MINNESOTA HEALTH CARE DISPARITIES

By Insurance Type

Results for care delivered in 2021

MN Community MEASUREMENT

DEPARTMENT OF HUMAN SERVICES

RELEASED MAY 2023

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ABOUT MN COMMUNITY MEASUREMENT

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

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

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

ABOUT MN DEPARTMENT OF HUMAN SERVICES

The MN Department of Human Services (MN DHS) is the state Medical Assistance (Medicaid) agency responsible for purchasing health care services for 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

Even as the health care system across Minnesota continues to recover and adjust from the impacts of the COVID-19 pandemic, widespread disparities in health care quality and performance persist across populations. These disparities can vary by socioeconomic status, health care coverage, race and ethnicity, country of origin and impact both the quality of care received by patients and their health outcomes. Through stratification of data collected and reported by medical groups and health plans in the state, a better understanding of the specific areas of where these disparities exist can help stakeholders develop and implement informed strategies to reduce those disparities.

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

When compared to the overall Minnesota population, patients enrolled in MHCP are of lower socioeconomic status and include a disproportionate number of persons of color, American Indian or Alaska Natives, persons with disabilities, and elderly adults. These enrollees often experience barriers or significant challenges to receiving optimal health care. Because of this, these individuals might not receive care that meets best practices as often as patients insured with other types of insurance (e.g., commercial insurance).

Specifically, this report summarizes health care quality for patients enrolled in Minnesota Health Care Programs Managed Care (MHCP MCO), makes comparisons by insurance type, and features statewide MHCP MCO results by race 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 collected in this report were collected by MNCM in 2022 for 2021 dates of service.

ACKNOWLEDGEMENTS

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

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

OVERVIEW OF QUALITY MEASURES

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

PREVENTIVE HEALTH

1. **Breast Cancer Screening***
2. **Childhood Immunization Status (Combo 10)***
3. **Colorectal Cancer Screening**

CHRONIC CONDITIONS

4. **Controlling High Blood Pressure***
5. **Optimal Diabetes Care**
   - *Blood pressure control*
   - *Daily aspirin*
   - *HbA1c control*
   - *Statin use*
   - *Tobacco-free*
6. **Optimal Vascular Care**
   - *Blood pressure control*
   - *Daily aspirin*
   - *Statin use*
   - *Tobacco-free*
7. **Optimal Asthma Control – Adults**
8. **Optimal Asthma Control – Children**

MENTAL HEALTH

9. **Adolescent Mental Health and/or Depression Screening**

ADOLESCENT DEPRESSION SUITE

10. **Follow-up PHQ-9/PHQ-9M at Six Months**
11. **Response at Six Months**
12. **Remission at Six Months**
13. **Follow-up PHQ-9/PHQ-9M at 12 Months**
14. **Response at 12 Months**
15. **Remission at 12 Months**

ADULT DEPRESSION SUITE

16. **Follow-up PHQ-9/PHQ-9M at Six Months**
17. **Response at Six Months**
18. **Remission at Six Months**
19. **Follow-up PHQ-9/PHQ-9M at 12 Months**
20. **Response at 12 Months**
21. **Remission at 12 Months**

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

KEY FINDINGS

- Statewide MHCP MCO average rates statistically significantly decreased in 2021 compared to 2020 for two measures: Breast Cancer Screening and Childhood Immunization Status (Combo 10).
    - The Childhood Immunization Status measure had the largest decrease of 5.6 percentage points.
- Statewide MHCP MCO average rates statistically significantly increased in 2021 compared to 2020 for five measures: Colorectal Cancer Screening; Controlling High Blood Pressure; Optimal Asthma Control – Adults; Optimal Diabetes Care; Adolescent Mental Health and/or Depression Screening.
    - The Controlling High Blood Pressure measure had the largest increase of 5.1 percentage points.
- In 2021, statewide MHCP MCO average rates were consistently and significantly lower than the other purchasers' statewide rates for all measures, except for Controlling High Blood Pressure.
    - The largest gap occurred in the Childhood Immunization Status measure, with a difference of 26.6 percentage points between the two populations.
    - Since 2017, these gaps have significantly narrowed for six measures: Colorectal Cancer Screening; Optimal Asthma Control – Adults; Optimal Asthma Control – Children; Optimal Diabetes Care; Optimal Vascular Care; Adolescent Mental Health and/or Depression Screening.
    - Since 2017, these gaps have significantly widened for two measures: Breast Cancer Screening and Childhood Immunization Status (Combo 10).
- Statewide MHCP MCO average rates vary by race/ethnicity, country of origin and preferred language:
    - The rates for MHCP MCO patients who are Black are significantly below the MHCP MCO statewide averages on 13 out of the 21 measures found in this report.
    - The rates for MHCP MCO patients who are Indigenous/Native are significantly below the MHCP MCO statewide averages on seven out of the 21 measures found in this report.
    - The rates for MHCP MCO patients from Laos are significantly below the MHCP MCO statewide averages for three of the six adult depression measures: Follow-up PHQ-9/9M at Six Months; Follow-up PHQ-9/9M at 12 Months; Response at 12 Months.
    - The rates for MHCP MCO patients who prefer to speak Hmong are significantly below the MHCP MCO statewide averages for four of the six adult depression measures: Follow-up PHQ-9/9M at Six Months; Follow-up PHQ-9/9M at 12 Months; Response at Six Months; Response at 12 Months.

SUMMARY TABLE 1

2021 MHCP MCO STATEWIDE RATES COMPARED TO PREVIOUS YEAR

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

QUALITY MEASURE	2021 MHCP MCO Statewide Rate	2020 MHCP MCO Statewide Rate	MHCP MCO Statewide Percentage Point Change (2021-2020)
PREVENTIVE HEALTH MEASURES			
Breast Cancer Screening	54.4% (N = 48,376)	56.9% (N = 40,339)	-2.4%*
Childhood Immunization Status (Combo 10)	41.0% (N = 3,717)	46.6% (N = 3,430)	-5.6%*
Colorectal Cancer Screening	58.3% (N = 117,919)	56.8% (N = 87,451)	+1.5%*
CHRONIC CONDITIONS MEASURES			
Controlling High Blood Pressure	67.5% (N = 10,821)	62.3% (N = 11,116)	+5.1%*^
Optimal Asthma Control – Adults	43.1% (N = 35,127)	41.2% (N = 27,271)	+1.9%*
Optimal Asthma Control - Children	52.2% (N = 18,413)	52.5% (N = 16,400)	-0.3%
Optimal Diabetes Care	33.2% (N = 48,670)	31.4% (N = 35,137)	+1.8%*
Optimal Vascular Care	43.2% (N = 18,490)	42.9% (N = 13,724)	+0.3%
MENTAL HEALTH MEASURES			
Adolescent Mental Health and/or Depression Screening	91.1% (N = 40,264)	89.5% (N = 28,074)	+1.6%*
Adolescent Depression: Remission at Six Months	6.2% (N = 3,298)	7.2% (N = 3,191)	-1.0%
Adult Depression: Remission at Six Months	7.6% (N = 21,732)	8.0% (N = 22,184)	-0.4%

*Statistically significant difference ($p < 0.05$) NA = Not applicable
N = Total number of patients (denominator)
^While there was a statistically significant increase in rate for this measure, there was a decrease in the number of patients included in the denominator.

SUMMARY TABLE 2

2021 SUMMARY OF STATEWIDE DIFFERENCES BY INSURANCE TYPE

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

QUALITY MEASURE	2021 MHCP MCO Statewide Rate	2021 Other Purchasers Statewide Rate	2021 Rate Difference (MHCP - Other Purchasers)	Rate Difference Over Time^ (MHCP - Other Purchasers)
PREVENTIVE HEALTH MEASURES				
Breast Cancer Screening	54.4% (N = 48,376)	75.6% (N = 292,939)	21.2%*	Gap widened* (2017-2021)
Childhood Immunization Status (Combo 10)	41.0% (N = 3,717)	67.6% (N = 2,822)	26.6%*	Gap widened* (2017-2021)
Colorectal Cancer Screening	58.3% (N = 117,919)	74.1% (N = 1,091,212)	15.8%*	Gap narrowed* (2017-2021)
CHRONIC CONDITIONS MEASURES				
Controlling High Blood Pressure	67.5% (N = 10,821)	69.4% (N = 8,147)	1.9%	Gap stable (2020-2021)†
Optimal Asthma Control - Adults	43.1% (N = 35,127)	54.8% (N = 93,714)	11.7%*	Gap narrowed* (2017-2021)
Optimal Asthma Control - Children	52.2% (N = 18,413)	61.1% (N = 34,447)	8.9%*	Gap narrowed* (2017-2021)
Optimal Diabetes Care	33.2% (N = 48,670)	46.1% (N = 241,196)	12.9%*	Gap narrowed* (2017-2021)
Optimal Vascular Care	43.2% (N = 18,490)	58.7% (N = 142,088)	15.5%*	Gap narrowed* (2017-2021)
MENTAL HEALTH MEASURES				
Adolescent Mental Health and/or Depression Screening	91.1% (N = 40,264)	92.9% (N = 107,196)	1.8%*	Gap narrowed* (2017-2021)
Adolescent Depression: Remission at Six Months	6.2% (N = 3,298)	7.9% (N = 7,631)	1.7%*	Gap stable (2019 – 2021)†
Adult Depression: Remission at Six Months	7.6% (N = 21,732)	11.1% (N = 67,828)	3.5%*	Gap stable (2019-2021)†

*Statistically significant difference ($p < 0.05$)
^ Based on last five years (2017-2021)
† First year of current measure specifications available

SUMMARY TABLE 3

2021 SUMMARY OF FINDINGS BY RACE/ETHNICITY

Table 3 compares the 2021 MHCP MCO rate of each racial/ethnicity group to the 2021 MHCP MCO statewide averages.

MEASURE	2021 MHCP MCO Statewide Average	RACE						ETHNICITY	
		Asian	Black	Indigenous / Native	Multi- Race	Native Hawaiian/ Pacific Islander	White	Hispanic/ Latinx	Not Hispanic/ Latinx
PREVENTIVE HEALTH MEASURES									
Breast Cancer Screening	54.4%	●	▼	▼	●	●	▲	▲	●
Childhood Immunization Status (Combo 10)	41.0%	●	▼	●	●	●	●	●	●
Colorectal Cancer Screening	58.3%	▲	▼	▼	▼	▼	▲	▼	●
CHRONIC CONDITIONS MEASURES									
Controlling High Blood Pressure	67.5%	●	▼	●	●	NR	▲	●	●
Optimal Asthma Control - Adults	43.1%	▲	▼	▼	●	●	●	●	●
Optimal Asthma Control - Children	52.2%	▲	●	●	●	●	●	▲	●
Optimal Diabetes Care	33.2%	▲	▼	▼	▼	●	●	●	●
Optimal Vascular Care	43.2%	▲	▼	▼	●	●	●	▲	●
MENTAL HEALTH MEASURES									
Adolescent Mental Health and/or Depression Screening	91.1%	●	▼	▼	●	▲	▲	●	●
Adolescent Depression: Remission at Six Months	6.2%	●	●	●	●	●	●	●	●
Adult Depression: Remission at Six Months	7.6%	●	●	●	●	●	●	●	●

▲ Significant above statewide MHCP MCO statewide average

● Average

▼ Significantly below statewide MHCP MCO statewide average

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

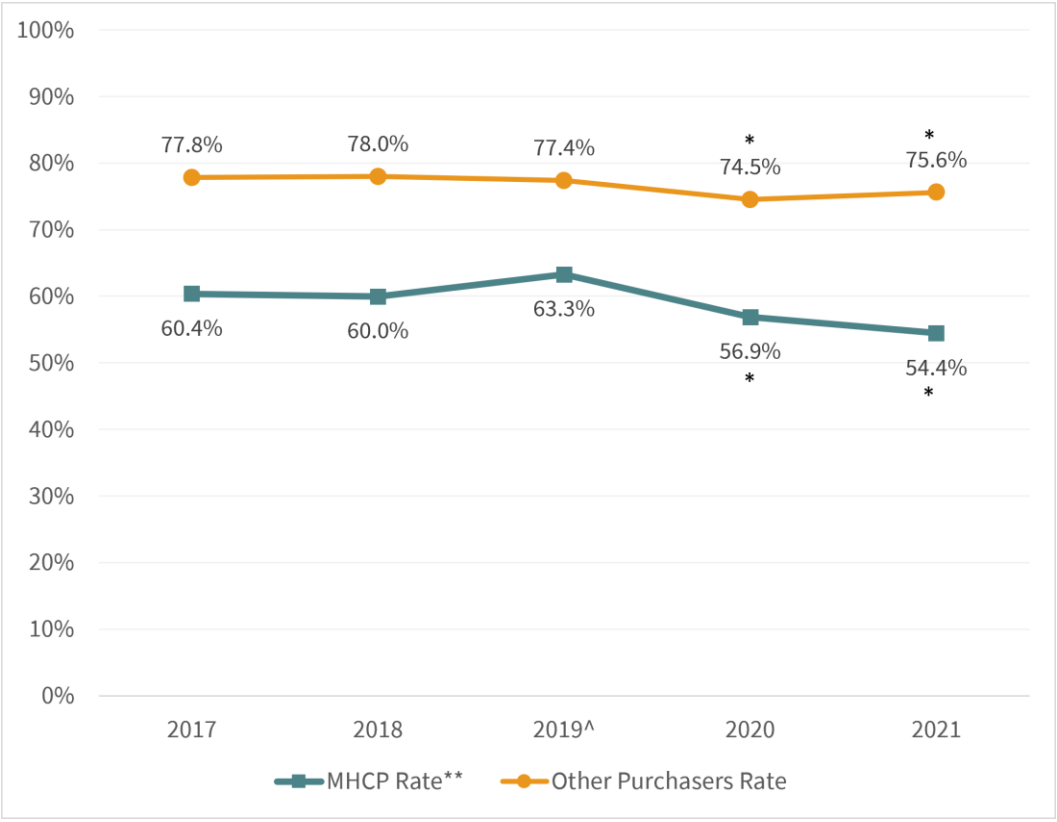
BREAST CANCER SCREENING

The percentage of women 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years.[2]

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

TREND IN BREAST CANCER SCREENING

2017 – 2021



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

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

*Rate statistically significantly changed from previous year

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

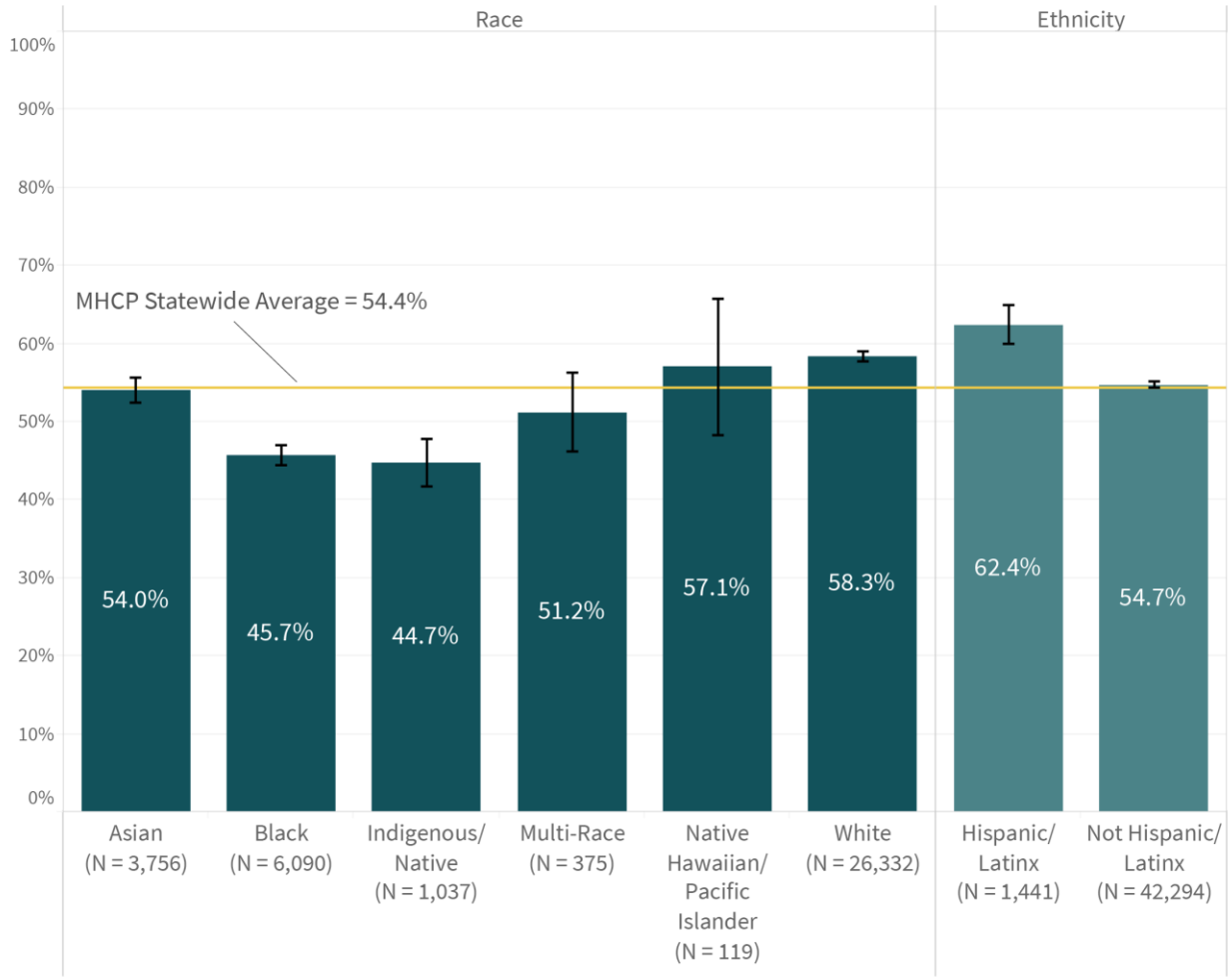
KEY TAKEAWAYS

- From 2020 to 2021, the MHCP statewide average for the Breast Cancer Screening measure statistically significantly decreased by 2.4 percentage points.
- In 2021, the 21.2 percentage point gap between the MHCP statewide average and the Other Purchasers statewide average was statistically significant.

BREAST CANCER SCREENING (Continued)

MHCP* RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

Race

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

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

Ethnicity

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

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

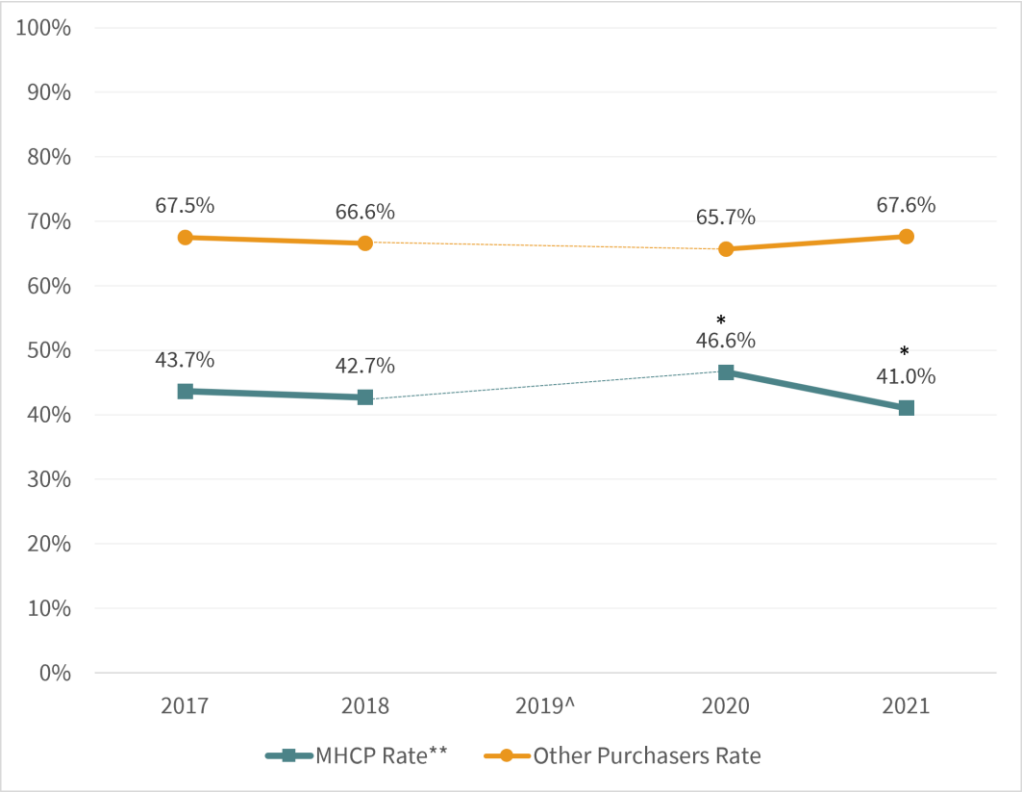
CHILDHOOD IMMUNIZATION STATUS (COMBO 10)

The percentage of children 2 years of age who had the following by their second birthday: Four diphtheria; Tetanus and acellular pertussis (DTaP); Three polio (IPV); One measles, mumps and rubella (MMR); Three *haemophilus influenza* type B (HiB); Three hepatitis B; One chicken pox (VZV); Four pneumococcal conjugate (PCV); One hepatitis A; Two or three rotavirus (RV); Two influenza vaccines. [3]

