA1c control and being tobacco-free compared to the respective overall averages by component.

MHCP MCO patients from Laos have statistically significantly higher rates of statin use and being tobacco-free. However, these patients also have statistically significantly lower rates of HbA1c control and blood pressure control.

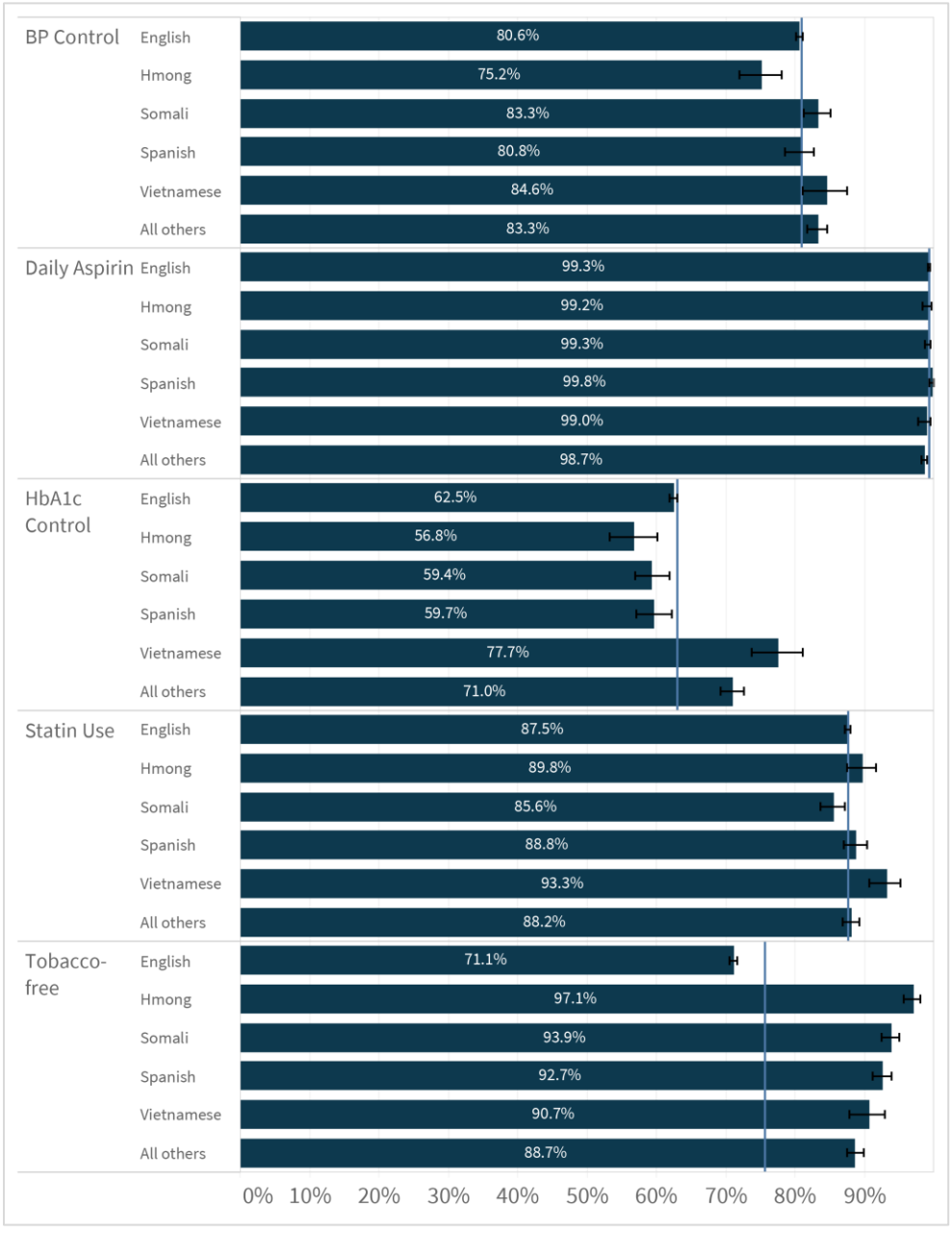
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL DIABETES CARE:

Focus on components

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year (2019 dates of service)



OVERALL MHCP MCO PREFERRED LANGUAGE AVERAGES

by component
(represented by blue line)

- **BP Control:** 80.9%
- **Daily Aspirin:** 99.3%
- **HbA1c Control:** 63.0%
- **Statin Use:** 87.7%
- **Tobacco-free:** 75.6%

MHCP MCO patients with diabetes who speak Somali have statistically significantly lower rates of HbA1c control and statin use, but statistically significantly higher rates of being tobacco free.

MHCP MCO patients with diabetes who speak Hmong have statistically significantly lower rates of HbA1c control and blood pressure control. However, these patients also have statistically significantly high rates of being tobacco free.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL VASCULAR CARE

Cardiovascular disease accounts for one-third of all U.S. deaths each year.[7] It is estimated that the United States spends about $214 billion annually on cardiovascular disease.[7]

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).

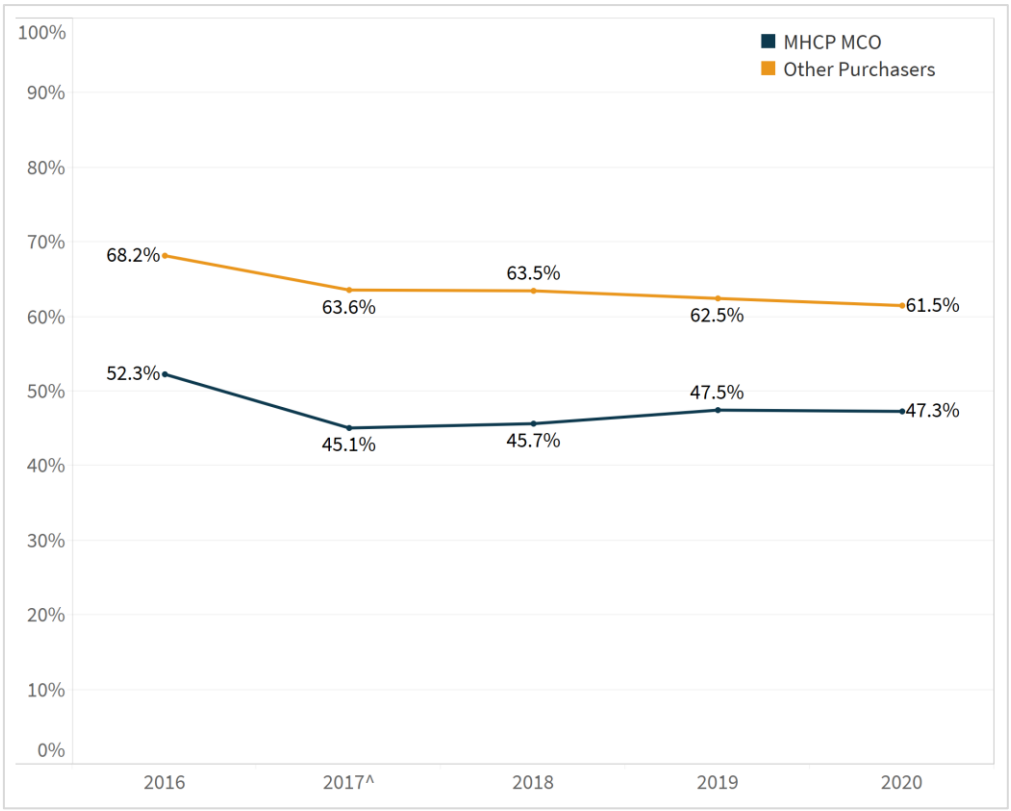
Measure Description

The percentage of patients 18 – 75 years of age who had a diagnosis of ischemic vascular disease (IVD) and whose IVD was optimally managed as defined by achieving ALL four of the following:

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. On daily aspirin or anti-platelet, unless allowed contraindications or exceptions are present

TREND IN OPTIMAL VASCULAR CARE

2016 – 2020 report years



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.

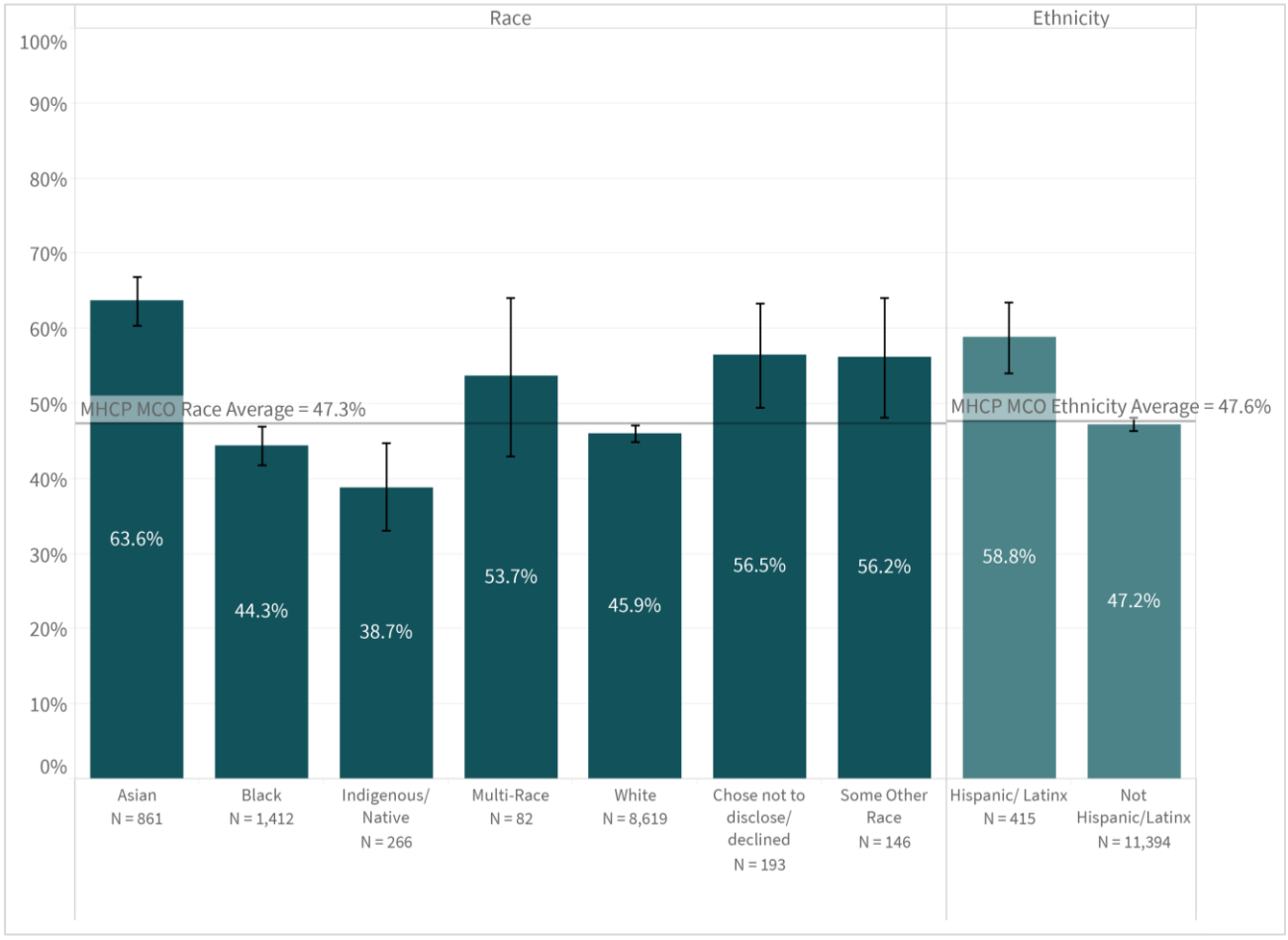
^The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to a change in statewide rates for this measure.

The Optimal Vascular Care rate for MHCP MCO patients did not statistically significantly change since the 2019 report year. However, the gap between MHCP MCO and Other Purchasers remains statistically significant.

OPTIMAL VASCULAR CARE

MHCP MCO RATES BY RACE/ETHNICITY

2020 report year (2019 dates of service)



The optimal care rates for MHCP MCO patients who are Asian are statistically significantly higher than the MHCP MCO race average. Indigenous/Native MHCP MCO patients have statistically significantly lower rates of optimal care compared to the MHCP MCO race average.

Hispanic/Latinx MHCP MCO patients have a statistically significantly higher rate of optimal care than the MHCP MCO ethnicity average.

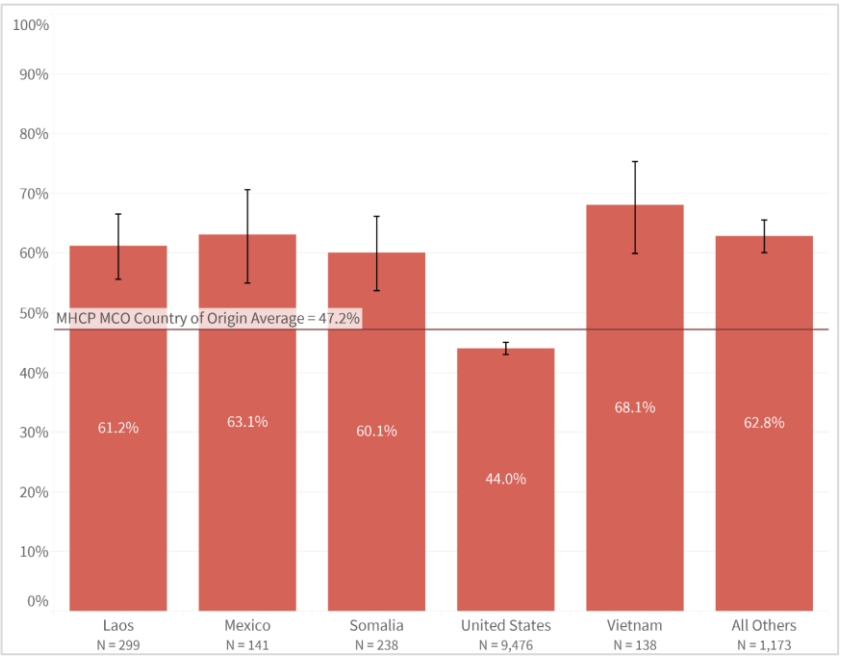
Native Hawaiian/Other Pacific Islander, Patient Reported Race Unknown and Ethnicity Not Reported categories had less than 30 patients reported, which does not meet the reporting threshold for reliability.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL VASCULAR CARE

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)

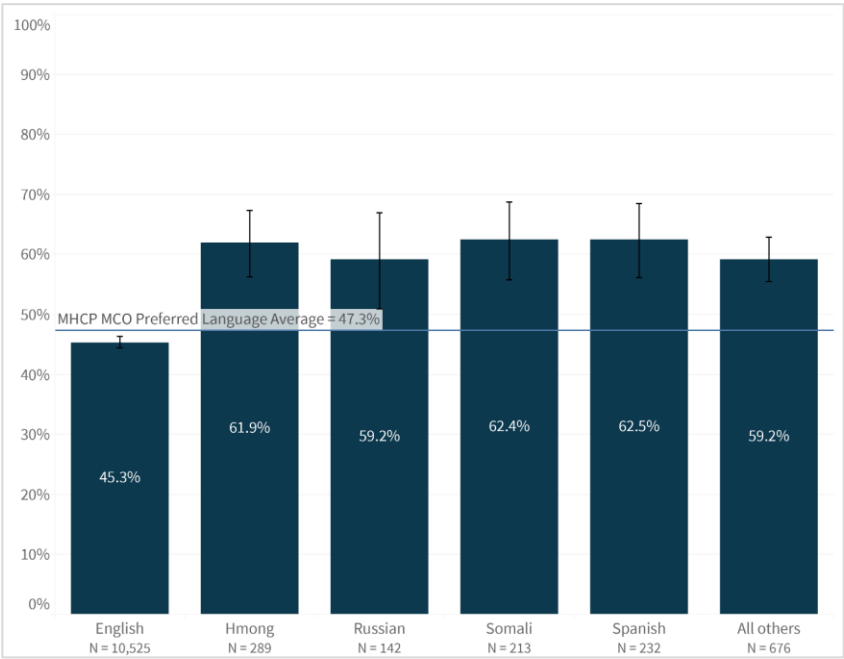


Patients from Laos, Mexico, Somalia, the United States and Vietnam make up the largest proportion of the eligible MHCP MCO population.

