HEALTH CARE IN MINNESOTA:

Disparities by Insurance Type

For care delivered in 2024

MN Community MEASUREMENT

DEPARTMENT OF HUMAN SERVICES

ABOUT
MNCM & DHS

MN COMMUNITY MEASUREMENT (MNCM)

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 collaborating with community partners 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.

MN DEPARTMENT OF HUMAN SERVICES (DHS)

The MN Department of Human Services (MN DHS) is the state Medical Assistance (Medicaid) agency responsible for purchasing health care services for approximately 1.4 million Minnesotans (Minnesota Department of Human Services, 2023), about 25% of the state's population. Most Minnesotans enrolled in Medicaid receive services through the state's contracted managed care organizations. Minnesota Medicaid plays a critical role in ensuring access to high quality care for vulnerable populations including children, persons with disabilities, and seniors. DHS's mission is, working with others, to help people meet their basic needs so they can live in dignity and achieve their highest potential.

REPORT AUTHORS & CONTRIBUTORS

Jess Donovan, MPH, BSN
MN Community Measurement

Alyssa Breen, PhD
MN Department of Human Services

Sterling Kowalski, MS
MN Department of Human Services

Jay Wilson, MSW
MN Department of Human Services

TABLE OF CONTENTS

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 and to the many members of MNCM committees, workgroups and staff providing ongoing guidance to shape this important work.

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

SECTION 1:
Report Overview

For over 15 years, MNCM has partnered with DHS to measure health care quality by insurance type. This report summarizes MNCM's analysis comparing key measures for Minnesotans enrolled in a Minnesota Health Care Program (MHCP). The measures featured in this report (summarized on right) include those meeting legislative requirements (MN Statute 256B.072 Section 1d, 2025), plus additional measures chosen by DHS and MNCM to identify and examine gaps in quality for patients enrolled in MHCP, with the goal of informing community efforts on improvement.

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

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

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

The data collected in this report were collected by MNCM in 2025 for 2024 dates of service.

QUALITY MEASURES

Below are the measures featured in this report:

Preventive Health

- Colorectal Cancer Screening
- Breast Cancer Screening
- Childhood Immunization Status (Combo 10)
- Immunizations for Adolescents

Chronic Conditions

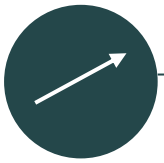
- Optimal Diabetes Care, plus five components:
  - HbA1c Control
  - Blood Pressure Control
  - Daily Aspirin Use
  - Statin Use
  - Tobacco-free
- Optimal Vascular Care, plus four components:
  - Blood Pressure Control
  - Daily Aspirin Use
  - Statin Use
  - Tobacco-free
- Optimal Asthma Control –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

Mental Health

- Adolescent Mental Health and/or Depression Screening
- Adolescent Depression: Remission at Six Months
- Adult Depression: Remission at Six Months

KEY FINDINGS

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



Rate Changes from 2023 to 2024 for MHCP

- **Improvements:** Breast Cancer Screening had the largest rate increase from 2023 (4.7 percentage points), followed by Controlling High Blood Pressure (2.2 percentage points), and Colorectal Cancer Screening (1.3 percentage points).
- **Stable Measures:** The rates for Immunizations for Adolescents (Combo 2), Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Control – Adults, Optimal Asthma Control – Children, Adolescent Mental Health and/or Depression Screening, Adolescent Depression: Remission at Six Months, and Adult Depression: Remission at Six Months remained unchanged from 2023.
- **Declines:** The rate for Childhood Immunization Status (Combo 10) declined by almost five percentage points from 2023 to 2024 in the MHCP population. This finding is not unique to the MHCP population and was observed at the statewide level as well.

Gaps Between MHCP and Other Purchasers

- Across all measures, the MHCP population had lower rates of health screenings and outcomes compared to the Other Purchasers population.
- The largest gap in rates between the populations was observed in the Childhood Immunization Status (Combo 10) measure, with a difference of almost 27 percentage points.

Disparities in Race, Ethnicity, Language, and Country of Origin

- Patients who are Black or Indigenous/Native patients consistently experienced lower rates across cancer screenings, immunizations, and chronic conditions.
- For rates for Black and Indigenous/Native patients were below the statewide MHCP MCO rate for over half of the measures (8 out of 12 measures (67%) and 7 out of 12 measures (58%), respectively).
- Compared to MHCP statewide averages, patients who prefer to speak languages other than English had higher rates of Optimal Diabetes Care, Optimal Vascular Care, and Optimal Asthma Control – Children, but lower rates of Colorectal Cancer Screening and Adolescent Mental Health screening.
- Compared to MHCP statewide averages, patients born outside of the United Statese had higher rates of Optimal Diabetes Care, Optimal Vascular Care, and Optimale Asthma Control – Children, but lower rates of Colorectal Cancer Screening.

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

The table below displays the statewide average changes from the current year to the previous year for the MHCP MCO population for each quality measure. Denominators for each measure are displayed below the rate in each column. Statistically significant differences are denoted by an asterisk (*) and are based on 95% confidence intervals ($p < 0.05$).

Measure	2023 Rate	2023 Denominator	2024 Rate	2024 Denominator	Percentage Point Change
Breast Cancer Screening	58.1%	59,745	62.8%	47,325	+4.7%*
Childhood Immunization Status (Combo 10)	30.2%	9,275	25.7%	9,071	-4.5%*
Colorectal Cancer Screening	54.8%	147,216	56.1%	123,195	+1.3%*
Immunizations for Adolescents (Combo 2)	29.1%	9,326	29.5%	8,786	+0.4%
Controlling High Blood Pressure	67.0%	11,178	69.2%	10,144	+2.2%*
Optimal Diabetes Care	36.2%	49,141	36.1%	42,997	-0.1%
Optimal Vascular Care	43.7%	18,708	42.9%	17,707	-0.8%
Optimal Asthma Control – Adults	43.6%	34,338	44.4%	30,707	+0.8%
Optimal Asthma Control – Children	49.5%	17,966	50.5%	16,042	+1.0%
Adolescent Mental Health and/or Depression Screening	92.3%	38,558	92.1%	32,678	-0.2%
Adolescent Depression: Remission at Six Months	6.2%	2,961	6.1%	2,268	-0.1%
Adult Depression: Remission at Six Months	7.8%	19,308	7.4%	17,340	-0.4%

TABLE 2: Summary of Statewide Average Differences by Insurance Type

The table below displays the difference in statewide averages between the MHCP MCO population and the Other Purchasers population. The results shown represent measurement year 2024. Statistically significant differences are based on 95% confidence intervals ($p < 0.05$) and are denoted with an asterisk (*). To calculate the rate difference over time, MHCP rates from 2020 to 2024 were used.

Measure	MHCP MCO Statewide Average	Other Purchasers Statewide Average	Rate Difference	Rate Difference Over Time
Breast Cancer Screening	62.8%	81.4%	-18.6%*	Gap widened*
Childhood Immunization Status (Combo 10)	25.7%	52.5%	-26.7%*	Gap widened*
Colorectal Cancer Screening	56.1%	73.5%	-17.4%*	Gap widened*
Immunizations for Adolescents (Combo 2)	29.5%	37.2%	-7.7%*	Gap stable
Controlling High Blood Pressure	69.2%	72.4%	-3.2%*	Gap widened*
Optimal Diabetes Care	36.1%	49.2%	-13.2%*	Gap widened*
Optimal Vascular Care	42.9%	56.8%	-13.9%*	Gap widened*
Optimal Asthma Control – Adults	44.4%	56.1%	-11.7%*	Gap widened*
Optimal Asthma Control – Children	50.5%	56.3%	-5.8%	Gap narrowed*
Adolescent Mental Health and/or Depression Screening	92.1%	93.9%	-1.8%*	Gap stable
Adolescent Depression: Remission at Six Months	6.1%	8.0%	-1.9%*	Gap stable
Adult Depression: Remission at Six Months	7.4%	10.7%	-3.2%*	Gap stable

TABLE 3: Summary of Findings by Race/Ethnicity

The table below compares the MHCP MCO rate of each race/ethnicity group to the MHCP MCO statewide average for measurement year 2024.