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

TREND IN CHILDHOOD IMMUNIZATION STATUS

2017 – 2021



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

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

*Rate statistically significantly changed from previous year

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

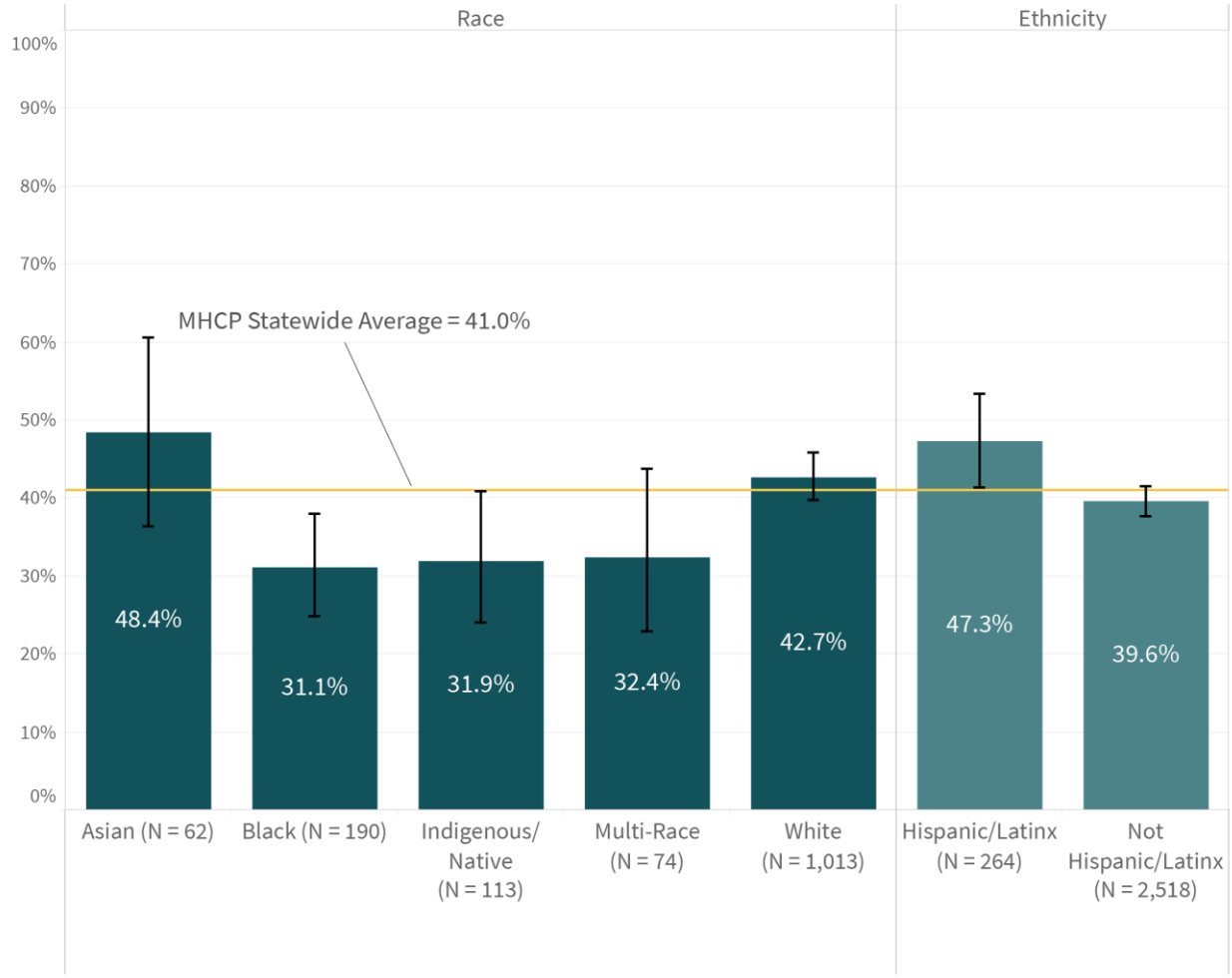
KEY TAKEAWAYS

- From 2020 to 2021, the MHCP statewide average for the Childhood Immunization Status (Combo 10) measure statistically significantly decreased by 5.6 percentage points.
- In 2021, the 26.6 percentage point gap between the MHCP statewide average and the Other Purchasers statewide average was statistically significant.

CHILDHOOD IMMUNIZATION STATUS (COMBO 10) (Continued)

MHCP* RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

Race

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

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

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

COLORECTAL CANCER SCREENING

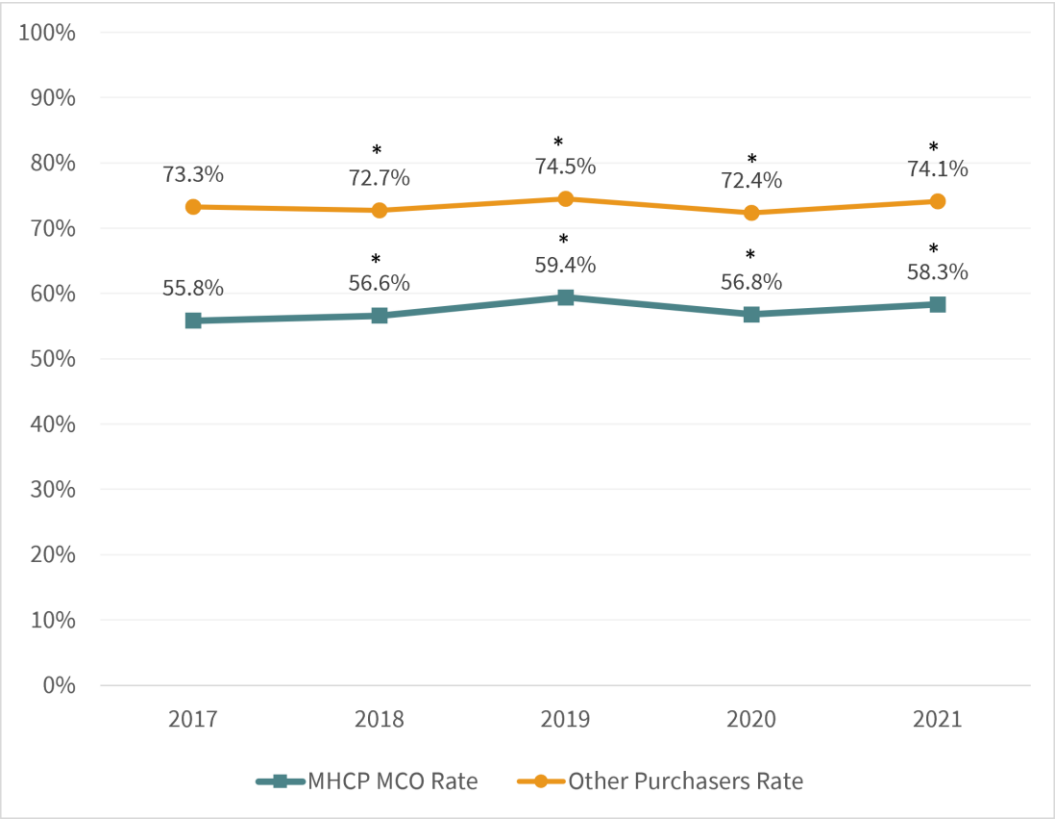
The percentage of adults 51-75 years of age who are up-to-date with one of the following appropriate screenings:

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

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

TREND IN COLORECTAL CANCER SCREENING

2017 – 2021



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

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

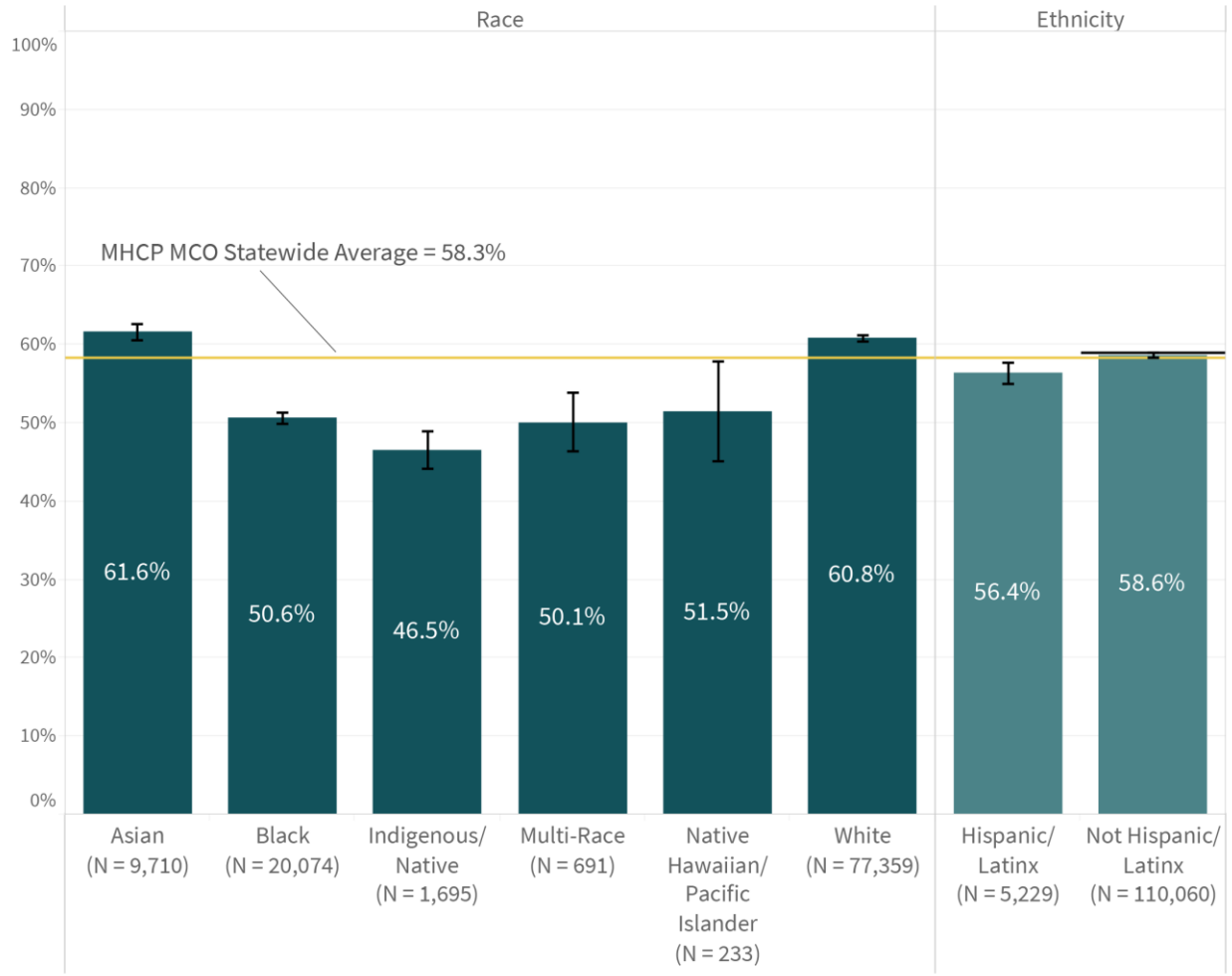
- From 2020 to 2021, the MHCP MCO statewide average for the Colorectal Cancer Screening measure statistically significantly increased by 1.5 percentage points.
- In 2021, the 15.8 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

COLORECTAL CANCER SCREENING

(Continued)

MHCP MCO RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

Race

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

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

Ethnicity

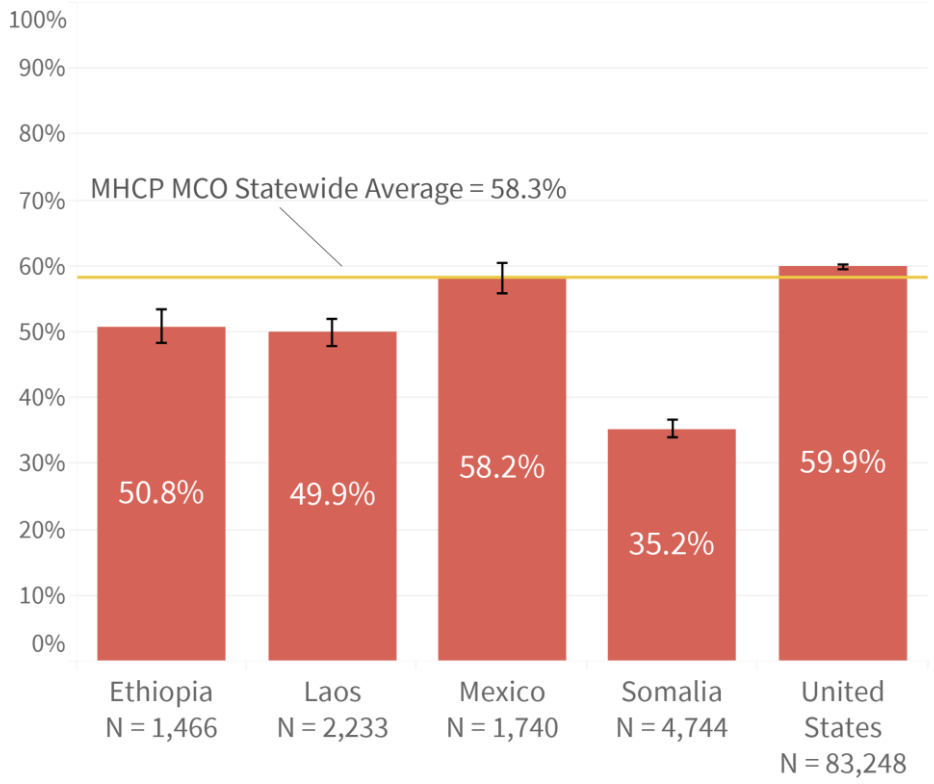
Compared to the MHCP MCO statewide average, the screening rate for MHCP MCO patients who are Hispanic/Latinx is statistically significantly lower.

COLORECTAL CANCER SCREENING

(Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

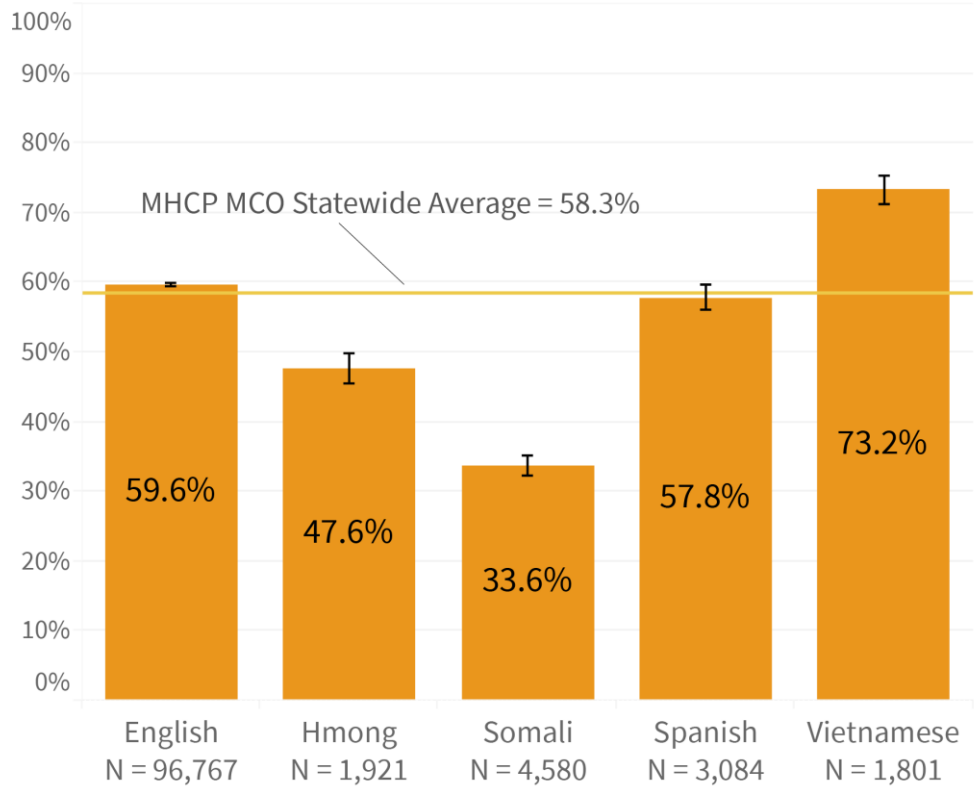
- Patients from Ethiopia, Laos, Mexico, Somalia or the United States make up 86 percent of the eligible MHCP MCO population for the Colorectal Cancer Screening measure.
- Compared to the MHCP MCO statewide average, the screening rate(s) for MHCP MCO patients who are from:
    - The United States is statistically significantly higher.
    - Ethiopia, Laos or Somalia are statistically significantly lower.

COLORECTAL CANCER SCREENING

(Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 93 percent of the eligible MHCP MCO population for the Colorectal Cancer Screening measure.
- Compared to the MHCP MCO statewide average, the screening rate(s) for MHCP MCO patients who speak:
    - English or Vietnamese are statistically significantly higher.
    - Hmong or Somali are statistically significantly lower.

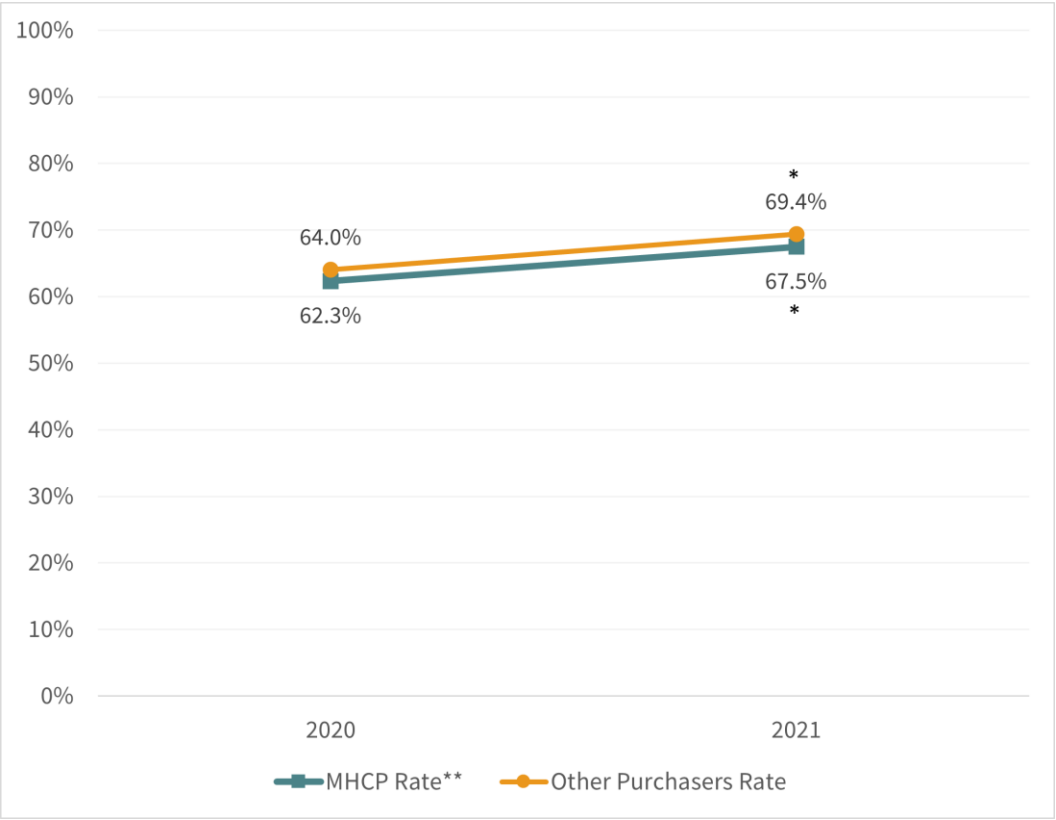
CONTROLLING HIGH BLOOD PRESSURE (Continued)

The percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. [4]

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

TREND IN CONTROLLING HIGH BLOOD PRESSURE

2020 – 2021



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

*Rate statistically significantly changed from previous year

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

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

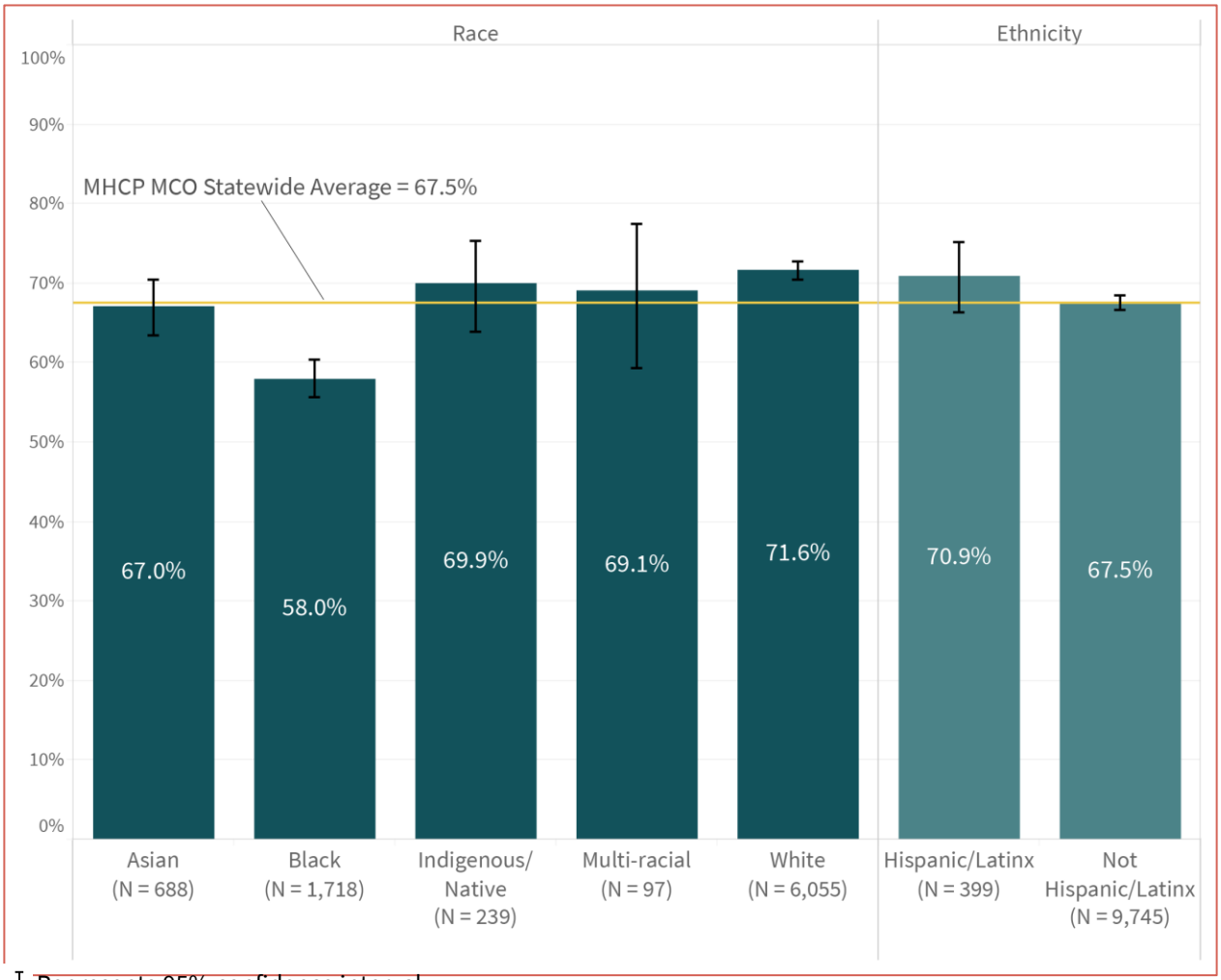
KEY TAKEAWAYS

- From 2020 to 2021, the MHCP statewide average for the Controlling High Blood Pressure measure statistically significantly increased by 5.1 percentage points.