Patients from the United States have statistically significantly lower rates of optimal vascular care compared to the country of origin average, while patients from Laos, Mexico, Somalia and Vietnam have statistically significantly higher rates.

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year(2019 dates of service)



Patients who speak English, Hmong, Russian, Somali, or Spanish make up the largest proportion of the eligible MHCP MCO population.

Patients who speak English have statistically significantly lower rates of optimal care compared to the preferred language average, while patients who speak Hmong, Russian, Somali or Spanish have statistically significantly higher rates of optimal care.

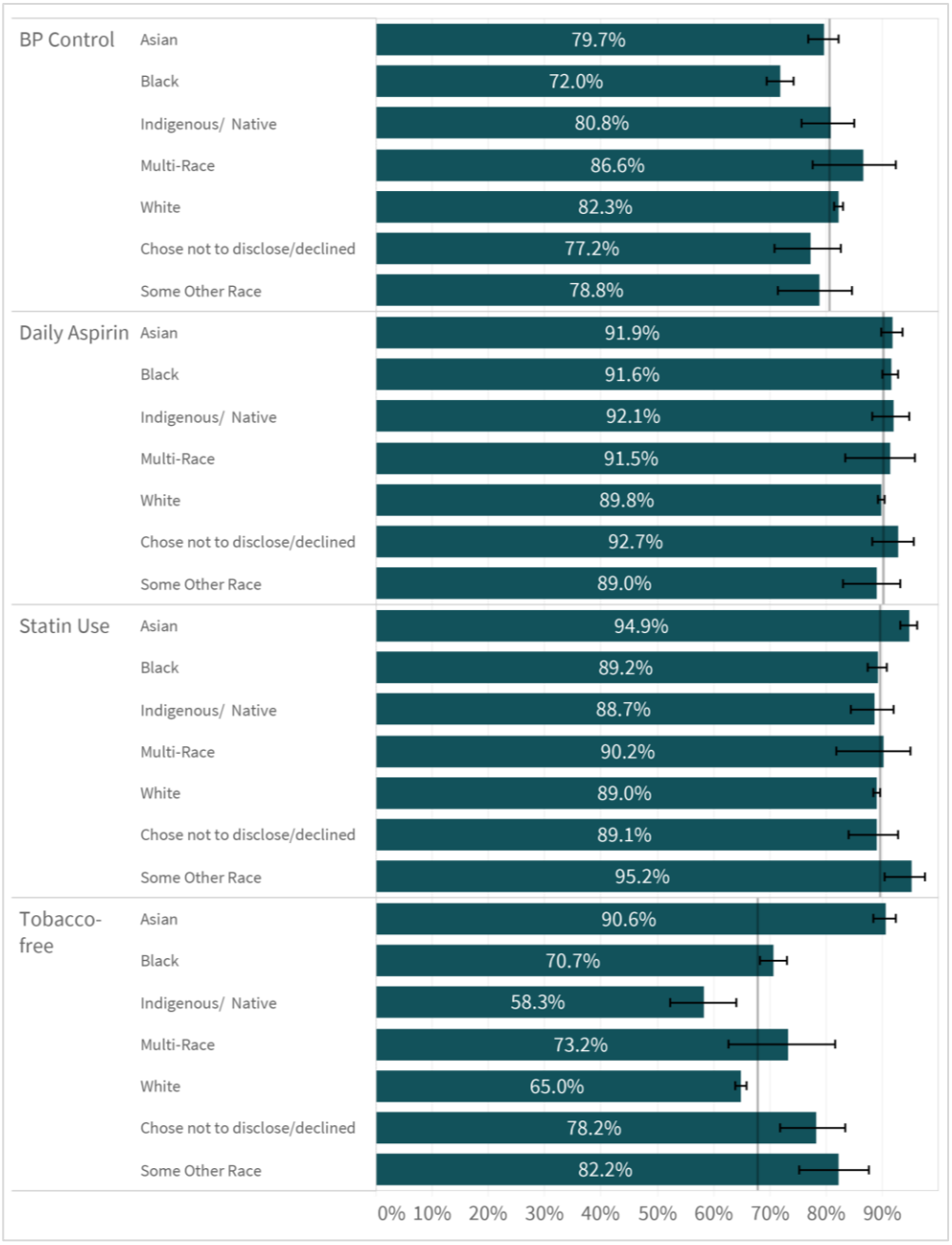
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin or preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL VASCULAR CARE:

Focus on components

MHCP MCO RATES BY RACE

2020 report year (2019 dates of service)



OVERALL MHCP MCO RACE AVERAGES

by component
(represented by grey line)

- **BP Control:** 80.7%
- **Daily Aspirin:** 90.3%
- **Statin Use:** 89.6%
- **Tobacco-free:** 67.9%

Among eligible MHCP MCO patients with ischemic vascular disease, Asian patients have statistically significantly higher rates of statin use and being tobacco-free.

Among eligible MHCP MCO patients with ischemic vascular disease, Black patients have statistically significantly lower rates of blood pressure control.

Native Hawaiian/Other Pacific Islander and Patient Reported Race Unknown categories had less than 30 patients reported, which does not meet the reporting threshold for reliability.

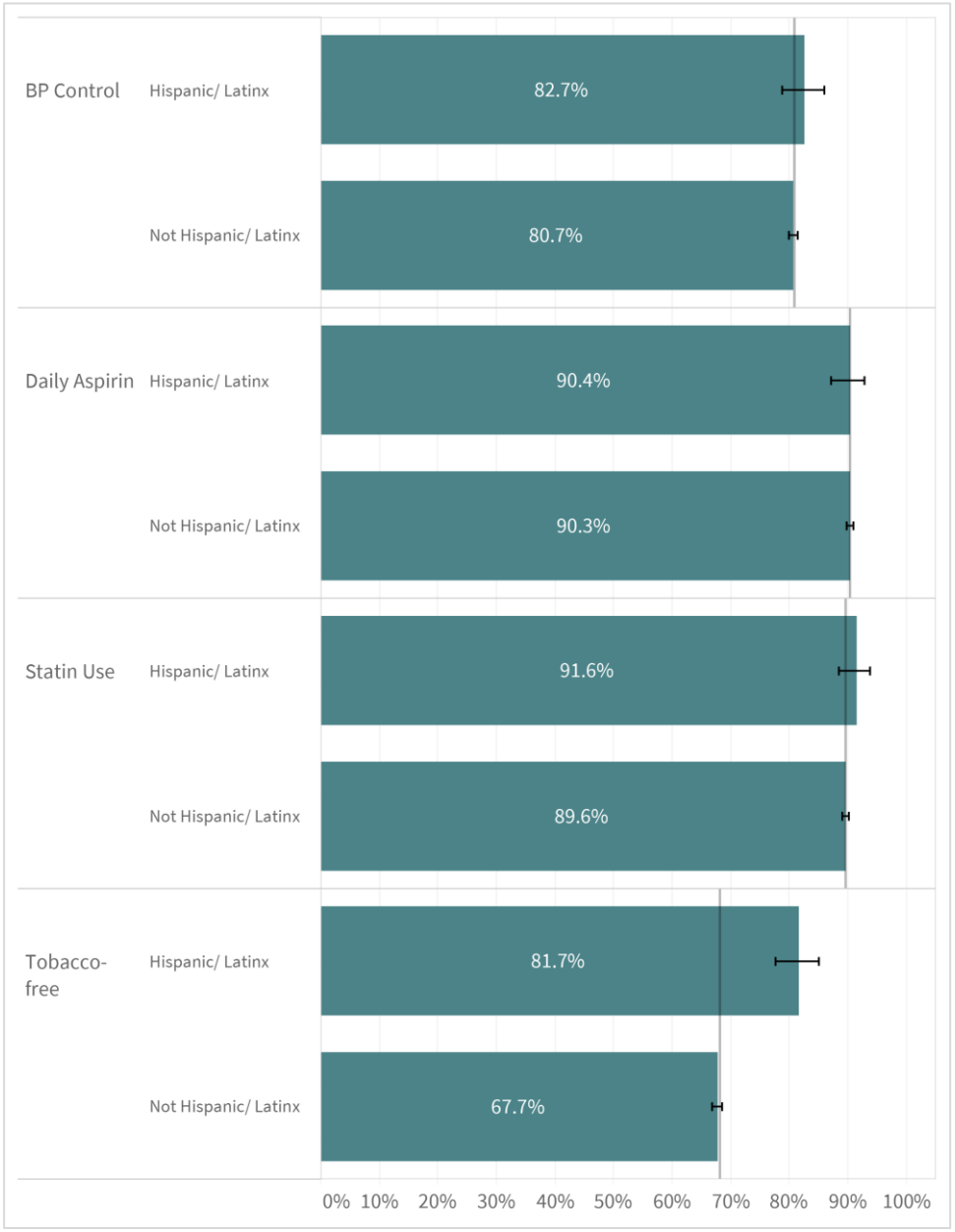
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL VASCULAR CARE:

Focus on components

MHCP MCO RATES BY ETHNICITY

2020 report year (2019 dates of service)



OVERALL MHCP MCO ETHNICITY AVERAGES

by component
(represented by grey line)

- **BP Control:** 80.8%
- **Daily Aspirin:** 90.3%
- **Statin Use:** 89.7%
- **Tobacco-free:** 68.2%

Among eligible MHCP MCO patients with ischemic vascular disease, those who are of Hispanic/Latinx ethnicity have statistically significantly higher rates of being tobacco-free compared to the overall ethnicity average for that component.

The Ethnicity Not Reported category had less than 30 patients reported, which does not meet the reporting threshold for reliability.

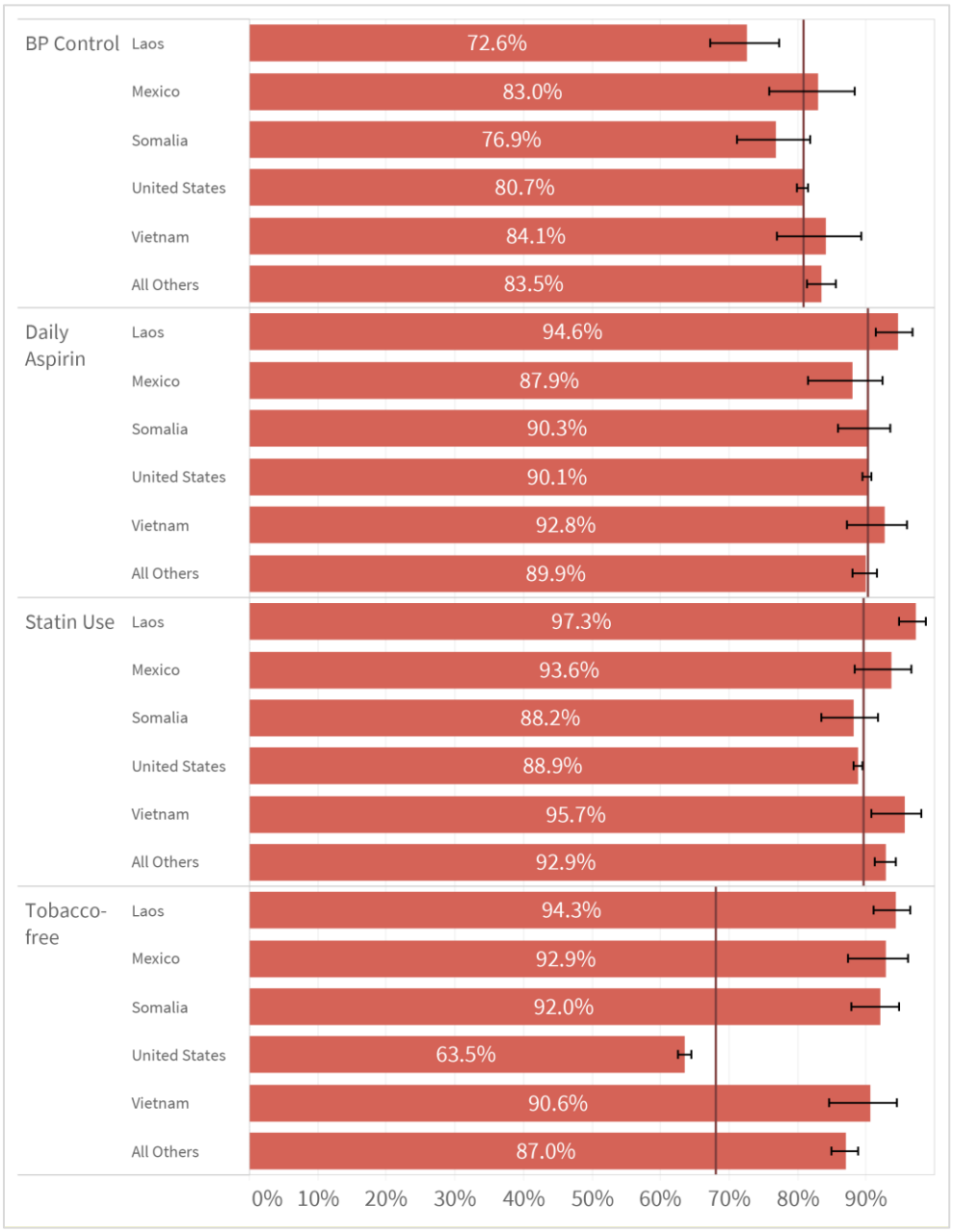
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL VASCULAR CARE:

Focus on components

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)



OVERALL MHCP MCO COUNTRY OF ORIGIN AVERAGES

by component
(represented by dark red line)

- **BP Control:** 80.8%
- **Daily Aspirin:** 90.2%
- **Statin Use:** 89.6%
- **Tobacco-free:** 68.0%

MHCP MCO patients from Laos have statistically significantly higher rates of daily aspirin use, statin use and being tobacco-free compared to the country of origin averages for each component. However, these patients also have statistically significantly lower rates of blood pressure control.

MHCP MCO patients from Vietnam have statistically significantly higher rates of statin use and being toabacco-free compared to the country of origin averages for each component.