Table Key

▲ Above	Rate is significantly above the MHCP statewide average
● Average	Rate is not statistically different than the MHCP statewide average
▼ Below	Rate is significantly below the MHCP statewide average
NR	Not reportable; did not meet the minimum number of patients needed for statistically reliable results

Preventive Health

Measure	MHCP MCO Statewide Average	Asian	Black	Indigenous/ Native	Multi Race	Native Hawaiian	White	Hispanic/Latinx	Not Hispanic/Latinx
Colorectal Cancer Screening	56.1%	▲ Above	▼ Below	▼ Below	● Average	▼ Below	▲ Above	● Average	● Average
Breast Cancer Screening	62.8%	● Average	▼ Below	▼ Below	● Average	● Average	● Average	▲ Above	● Average
Childhood Immunization Status	25.7%	▲ Above	▼ Below	▼ Below	● Average	NR	● Average	▲ Above	● Average
Immunizations for Adolescents	29.5%	▲ Above	● Average	● Average	● Average	NR	● Average	▲ Above	● Average

TABLE 3: Summary of Findings by Race/Ethnicity Continued

Chronic Conditions

Measure	MHCP MCO Statewide Average	Asian	Black	Indigenous/ Native	Multi Race	Native Hawaiian	White	Hispanic/Latinx	Not Hispanic/Latinx
Controlling High Blood Pressure	69.2%	● Average	▼ Below	● Average	▼ Below	NR	▲ Above	● Average	● Average
Optimal Diabetes Care	36.1%	▲ Above	▼ Below	▼ Below	▼ Below	● Average	▲ Above	● Average	● Average
Optimal Vascular Care	42.9%	▲ Above	▼ Below	▼ Below	● Average	● Average	● Average	▲ Above	● Average
Optimal Asthma Control – Adults	44.4%	▲ Above	▼ Below	▼ Below	● Average	● Average	▲ Above	● Average	● Average
Optimal Asthma Control – Children	50.5%	▲ Above	● Average	▼ Below	● Average	● Average	● Average	● Average	● Average

Mental Health

Measure	MHCP MCO Statewide Average	Asian	Black	Indigenous/ Native	Multi Race	Native Hawaiian	White	Hispanic/Latinx	Not Hispanic/Latinx
Adolescent Mental Health Screening	92.1%	▲ Above	▼ Below	● Average	▲ Above	● Average	▲ Above	● Average	● Average
Adolescent Depression: Remission at Six Months	6.1%	● Average	● Average	● Average	● Average	NR	● Average	● Average	● Average
Adult Depression: Remission at Six Months	7.4%	▲ Above	● Average	● Average	● Average	NR	● Average	● Average	● Average

SECTION 2:
Preventive Health

Preventive health includes services such as routine exams, immunizations, and screenings. These services play a vital role in preventing disease and catching health care conditions early when they are typically easier to treat. However, in 2015, it was estimated that only 8% of adults 35 years and older in the United States received all recommended, clinically appropriate preventive services. (Borsky et al, 2018). Barriers to receiving preventive care are multi-faceted and can range from system-level barriers such as insurance coverage and cost to patient- and provider-level barriers such as fear of discrimination, language barriers, and family/work responsibility (Sobatino et al, 2015a). These barriers are especially true for low-income, publicly insured populations, and interventions to that address these barriers are critical to improve access to care (Sobatino et al, 2015b).

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

Measures

The measures featured in this section of the report are stewarded by the National Committee for Quality Assurance (NCQA) and use the Healthcare Effectiveness Data and Information Set (HEDIS) measure definitions. HEDIS® is a registered trademark of NCQA.

Measures Reported by Medical Groups/Clinics:

Colorectal Cancer Screening

Measures Reported by Health Plans:

Breast Cancer Screening

Childhood Immunization Status (Combo 10)

Immunizations for Adolescents (Combo 2)

COLORECTAL CANCER SCREENING:
Rates Over Time

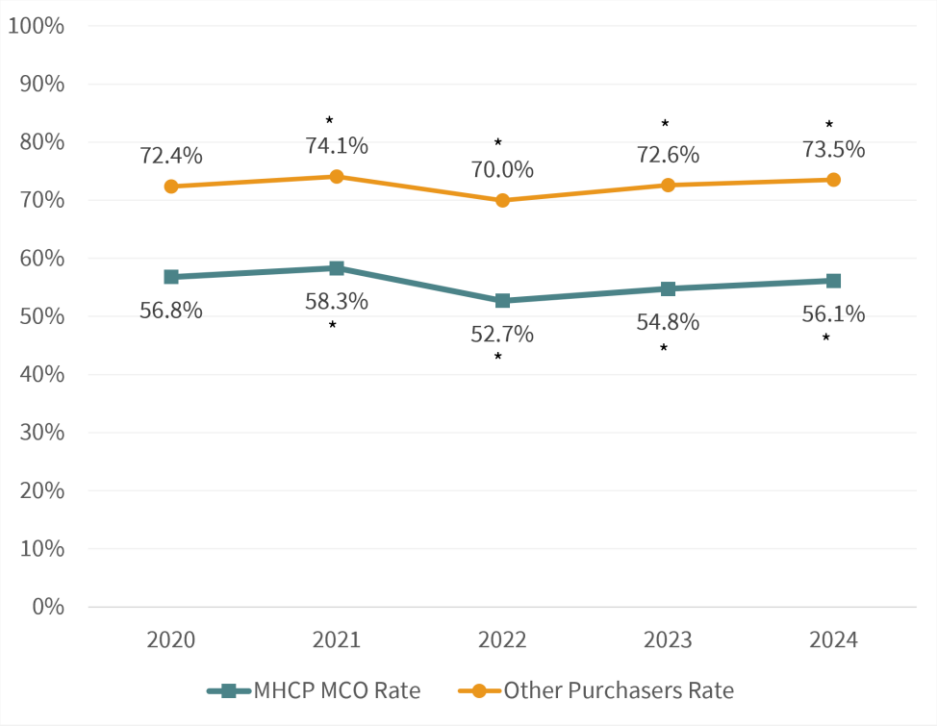
2020 – 2024 measurement years

Measure Definition: The percentage of members 45-75 years of age who had appropriate screening for colorectal cancer:

- 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
- FIT-DNA during the measurement year or two years prior OR
- Guaiac-based fecal occult blood test (gFOBT) or FIT during the measurement year

NOTES:

- The MHCP population in this graph represents only those with managed care (MCO).
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.
- In 2022, the eligible age range for this measure was expanded to include 45–75-year-olds, which aligns with the U.S. Preventive Services Task Force (USPSTF) recommendation. Rates prior to 2022 used an eligible age range of 50-75.