CONTROLLING HIGH BLOOD PRESSURE (Continued)

MHCP* RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

Race

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

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

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

OPTIMAL DIABETES CARE

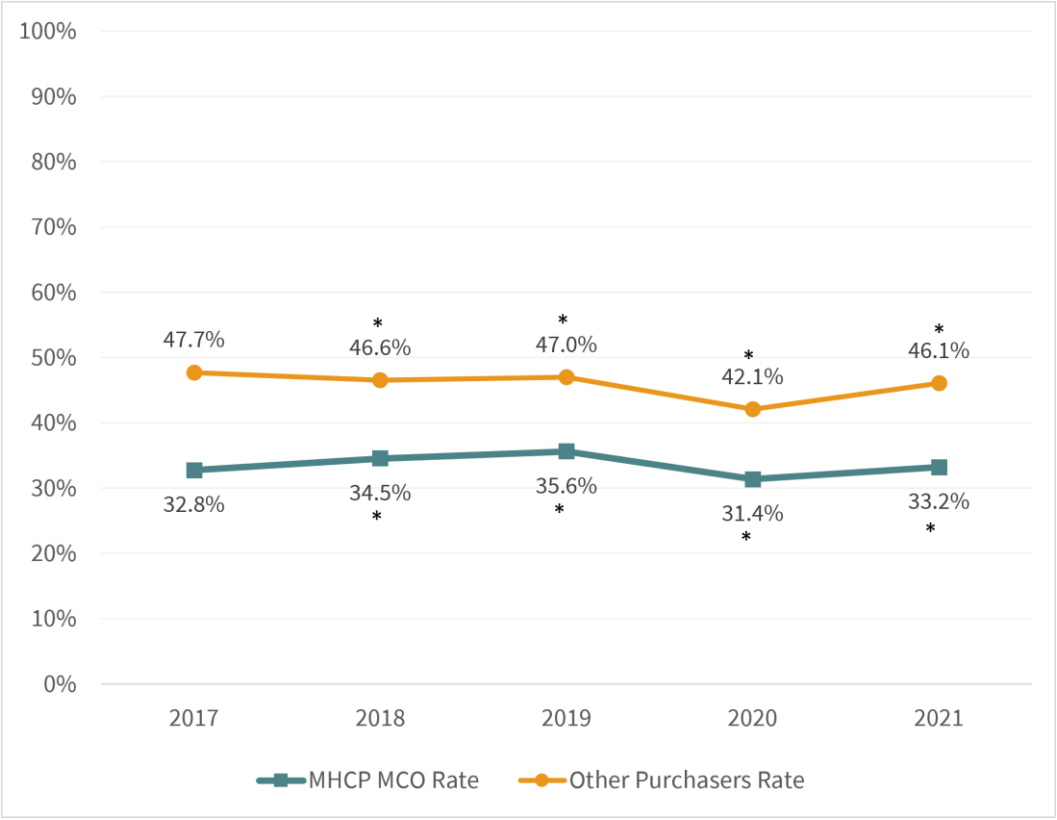
The percentage of patients 18-75 years of age with diabetes (type 1 or 2) whose diabetes was optimally managed as defined as achieving ALL five of the following components:

1. HbA1c less than 8.0 mg/mL
2. Blood pressure less than 140/90 mmHg
3. On a statin medication, unless allowed contraindications or exceptions are present
4. Non-tobacco use
5. If patient has ischemic vascular disease, on a daily aspirin or antiplatelet, unless allowed contraindications or exceptions are present

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

TREND IN OPTIMAL DIABETES CARE

2017 – 2021



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

*Rate statistically significantly changed from previous year

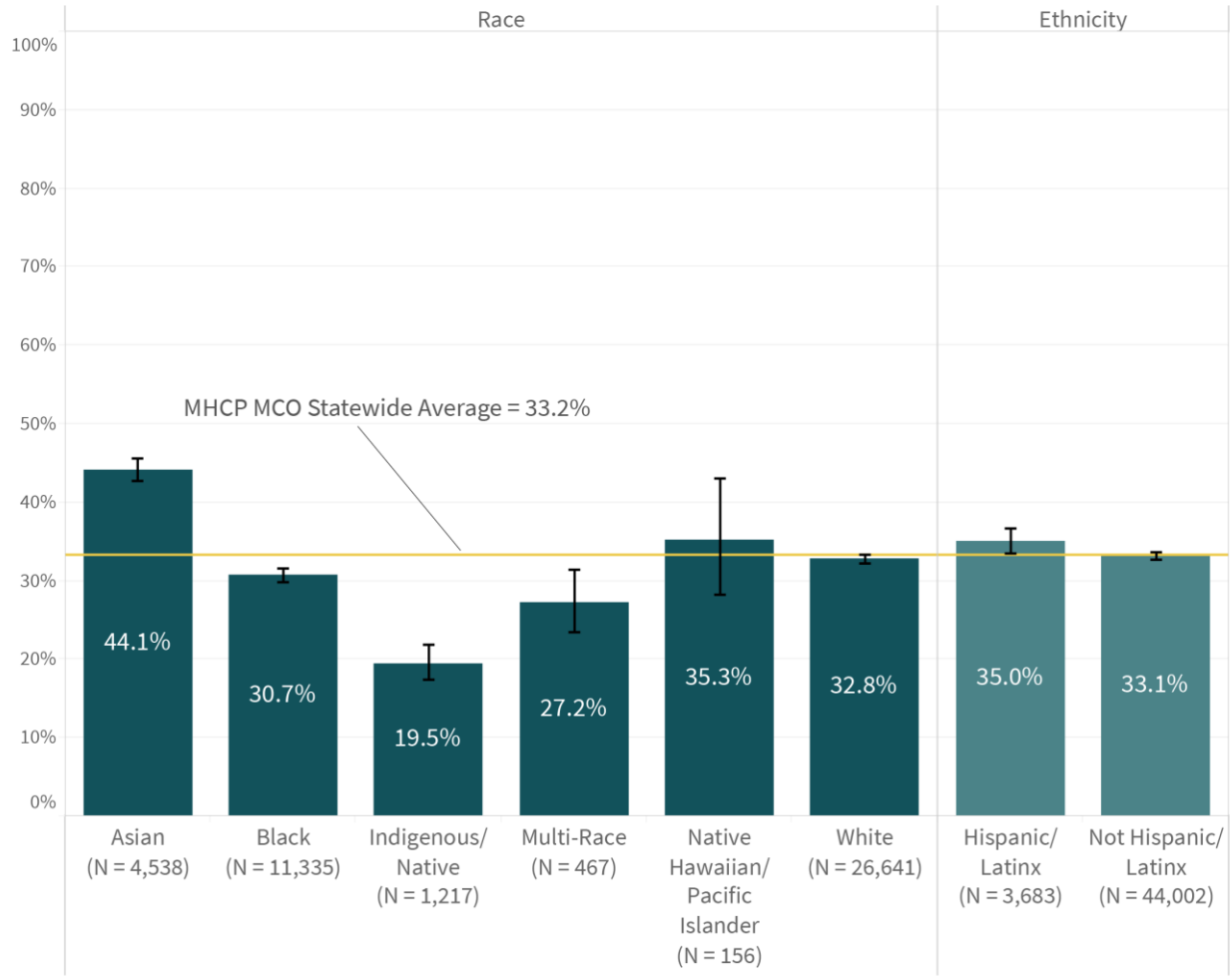
KEY TAKEAWAYS

- From 2020 to 2021, the MHCP MCO statewide average for the Optimal Diabetes Care measure statistically significantly increased by 1.8 percentage points.
- In 2021, the 12.9 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

OPTIMAL DIABETES CARE (Continued)

MHCP MCO RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

Race

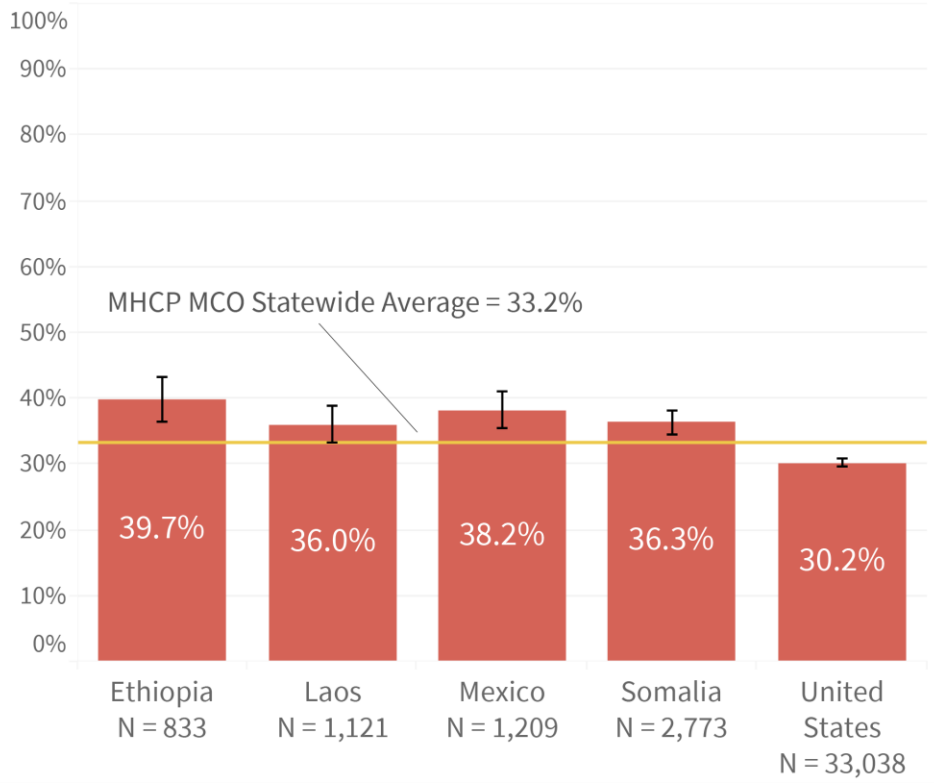
Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who are:

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

OPTIMAL DIABETES CARE (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



I Represents 95% confidence interval

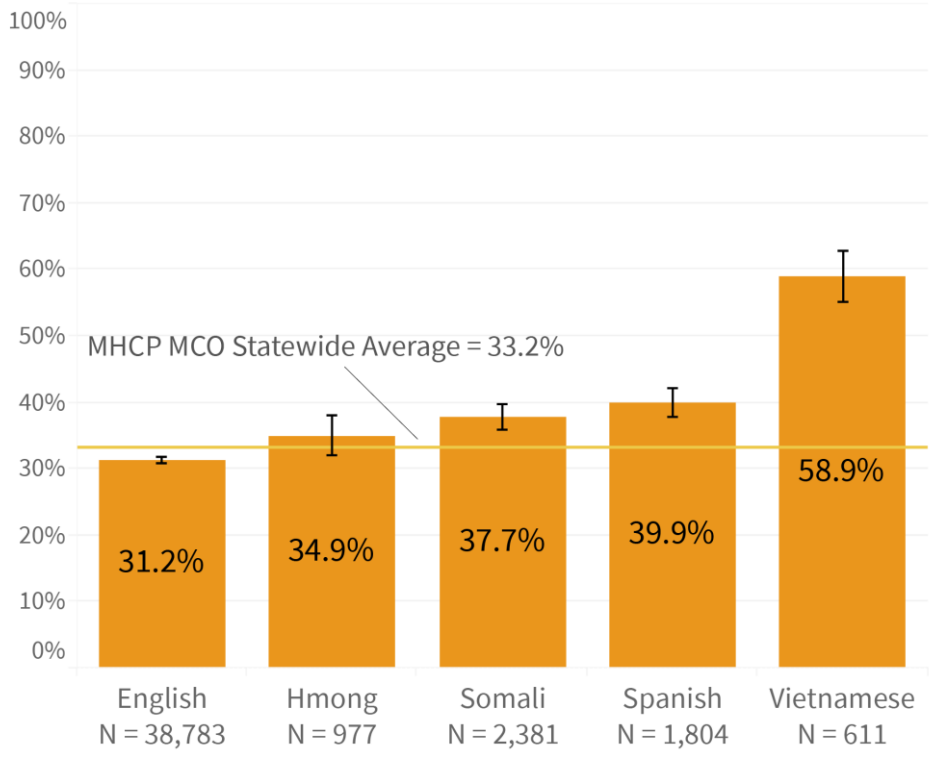
KEY TAKEAWAYS

- Patients from Ethiopia, Laos, Mexico, Somalia or the United States make up 86 percent of the eligible MHCP MCO population for the Optimal Diabetes Care measure.
- Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who are from:
    - Ethiopia, Mexico or Somalia are statistically significantly higher.
    - The United States is statistically significantly lower.

OPTIMAL DIABETES CARE (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



I Represents 95% confidence interval

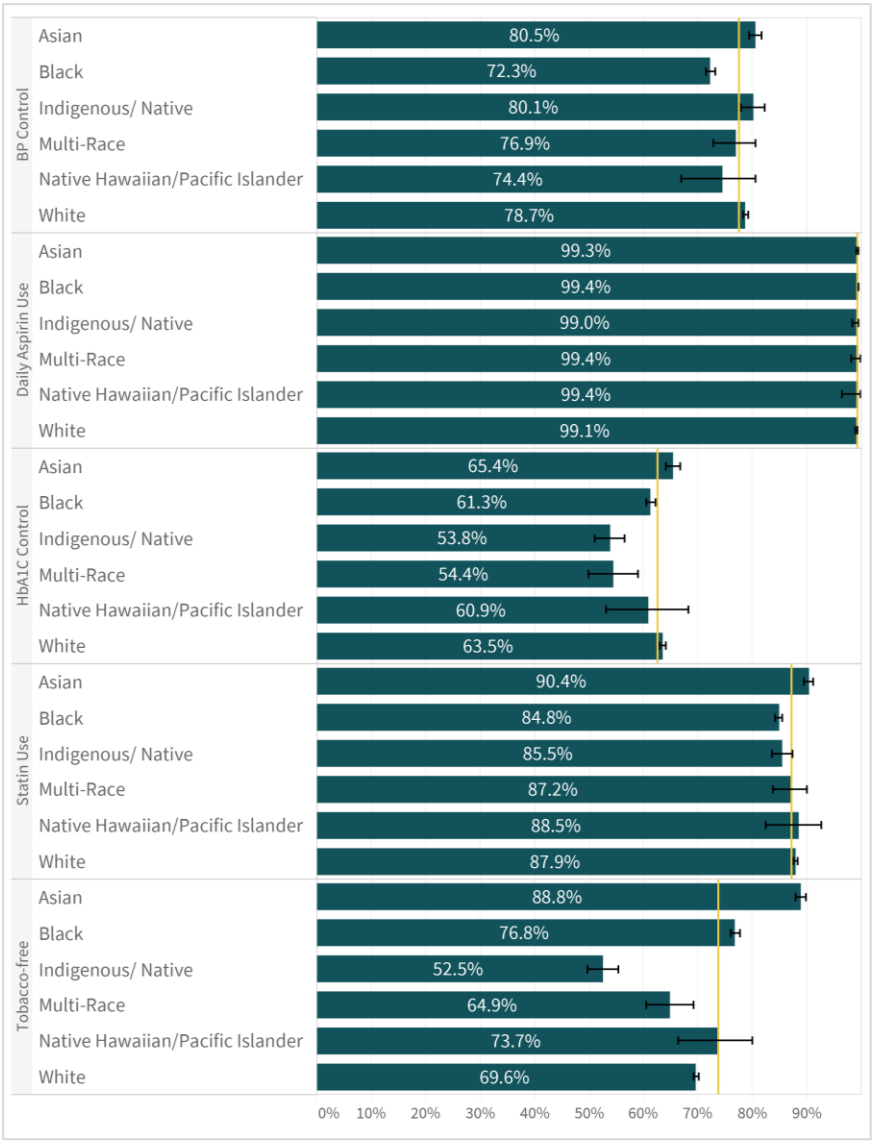
KEY TAKEAWAYS

- Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 93 percent of the eligible MHCP MCO population for the Optimal Diabetes Care measure.
- Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who speak:
    - Somali, Spanish or Vietnamese are statistically significantly higher.
    - English is statistically significantly lower.

OPTIMAL DIABETES CARE: COMPONENTS

MHCP MCO RATES BY RACE

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 77.4%
- **Daily Aspirin:** 99.2%
- **HbA1c Control:** 62.5%
- **Statin Use:** 87.2%
- **Tobacco-free:** 77.4%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 4,538
- **Black:** 11,335
- **Indigenous/ Native:** 1,217
- **Multi-Race:** 467
- **Native Hawaiian/ Pacific Islander:** 156
- **White:** 26,641

⊢⊣ Represents 95% confidence interval

KEY TAKEAWAYS

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

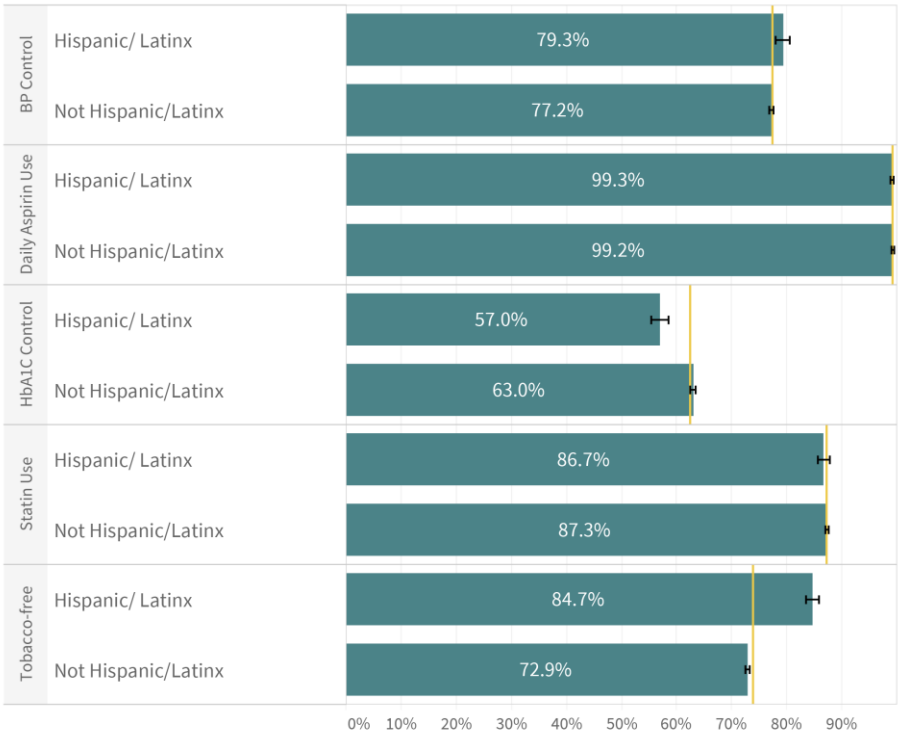
- Asian have statistically significantly higher rates of all components, except for daily aspirin use, which is average.
- Black have statistically significantly lower rates of blood pressure control and statin use, but statistically significantly higher rates of daily aspirin use and being tobacco-free.
- Indigenous/Native have statistically significantly lower rates of HbA1c control and being tobacco-free.

OPTIMAL DIABETES CARE: COMPONENTS

(Continued)

MHCP MCO RATES BY ETHNICITY

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 77.4%
- **Daily Aspirin:** 99.2%
- **HbA1c Control:** 62.5%
- **Statin Use:** 87.2%
- **Tobacco-free:** 77.4%

DENOMINATORS BY ETHNICITY

(Denominators are the same for each measure)

- **Hispanic/Latinx:**
- 3,683
- **Not Hispanic/Latinx:** 44,002

⟼ Represents 95% confidence interval

KEY TAKEAWAYS

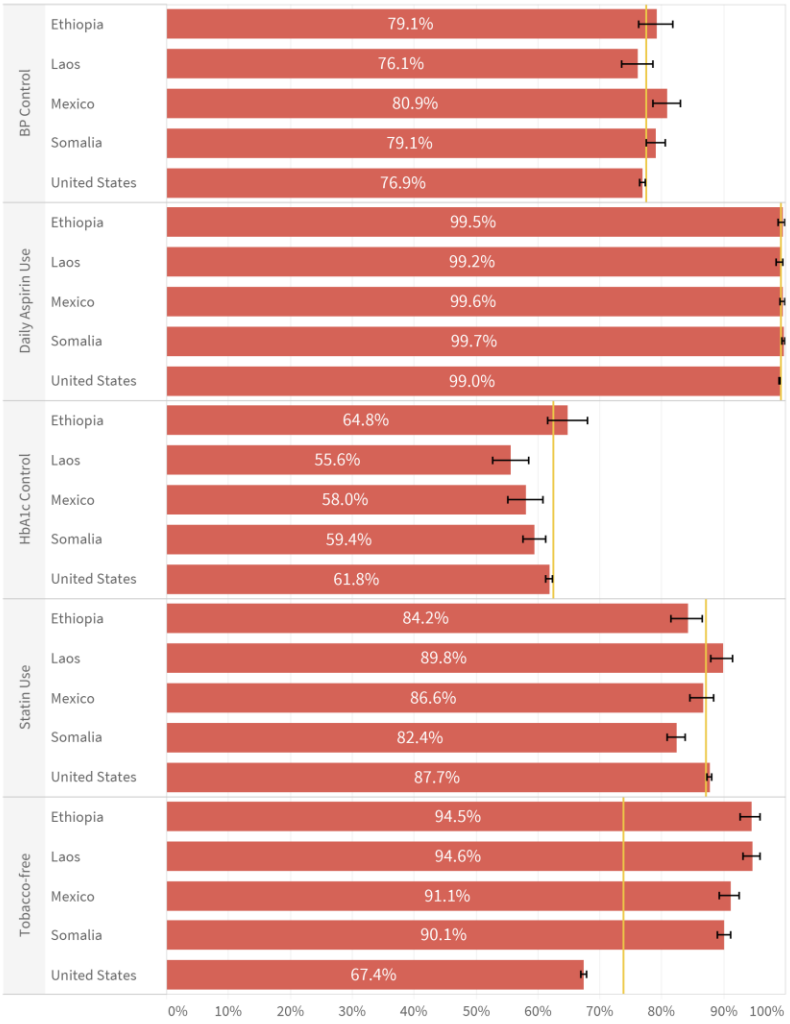
Compared to the MHCP MCO statewide averages for the above components, MHCP MCO patients who are Hispanic/Latinx have statistically significantly higher rates of being tobacco-free and blood pressure control, but a statistically significantly lower rate of HbA1c control.