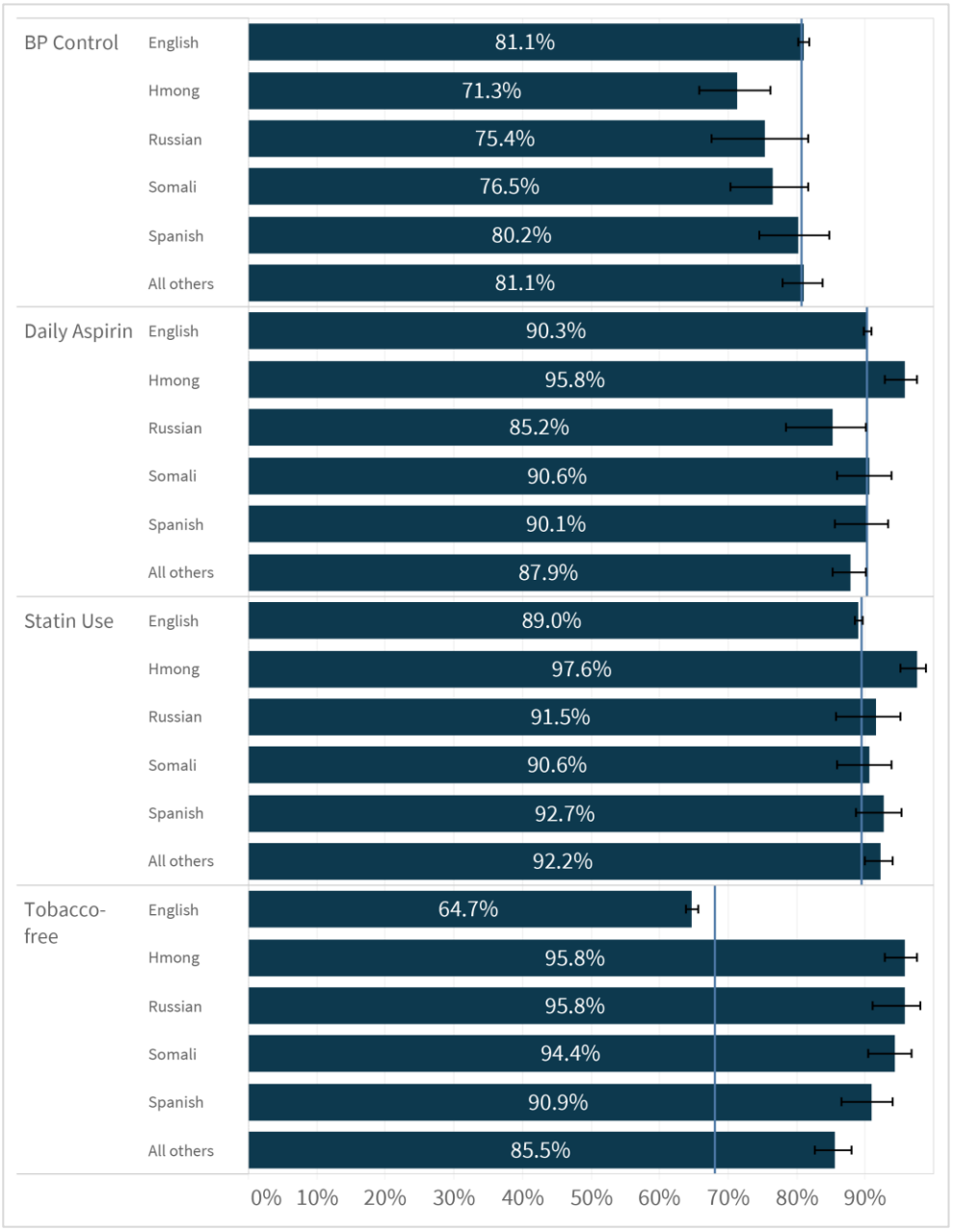
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL VASCULAR CARE:

Focus on components

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year (2019 dates of service)



OVERALL MHCP MCO PREFERRED LANGUAGE AVERAGES

by component
(represented by blue line)

- **BP Control:** 80.7%
- **Daily Aspirin:** 90.2%
- **Statin Use:** 89.5%
- **Tobacco-free:** 68.0%

MHCP MCO patients with ischemic vascular disease who speak Hmong have statistically significantly higher rates of daily aspirin use, statin use and being tobacco-free compared to the overall preferred language averages for each component. However, these patients also have statistically significantly lower rates of blood pressure control.

MHCP MCO patients with ischemic vascular disease who speak English have statistically significantly lower rates of being tobacco-free compared to the overall preferred language average for the component.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL ASTHMA CONTROL – ADULTS

In 2018, the CDC estimated that over 19 million adults had asthma in the United States.[8] Nationally, approximately 38.3% of adults with asthma had a visit to an emergency department (ED) for asthma-related care in 2017 and approximately 4.2% had an inpatient stay in the hospital.[8] It is estimated that the United States spends over $80 billion annually on treated asthma.[9]

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).

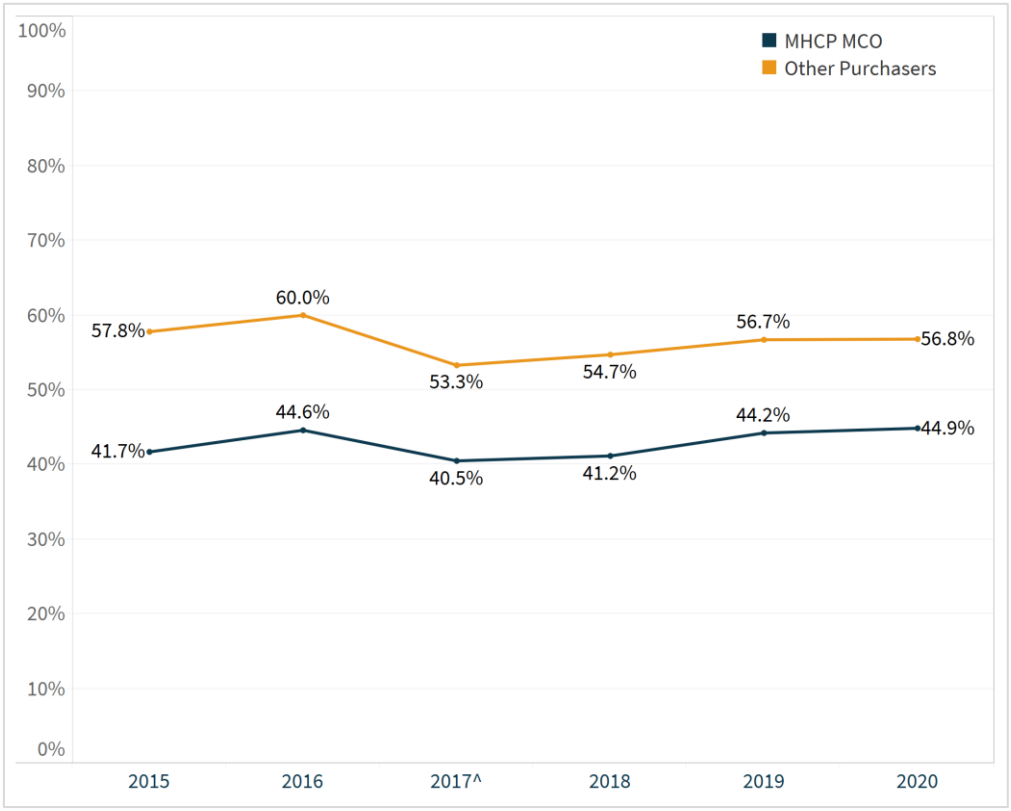
Measure Description

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 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)

TREND IN OPTIMAL ASTHMA CONTROL - ADULTS

2015 – 2020 report years



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.

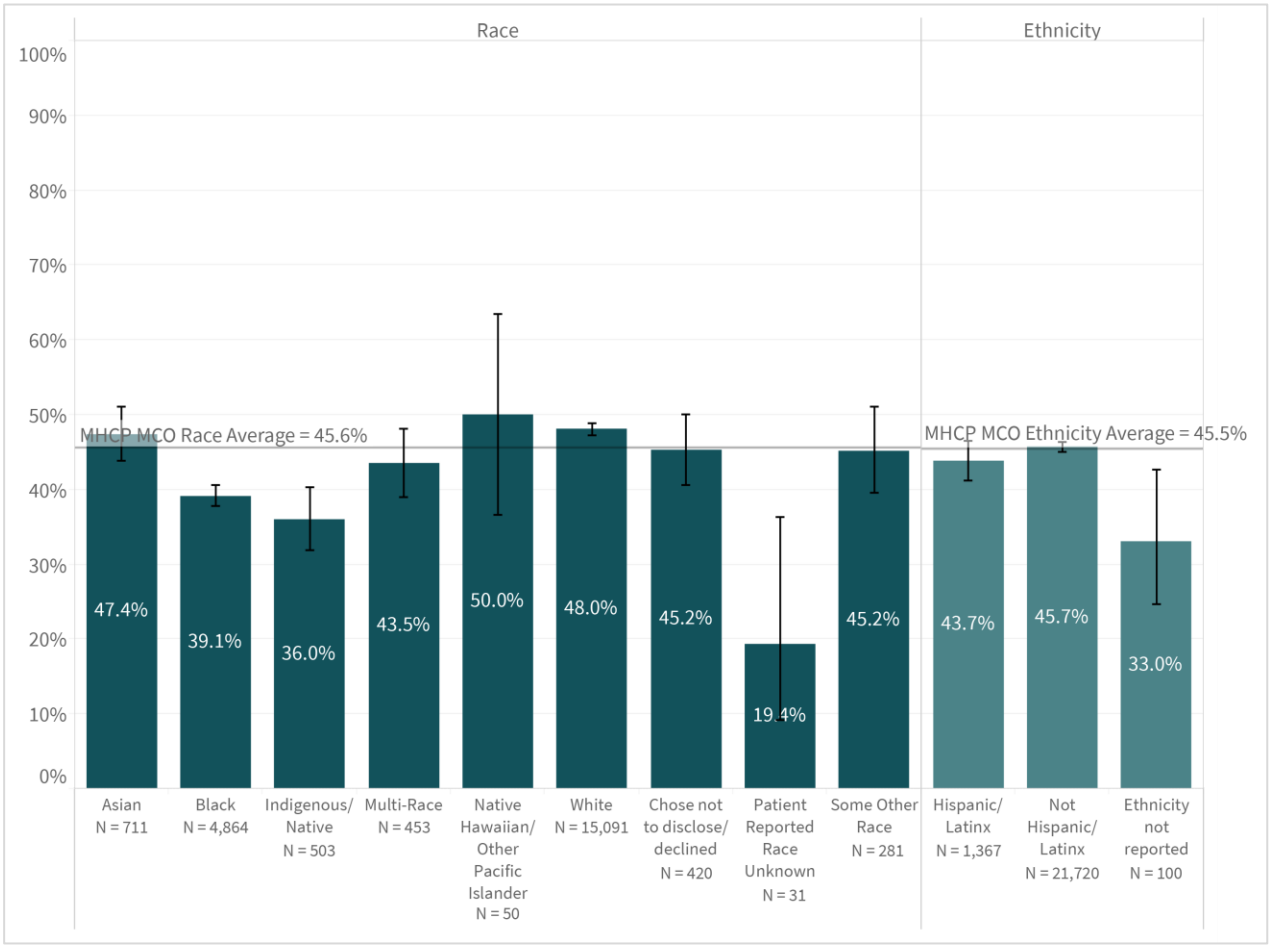
^The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to a change in statewide rates for this measure.

The Optimal Asthma Control rate for MHCP MCO adults did not statistically significantly change from the 2019 report year. While a significant gap remains between MHCP MCO and Other Purchasers (11.9 percentage points), it has statistically significantly narrowed since 2015.

OPTIMAL ASTHMA CONTROL – ADULTS

MHCP MCO RATES BY RACE/ETHNICITY

2020 report year (2019 dates of service)



The optimal care rates for MHCP MCO patients who are White are statistically significantly higher than the MHCP MCO race average. MHCP MCO patients who are Black or Indigenous/Native have statistically significantly lower rates of optimal care compared to the MHCP MCO race average.

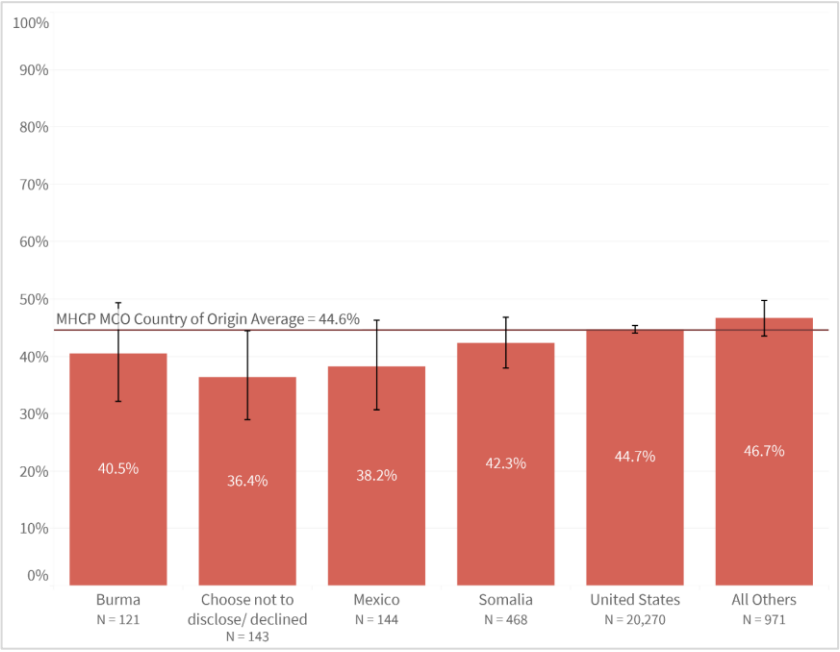
Both Hispanic/Latinx and non-Hispanic/Latinx MHCP MCO patients have average rates of optimal care when compared to the MHCP MCO ethnicity average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL ASTHMA CONTROL – ADULTS

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)

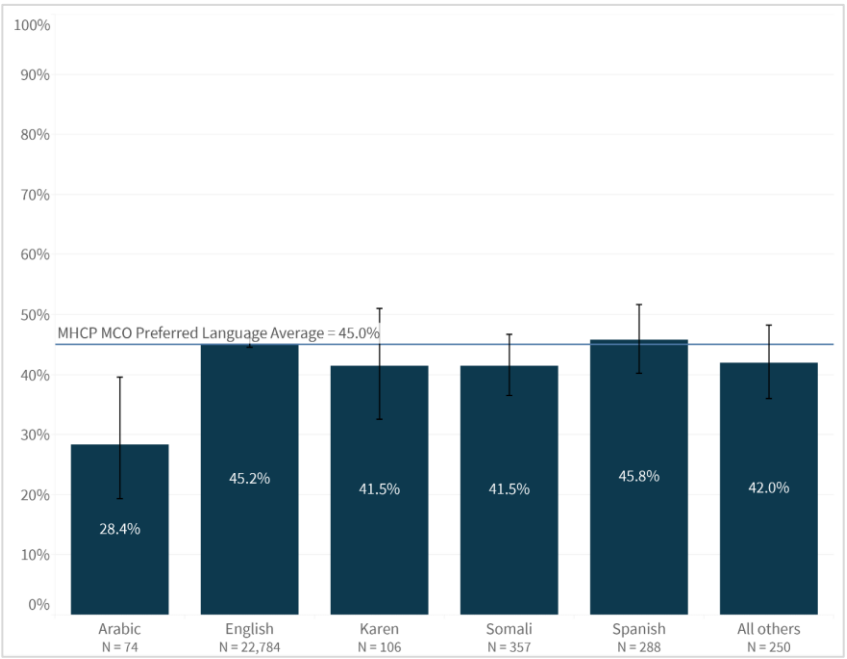


Patients from Burma, Mexico, Somalia, the United States or those who chose not to disclose their country of origin make up the largest proportion of the eligible MHCP MCO population.

The optimal rates for each country/category are average.

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year (2019 dates of service)



Patients who Arabic, English, Karen, Somali or Spanish make up the largest proportion of the eligible MHCP MCO population.

Patients who speak Arabic have statistically significantly lower rates of optimal control compared to the MHCP MCO preferred language average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin or preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL ASTHMA CONTROL – CHILDREN

Over 5 million children (< 18 years of age) had asthma in 2018.[8] In 2017, 85.3% of children with asthma had an emergency department visit and 10.3% had an inpatient hospital stay.[8] Furthermore, it is estimated that children with asthma missed about 2.3 school days each year between 2008 and 2013.[9]

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).