View data table for Colorectal Cancer Screening: Rates Over Time

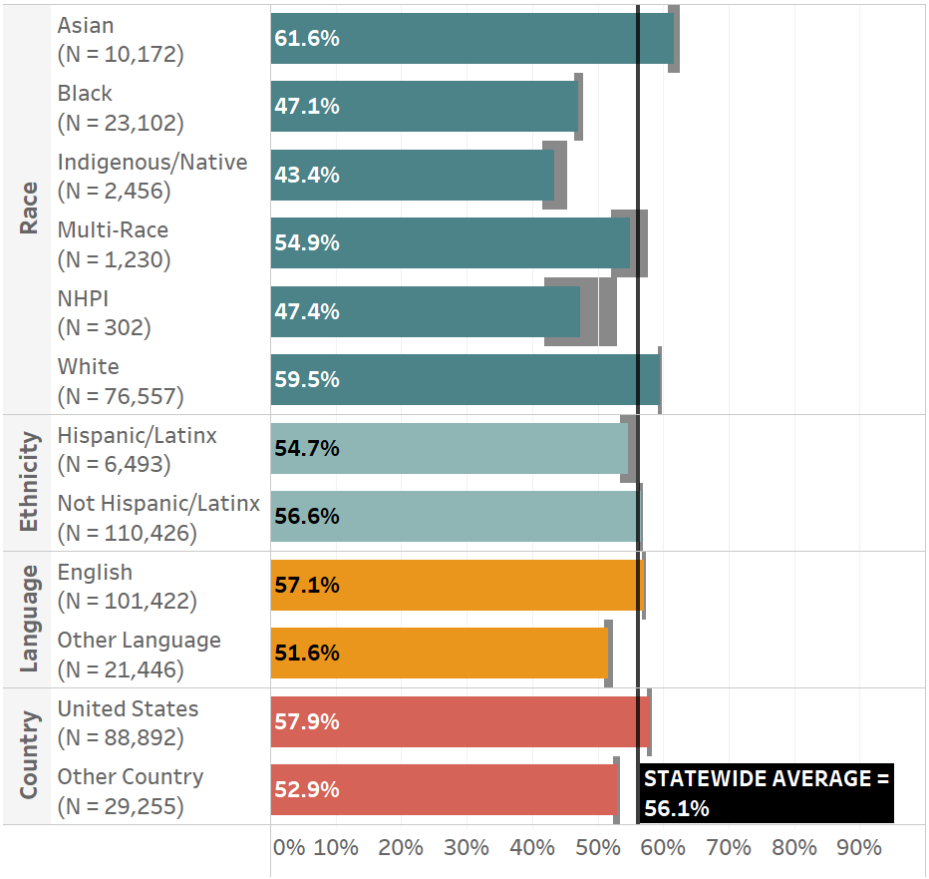
FINDINGS

- From 2023 to 2024, the rate of Colorectal Cancer Screening significantly increased by 1.3 percentage points for the MHCP population.
- In 2024, there was a significant 17.4 percentage point gap in screening rates between the Other Purchasers population (73.5%) and the MHCP population (56.1%).

COLORECTAL CANCER SCREENING:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Colorectal Cancer Screening: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

Compared to the MHCP MCO statewide average, **lower** rates of screening were observed among Black, Indigenous/Native, and NHPI patients, as well as patients who prefer languages other than English, and those born outside the United States.

In contrast, **higher** rates of screening were observed among Asian and White patients, patients who prefer to speak English, and those born in the United States.

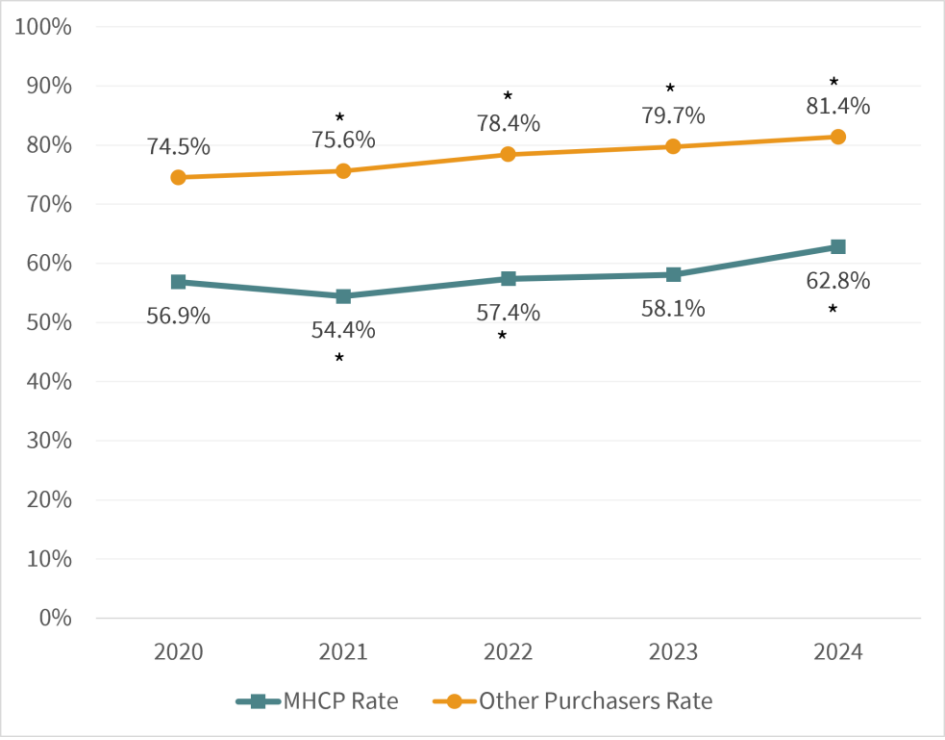
BREAST CANCER SCREENING:
Rates Over Time

2020 – 2024 measurement years

Measure Definition: The percentage of members 50-74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer (NCQA, n.d.-a).

NOTES:

- This measure does not allow the separation of managed care (MCO) and fee-for-service (FFS) for the MHCP population, so the rate includes both.
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Breast Cancer Screening: Rates Over Time

FINDINGS

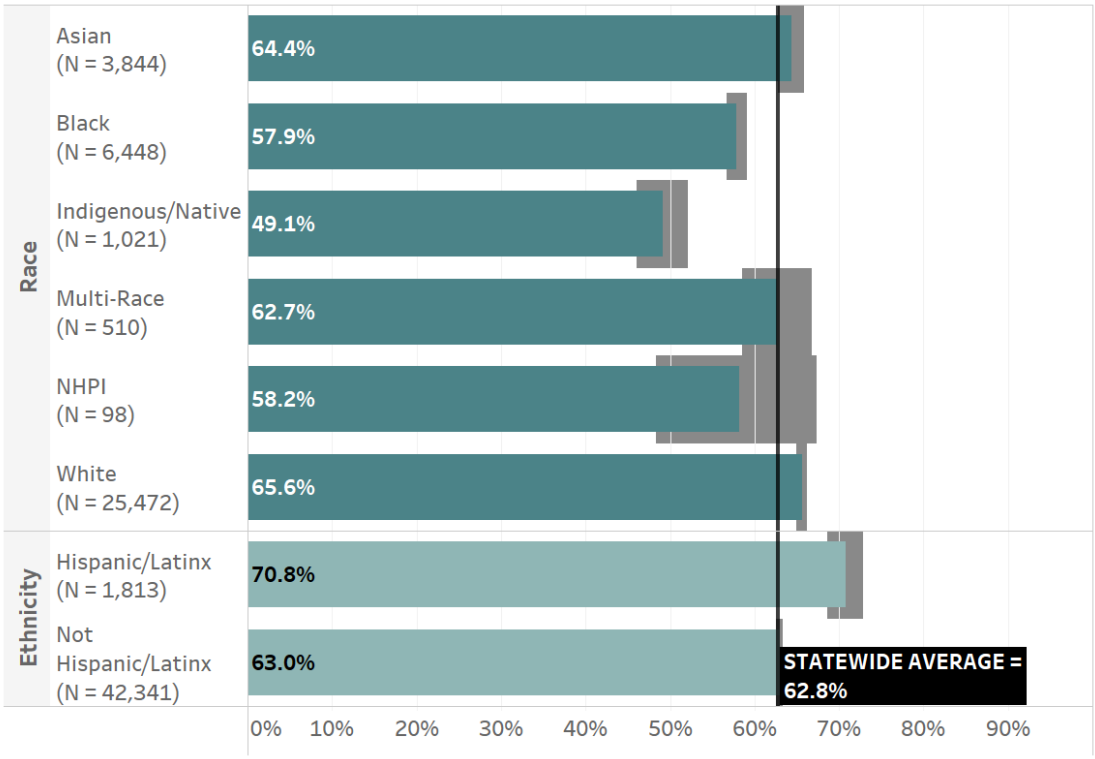
- From 2023 to 2024, the rate of Breast Cancer Screening significantly increased by nearly 5 percentage points for the MHCP population.
- In 2024, there was a significant 18.6 percentage point gap in screening rates between the Other Purchasers population (81.4%) and the MHCP population (62.8%).

BREAST CANCER SCREENING:
MHCP Rates by Race/Ethnicity

2024 measurement year

NOTES:

- Stratification by Preferred Language and Country of Origin is not available for this measure. For more information, view the Methodology appendix.
- The "Statewide Average" for this chart refers to the overall rate for the MHCP population only. This measure does not allow the separation of managed care (MCO) and fee-for-service (FFS), so the rate includes both.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Breast Cancer Screening: MHCP Rates by Race/Ethnicity

FINDINGS

Compared to the MHCP statewide average, **lower** rates of screening were observed among Black and Indigenous/Native patients.

In contrast, **higher** rates of screening were observed among White patients and Hispanic/Latinx patients.