OPTIMAL DIABETES CARE: COMPONENTS

(Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 77.4%
- **Daily Aspirin:** 99.2%
- **HbA1c Control:** 62.5%
- **Statin Use:** 87.2%
- **Tobacco-free:** 77.4%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- **Ethiopia:** 833
- **Laos:** 1,121
- **Mexico:** 1,209
- **Somalia:** 2,773
- **United States:** 33,038

⊢ Represents 95% confidence interval

KEY TAKEAWAYS

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

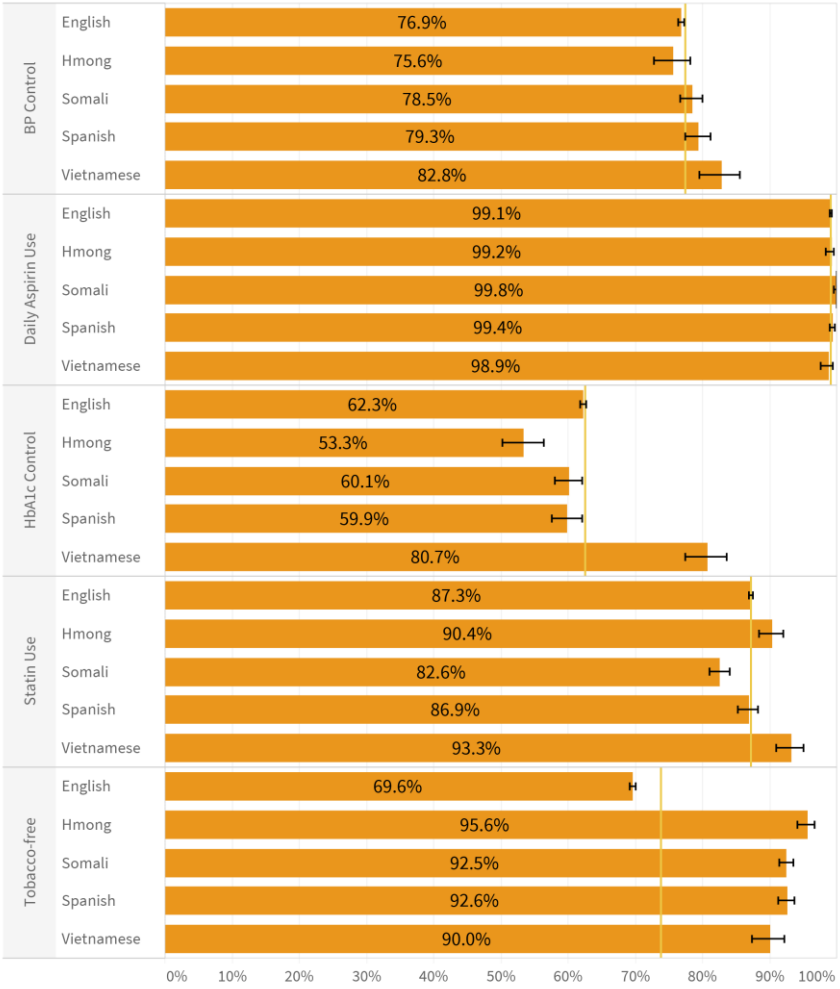
- Ethiopia have a statistically significantly higher rate of being tobacco-free, but statistically significantly lower rate of statin use.
- Laos have statistically significantly higher rates of statin use and being tobacco free, but a statistically significantly lower rate of HbA1c control.
- Mexico have statistically significantly higher rates of blood pressure control and being tobacco-free, but a statistically significantly lower rate of HbA1c control.
- Somalia have statistically significantly higher rates of daily aspirin use and being tobacco-free, but statistically significantly lower rates of statin use and HbA1c control.

OPTIMAL DIABETES CARE: COMPONENTS

(Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 77.4%
- **Daily Aspirin:** 99.2%
- **HbA1c Control:** 62.5%
- **Statin Use:** 87.2%
- **Tobacco-free:** 77.4%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **English:** 38,783
- **Hmong:** 977
- **Somali:** 2,381
- **Spanish:** 1,804
- **Vietnamese:** 611

⊢ Represents 95% confidence interval

KEY TAKEAWAYS

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

- Hmong have statistically significantly higher rates of statin use and being tobacco-free, but statistically significantly lower rates of HbA1c control.
- Somali have statistically significantly higher rates of daily aspirin use and being tobacco-free, but statistically significantly lower rates of HbA1c control and statin use.
- Vietnamese have statistically significantly higher rates for all components, except for daily aspirin use, which is average.
- Spanish have a statistically significantly higher rate of being tobacco-free.

OPTIMAL VASCULAR CARE

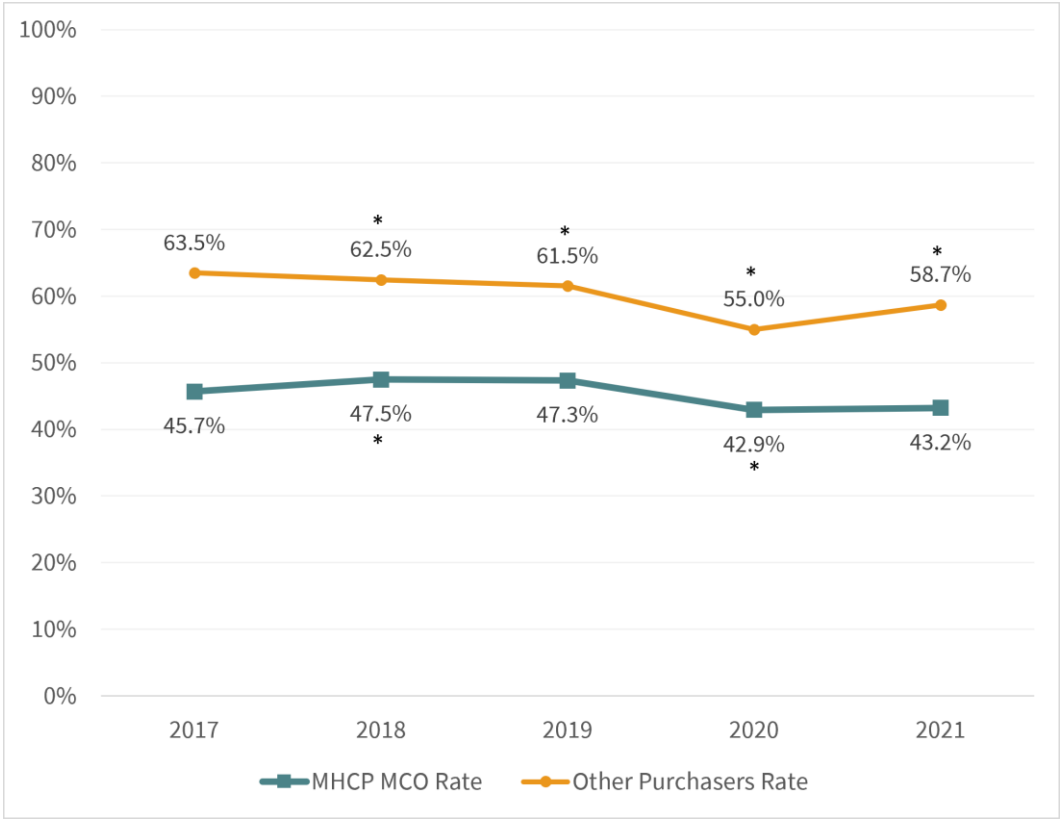
The percentage of patients 18-75 years of age with ischemic vascular disease (IVD) whose IVD was optimally managed as defined as achieving ALL four of the following components:

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

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

TREND IN OPTIMAL VASCULAR CARE

2017 – 2021



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

*Rate statistically significantly changed from previous year

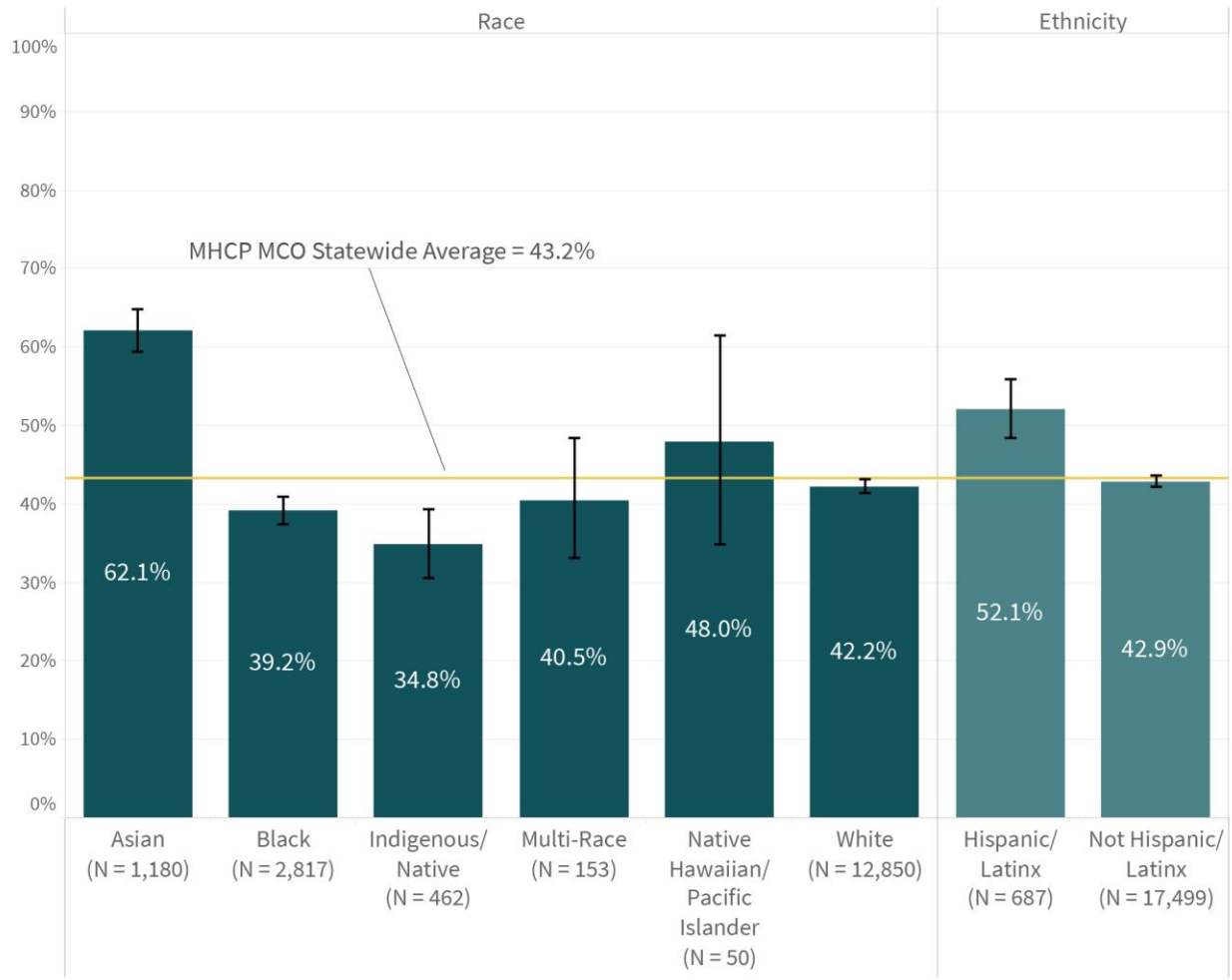
KEY TAKEAWAYS

- From 2020 to 2021, the MHCP MCO statewide average for the Optimal Vascular Care measure remained stable.
- In 2021, the 15.5 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

OPTIMAL VASCULAR CARE (Continued)

MHCP MCO RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

Race

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

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

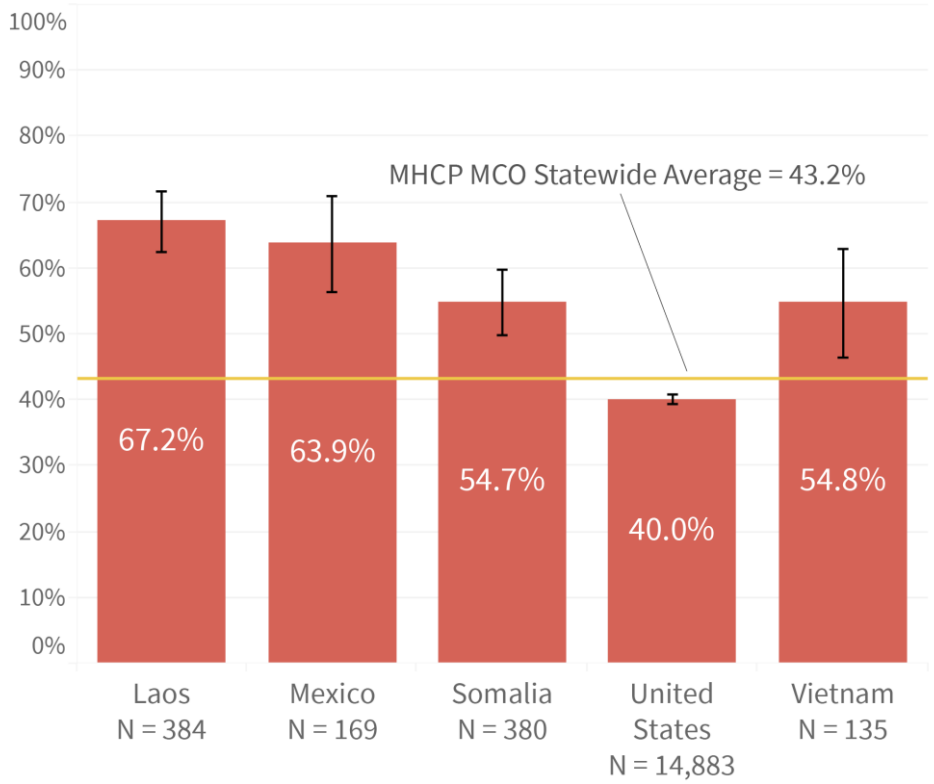
Ethnicity

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

OPTIMAL VASCULAR CARE (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



I Represents 95% confidence interval

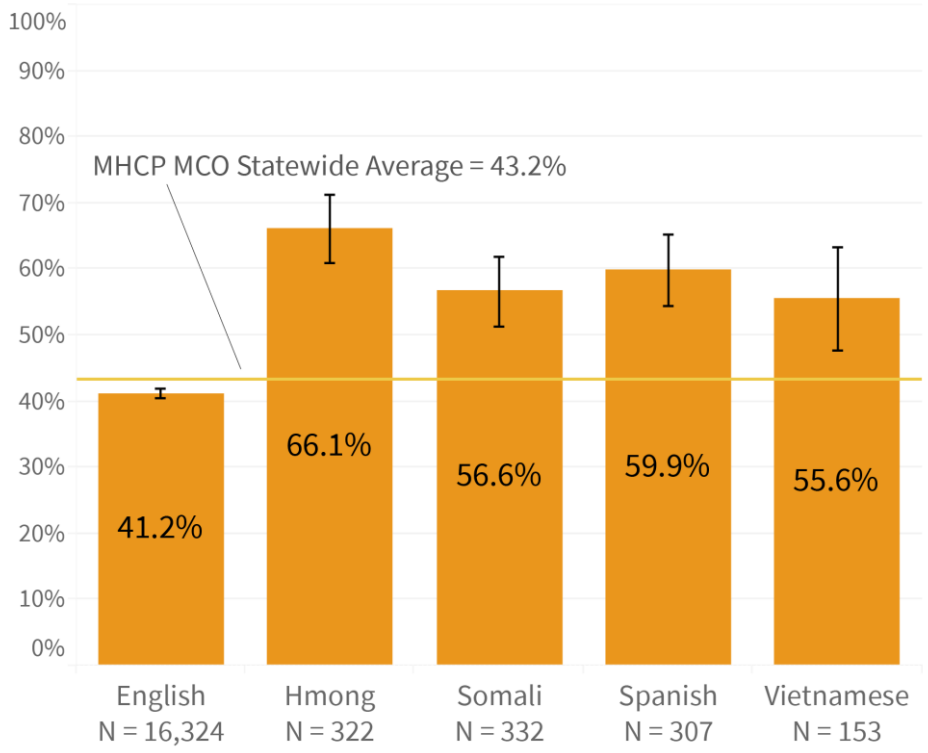
KEY TAKEAWAYS

- Patients from Laos, Mexico, Somalia, the United States or Vietnam make up 90 percent of the eligible MHCP MCO population for the Optimal Vascular Care measure.
- Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients from:
    - Laos, Mexico, Somalia or Vietnam are statistically significantly higher.
    - The United States is statistically significantly lower.

OPTIMAL VASCULAR CARE (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



I Represents 95% confidence interval

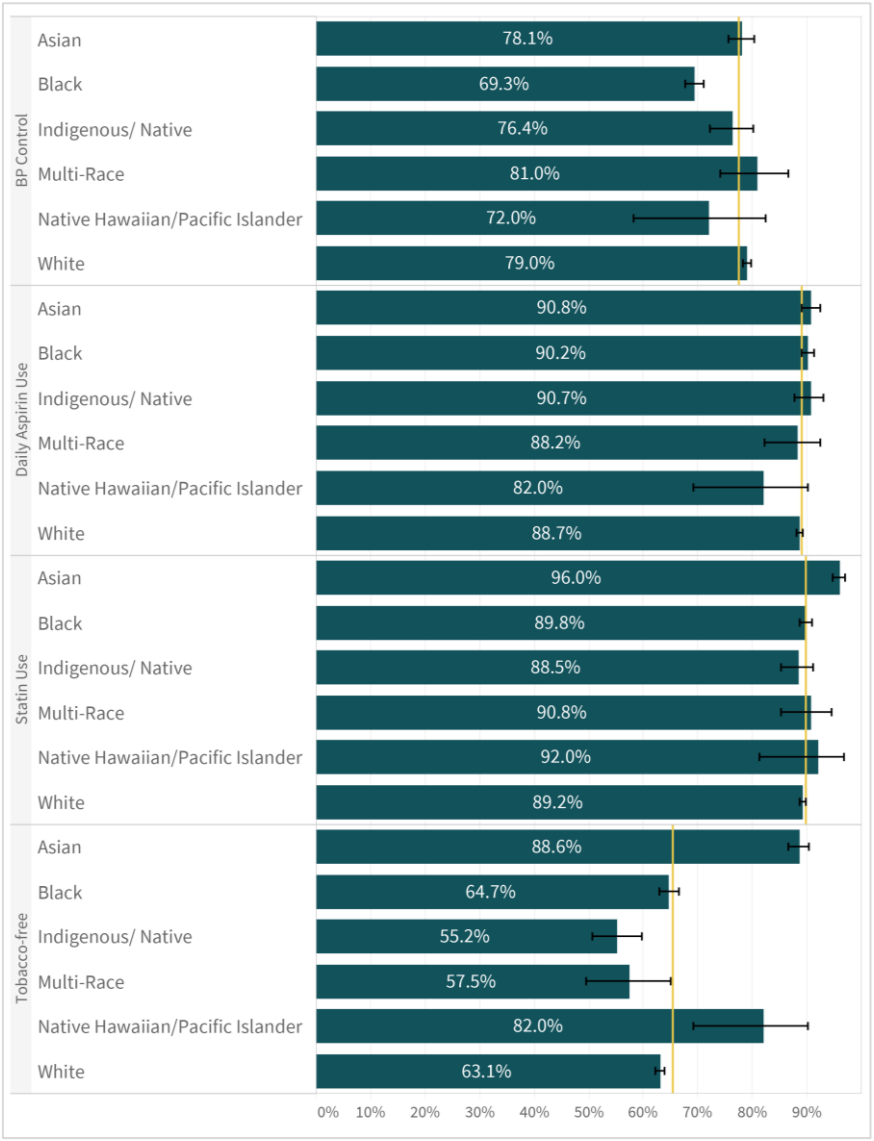
KEY TAKEAWAYS

- Patients who prefer to speak English, Hmong, Somali, Spanish or Vietnamese make up 95 percent of the eligible MHCP MCO population for the Optimal Vascular Care measure.
- Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who speak:
    - Hmong, Somali, Spanish or Vietnamese are statistically significantly higher.
    - English is statistically significantly lower.