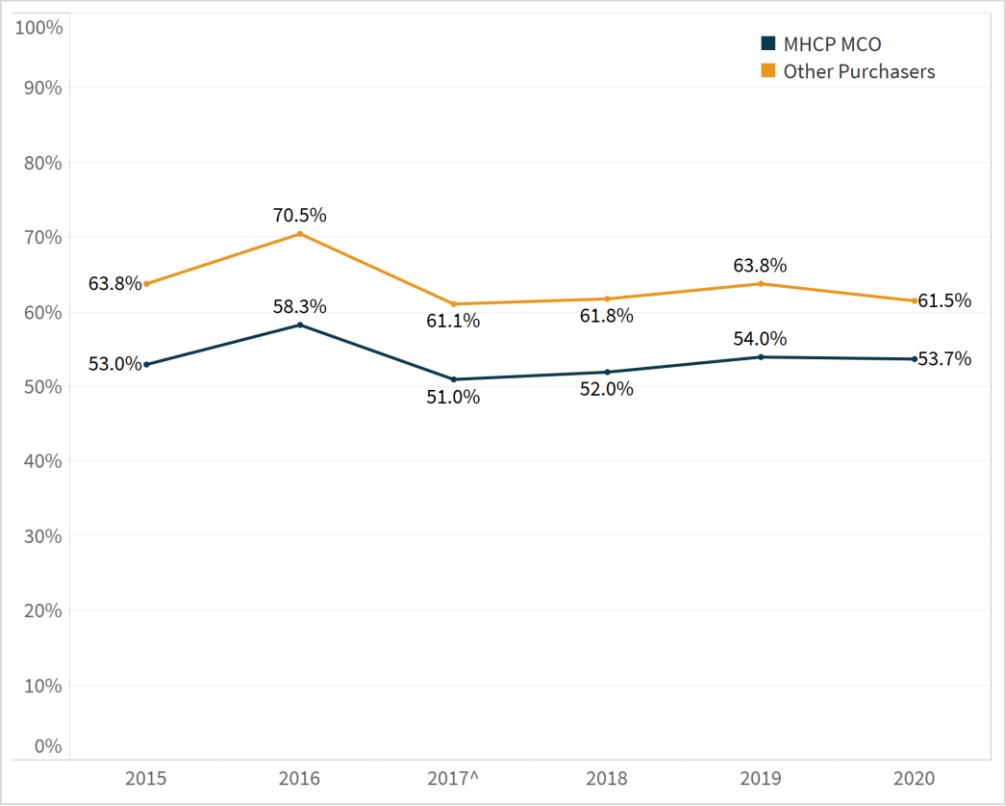
Measure Description

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 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)

TREND IN OPTIMAL ASTHMA CONTROL - CHILDREN

2015 – 2020 report years



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.

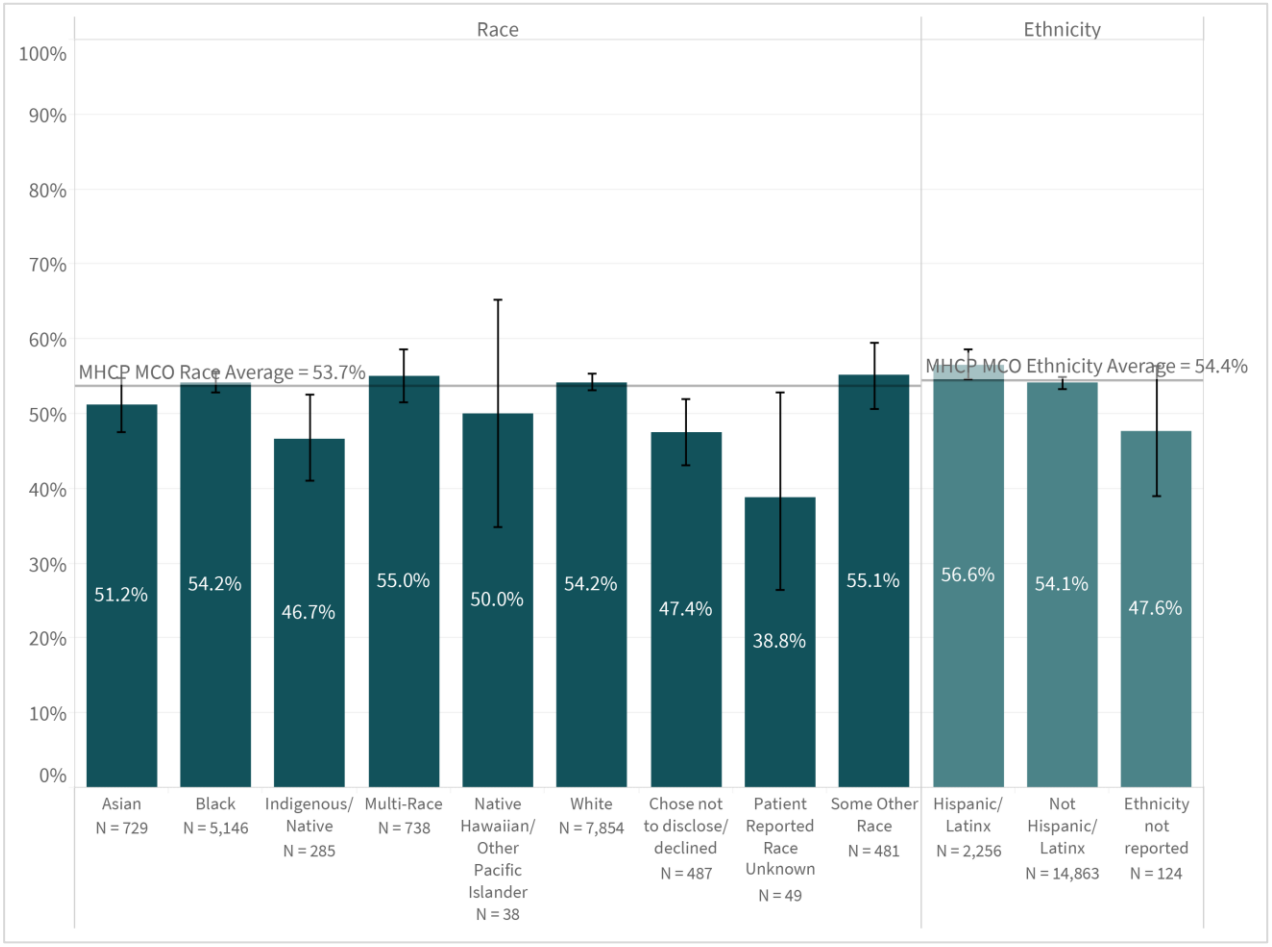
^The criteria for including patients in the measure denominator changed in 2017. This change may have contributed to a change in statewide rates for this measure.

The Optimal Asthma Control rate for MHCP MCO children did not statistically significantly change from the 2019 report year. The gap between the MHCP MCO population and the Other Purchasers population remains statistically significant (7.8 percentage points). However, this gap has statistically significantly narrowed since 2015.

OPTIMAL ASTHMA CONTROL – CHILDREN

MHCP MCO RATES BY RACE/ETHNICITY

2020 report year (2019 dates of service)



The optimal care rates for MHCP MCO patients who are Indigenous/Native have statistically significantly lower than the MHCP MCO race average.

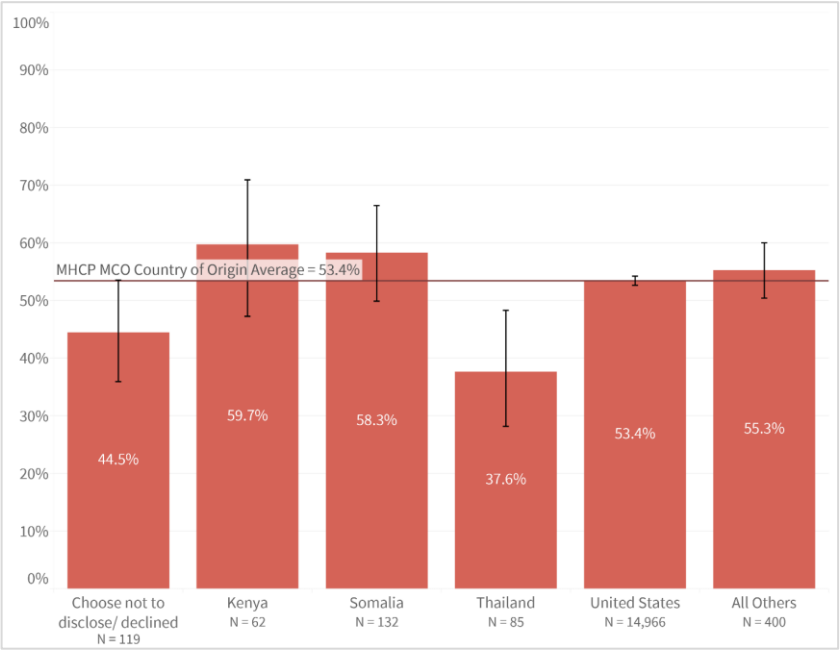
Both Hispanic/Latinx and non-Hispanic/Latinx MHCP MCO patients have average rates of optimal care when compared to the MHCP MCO ethnicity average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

OPTIMAL ASTHMA CONTROL – CHILDREN

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)

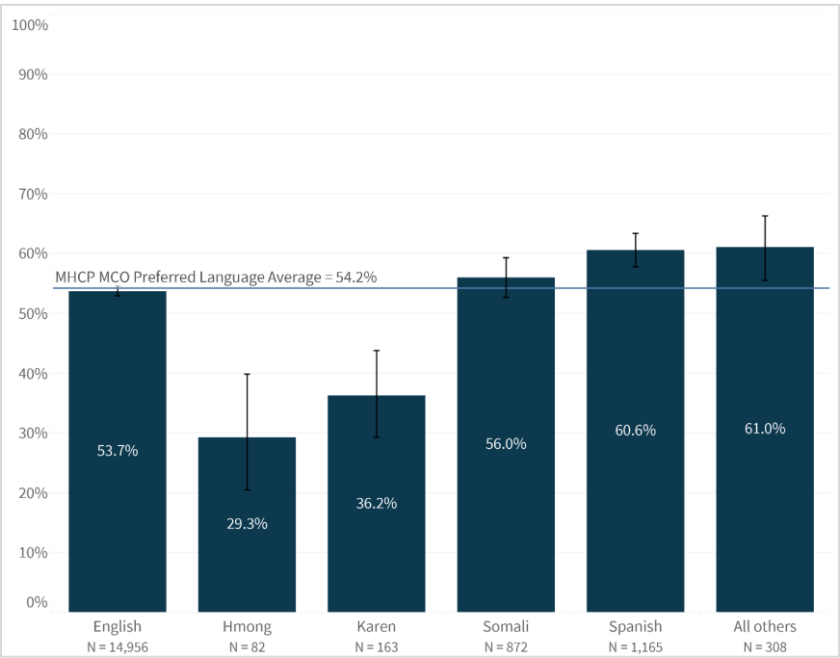


Patients who chose not to disclose their country of origin or those from Kenya, Somalia, Thailand or the United States make up the largest proportion of the eligible MHCP MCO population.

Patients from Thailand have statistically significantly lower rates of optimal control compared to the MHCP MCO country of origin average.

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year (2019 dates of service)



Patients who speak English, Hmong, Karen, Somali or Spanish make up the largest proportion of the eligible MHCP MCO population.

Patients who speak Karen or Hmong have statistically significantly lower rates of screening compared to the MHCP MCO preferred language average. Meanwhile, patients who speak Spanish have statistically significantly higher rates of screening.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin or preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

According to CDC's 2019 Youth Risk Behavior Survey, approximately 37 percent of high school students reported persistent feelings of sadness or hopelessness.[10] This is a 40 percent increase since 2009.[10] Additionally, it is estimated that in 2007, approximately 13-20% of children in the United States experienced a mental health disorder, making screening an important component of adolescent health care.[11]

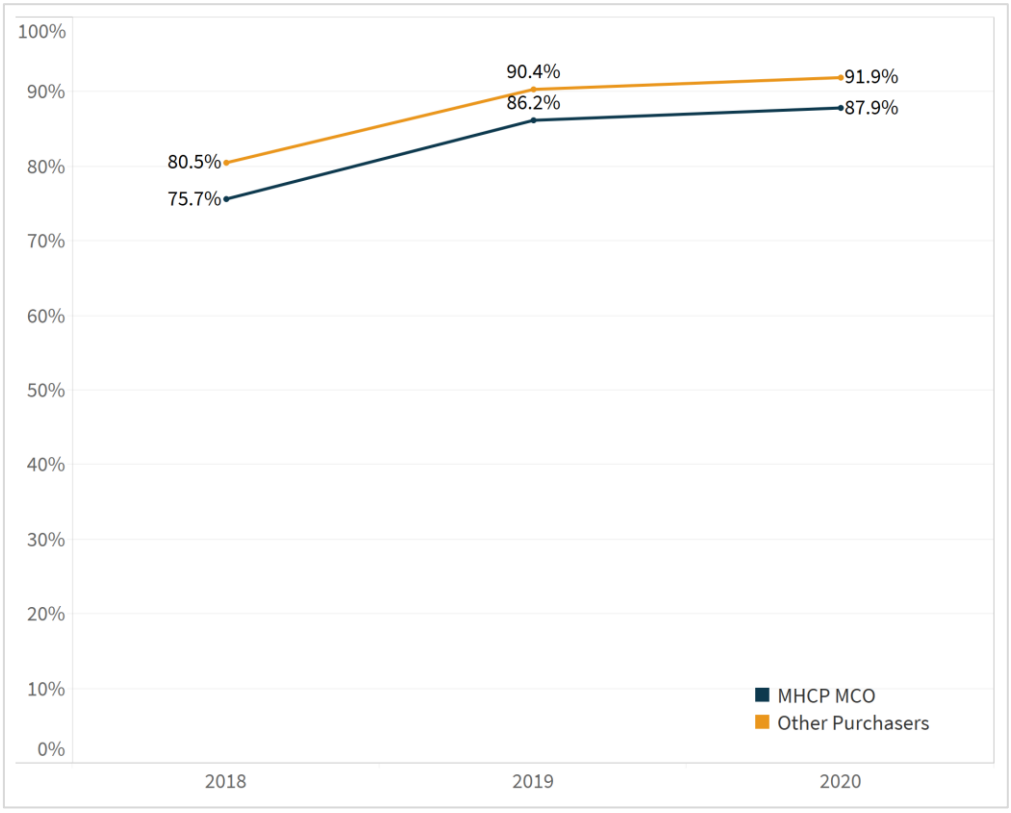
Medical groups and clinics report data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

Measure Description

The percentage of patients ages 12 – 17 who were screened for mental health and/or depression at a well-child visit using a specified tool.

TREND IN ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

2018 – 2020 report years



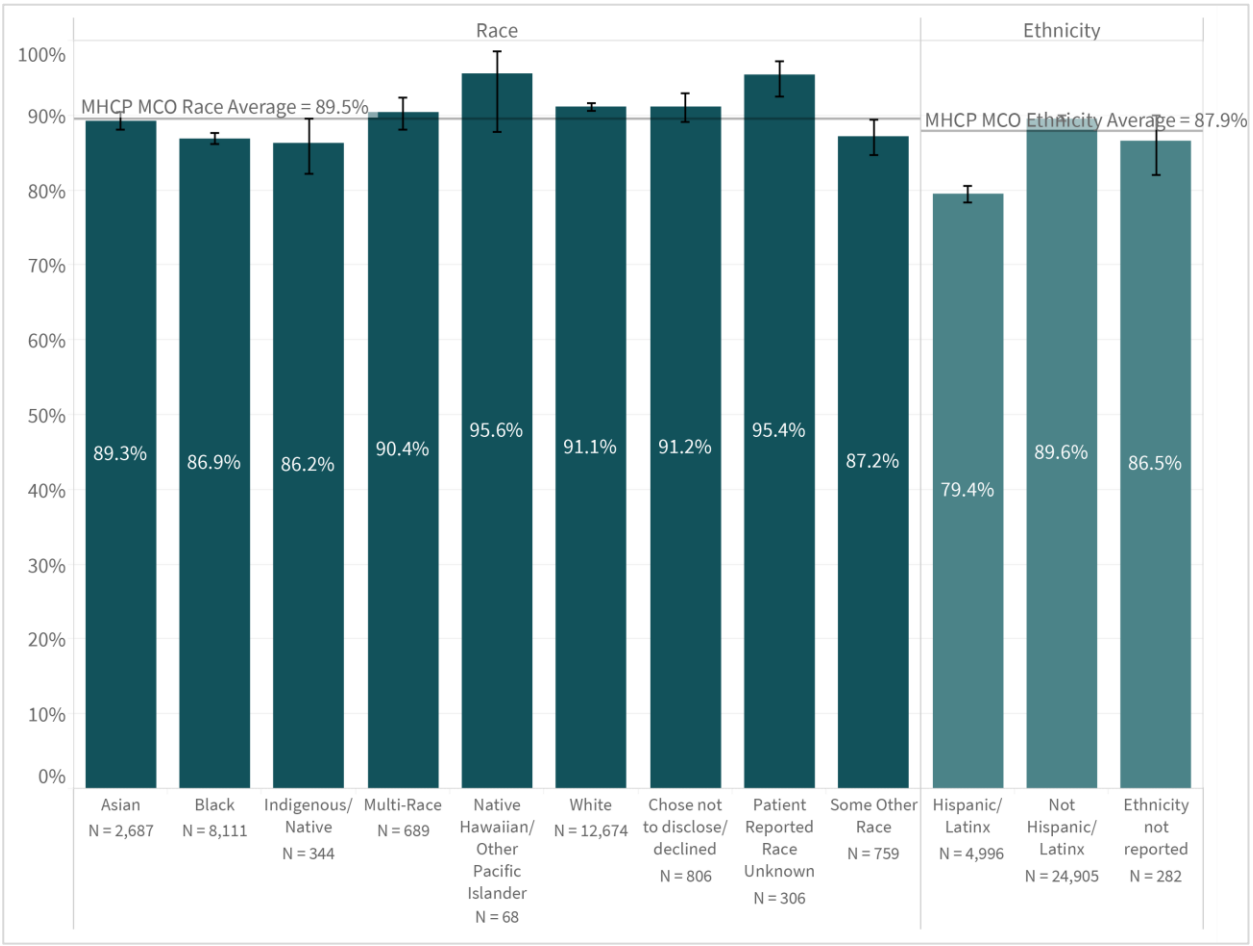
Caution is recommended when making comparisons from year to year. Annual rate differences can occur due to natural variation, changes in measurement specifications, changes in data sources and other factors.