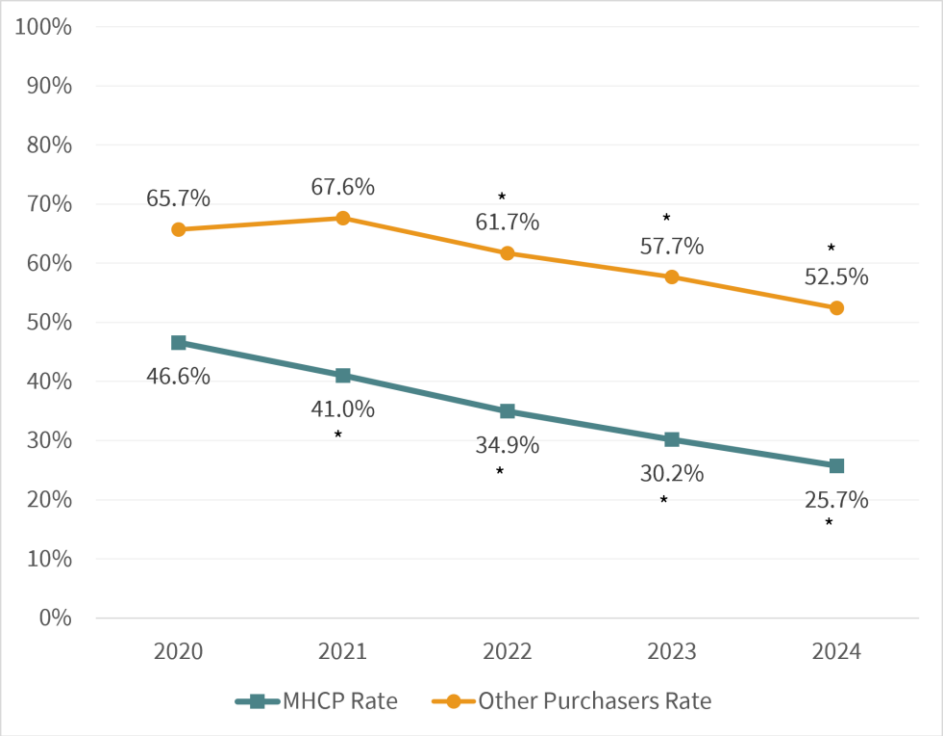
CHILDHOOD IMMUNIZATION STATUS (COMBO 10): Rates Over Time

2020 – 2024 measurement years

Measure Definition: The percentage of children 2 years of age who had 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 (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday (NCQA, n.d.-b).

NOTES:

- This measure does not allow the separation of managed care (MCO) and fee-for-service (FFS) for the MHCP population, so the rate includes both.
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Childhood Immunization Status: Rates Over Time

FINDINGS

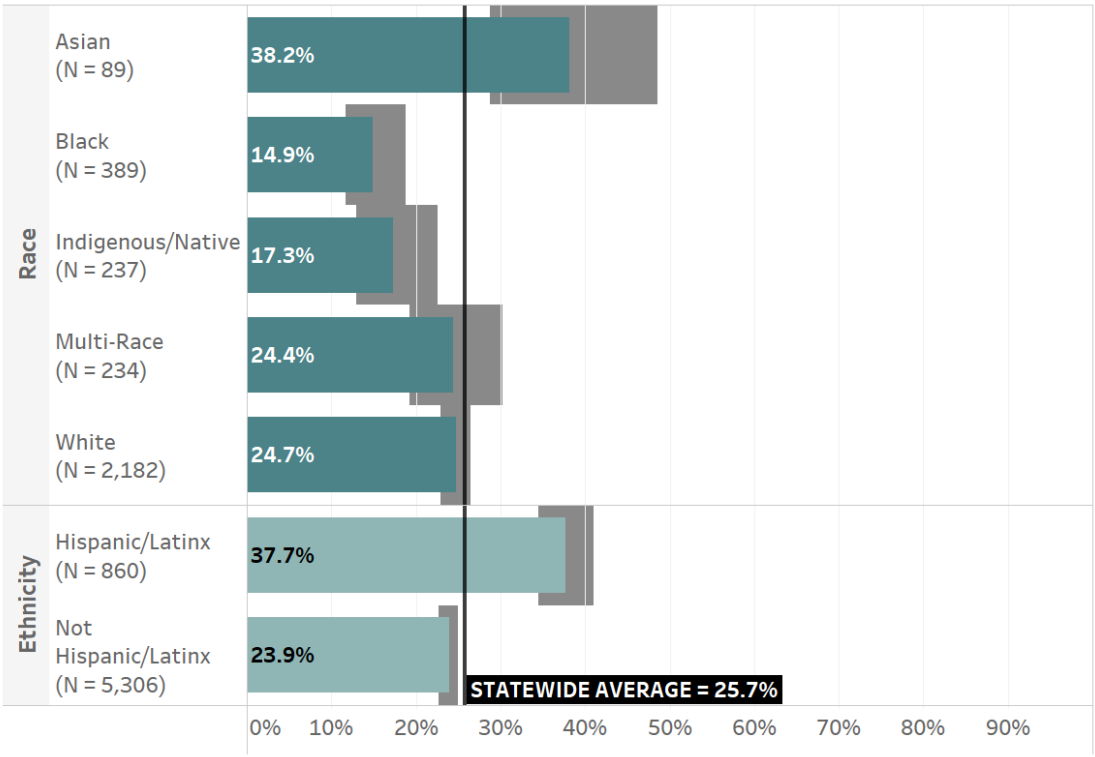
- From 2023 to 2024, the rate of Childhood Immunization Status significantly decreased by 4.5 percentage points for the MHCP population.
- For both populations, the rate of childhood immunizations continues to significantly decline.
- In 2024, there was a significant 26.8 percentage point gap in rates between the Other Purchasers population (52.5%) and the MHCP population (25.7%).

CHILDHOOD IMMUNIZATION STATUS (COMBO 10):
MHCP Rates by Race/Ethnicity

2024 measurement year

NOTES:

- Stratification by Preferred Language and Country of Origin is not available for this measure. For more information, view the Methodology appendix.
- The "Statewide Average" for this chart refers to the overall rate for the MHCP population only. This measure does not allow the separation of managed care (MCO) and fee-for-service (FFS), so the rate includes both.
- Grey shading next to bars represents 95% confidence interval.
- The Native Hawaiian/Pacific Islander group had less than 60 patients for this measure, which is below the reporting threshold and so have been excluded from the graph.



View data table for Childhood Immunization Status: MHCP Rates by Race/Ethnicity

FINDINGS

Compared to the MHCP statewide average, a **lower** rate of childhood immunizations was observed among Black and Indigenous/Native patients.

In contrast, **higher** rates of childhood immunizations were observed among Asian patients and Hispanic/Latinx patients.

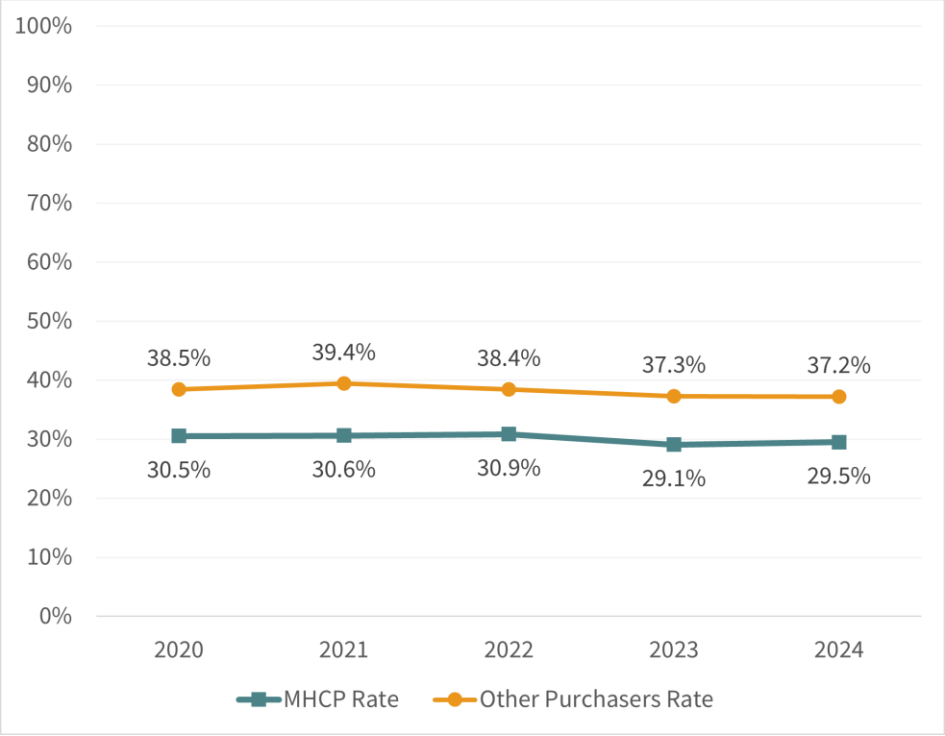
IMMUNIZATIONS FOR ADOLESCENTS (COMBO 2): Rates Over Time