OPTIMAL VASCULAR CARE: COMPONENTS

MHCP MCO RATES BY RACE

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 77.4%
- **Daily Aspirin:** 89.0%
- **Statin Use:** 89.8%
- **Tobacco-free:** 65.4%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 1,180
- **Black:** 2,817
- **Indigenous/Native:** 462
- **Multi-Race:** 153
- **Native Hawaiian/Pacific Islander:** 50
- **White:** 12,850

⊢ Represents 95% confidence interval

KEY TAKEAWAYS

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

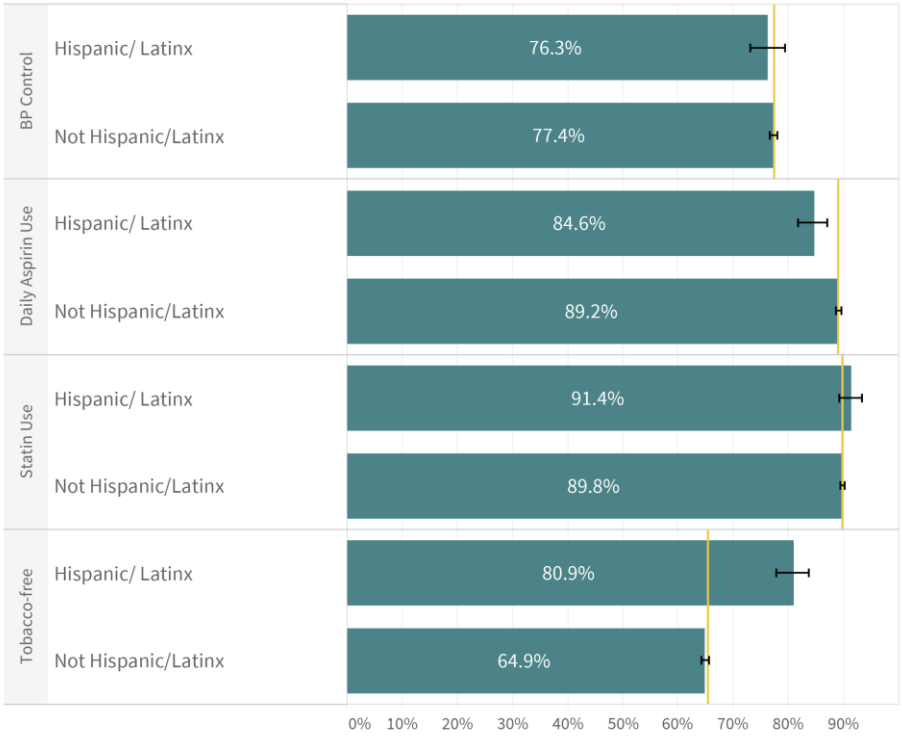
- Asian have statistically significantly higher rates of daily aspirin use and being tobacco-free.
- Indigenous/Native or White have statistically significantly lower rates of being tobacco-free.
- Black have statistically significantly lower rates of blood pressure control.

OPTIMAL VASCULAR CARE: COMPONENTS

(Continued)

MHCP MCO RATES BY ETHNICITY

2021 measurement year



Represents 95% confidence interval

OVERALL MHCP MCO STATEWIDE AVERAGES

by component
(represented by yellow line)

- **BP Control:** 77.4%
- **Daily Aspirin:** 89.0%
- **Statin Use:** 89.8%
- **Tobacco-free:** 65.4%

DENOMINATORS BY ETHNICITY

(Denominators are the same for each measure)

- **Hispanic/Latinx:** 687
- **Not Hispanic/Latinx:** 17,499

KEY TAKEAWAYS

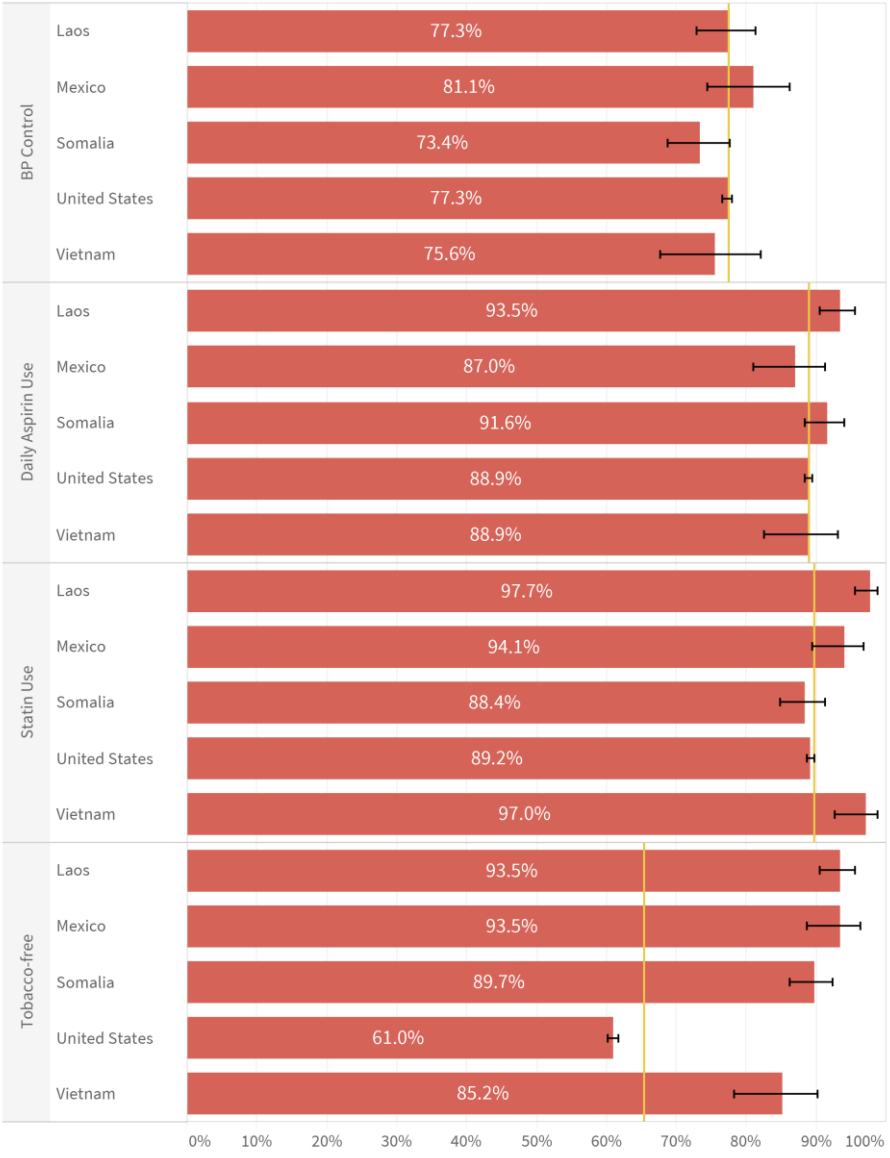
Compared to the MHCP MCO statewide average, MHCP MCO patients who are Hispanic/Latinx have a statistically significantly higher rate of being tobacco-free, but a statistically significantly lower rate of daily aspirin use.

OPTIMAL VASCULAR CARE: COMPONENTS

(Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component (represented by yellow line)

- **BP Control:** 75.5%
- **Daily Aspirin:** 88.0%
- **Statin Use:** 88.7%
- **Tobacco-free:** 66.9%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- **Laos:** 384
- **Mexico:** 169
- **Somalia:** 380
- **United States:** 14,883
- **Vietnam:** 135

⊢ Represents 95% confidence interval

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for the above components:

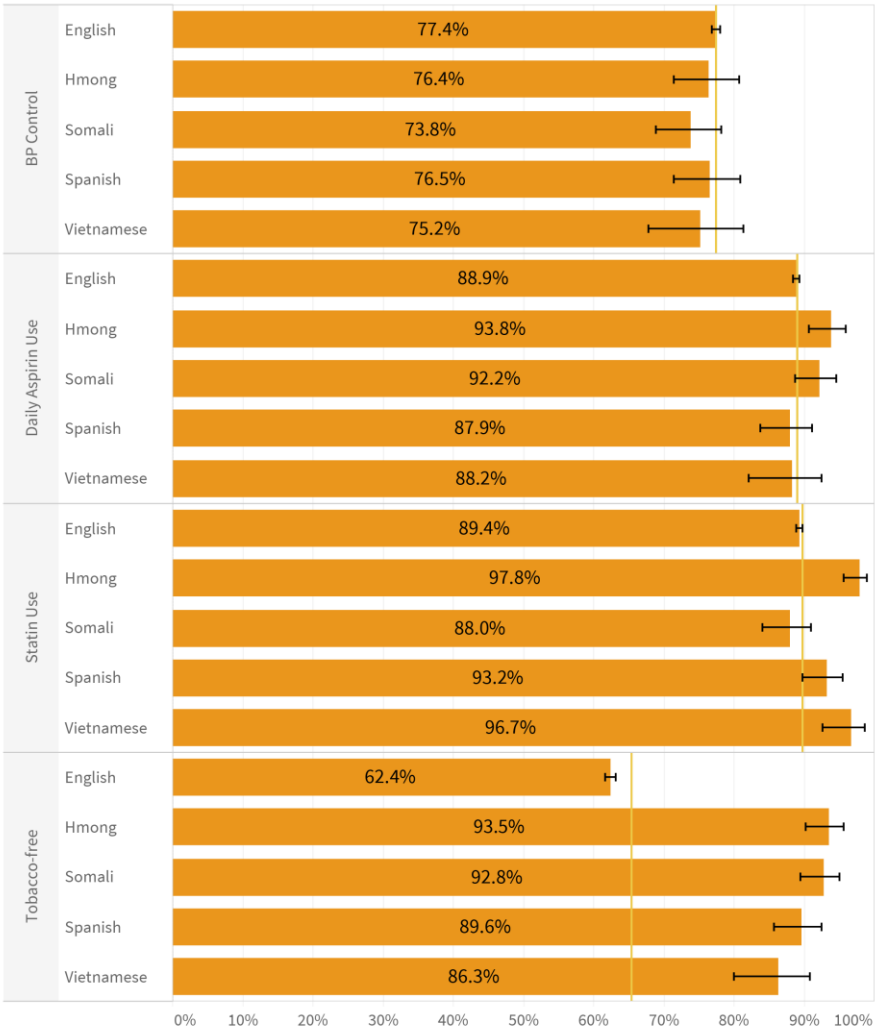
- MHCP MCO patients from Laos have statistically significantly higher rates for all components, except for blood pressure control, which is average.
- MHCP MCO patients from Mexico and Somalia have statistically significantly higher rates of being tobacco-free.
- MHCP MCO patients from Vietnam have statistically significantly higher rates of statin use and being tobacco-free.

OPTIMAL VASCULAR CARE: COMPONENTS

(Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by component (represented by yellow line)

- **BP Control:** 77.4%
- **Daily Aspirin:** 89.0%
- **Statin Use:** 89.8%
- **Tobacco-free:** 65.4%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **English:** 16,324
- **Hmong:** 322
- **Somali:** 332
- **Spanish:** 307
- **Vietnamese:** 153

⊢ Represents 95% confidence interval

KEY TAKEAWAYS

Compared to the MHCP MCO statewide averages for the above components:

- MHCP MCO patients who speak Hmong have statistically significantly higher rates for all components, except for blood pressure control, which is average.
- MHCP MCO patients who speak Somali and patients who speak Spanish have statistically significantly higher rates of being tobacco-free.
- MHCP MCO patients who speak Vietnamese have statistically significantly higher rates of statin use and being tobacco-free.

OPTIMAL ASTHMA CONTROL - ADULTS

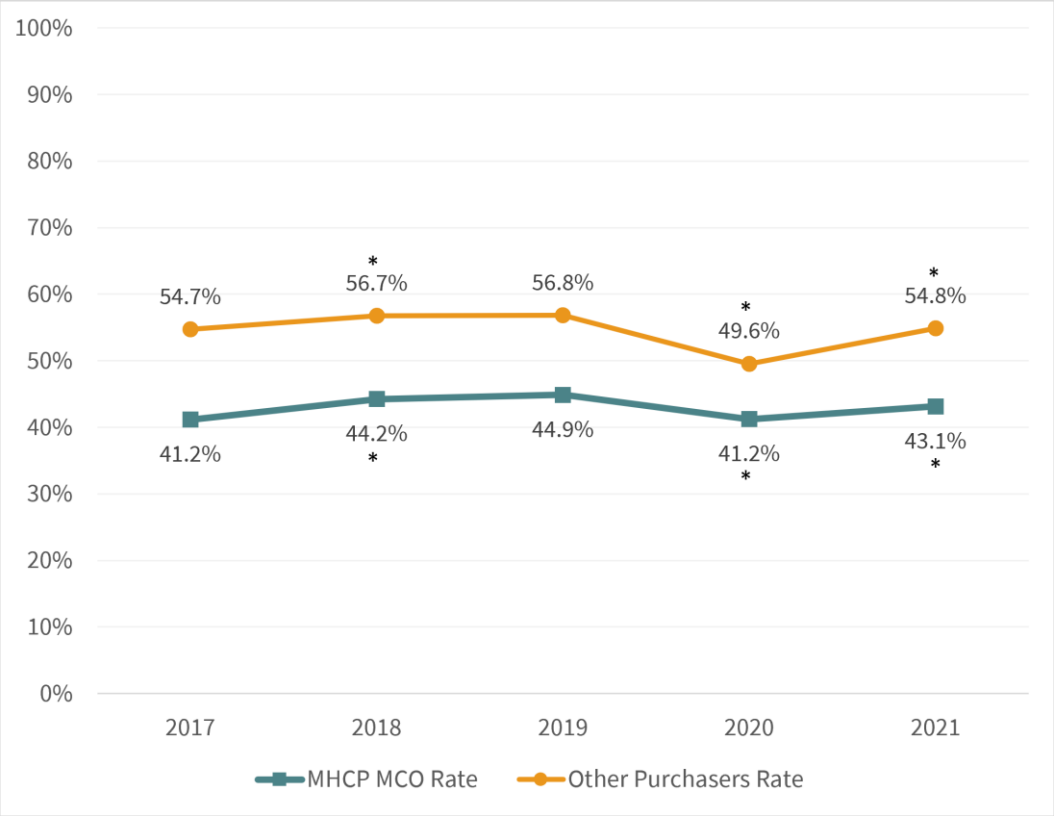
The percentage of adults (18-50 years of age) who had a diagnosis of asthma and whose asthma was optimally controlled as defined by achieving both of the following:

1. Asthma well-controlled as defined by the most recent **asthma control tool result**
2. Patient not at risk of exacerbation (i.e., fewer than two emergency department visit and/or hospitalizations due to asthma in the last 12 months)

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

TREND IN OPTIMAL ASTHMA CONTROL - ADULTS

2017 – 2021



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

*Rate statistically significantly changed from previous year

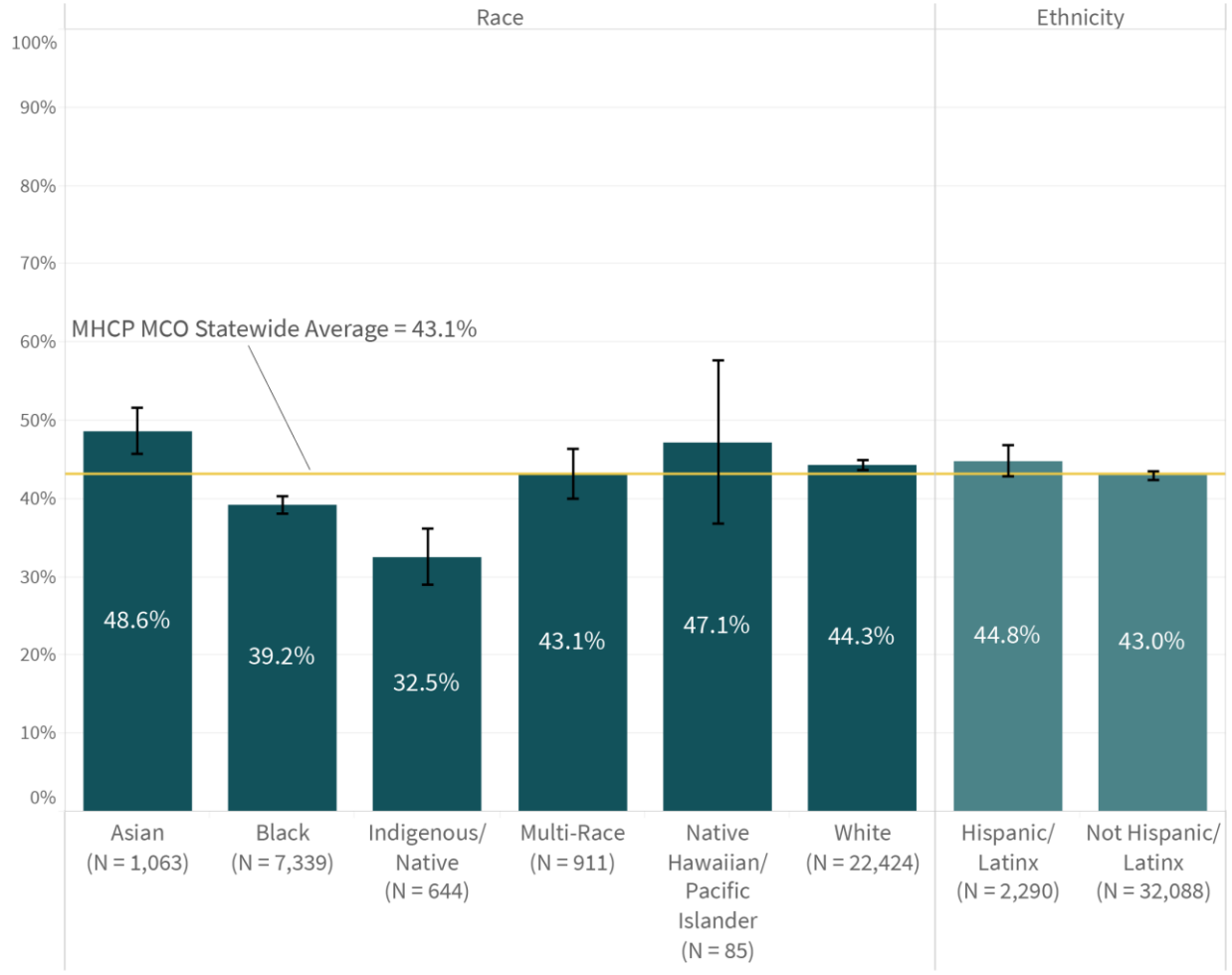
KEY TAKEAWAYS

- From 2020 to 2021, the MHCP MCO statewide average for the Optimal Asthma Control – Adults measure statistically significantly increased by 1.9 percentage points.
- In 2021, the 11.7 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

OPTIMAL ASTHMA CONTROL – ADULTS (Continued)

MHCP MCO RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

Race

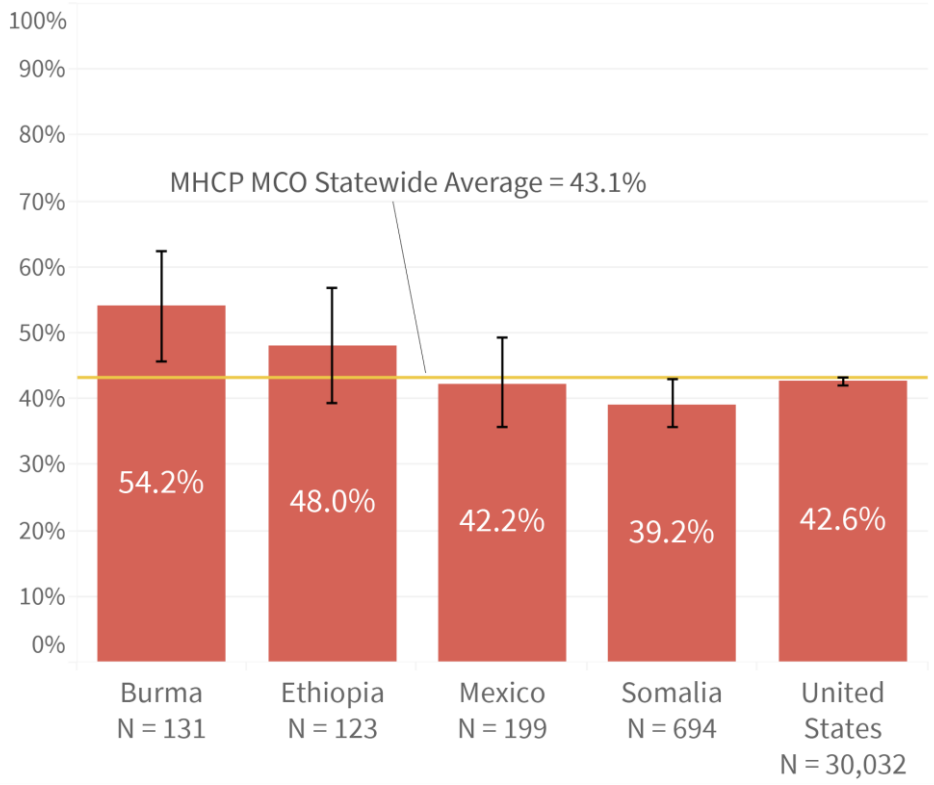
Compared to the MHCP MCO statewide average, the optimal care rate(s) for MHCP MCO patients who are:

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

OPTIMAL ASTHMA CONTROL – ADULTS (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



I Represents 95% confidence interval

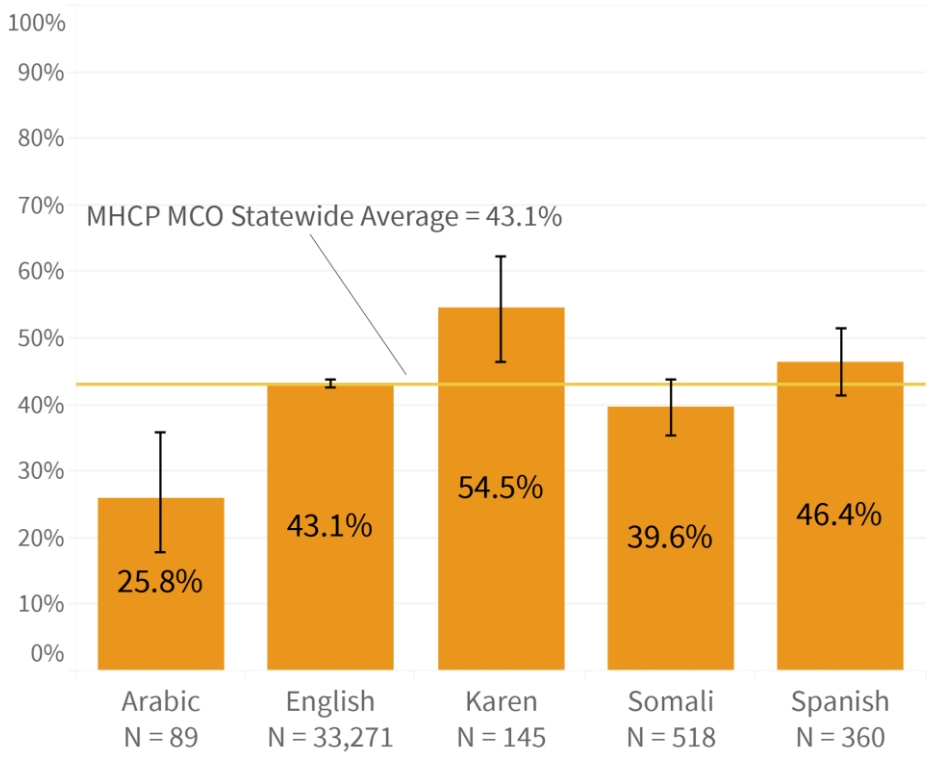
KEY TAKEAWAYS

- Adult patients from Burma, Ethiopia, Mexico, Somalia or the United States make up 95 percent of the eligible MHCP MCO population for the Optimal Asthma Control measure.
- Compared to the MHCP MCO statewide average, the optimal control rate for MHCP MCO adult patients from Burma is statistically significantly higher.