The Adolescent Mental Health and/or Depression Screening rate for MHCP MCO patients statistically significantly increased by 1.7 percentage points compared to the 2019 report year. While the gap in performance between patients insured by MHCP MCO and patients insured by Other Purchasers remains (3.5 percentage points), it has statistically significantly narrowed since 2018.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

MHCP MCO RATES BY RACE/ETHNICITY

2020 report year (2019 dates of service)



The screening rates for MHCP MCO patients who are White are statistically significantly higher than the MHCP MCO race average. MHCP MCO patients who are Black have statistically significantly lower rates of screening compared to the MHCP MCO race average.

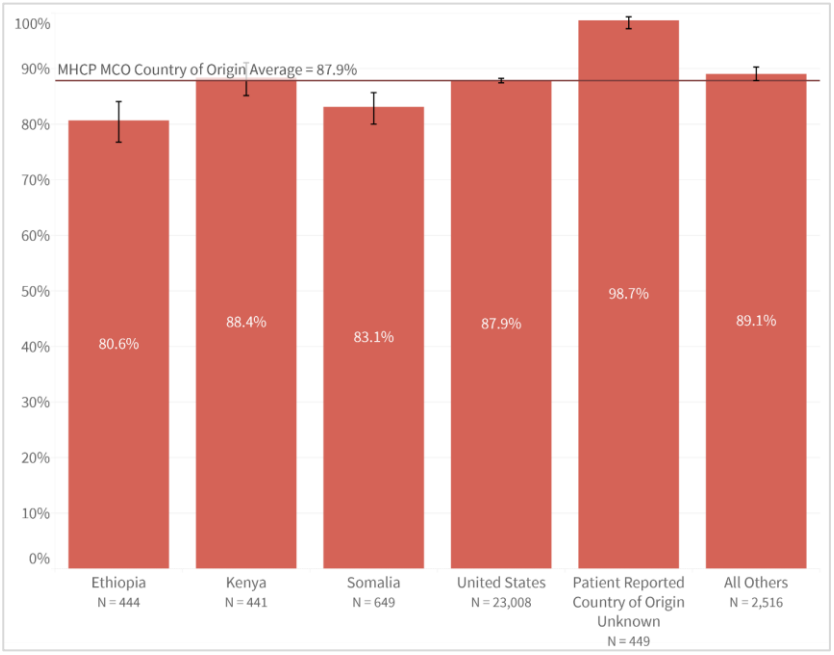
Hispanic/Latinx MHCP MCO patients have statistically significantly lower rates of screening compared to the MHCP MCO ethnicity average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)

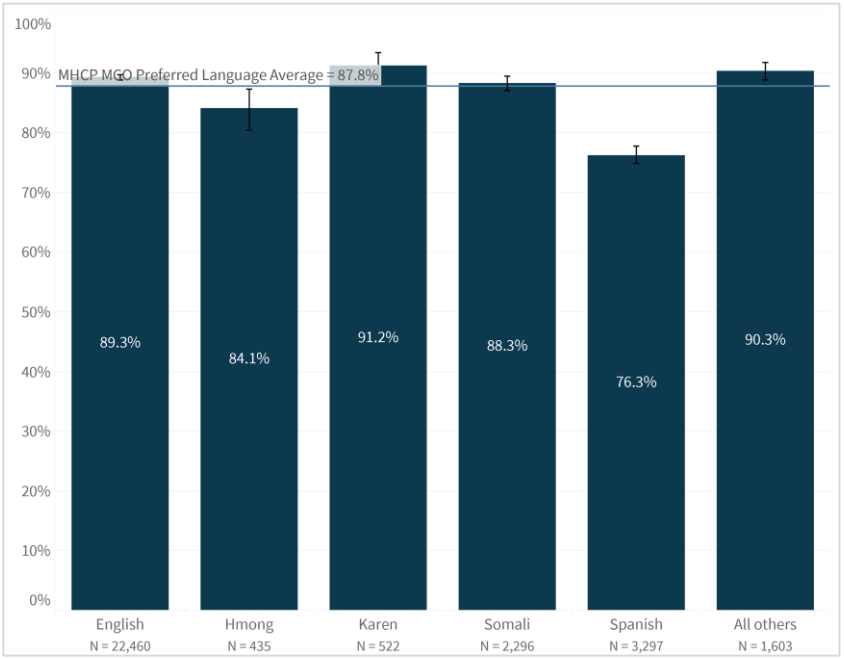


Patients from Ethiopia, Kenya, Somalia, the United States or reported that their country of origin is unknown make up the largest proportion of the eligible MHCP MCO population.

Patients from Somalia or Ethiopia have statistically significantly lower rates of screening compared to the MHCP MCO country of origin average.

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year (2019 dates of service)



Patients who speak English, Hmong, Karen, Somali or Spanish make up the largest proportion of the eligible MHCP MCO population.

Patients who speak Hmong or Spanish have statistically significantly lower rates of screening compared to the MHCP MCO preferred language average. Meanwhile, patients who speak English or Karen have statistically significantly higher rates of screening.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin or preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADULT DEPRESSION SUITE

Approximately one out of six adults will experience depression during their lifetime.[12] In fact, the National Alliance on Mental Illness (NAMI) reports that approximately eight percent of the United States population experienced at least one depressive episode in the past year.[13]

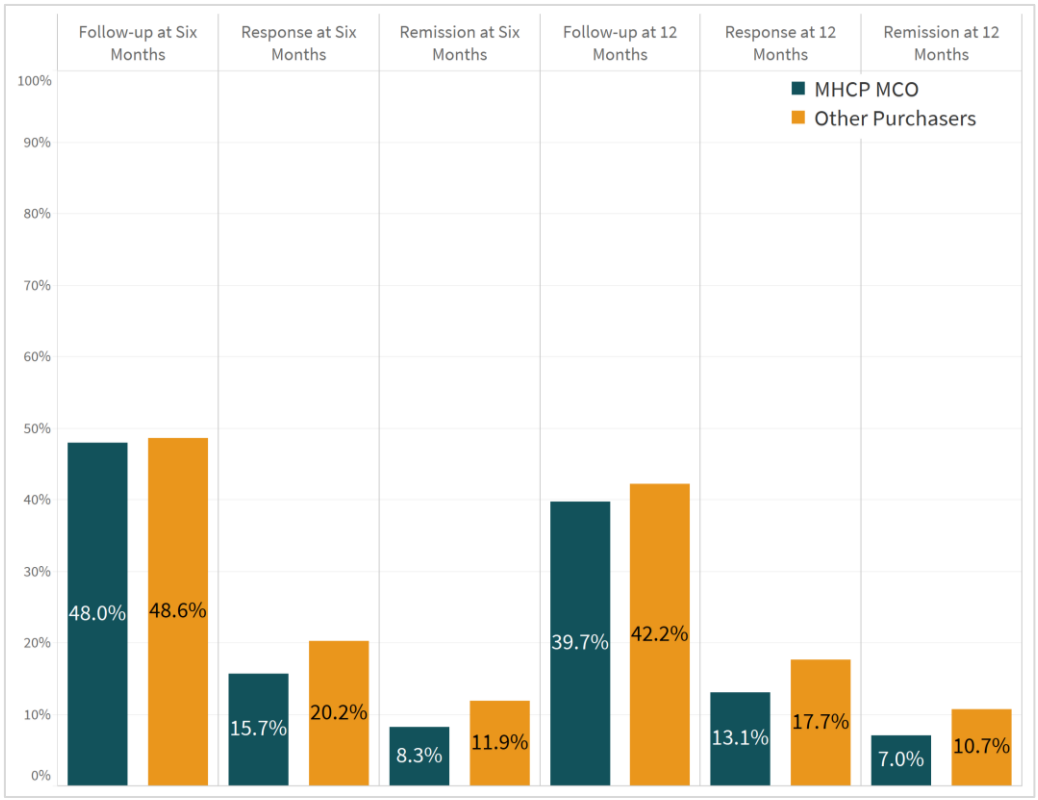
Medical groups and clinics report data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

Measure Descriptions

- **Follow-Up PHQ-9/PHQ-9M at Six/12 Months:** The percentage of adult patients (18 years and older) with depression who have a completed PHQ-9/PHQ-9M tool within six/12 months after the index event (+/- 60 days)
- **Response at Six /12 Months:** The percentage of adult patients with depression who demonstrated a response to treatment (at least 50 percent improvement) six/12 months after the index event (+/- 60 days)
- **Remission at Six/12 Months:** The percentage of adult patients with depression who reached remission (PHQ-9/ PHQ-9M score less than five) six/12 months after the index event (+/- 60 days)

ADULT DEPRESSION SUITE

2020 report year (2019 dates of service)



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.

NOTE: Trending is not available for the adult depression suite due to significant measure changes in the 2020 report year.

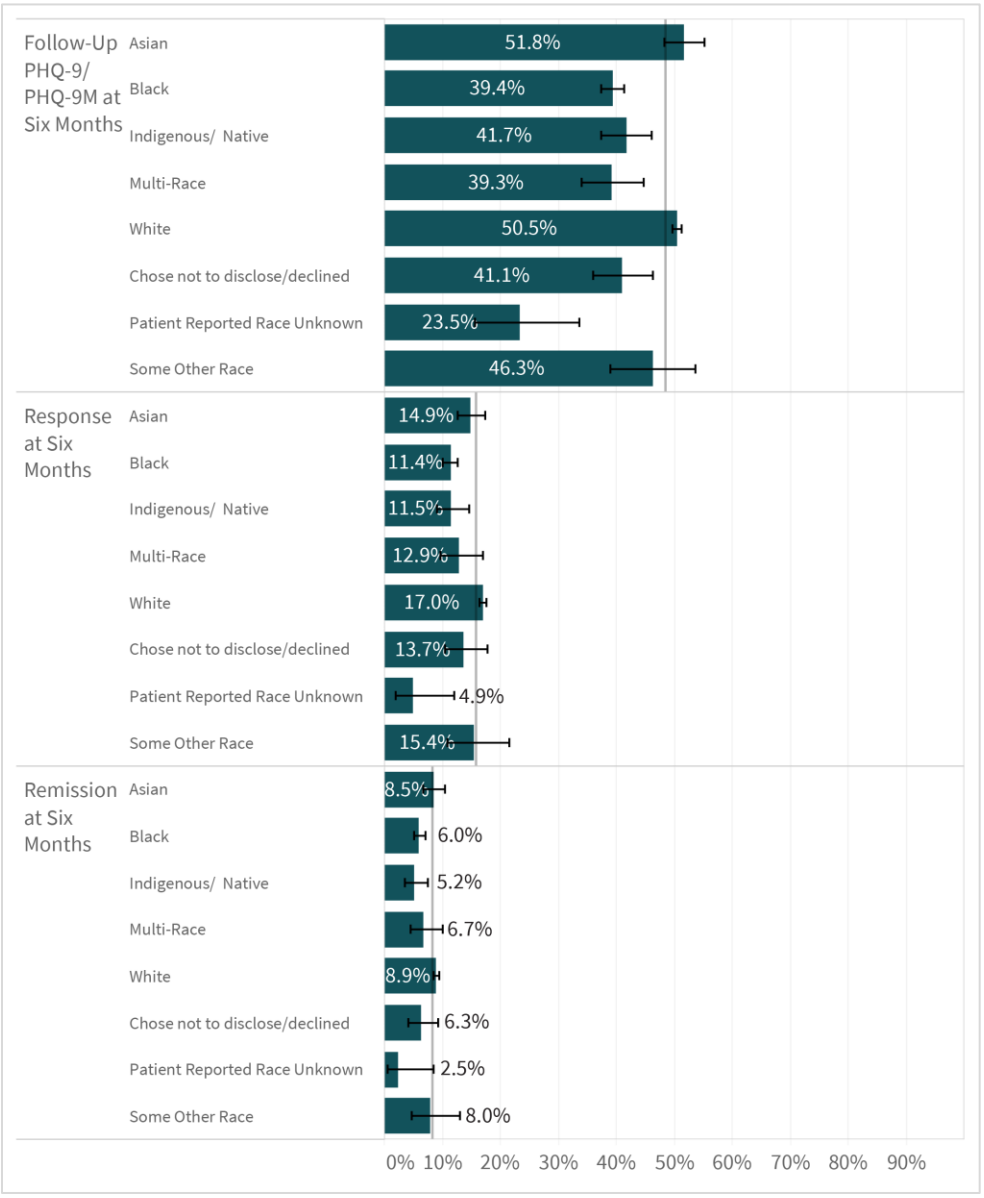
There is significant room for improvement across all six depression measures, regardless of payer type. However, there are significant differences in performance rates by insurance type. In particular, the Response at 12 Months measure has the largest gap between insurance types, with a significant difference of 4.6 percentage points.

ADULT DEPRESSION SUITE:

Six Month Measures

MHCP MCO RATES BY RACE

2020 report year (2019 dates of service)



OVERALL MHCP MCO RACE AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 48.5%
- **Response at Six Months:** 15.9%
- **Remission at Six Months:** 8.3%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 825
- **Black:** 2,306
- **Indigenous/Native:** 503
- **Multi-Race:** 326
- **White:** 14,646
- **Chose Not to Disclose/Declined:** 336
- **Patient Reported Race Unknown:** 81
- **Some Other Race:** 175

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

Among eligible MHCP MCO adults with depression, Indigenous/Native and Black patients have statistically significantly lower rates of Follow-Up PHQ-9/PHQ-9M at Six Months, Response at Six Months and Remission at Six Months compared to the respective overall MHCP MCO race averages.