2020 – 2024 measurement years

Measure Definition[8]: The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

NOTES:

- This measure does not allow the separation of managed care (MCO) and fee-for-service (FFS) for the MHCP population, so the rate includes both.
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Immunizations for Adolescents: Rates Over Time

FINDINGS

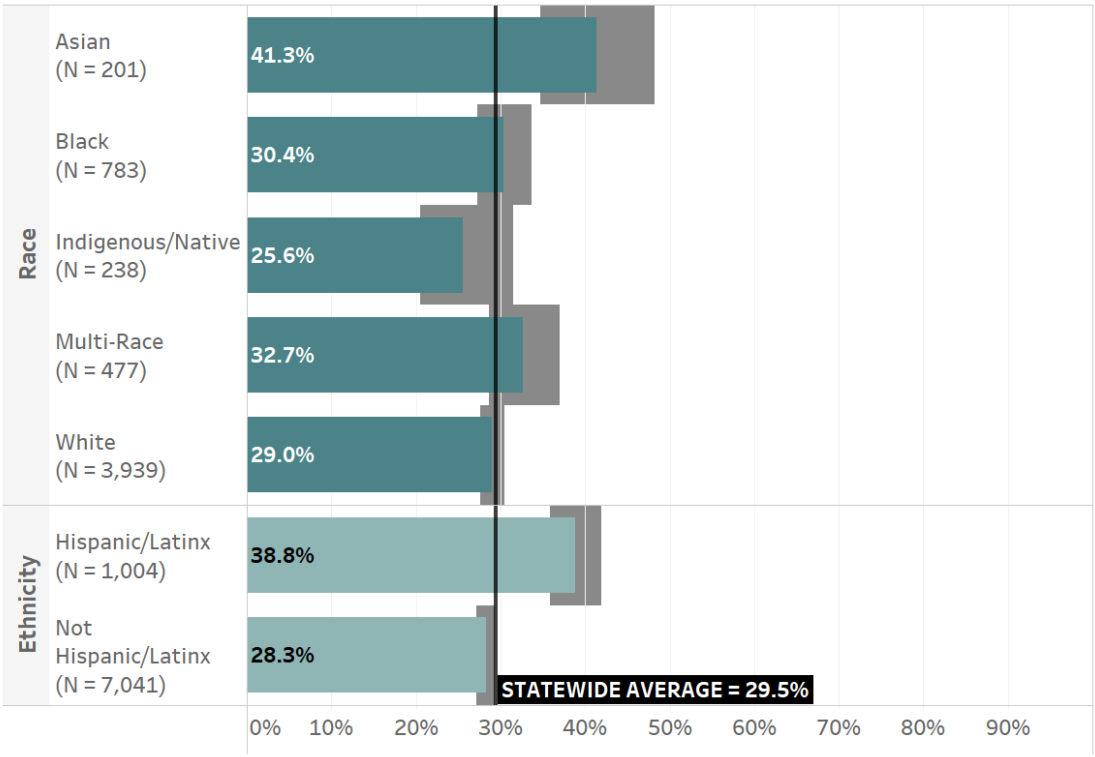
- From 2023 to 2024, the rate of Immunizations for Adolescents remained stable for both populations (no significant rate changes).
- In 2024, there was a significant 7.7 percentage point gap in rates between the Other Purchasers population (37.2%) and the MHCP population (29.5%).

IMMUNIZATIONS FOR ADOLESCENTS (COMBO 2):
MHCP Rates by Race/Ethnicity

2024 measurement year

NOTES:

- Stratification by Preferred Language and Country of Origin is not available for this measure. For more information, view the Methodology appendix.
- The "Statewide Average" for this chart refers to the overall rate for the MHCP population only. This measure does not allow the separation of managed care (MCO) and fee-for-service (FFS), so the rate includes both.
- Grey shading next to bars represents 95% confidence interval.
- The Native Hawaiian/Pacific Islander group had less than 60 patients for this measure, which is below the reporting threshold and so have been excluded from the graph.



View data table for Immunizations for Adolescents: MHCP Rates by Race/Ethnicity

FINDINGS

Compared to the MHCP statewide average, **higher** rates of adolescent immunizations were observed among Asian patients and Hispanic/Latinx patients.

SECTION 3:
Chronic Conditions

In 2023, over 76% of adults in the United States reported having at least one chronic condition (Watson et al, 2025). The prevalence of chronic conditions such as heart disease and diabetes continues to grow and are key contributors to morbidity and mortality throughout the country (Watson et al, 2025; Hacker, 2024). Moreover, chronic conditions place a significant burden on the healthcare system, and it is estimated that by 2030, the cost of these conditions will reach $47 trillion worldwide (Hacker, 2024).

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

Measures

The Controlling High Blood Pressure measure is stewarded by NCQA and defined by the HEDIS measure specifications. All other measures in this section are stewarded by MN Community Measurement.

Measures Reported by Medical Groups/Clinics:

Optimal Diabetes Care

Optimal Vascular Care

Optimal Asthma Control (Adults & Children)

Measures Reported by Health Plans:

Controlling High Blood Pressure

OPTIMAL DIABETES CARE:
Rates Over Time

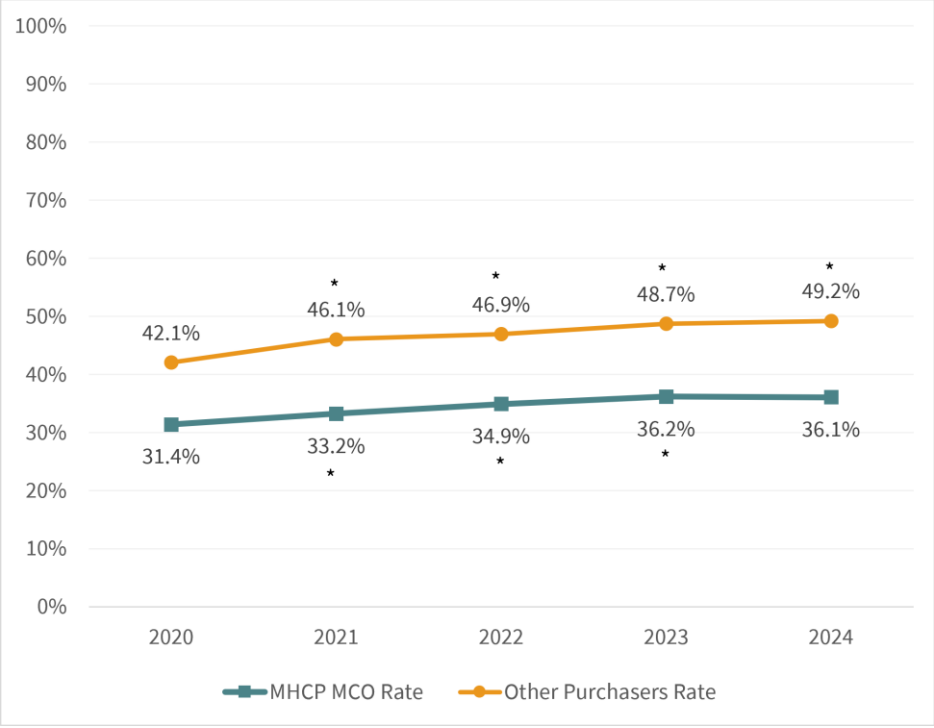
2020 – 2024 measurement years

Measure Definition: 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:

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

NOTES:

- The MHCP population in this graph represents only those with managed care (MCO).
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Optimal Diabetes Care: Rates Over Time

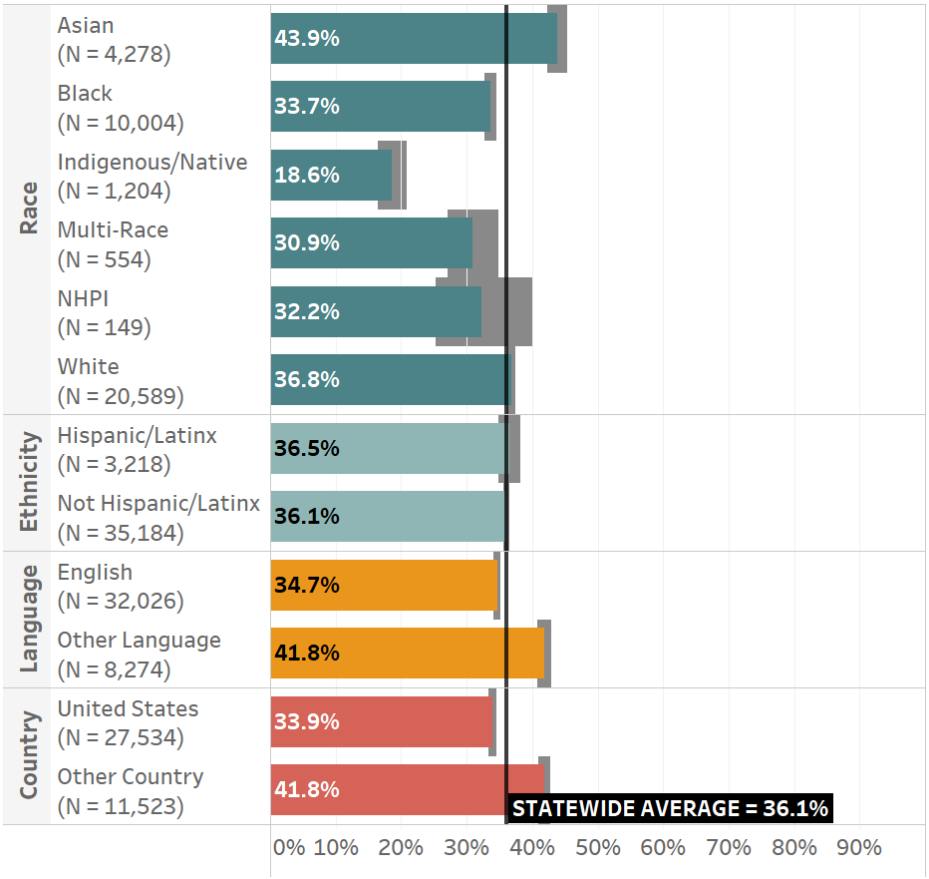
FINDINGS

- From 2023 to 2024, the rate of Optimal Diabetes Care remained stable (no significant change) for the MHCP MCO population.
- In 2024, there was a significant 13.2 percentage point gap in rates between the Other Purchasers population (49.2%) and the MHCP MCO population (36.1%).

OPTIMAL DIABETES CARE:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Diabetes Care: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

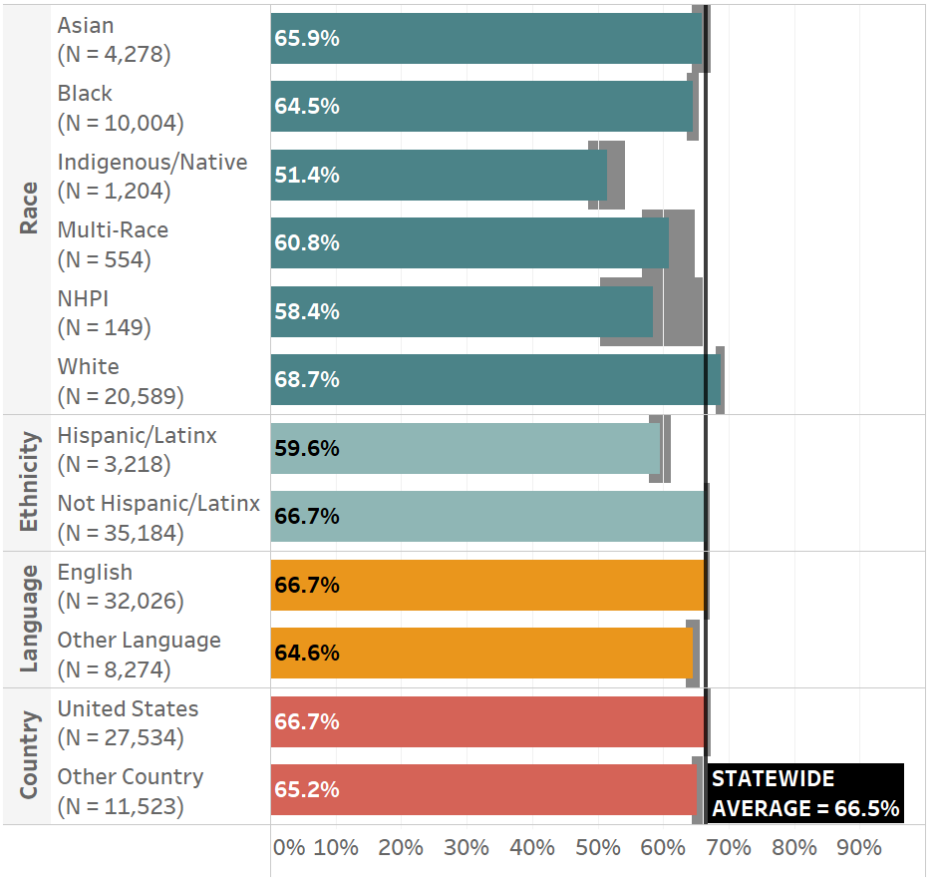
Compared to the MHCP MCO statewide average, **lower** rates of optimal care were observed among Black, Indigenous/Native, and Multi-Race patients, as well as patients who prefer to speak English, and those born in the United States.

In contrast, **higher** rates of optimal care were observed among Asian patients, patients who prefer languages other than English, and those born outside of the United States.

OPTIMAL DIABETES CARE – HBA1C CONTROL:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Diabetes Care – HbA1c Control: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

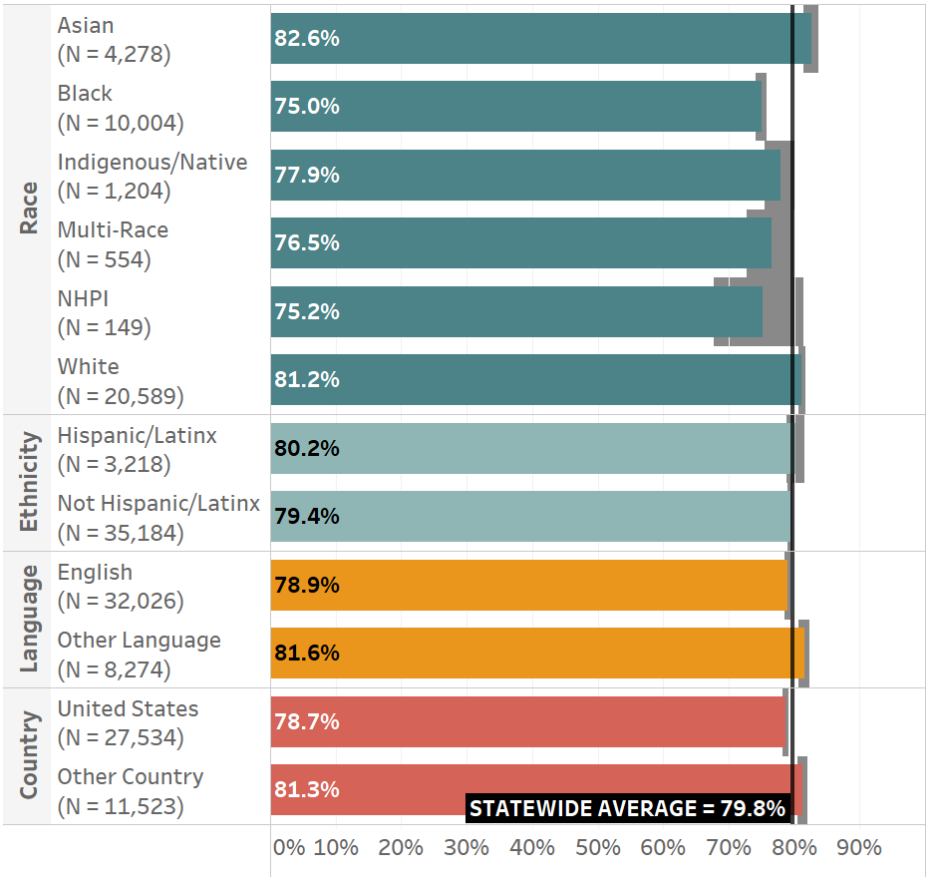
Compared to the MHCP MCO statewide average, **lower** rates of hbA1c control were observed among Black, Indigenous/Native, Native Hawaiian/Pacific Islander, and Multi-Race patients, as well as Hispanic/Latinx patients, and those who prefer a language other than English.