OPTIMAL ASTHMA CONTROL – ADULTS (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

- Adult patients who prefer to speak Arabic, English, Karen, Somali or Spanish make up 99 percent of the eligible MHCP MCO population for the Optimal Asthma Control measure.
- Compared to the MHCP MCO statewide average, the optimal control rate for MHCP MCO adults who speak:
    - Karen is statistically significantly higher.
    - Arabic is statistically significantly lower.

OPTIMAL ASTHMA CONTROL – CHILDREN

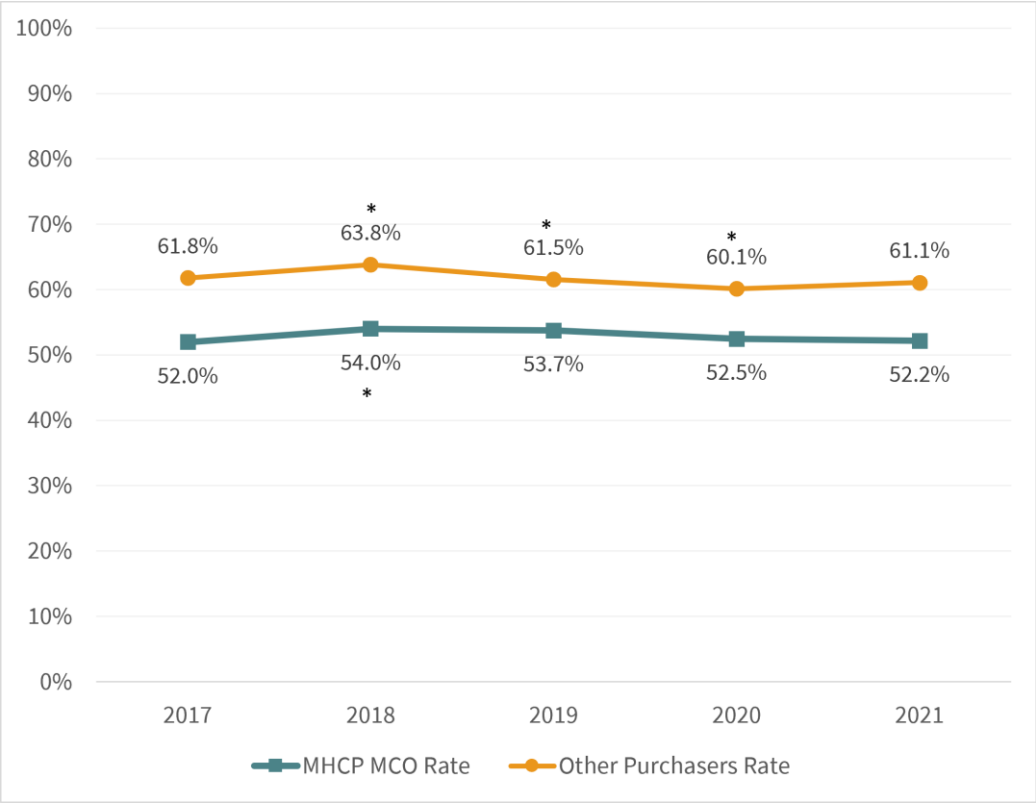
The percentage of children (5-17 years of age) who had a diagnosis of asthma and whose asthma was optimally controlled as defined by achieving both of the following:

1. Asthma well-controlled as defined by the most recent asthma control tool result
2. Patient not at risk of exacerbation (i.e., fewer than two emergency department visit and/or hospitalizations due to asthma in the last 12 months)

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

TREND IN OPTIMAL ASTHMA CONTROL - CHILDREN

2017– 2021



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

*Rate statistically significantly changed from previous year

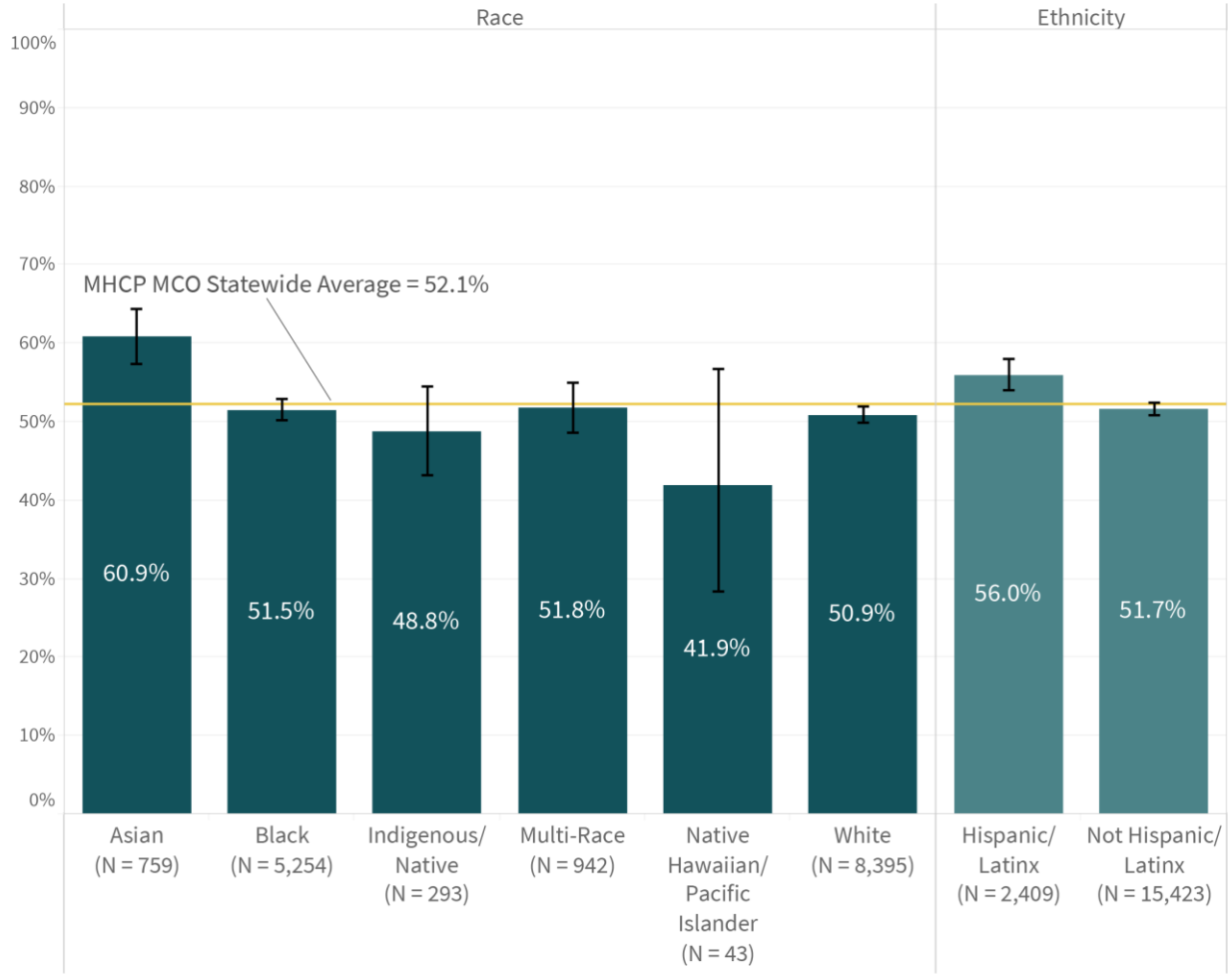
KEY TAKEAWAYS

- From 2020 to 2021, the MHCP MCO statewide average for the Optimal Asthma Control – Children measure remained stable.
- In 2021, the 8.9 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

OPTIMAL ASTHMA CONTROL – CHILDREN (Continued)

MHCP MCO RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

Race

Compared to the MHCP MCO statewide average, the optimal care rate for MHCP MCO children who are Asian is statistically significantly higher.

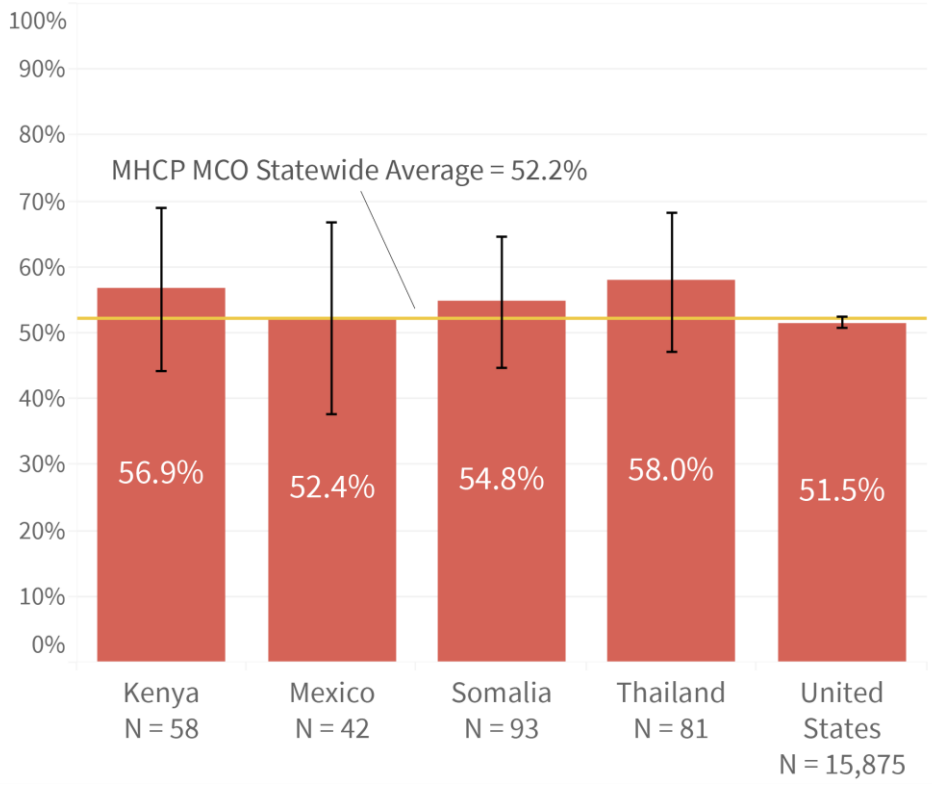
Ethnicity

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

OPTIMAL ASTHMA CONTROL – CHILDREN (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



I Represents 95% confidence interval

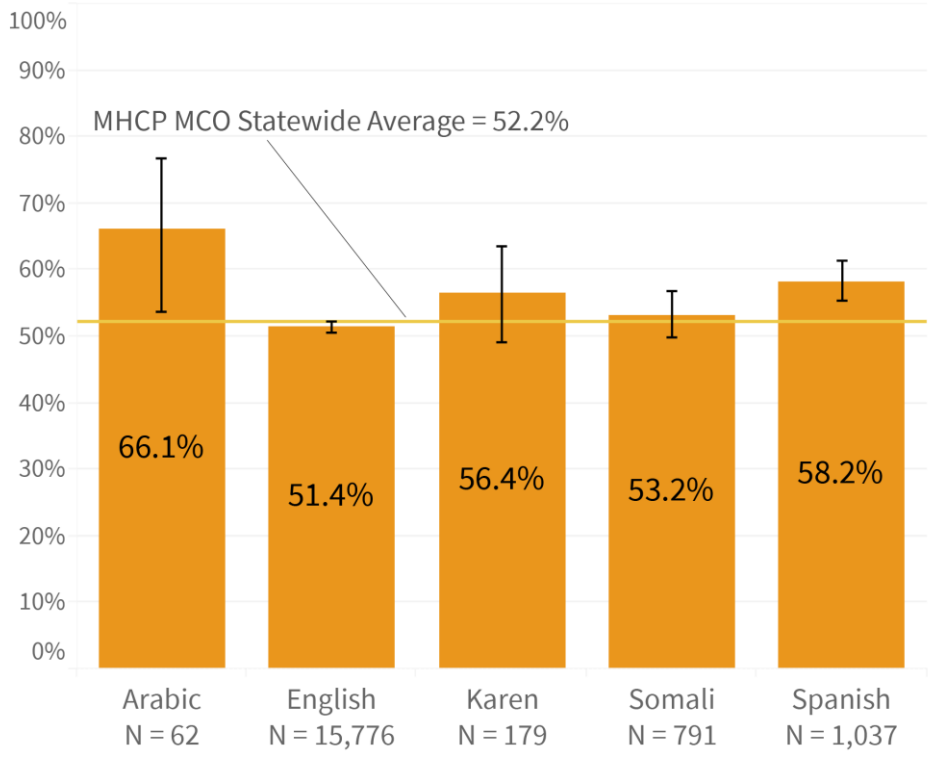
KEY TAKEAWAYS

- Child patients from Kenya, Mexico, Somalia, Thailand or the United States make up 97 percent of the eligible MHCP MCO population for the Optimal Asthma Control measure.
- Compared to the MHCP MCO statewide average, the optimal control rates for all the above countries were not statistically different.

OPTIMAL ASTHMA CONTROL – CHILDREN (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

- Child patients who prefer to speak Arabic, English, Karen, Somali or Spanish make up 98 percent of the eligible MHCP MCO population for the Optimal Asthma Control measure.
- Compared to the MHCP MCO statewide average, the optimal control rates for MHCP MCO children who speak Arabic or Spanish are statistically significantly higher.

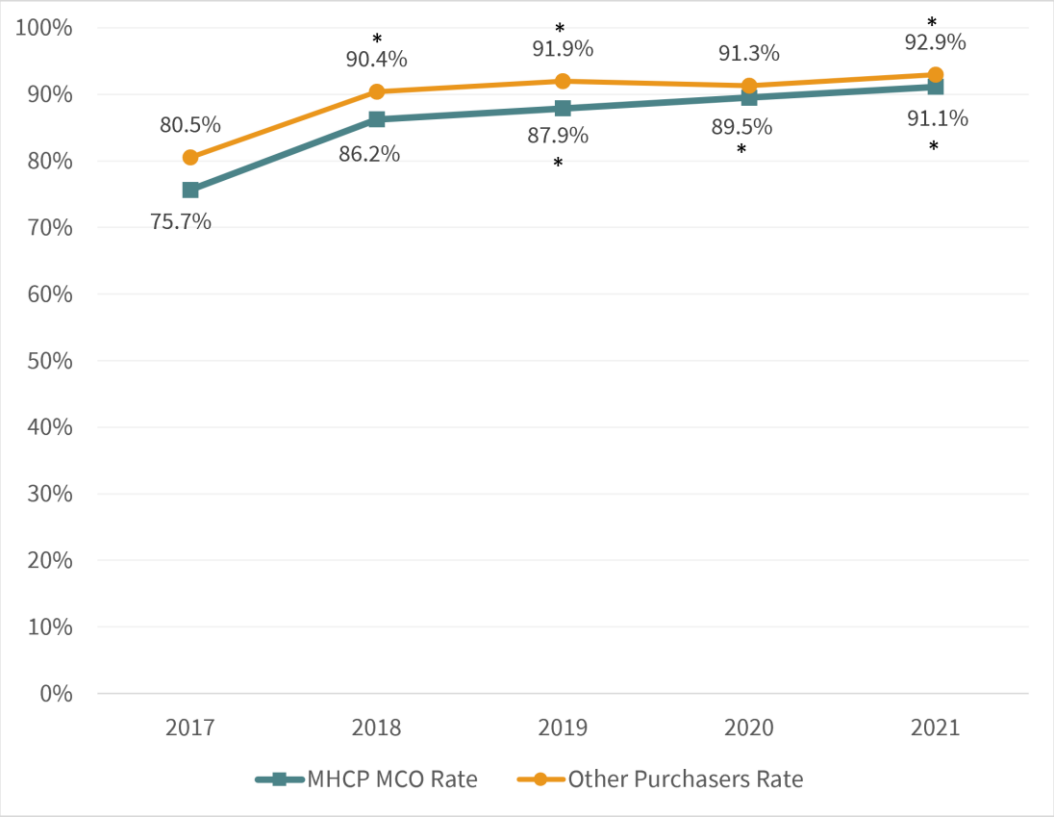
ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

The percentage of patients ages 12-17 who were screened for mental health and/or depression at using one of the **specified tools** during the measurement period.

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

TREND IN ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

2017 – 2021



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

*Rate statistically significantly changed from previous year

KEY TAKEAWAYS

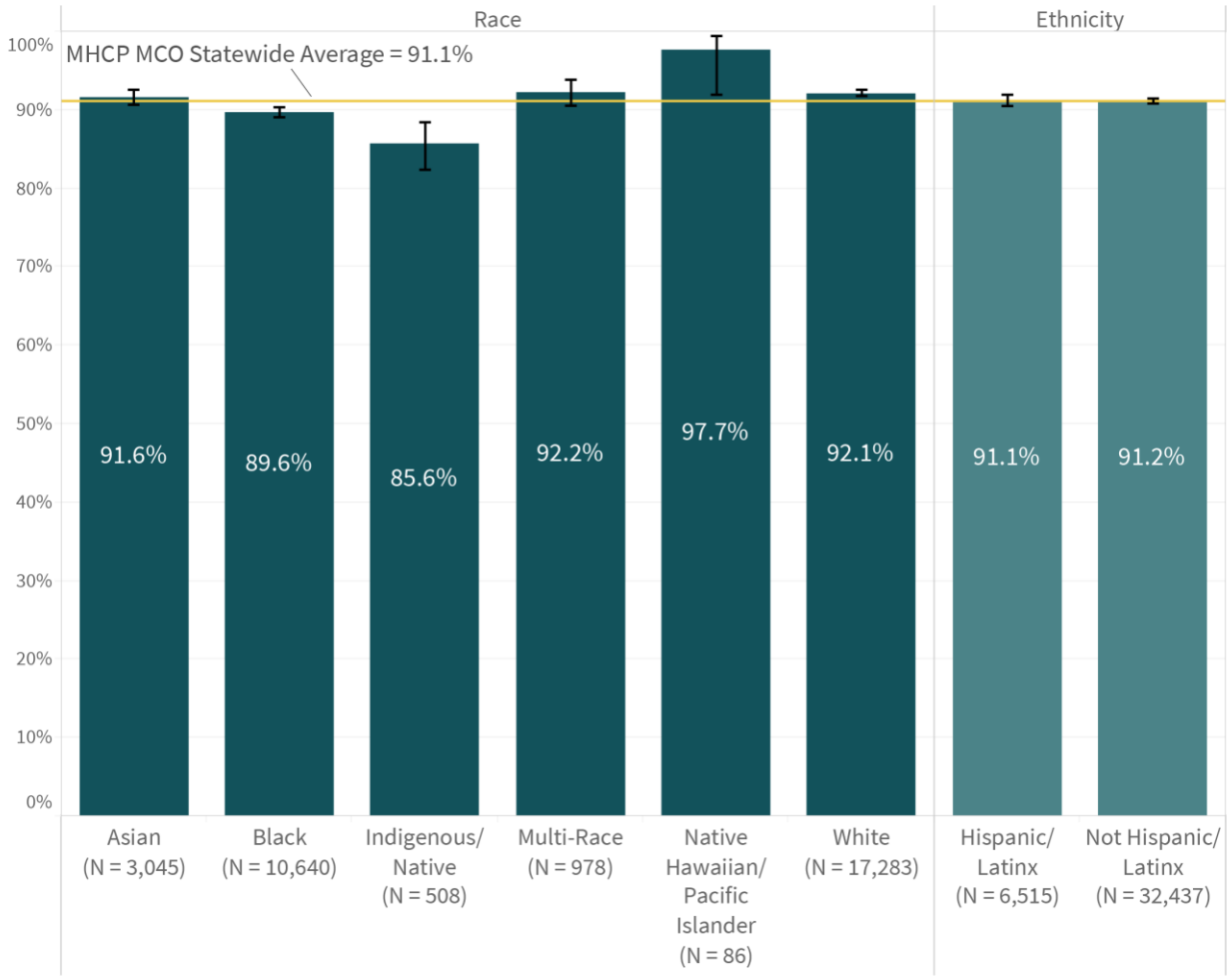
- From 2020 to 2021, the MHCP MCO statewide average for the Adolescent Mental Health and/ or Depression Screening measure statistically significantly increased by 1.6 percentage points.
- In 2021, the 1.8 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

(Continued)