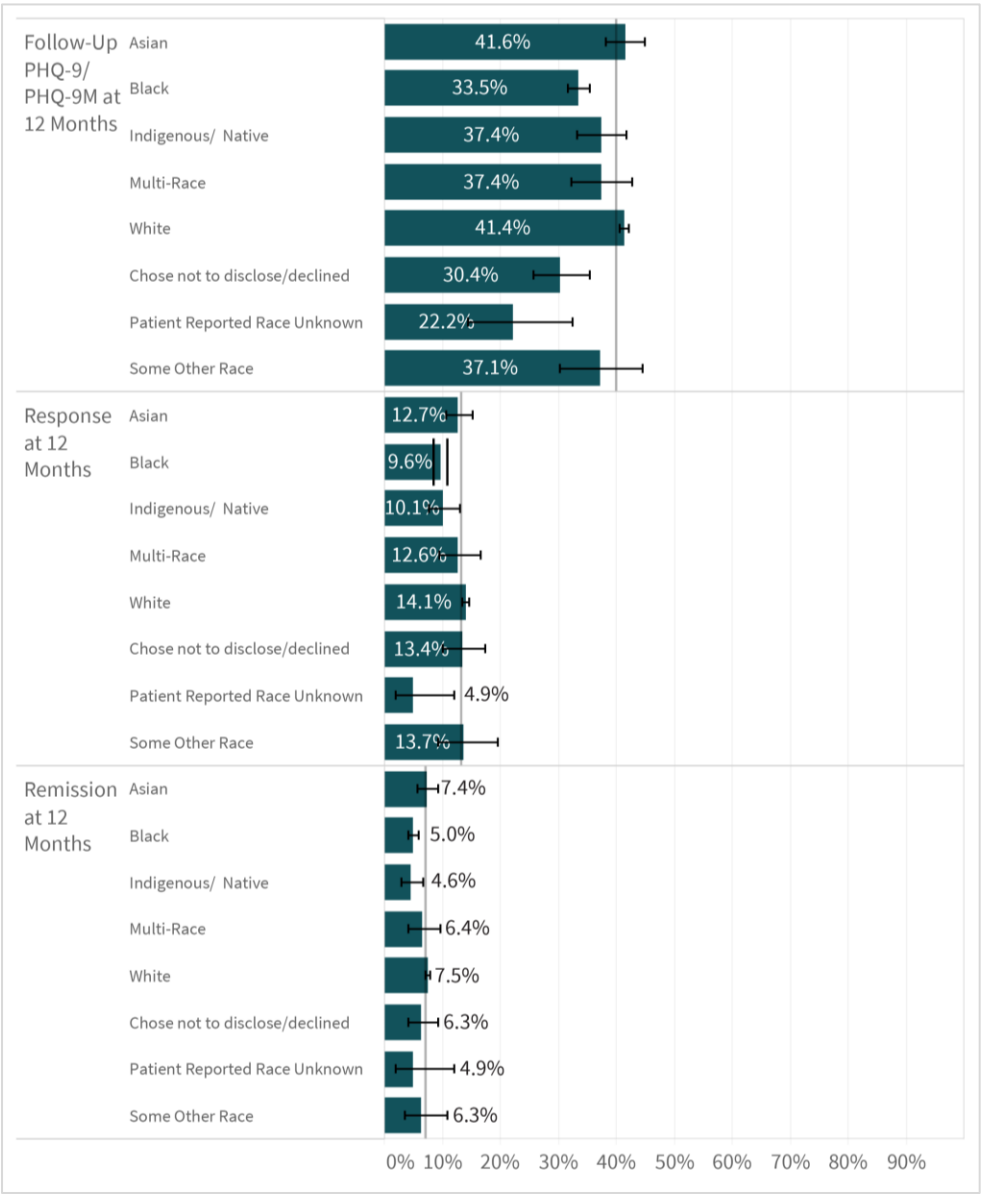
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADULT DEPRESSION SUITE:

12 Month Measures

MHCP MCO RATES BY RACE

2020 report year (2019 dates of service)



OVERALL MHCP MCO RACE AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 40.0%
- **Response at Six Months:** 13.3%
- **Remission at Six Months:** 7.1%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 825
- **Black:** 2,306
- **Indigenous/Native:** 503
- **Multi-Race:** 326
- **White:** 14,646
- **Chose Not to Disclose/Declined:** 336
- **Patient Reported Race Unknown:** 81
- **Some Other Race:** 175

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

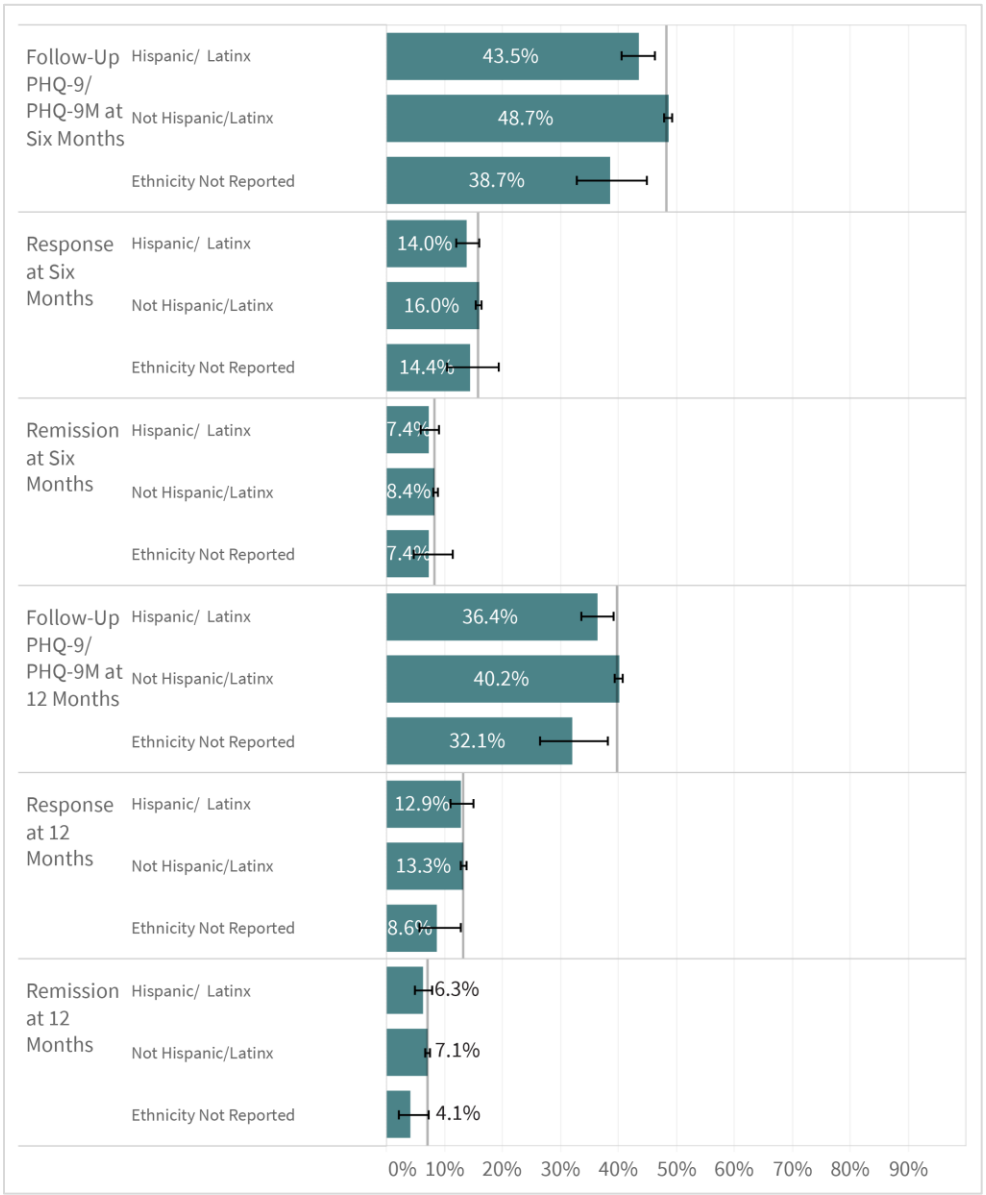
Among eligible MHCP MCO adults with depression, Black patients have statistically significantly lower rates of Follow-Up PHQ-9/PHQ-9M at 12 Months, Response at 12 Months and Remission at 12 Months compared to the respective overall MHCP MCO race averages.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADULT DEPRESSION SUITE

MHCP MCO RATES BY ETHNICITY

2020 report year (2019 dates of service)



OVERALL MHCP MCO ETHNICITY AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 48.3%
- **Response at Six Months:** 15.8%
- **Remission at Six Months:** 8.3%
- **Follow-Up PHQ-9/PHQ-9M at 12 Months:** 39.8%
- **Response at 12 Months:** 13.2%
- **Remission at 12 Months:** 7.1%

DENOMINATORS BY ETHNICITY

(Denominators are the same for each measure)

- **Hispanic/Latinx:** 1,111
- **Not Hispanic/Latinx:** 18,644
- **Ethnicity Not Reported:** 243

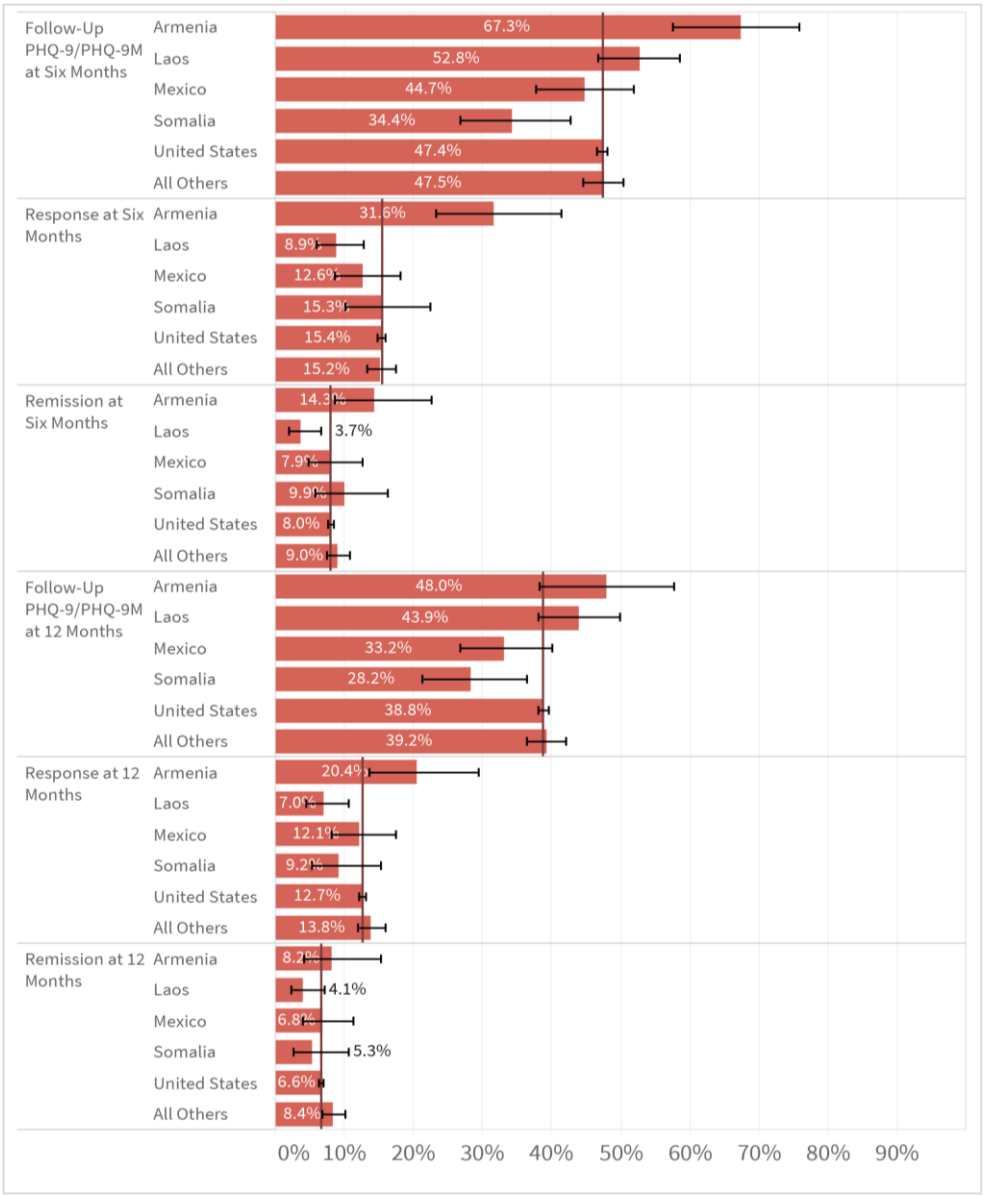
Among eligible MHCP MCO adults with depression, Hispanic/Latinx patients have statistically significantly lower rates of Follow-Up PHQ-9/PHQ-9M at Six Months compared to the overall MHCP MCO ethnicity average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADULT DEPRESSION SUITE

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)



OVERALL MHCP MCO COUNTRY OF ORIGIN AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 47.5%
- **Response at Six Months:** 15.4%
- **Remission at Six Months:** 8.0%
- **Follow-Up PHQ-9/PHQ-9M at 12 Months:** 38.8%
- **Response at 12 Months:** 12.7%
- **Remission at 12 Months:** 6.7%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- **Armenia:** 98
- **Laos:** 271
- **Mexico:** 190
- **Somalia:** 131
- **United States:** 16,694
- **All Others:** 1,124

Patients from Armenia, Laos, Mexico, Somalia or the United States make up the largest proportion of the eligible MHCP MCO population.

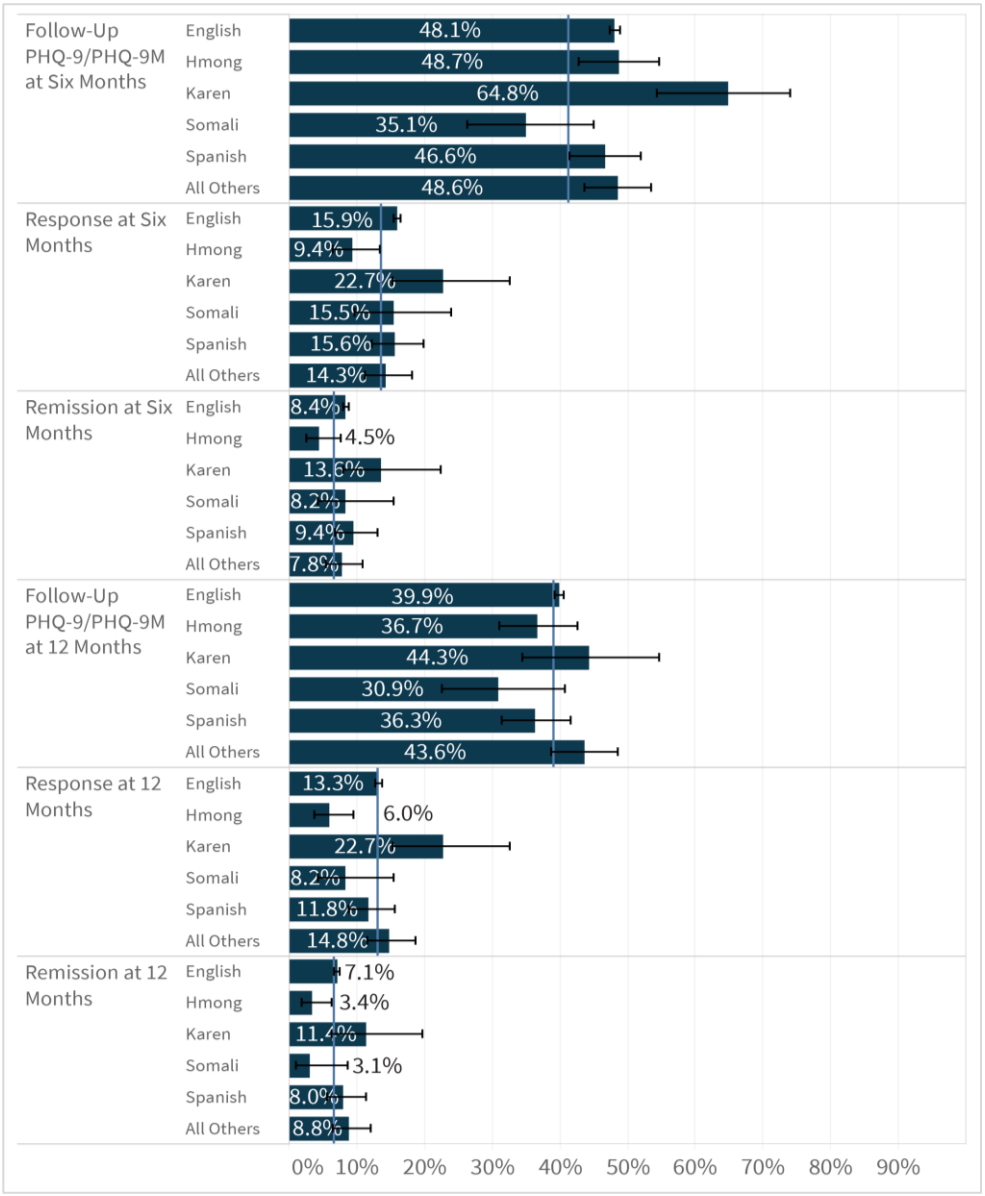
Patients from Laos have statistically significantly lower rates of Response at Six Months, Remission at Six Months and Response at 12 Months. Patients from Armenia have statistically significantly higher rates of Follow-up PHQ-9/PHQ-9M at Six Months, Response at Six Months, Remission at Six Months and Response at 12 Months compared to the respective overall MHCP MCO country of origin averages.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADULT DEPRESSION SUITE

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year (2019 dates of service)



OVERALL MHCP MCO PREFERRED LANGUAGE AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 48.1%
- **Response at Six Months:** 15.8%
- **Remission at Six Months:** 8.3%
- **Follow-Up PHQ-9/PHQ-9M at 12 Months:** 39.8%
- **Response at 12 Months:** 13.2%
- **Remission at 12 Months:** 7.1%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **English:** 19,372
- **Hmong:** 267
- **Karen:** 88
- **Somali:** 97
- **Spanish:** 339
- **All Others:** 385

Patients who speak English, Hmong, Karen, Somali and Spanish make up the largest proportion of the eligible MHCP MCO population.