In contrast, a **higher** rate of hbA1c control was observed among White patients.

OPTIMAL DIABETES CARE – BP CONTROL:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Diabetes Care – BP Control: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

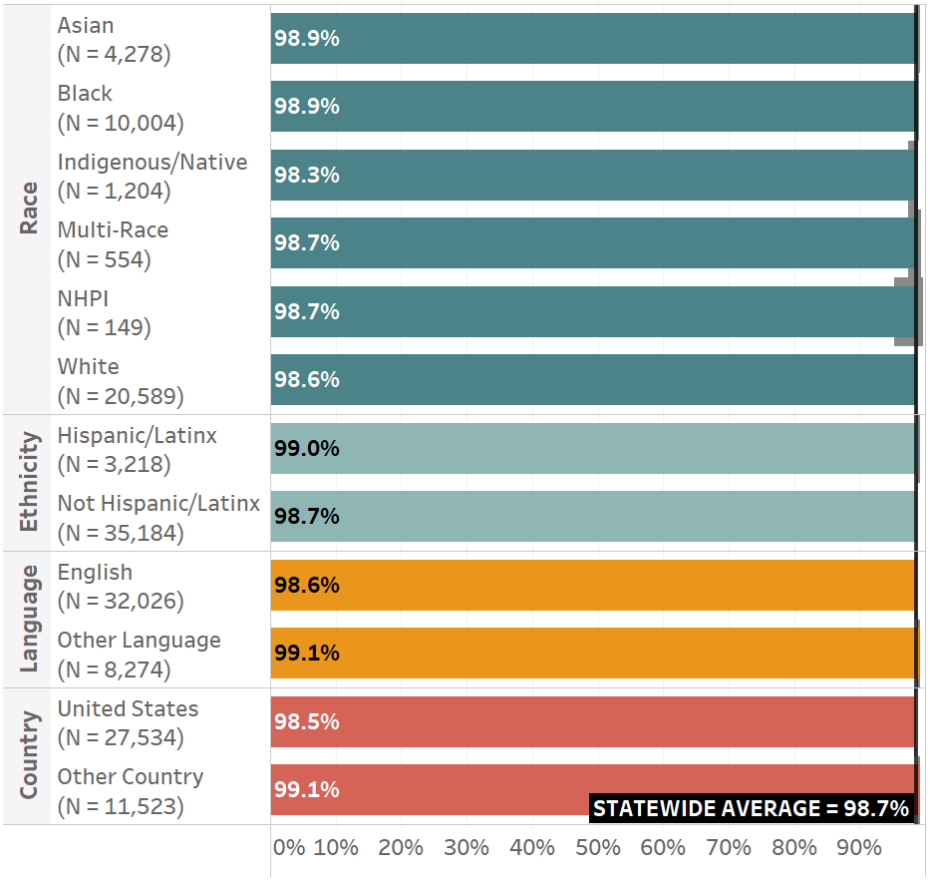
Compared to the MHCP MCO statewide average, **lower** rates of blood pressure control were observed among Black patients, patients who prefer to speak English, and those born in the United States.

In contrast, **higher** rates of blood pressure control were observed among Asian and White patients, patients who prefer languages other than English, and those born outside of the United States.

OPTIMAL DIABETES CARE – DAILY ASPIRIN USE:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Diabetes Care – Daily Aspirin Use: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

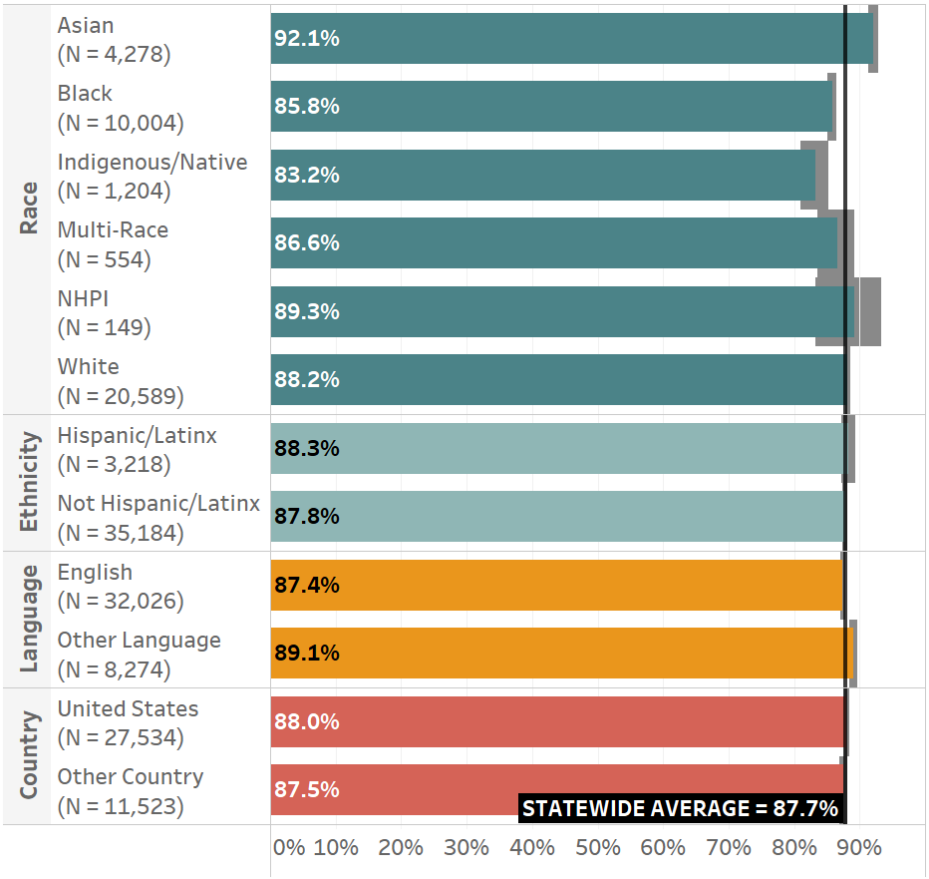
FINDINGS

Compared to the MHCP MCO statewide average, **higher** rates of daily aspirin use were observed among patients who prefer languages other than English and those born outside of the United States.