MHCP MCO RATES BY RACE/ETHNICITY

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAY

Race

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

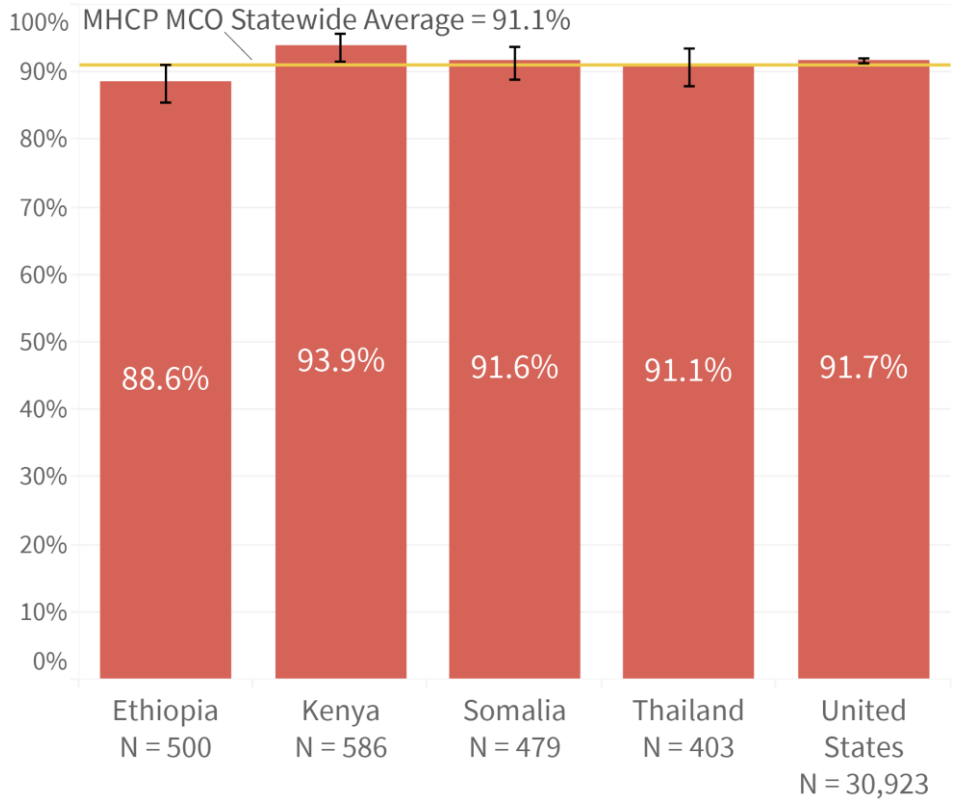
- Native Hawaiian/Pacific Islander or White are statistically significantly higher.
- Black or Indigenous/Native are statistically lower.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

(Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

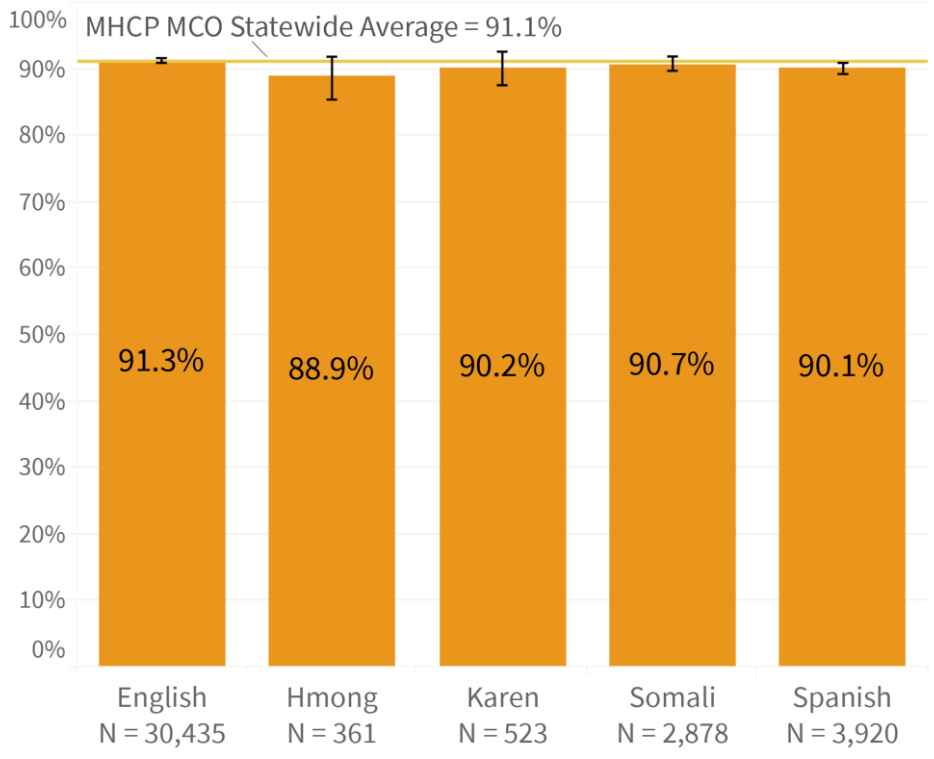
- Patients from Ethiopia, Kenya, Somalia, Thailand or the United States make up 92 percent of the eligible MHCP MCO population for the Adolescent Mental Health and/or Depression measure.
- Compared to the MHCP MCO statewide average, the screening rate for MHCP MCO patients from Kenya is statistically significantly higher.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING

(Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



I Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak English, Hmong, Karen, Somali or Spanish make up 96 percent of the eligible MHCP MCO population for the Adolescent Mental Health and/or Depression Screening measure.
- Compared to the MHCP MCO statewide average, the screening rates for all the above languages were not statistically different.

ADOLESCENT DEPRESSION SUITE

Follow-up PHQ-9/9M at Six/12 Months: The percentage of adolescent patients (age 12-17) with depression who have a completed PHQ-9/9M tool within 6/12 months after the index event (+/- 60 days).

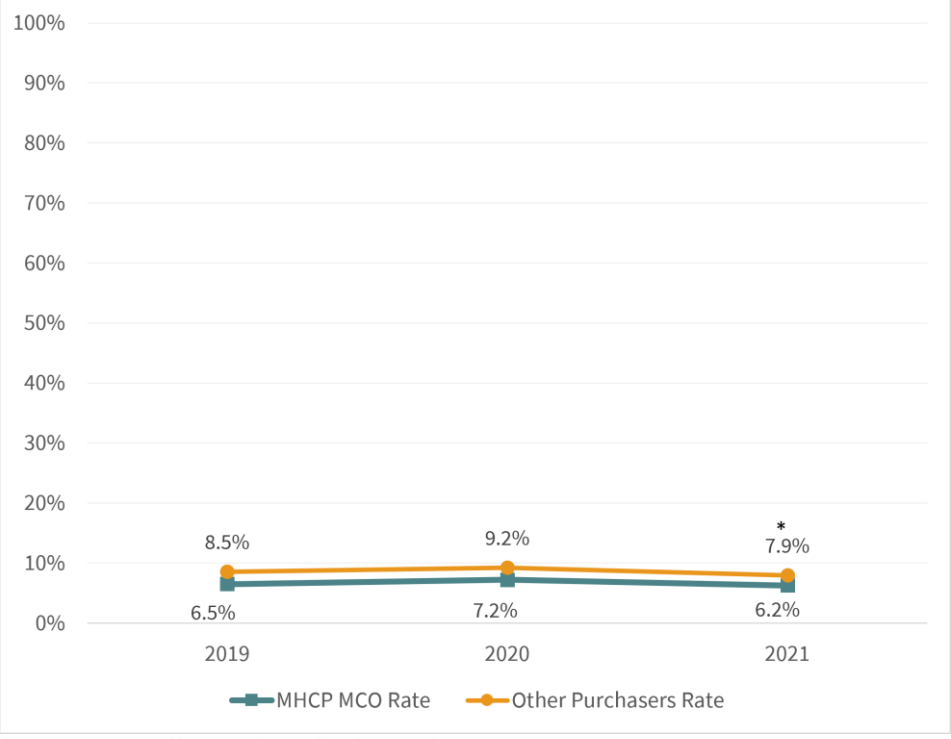
Response at Six/12 Months: The percentage of adolescent patients (age 12-17) with depression who demonstrated a response to treatment (at least 50 percent improvement) 6/12 months after the index event (+/- 60 days).

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

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

ADOLESCENT DEPRESSION: REMISSION AT SIX MONTHS

2019-2021



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

*Rate statistically significantly changed from previous year

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

KEY TAKEAWAYS

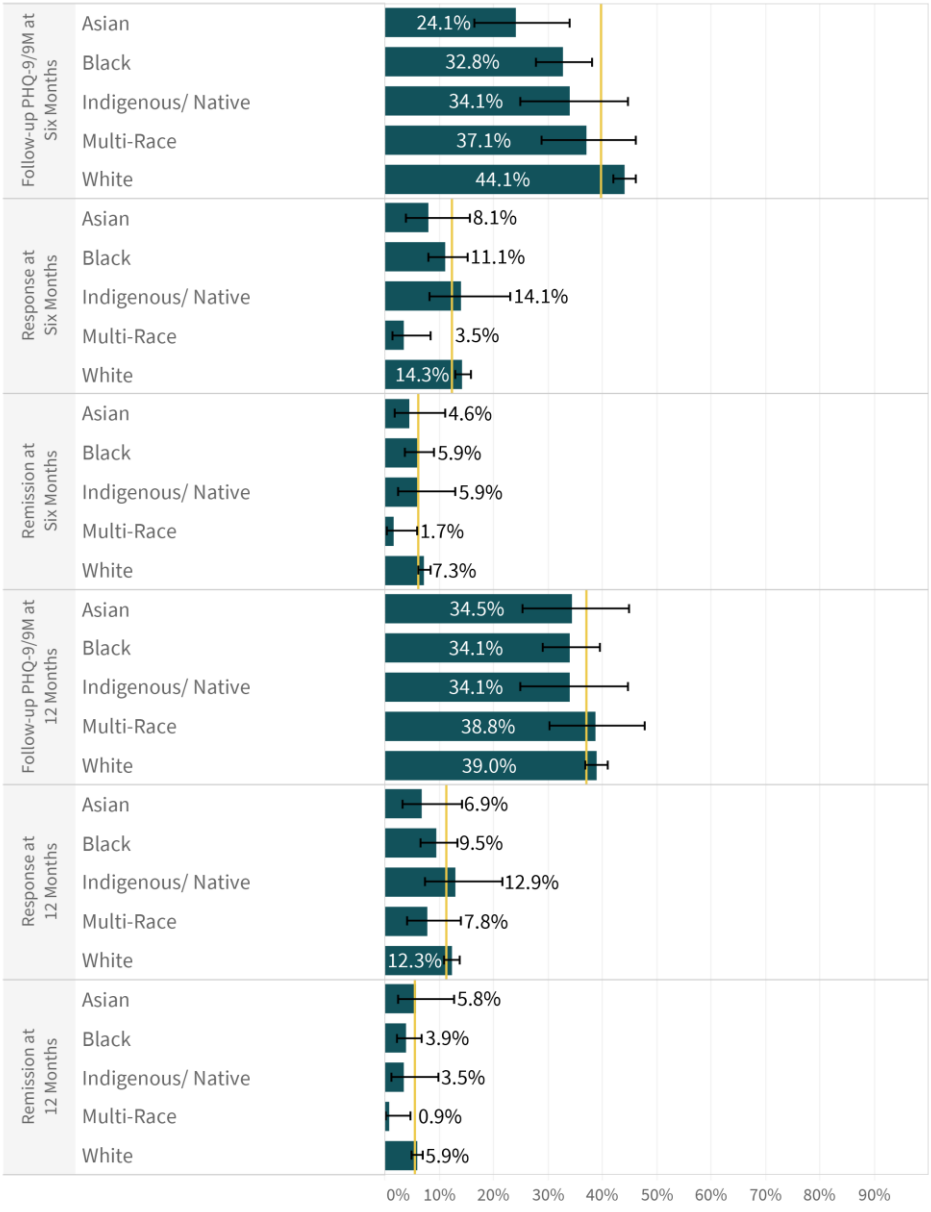
- From 2020 to 2021, the MHCP MCO statewide average for the Adolescent Depression: Remission at Six Months measure remained stable.
- In 2021, the 1.7 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

ADOLESCENT DEPRESSION SUITE

(Continued)

MHCP MCO RATES BY RACE

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

Six Month Measures

- Follow-up: 39.8%
- Response: 12.4%
- Remission: 6.2%

12 Month Measures

- Follow-up: 37.1%
- Response: 11.4%
- Remission: 5.5%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian:** 87
- **Black:** 305
- **Indigenous/Native:** 85
- **Multi-Race:** 116
- **White:** 2,127

⊢⊣ Represents 95% confidence interval

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

KEY TAKEAWAYS

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

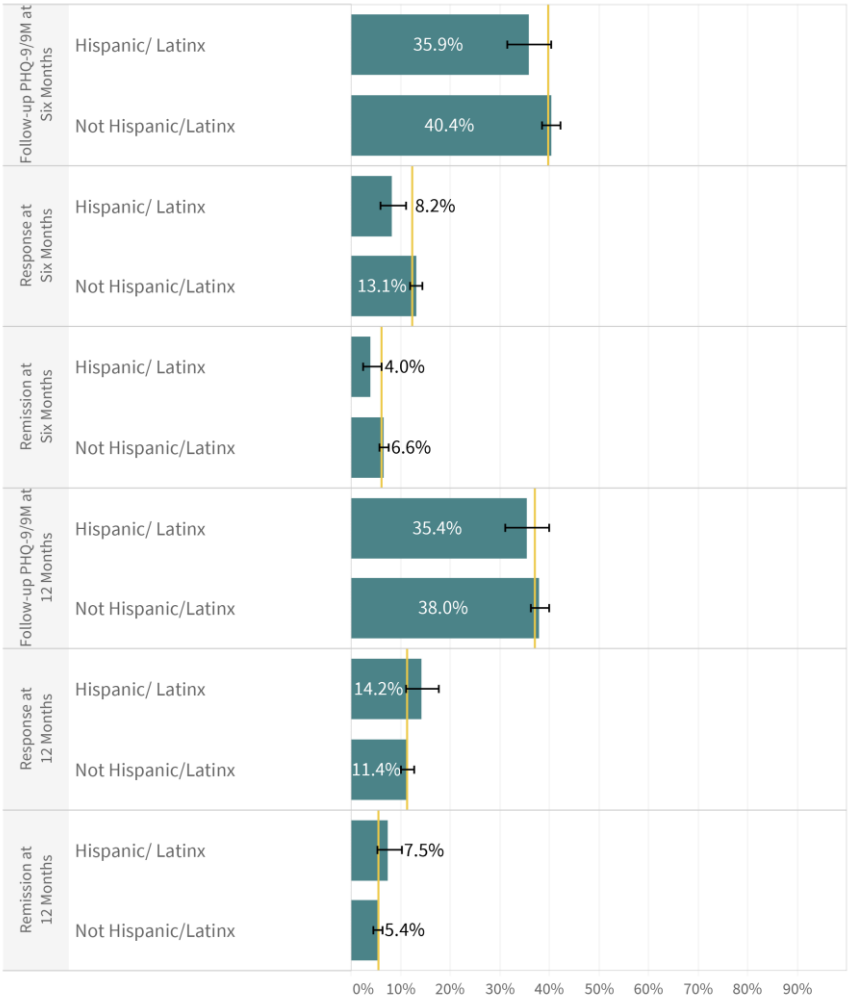
- Asian have statistically significantly lower rates of follow-up at six months.
- Multi-Race have statistically significantly lower rates of response at six months and remission at 12 months.

ADOLESCENT DEPRESSION SUITE

(Continued)

MHCP MCO RATES BY ETHNICITY

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

Six Month Measures

- Follow-up: 39.8%
- Response: 12.4%
- Remission: 6.2%

12 Month Measures

- Follow-up: 37.1%
- Response: 11.4%
- Remission: 5.5%

DENOMINATORS BY ETHNICITY

(Denominators are the same for each measure)

- **Hispanic/Latinx:** 429
- **Not Hispanic/Latinx:** 2,618

⊢⊣ Represents 95% confidence interval

KEY TAKEAWAYS

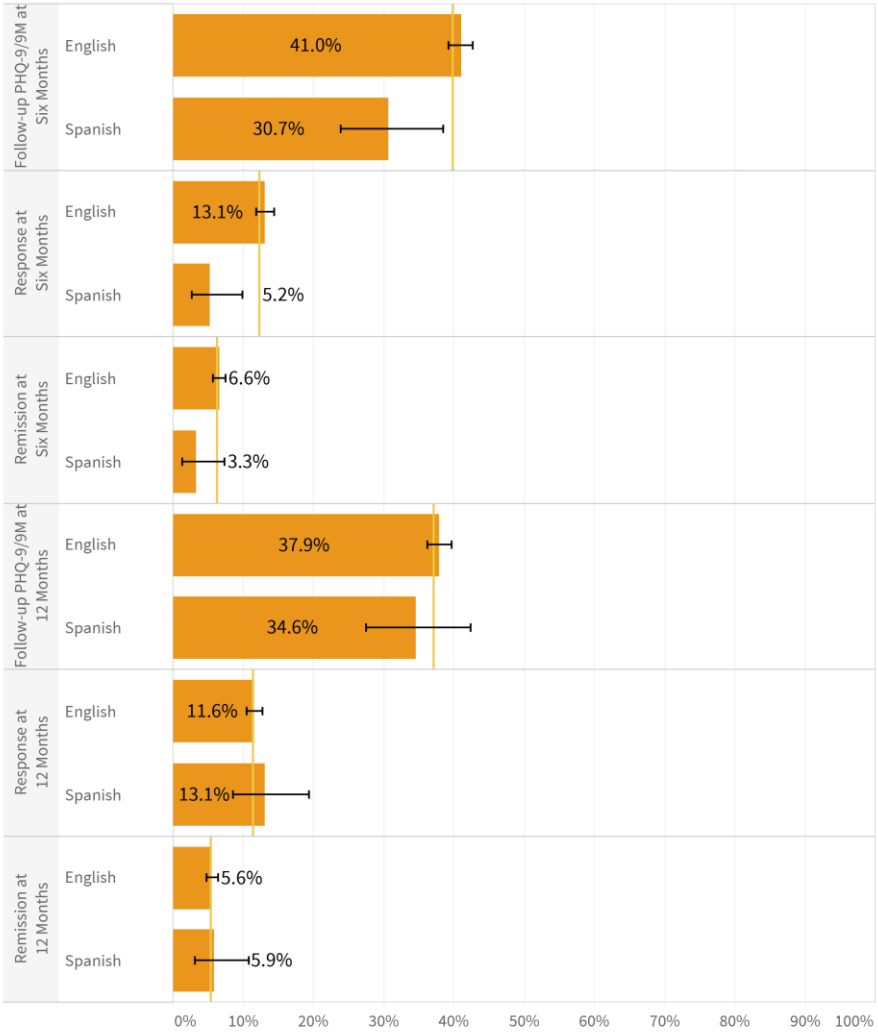
Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients who are Hispanic/Latinx have statistically significantly lower rates of response at six months.

ADOLESCENT DEPRESSION SUITE

(Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

Six Month Measures

- Follow-up: 39.8%
- Response: 12.4%
- Remission: 6.2%

12 Month Measures

- Follow-up: 37.1%
- Response: 11.4%
- Remission: 5.5%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **English:** 2,965
- **Spanish:** 153

⟼ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak English or Spanish make up 98 percent of the eligible MHCP MCO population for the Adolescent Depression measures.
- Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients who speak Spanish have statistically significantly lower rates of response at six months.

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

ADULT DEPRESSION SUITE

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

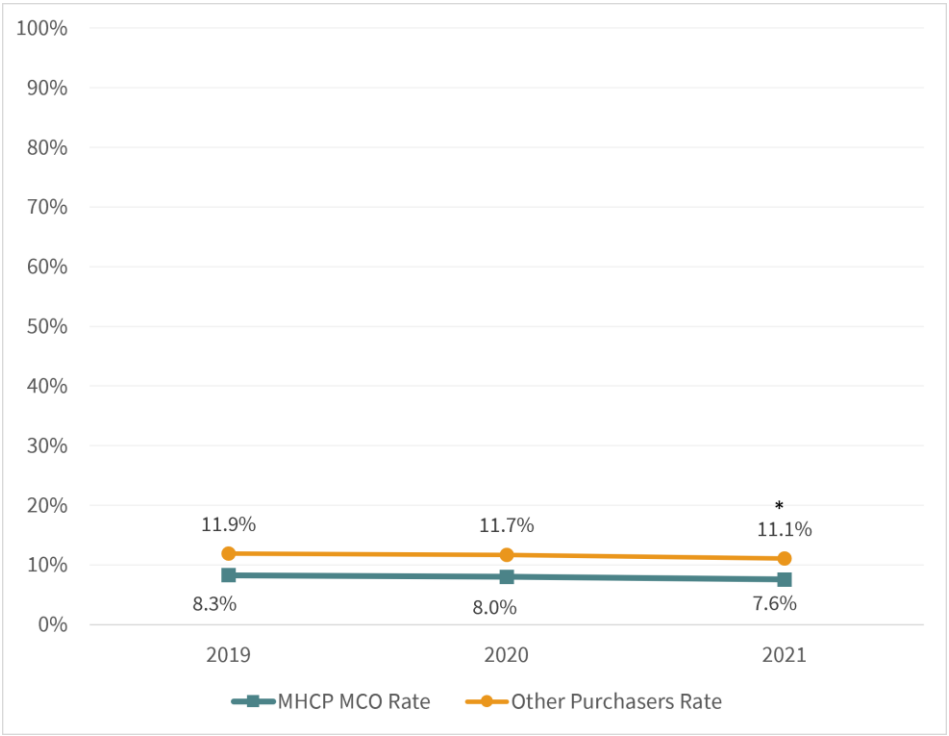
Response at Six/12 Months: The percentage of adult patients (18 years and older) with depression who demonstrated a response to treatment (at least 50 percent improvement) 6/12 months after the index event (+/- 60 days).