Patients who speak Hmong have statistically significantly lower rates of in all measures, except for Follow-Up PHQ-9M/PHQ-9M at 12 Months. Patients who speak Karen have statistically significantly higher rates of Follow-up PHQ-9/PHQ-9M at Six Months and Response at 12 Months compared to the respective overall MHCP MCO country of origin averages.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available preferred language information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADOLESCENT DEPRESSION SUITE

In 2017, it was estimated that approximately 3.2 million or 13.7 percent of adolescents between the ages of 12 and 17 had at least one depressive episode in the past year.[14] Additionally, adolescents reporting two or more races had a higher rate of having a depressive episode.[14]

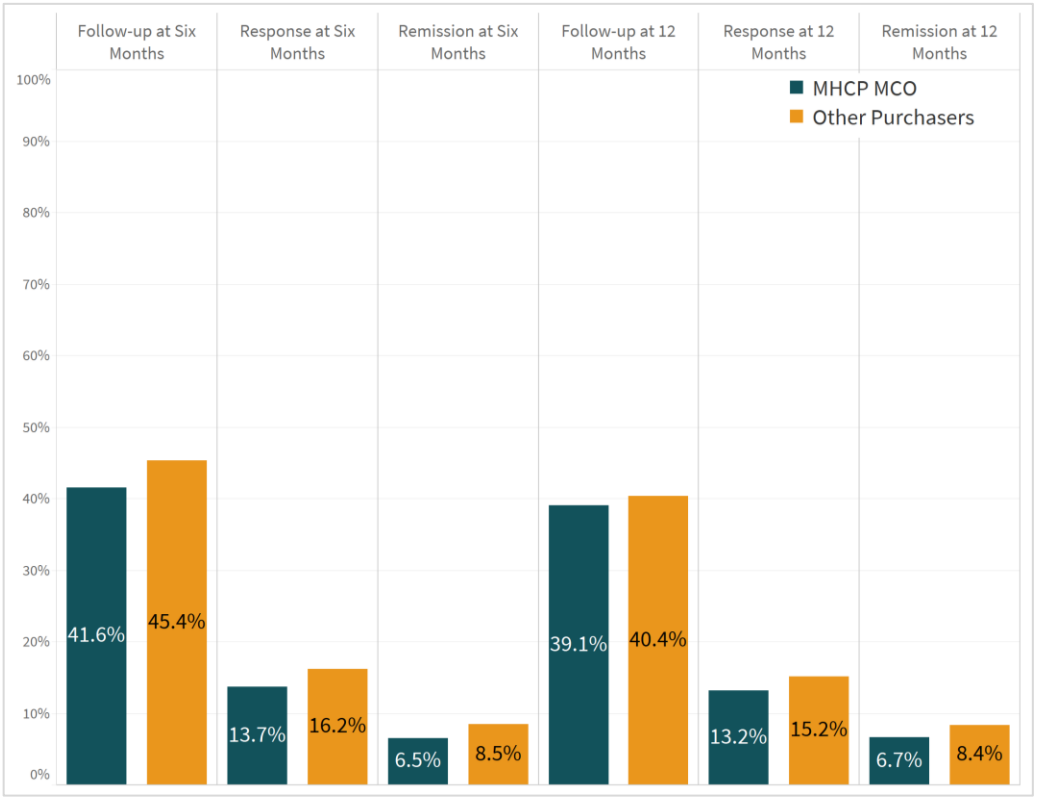
Medical groups and clinics report data directly to MNCM for this measure, based on electronic health records or paper-based medical charts (See Methodology Appendix).

Measure Descriptions

- **Follow-Up PHQ-9/PHQ-9M at Six/12 Months:** The percentage of adolescent patients (12-17 years) with depression who have a completed PHQ-9/PHQ-9M tool within six/12 months after the index event (+/- 60 days)
- **Response at Six /12 Months:** The percentage of adolescent patients with depression who demonstrated a response to treatment (at least 50 percent improvement) six/12 months after the index event (+/- 60 days)
- **Remission at Six/12 Months:** The percentage of adolescent patients with depression who reached remission (PHQ-9/ PHQ-9M score less than five) six/12 months after the index event (+/- 60 days)

ADOLESCENT DEPRESSION SUITE

2020 report year (2019 dates of service)



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.

NOTE: Trending is not available for the adolescent depression suite because 2020 was the first year measure was reported.

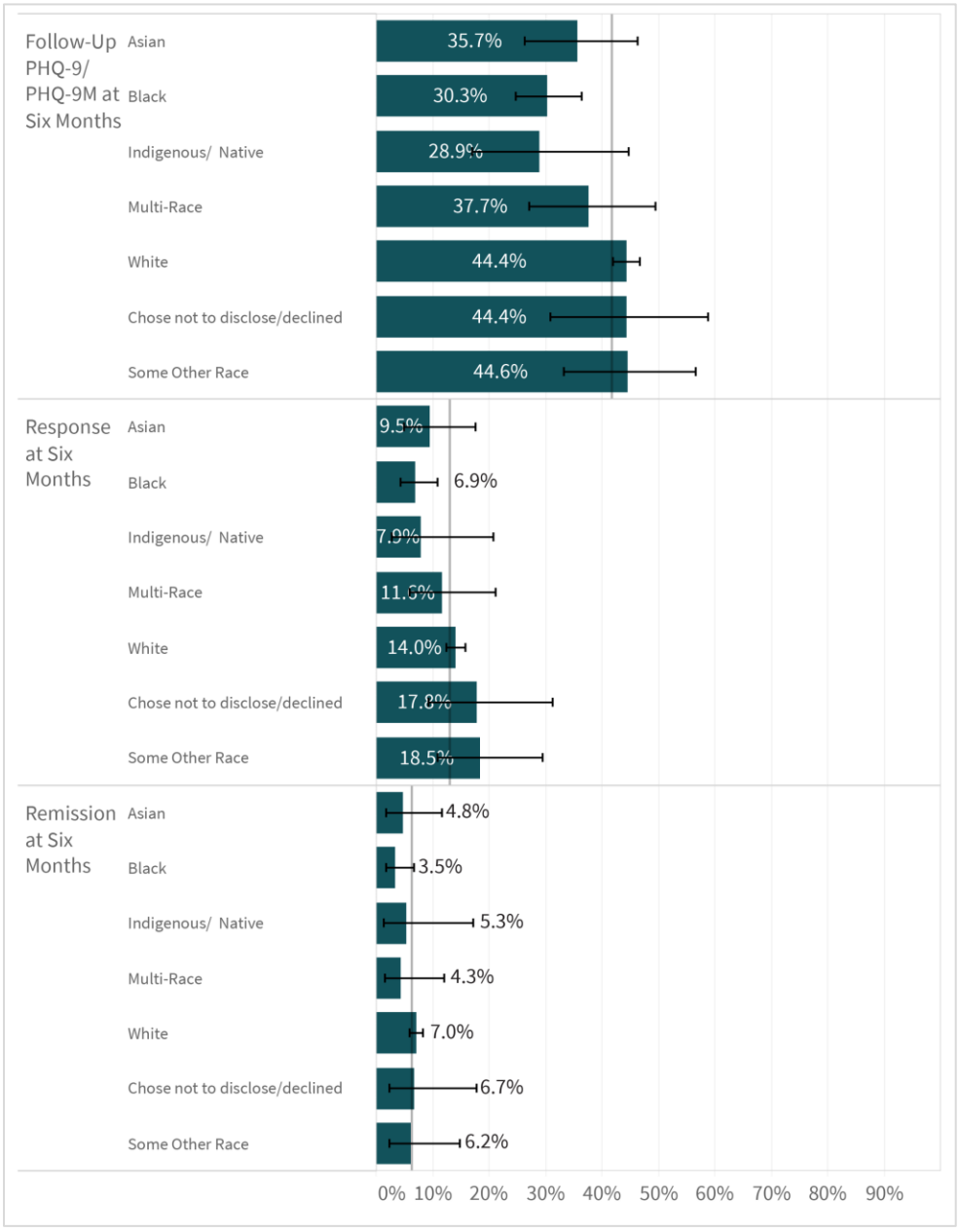
As with the adult depression suite, there is significant room for improvement across all six depression measures for the adolescent population, regardless of payer type. However, there are significant differences in performance by insurance type. In particular, the Follow-Up PHQ-9/PHQ-9M at Six Months measure has the largest gap between insurance types, with a significant difference of 3.8 percentage points.

ADOLESCENT DEPRESSION SUITE:

Six Month Measures

MHCP MCO RATES BY RACE

2020 report year (2019 dates of service)



OVERALL MHCP MCO RACE AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 41.8%
- **Response at Six Months:** 13.1%
- **Remission at Six Months:** 6.3%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 84
- **Black:** 231
- **Indigenous/Native:** 38
- **Multi-Race:** 69
- **White:** 1,603
- **Chose Not to Disclose/Declined:** 45
- **Some Other Race:** 65

Native Hawaiian/Other Pacific Islander and Patient Reported Race Unknown categories had less than 30 patients reported, which does not meet the reporting threshold for reliability.

Among eligible MHCP MCO adolescents with depression, Black patients have statistically significantly lower rates of Follow-Up PHQ-9/PHQ-9M at Six Months and Response at Six Months compared to the respective overall MHCP MCO race averages.

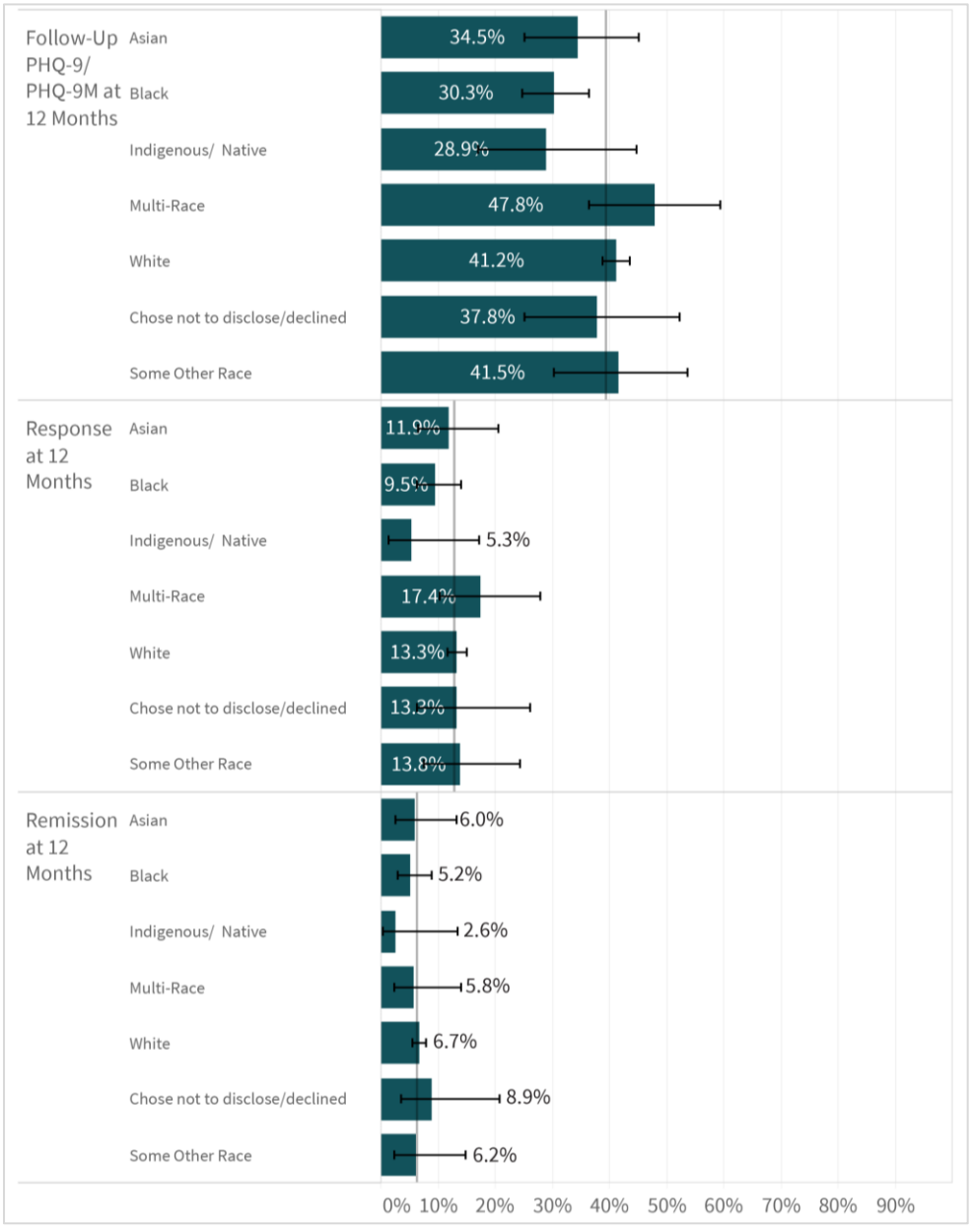
NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADOLESCENT DEPRESSION SUITE:

12 Month Measures

MHCP MCO RATES BY RACE

2020 report year (2019 dates of service)



OVERALL MHCP MCO RACE AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at 12 Months:** 39.5%
- **Response at 12 Months:** 12.8%
- **Remission at 12 Months:** 6.3%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 84
- **Black:** 231
- **Indigenous/Native:** 38
- **Multi-Race:** 69
- **White:** 1,603
- **Chose Not to Disclose/Declined:** 45
- **Some Other Race:** 65

Native Hawaiian/Other Pacific Islander and Patient Reported Race Unknown categories had less than 30 patients reported, which does not meet the reporting threshold for reliability.

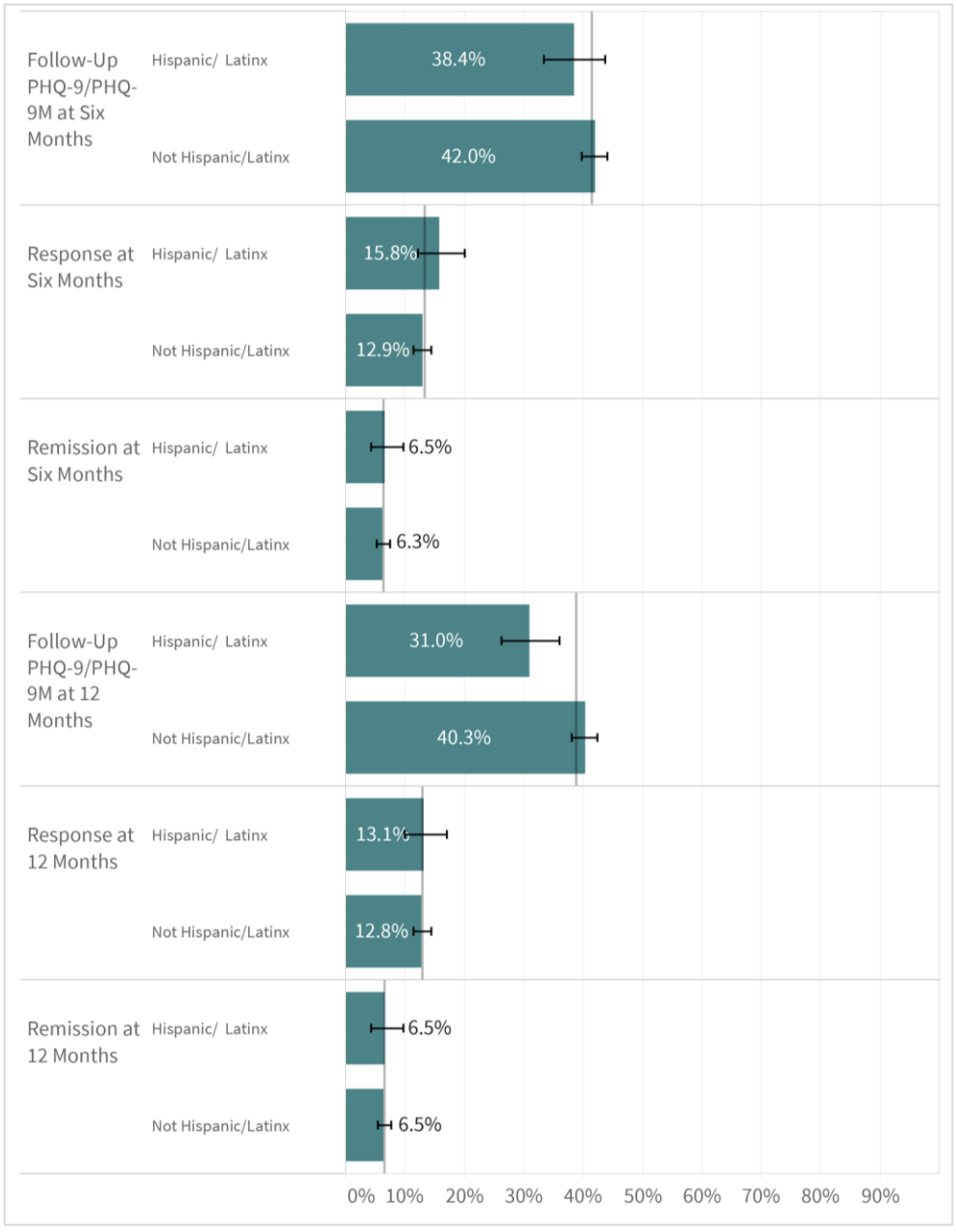
Among eligible MHCP MCO adults with depression, Black patients have statistically significantly lower rates of Follow-Up at PHQ-9/PHQ-9M at 12 Months compared to the overall MHCP MCO race average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADOLESCENT DEPRESSION SUITE

MHCP MCO RATES BY ETHNICITY

2020 report year (2019 dates of service)



OVERALL MHCP MCO ETHNICITY AVERAGES
by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 41.4%
- **Response at Six Months:** 13.3%
- **Remission at Six Months:** 6.3%
- **Follow-Up PHQ-9/PHQ-9M at 12 Months:** 38.9%
- **Response at 12 Months:** 12.9%
- **Remission at 12 Months:** 6.5%

DENOMINATORS BY ETHNICITY
(Denominators are the same for each measure)

- **Hispanic/Latinx:** 336
- **Not Hispanic/Latinx:** 1,995

Ethnicity Not Reported had less than 30 patients reported, which does not meet the reporting threshold for reliability.

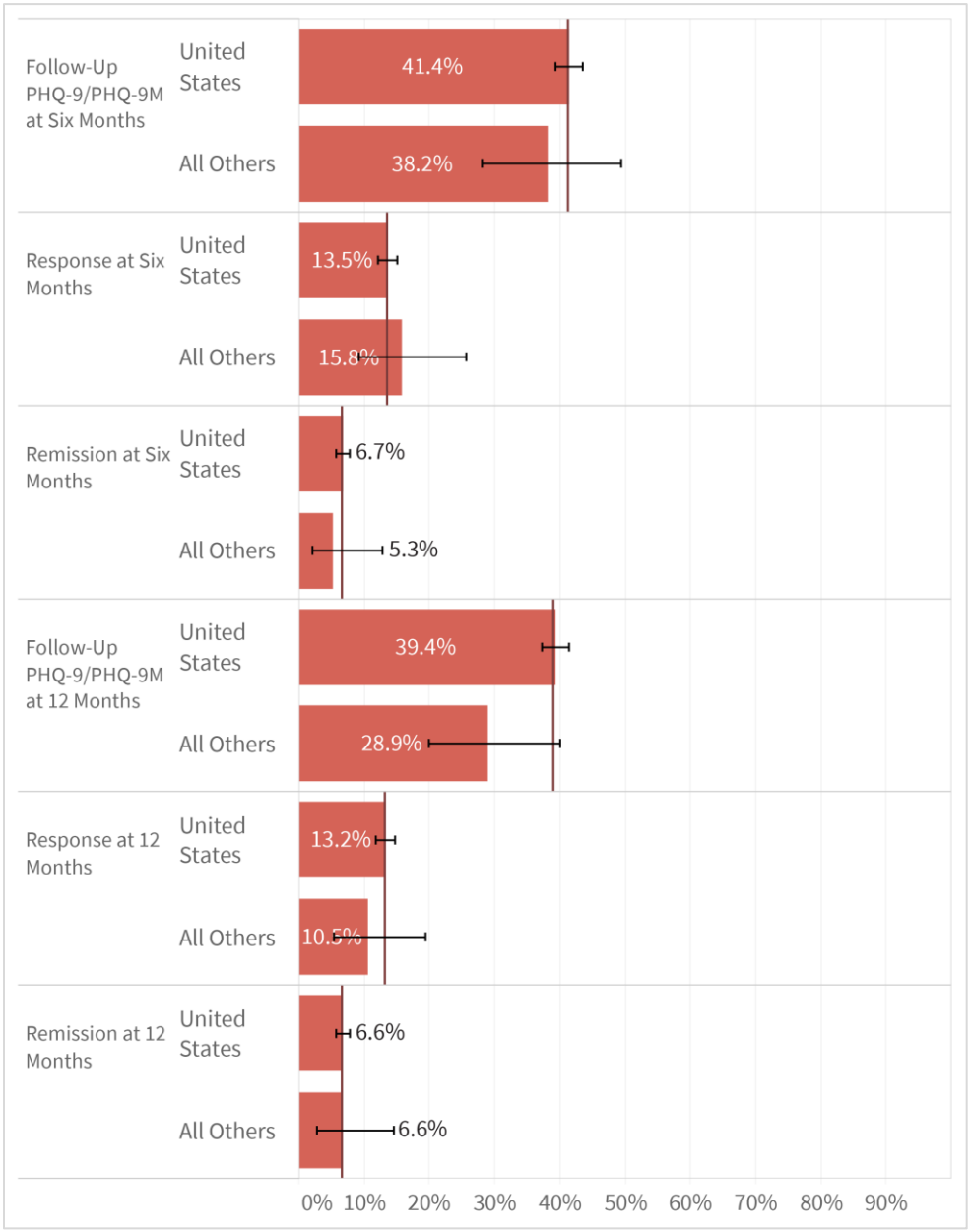
Among eligible MHCP MCO adolescents with depression, Hispanic/Latinx patients have statistically significantly lower rates of follow-up at 12 months compared to the overall MHCP MCO ethnicity average.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADOLESCENT DEPRESSION SUITE

MHCP MCO RATES BY COUNTRY OF ORIGIN

2020 report year (2019 dates of service)



OVERALL MHCP MCO COUNTRY OF ORIGIN AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 41.3%
- **Response at Six Months:** 13.6%
- **Remission at Six Months:** 6.6%
- **Follow-Up PHQ-9/PHQ-9M at 12 Months:** 39.0%
- **Response at 12 Months:** 13.1%
- **Remission at 12 Months:** 6.6%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- **United States:** 2,156
- **All Others:** 76

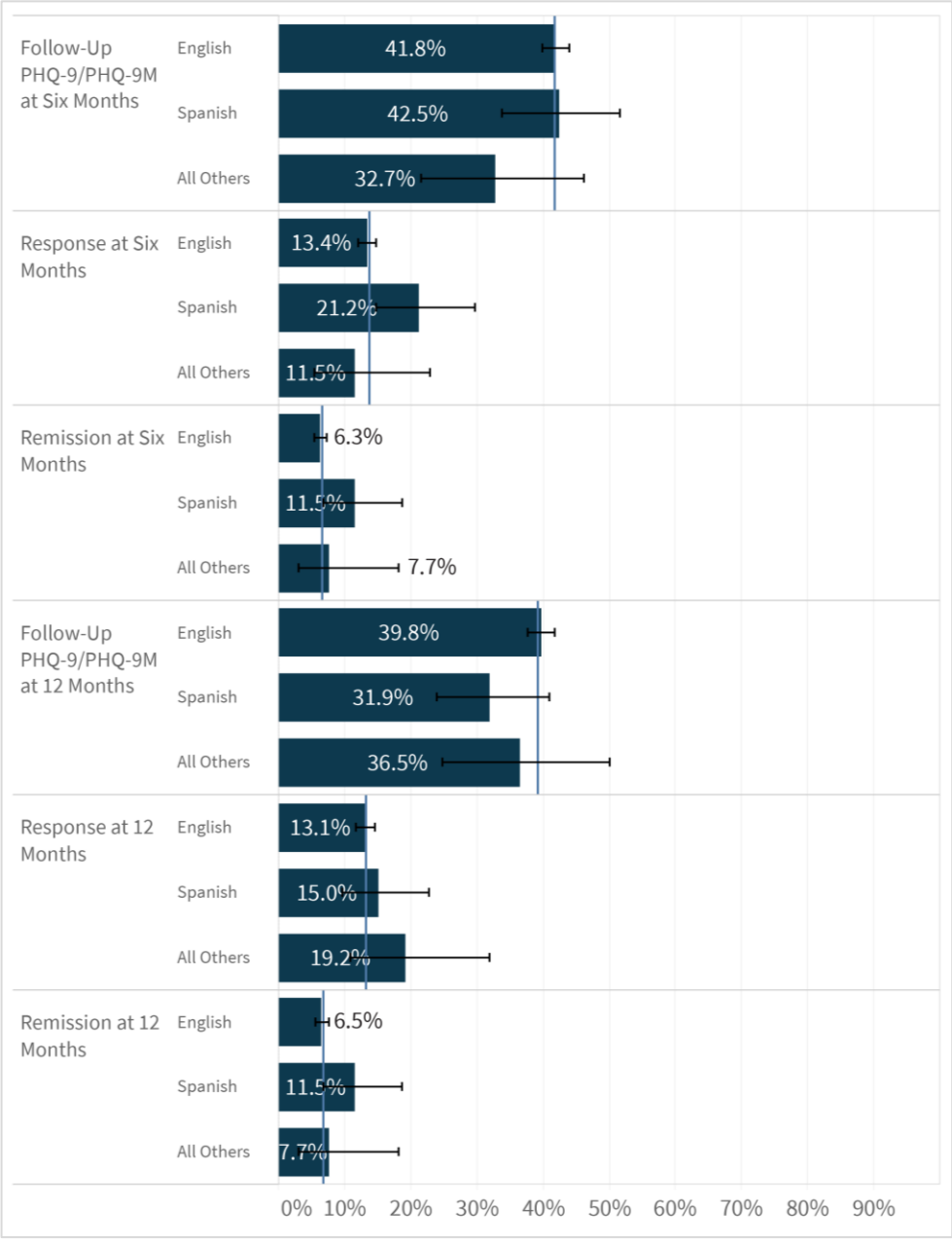
The United States was the only country of origin with large enough denominators (at least 30 patients) to allow comparisons in the MHCP MCO adolescent depression population. Among all six measures, patients born in the United States had average rates compared to the respective overall MHCP MCO country of origin averages.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available country of origin information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

ADOLESCENT DEPRESSION SUITE

MHCP MCO RATES BY PREFERRED LANGUAGE

2020 report year (2019 dates of service)



OVERALL MHCP MCO PREFERRED LANGUAGE AVERAGES

by measure
(represented by grey line)

- **Follow-Up PHQ-9/PHQ-9M at Six Months:** 41.7%
- **Response at Six Months:** 13.7%
- **Remission at Six Months:** 6.6%
- **Follow-Up PHQ-9/PHQ-9M at 12 Months:** 39.3%
- **Response at 12 Months:** 13.3%
- **Remission at 12 Months:** 6.8%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **English:** 2,256
- **Spanish:** 113
- **All Others:** 52

English and Spanish were the only two preferred languages with large enough denominators (at least 30 patients) to allow comparisons in the MHCP MCO adolescent depression population. Both groups had average rates for all six depression measures compared to the respective overall MHCP MCO preferred language averages.

NOTE: MHCP MCO statewide rates have been re-calculated for this figure to include only patients with available race/ethnicity information that has been collected via best practice. For more information on best practice, please visit the Methodology appendix.

DEFINITIONS

General Definitions

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**

Direct Data Submission (DDS) measures: Measures collected using the DDS process, which 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.

Insurance type: Health care insurance type includes the following categories:

- **Commercial** (employer-based and individual coverage)
- **State health care programs**, which include 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.

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:

- **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**

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**
- **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.

SUMMARY OF DEPRESSION MEASURE CHANGES

The following changes were implemented during the 2020 report year:

CHANGE	PREVIOUS REPORT YEAR	CURRENT REPORT YEAR
Age criteria	18 years and older at time of encounter	12 years and older at time of encounter
Expansion of follow-up window	+/- 30 days • 6-month measures: 5 – 7 months • 12-month measures: 11 – 13 months	+/- 60 days • 6-month measures: 4 – 8 months • 12-month measures: 10 – 14 months
Acceptable PRO tool	PHQ-9 only	PHQ-9 or PHQ-9M (regardless of age)
Required Exclusions	• Bipolar disorder • Personality disorder	• Bipolar disorder • Schizophrenia/psychotic disorder
Allowable Exclusions	• Permanent nursing home resident • Hospice/palliative care • Death	• Permanent nursing home resident • Hospice/palliative care • Death • Personality disorder – emotionally labile • Pervasive developmental disorder
Behavioral health provider	Diagnosis of major depression or dysthymia must be in the primary position for encounters in a behavioral health setting.	No restrictions on major depression or dysthymia diagnosis positioning for behavioral health providers.
Allowable timing of PHQ-9 /PHQ-9M	PHQ-9 score at the time of encounter	PHQ-9/PHQ-9M score at time of encounter or up to seven days prior

SOURCES

[1] Office of Disease Prevention and Health Promotion (2020). Healthy People 2020. Clinical Preventive Services. Retrieved from *https://www.healthypeople. gov/2020/leading-health-indicators/2020-lhi-topics/Clinical-Preventive-Services*

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