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

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

ADULT DEPRESSION: REMISSION AT SIX MONTHS

2019-2021



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

*Rate statistically significantly changed from previous year

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

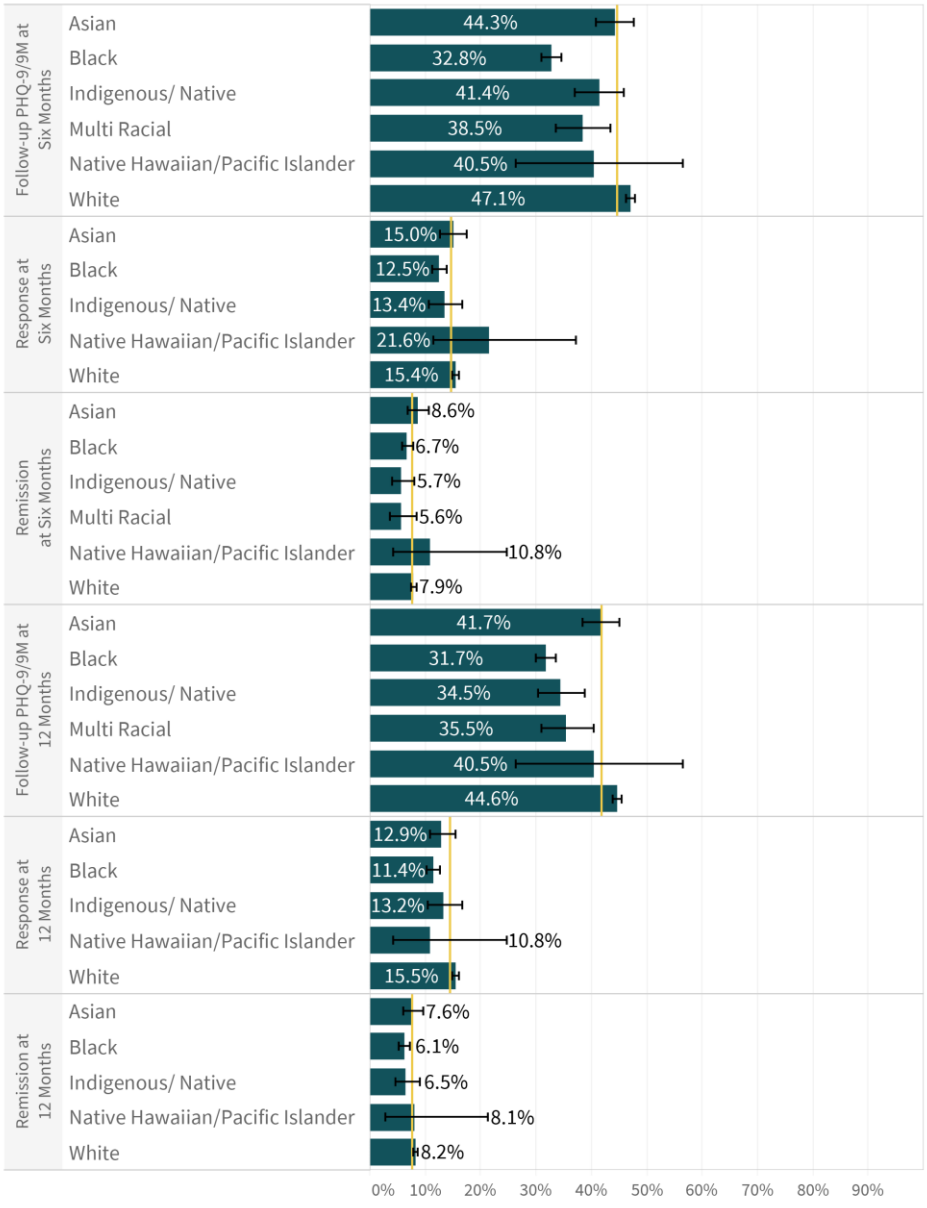
KEY TAKEAWAYS

- From 2020 to 2021, the MHCP MCO statewide average for the Adult Depression: Remission at Six Months measure remained stable.
- In 2021, the 3.5 percentage point gap between the MHCP MCO statewide average and the Other Purchasers statewide average was statistically significant.

ADULT DEPRESSION SUITE (Continued)

MHCP MCO RATES BY RACE

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

Six Month Measures

- Follow-up: 44.6%
- Response: 14.7%
- Remission: 7.6%

12 Month Measures

- Follow-up: 41.8%
- Response: 14.5%
- Remission: 7.7%

DENOMINATORS BY RACE

(Denominators are the same for each measure)

- **Asian: 829**
- **Black:** 2,378
- **Indigenous/Native:** 476
- **Multi-Race:** 377
- **Native Hawaiian/Pacific Islander:** 37
- **White:** 15,283

⊢⊣ Represents 95% confidence interval

KEY TAKEAWAYS

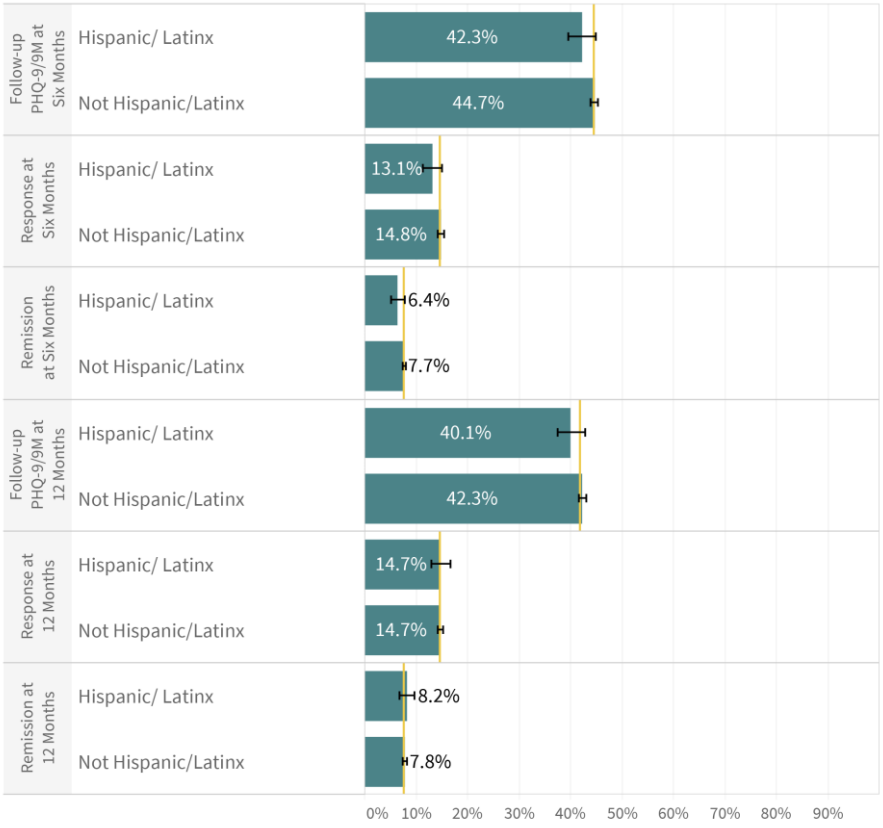
Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients who are:

- White have statistically significantly higher rates of follow-up at six and 12 months.
- Black have statistically significantly lower rates for all measures, except for the Remission at Six Months measure.

ADULT DEPRESSION SUITE (Continued)

MHCP MCO RATES BY ETHNICITY

2021 measurement year



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

Six Month Measures
- Follow-up: 44.6%
- Response: 14.7%
- Remission: 7.6%

12 Month Measures
- Follow-up: 41.8%
- Response: 14.5%
- Remission: 7.7%

DENOMINATORS BY ETHNICITY
(Denominators are the same for each measure)
- **Hispanic/Latinx:** 1,276
- **Not Hispanic/Latinx:** 19,210

⟼ Represents 95% confidence interval

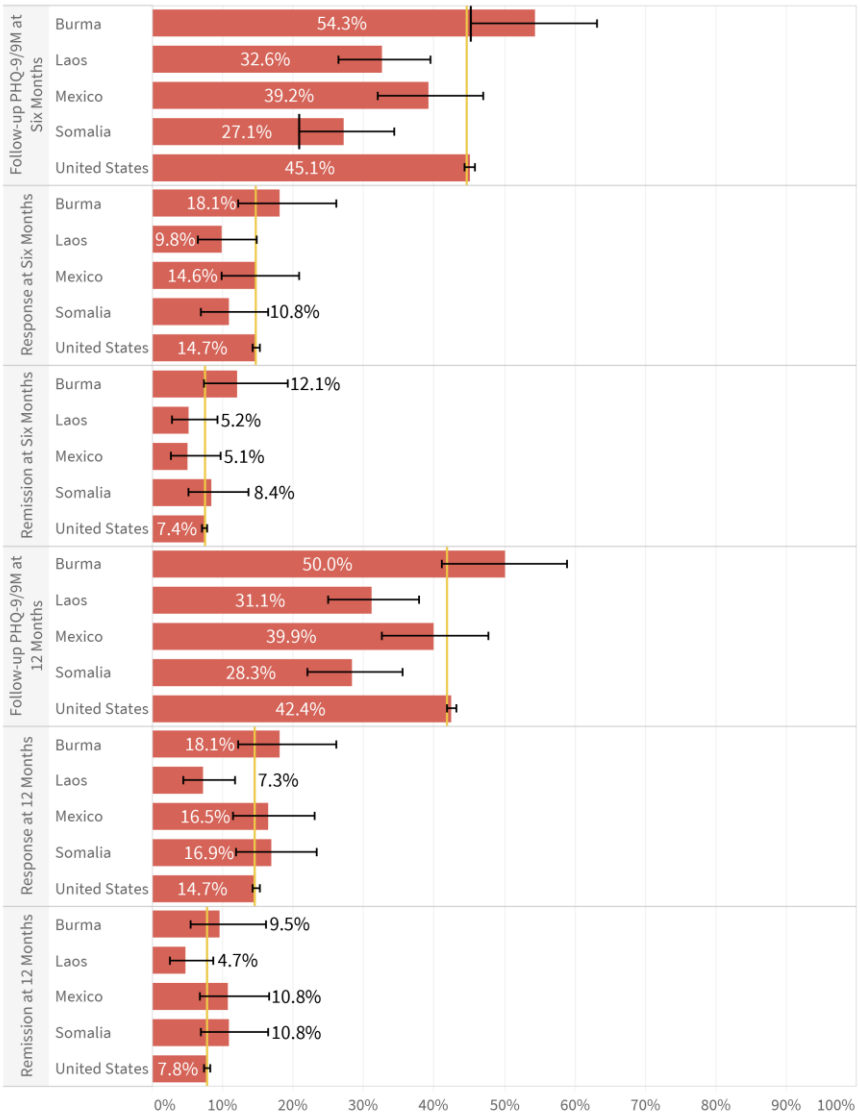
KEY TAKEAWAYS

Compared to MHCP MCO statewide averages for each measure, MHCP MCO patients who are Hispanic/Latinx or Not Hispanic/Latinx have average rates.

ADULT DEPRESSION SUITE (Continued)

MHCP MCO RATES BY COUNTRY OF ORIGIN

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

Six Month Measures

- Follow-up: 44.6%
- Response: 14.7%
- Remission: 7.6%

12 Month Measures

- Follow-up: 41.8%
- Response: 14.5%
- Remission: 7.7%

DENOMINATORS BY COUNTRY

(Denominators are the same for each measure)

- **Burma:** 116
- **Laos:** 193
- **Mexico:** 158
- **Somalia:** 166
- **United States:** 18,095

Represents 95% confidence interval

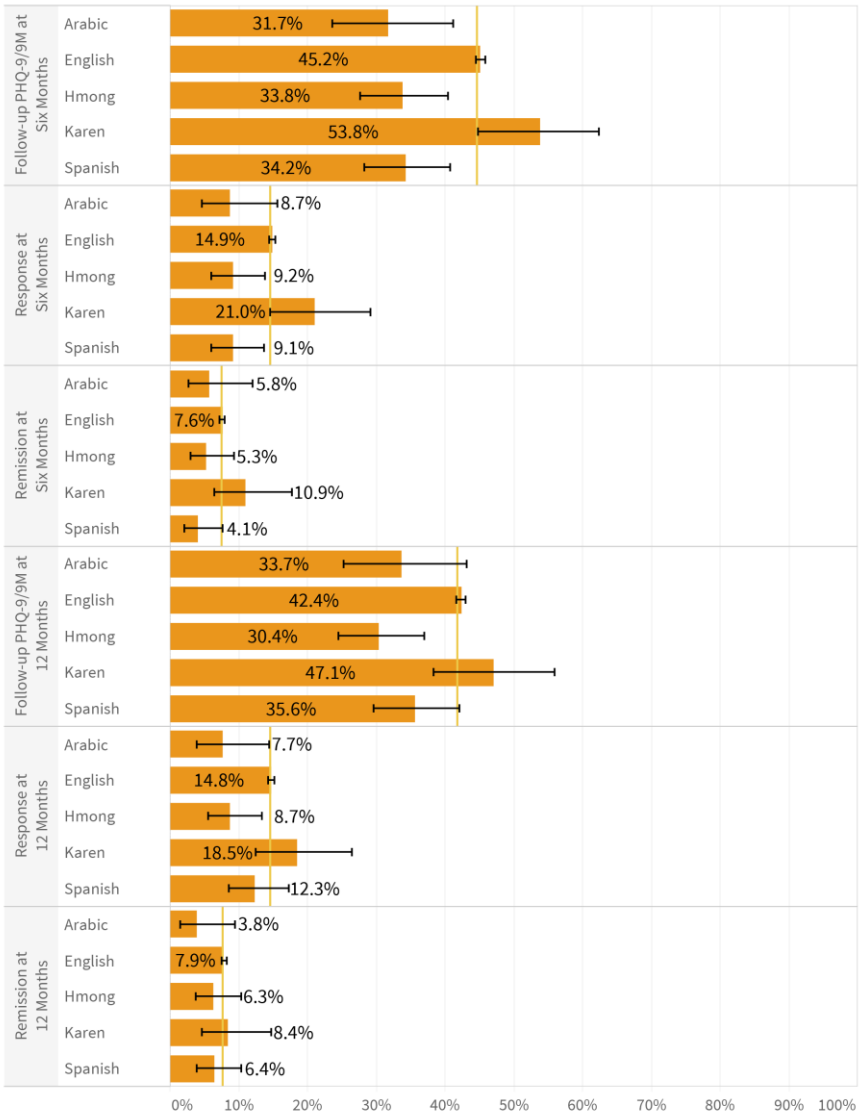
KEY TAKEAWAYS

- Patients from Burma, Laos, Mexico, Somalia or the United States make up 95 percent of the eligible MHCP MCO population for the Adult Depression measures.
- Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients from:
    - Laos have statistically significantly lower rates of follow-up at six and 12 months and response at 12 months.
    - Somalia have statistically significantly lower rates of follow-up at six and 12 months.

ADULT DEPRESSION SUITE (Continued)

MHCP MCO RATES BY PREFERRED LANGUAGE

2021 measurement year



OVERALL MHCP MCO STATEWIDE AVERAGES

by measure
(represented by yellow line)

Six Month Measures

- Follow-up: 44.6%
- Response: 14.7%
- Remission: 7.6%

12 Month Measures

- Follow-up: 41.8%
- Response: 14.5%
- Remission: 7.7%

DENOMINATORS BY LANGUAGE

(Denominators are the same for each measure)

- **Arabic:** 104
- **English:** 20,237
- **Hmong:** 207
- **Karen:** 119
- **Spanish:** 219

⊢⊣ Represents 95% confidence interval

KEY TAKEAWAYS

- Patients who prefer to speak Arabic, English, Hmong, Karen or Spanish make up 98 percent pf the eligible MHCP MCO population for the Adult Depression measures.
- Compared to the MHCP MCO statewide averages for each measure, MHCP MCO patients who speak:
  - Arabic have statistically significantly lower rates of follow-up at six months.
  - Hmong have statistically significantly lower rates of follow-up at six and 12 months and response at six and 12 months.
  - Spanish have statistically significantly lower rates of follow-up and response at six months.

DEFINITIONS

GENERAL DEFINITIONS

95% confidence interval: The degree of certainty in which the performance rate falls between the specified range of values.

Continuous enrollment criteria: The minimum amount of time for a member/patient to be enrolled in a health plan to be eligible for a HEDIS measure. It ensures the health plan has enough time to render services. If a member/patient does not meet minimum continuous enrollment criteria, they are not eligible to be included in the measure denominator.

Composite measures: A measure of two or more component measures, each of which individually reflects quality of care, combined into a single performance measure with a single score. The individual components are treated equally (not weighted). Every component must meet criteria to be counted in the numerator for the overall composite measure. The composite measures in this report include:

- **Optimal Diabetes Care**
- **Optimal Vascular Care**
- **Optimal Asthma Control – Adults**
- **Optimal Asthma Control – Children**

Clinical Data Submission measures: Measures include:

- **Optimal Diabetes Care**
- **Optimal Vascular Care**
- **Adult Depression Suite**
- **Adolescent Depression Suite**
- **Optimal Asthma Control – Children**
- **Optimal Asthma Control – Adults**
- **Colorectal Cancer Screening**
- **Adolescent Mental Health and/or Depression Screening**

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

Healthcare Effectiveness Data and Information Set (HEDIS) measures: A national set of performance measures used in the managed care industry and developed and maintain by the National Committee for Quality Assurance (NCQA). Clinical HEDIS measures use data from the administrative or hybrid data collection methodology. These measures include:

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

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

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

DEFINITIONS (Continued)

Minnesota Health Care Programs (MHCP): These health care programs (i.e., Medical Assistance including dual eligible and MinnesotaCare) provide service under both fee-for-service and managed care delivery systems purchased by DHS. This report only includes performance rates for the managed care (MCO) programs (i.e., Medical Assistance and MinnesotaCare).

National Committee for Quality Assurance (NCQA): A national, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations, as well as produces HEDIS measures.

Other Purchasers: This includes commercial (employer-based insurance coverage) and/or Medicare managed care data.

Outcome measures: These measures reflect the actual results of care. They are generally the most relevant measures for patients and the measures that providers most want to change. The outcome measures in this report include:

- **Controlling High Blood Pressure**
- **Optimal Diabetes Care**
- **Optimal Vascular Care**
- **Optimal Asthma Control – Adults**
- **Optimal Asthma Control – Children**
- **Adult Depression: Remission and Response measures**
- **Adolescent Depression: Remission and Response measures**

Patient Reported Outcome (PRO): Information reported by the patient.

Patient Report Outcome Measure (PROM): A validated instrument or survey tool that collects data from a patient.

- **Optimal Asthma Control measures – Adults and Children:** Asthma Control Test (ACT); Childhood Asthma Control Test (C-ACT); Asthma Control Questionnaire (ACQ); Asthma Therapy Assessment Questionnaire (ATAQ)
- **Adult and Adolescent Depression Suites:** Patient Health Questionnaire – 9 item version (PHQ-9/PHQ-9M)

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

The PRO-PM outcome measures in this report include:

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

The PRO-PM process measures in this report include:

- **Adolescent Mental Health and/or Depression Screening**

DEFINITIONS (Continued)

Process measures: A measure that shows whether steps proven to benefit patients are followed correctly. They measure whether an action was completed (e.g., having a medical exam or test, writing a prescription, or administering a drug). The process measures in this report include:

- **Breast Cancer Screening**
- **Childhood Immunization Status (Combo 10)**
- **Colorectal Cancer Screening**
- **Adolescent Mental Health and/or Depression Screening**

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

NOTES

Optimal Asthma Control

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

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

Adolescent Mental Health and/or Depression Screening

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

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

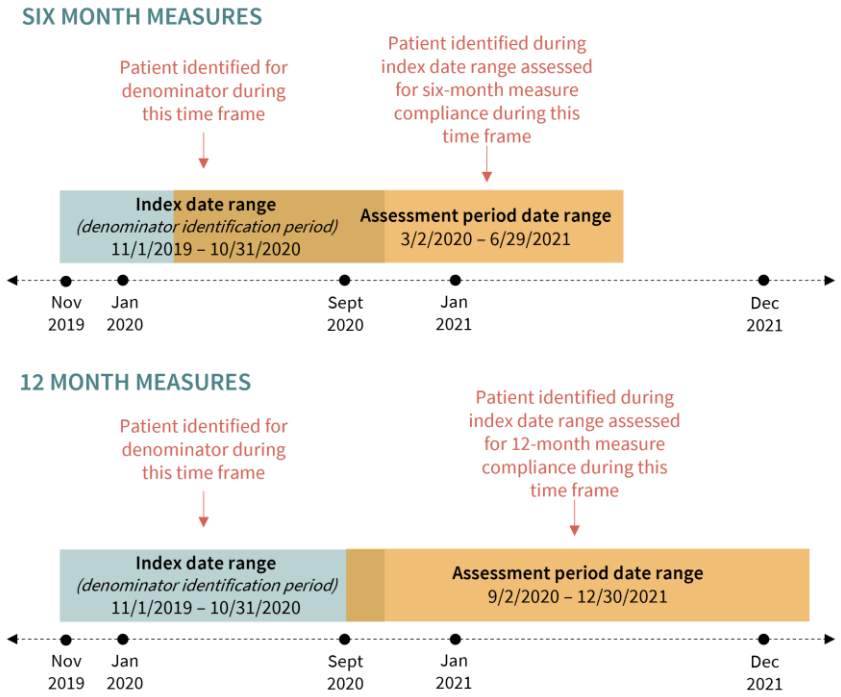
DEPRESSION MEASURES

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

- **Depression diagnosis:** The patient had an encounter with an eligible provider in an eligible specialty, coded with one of the diagnosis indicating Major Depression/Dysthymia during the denominator identification period.
- **PHQ-9/9M score greater than 9:** The patient completed a PHQ-9/PHQ-9M tool and the score was greater than 9 during the denominator identification period.
- **Age:** The patient was 12 years or older at the time of the encounter.

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

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



Example: A 23-year-old patient with depression was assessed at an encounter with an eligible provider on 12/2/2019 and had a PHQ-9 score of 20 (index event). Their six-month assessment period would be between 4/3/2020 and 8/1/2020. The patient would be considered numerator compliant for the six-month measures if the following was achieved during the assessment period:

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

The patient is then assessed 12 months after the index event (10/3/2020 to 1/31/2021) using the same criteria as above.

SOURCES

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

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

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

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