OPTIMAL DIABETES CARE – STATIN USE:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Diabetes Care – Statin Use: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

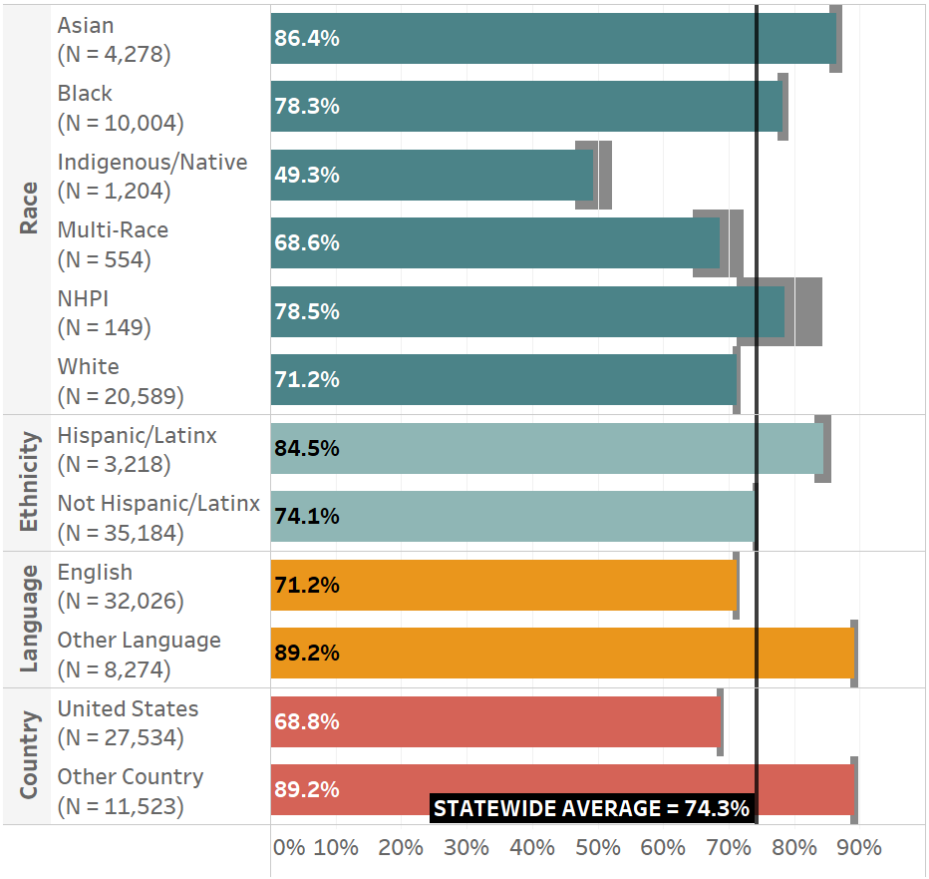
Compared to the MHCP MCO statewide average, **lower** rates of statin use were observed among Black and Indigenous/Native patients.

In contrast, **higher** rates of statin use were observed among Asian patients and patients who prefer languages other than English.

OPTIMAL DIABETES CARE – TOBACCO-FREE:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Diabetes Care – Tobacco-free: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

Compared to the MHCP MCO statewide average, **lower** rates of being tobacco-free were observed among Indigenous/Native, Multi-Race, and White patients, as well as patients who prefer to speak English, and those born in the United States.

In contrast, **higher** rates of being tobacco-free were observed among Asian and Black patients, Hispanic/Latinx patients, patients who prefer languages other than English, and those born outside of the United States.

OPTIMAL VASCULAR CARE:
Rates Over Time

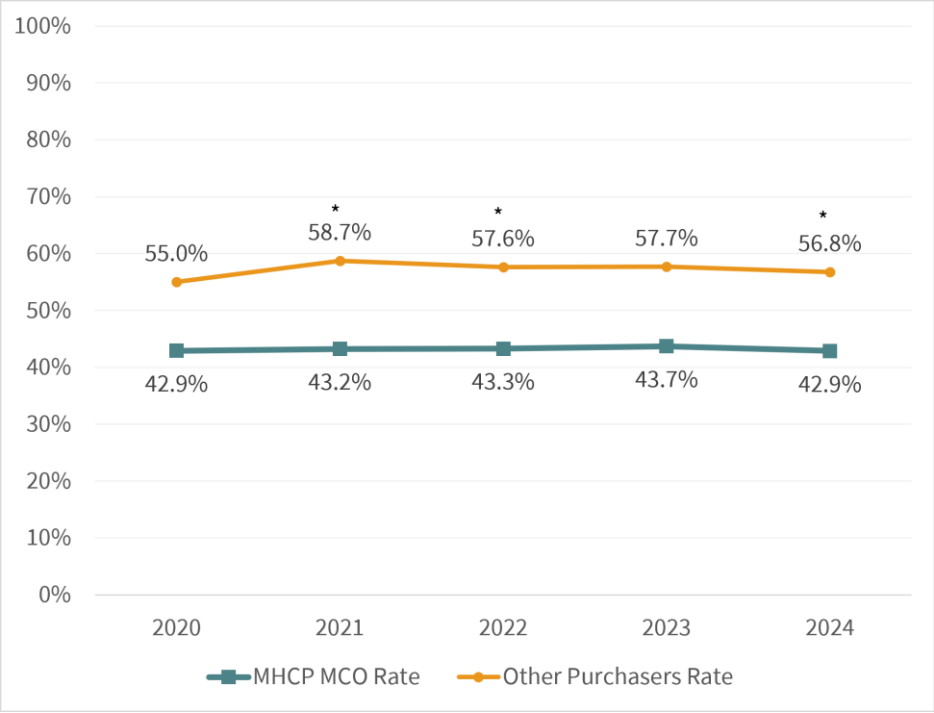
2020 – 2024 measurement years

Measure Definition: 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:

- Blood pressure less than 140/90 mmHg
- On a daily aspirin or antiplatelet, unless allowed contraindications or exceptions are present
- On a statin medication, unless allowed contraindications or exceptions are present
- Non-tobacco use

NOTES:

- The MHCP population in this graph represents only those with managed care (MCO).
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Optimal Vascular Care: Rates Over Time

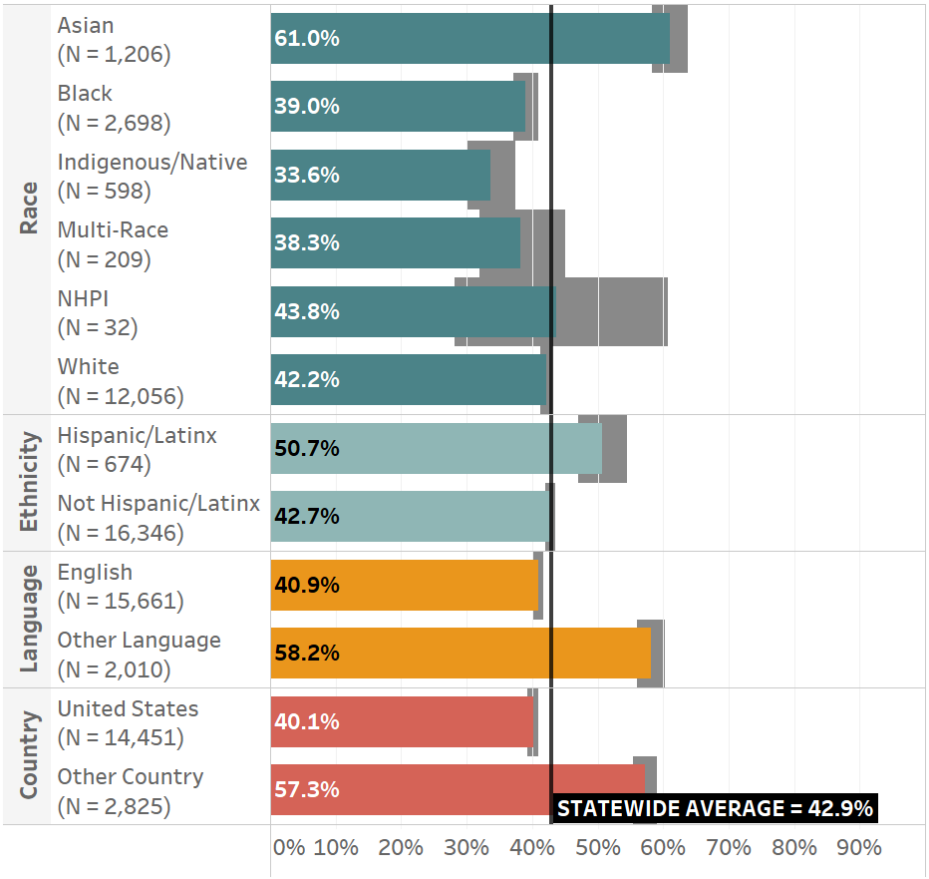
FINDINGS

- From 2023 to 2024, the rate of Optimal Vascular Care remained stable (no significant change) for the MHCP MCO population.
- In 2024, there was a significant 13.9 percentage point gap in rates between the Other Purchasers population (56.8%) and the MHCP population (42.9%).

OPTIMAL VASCULAR CARE:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Vascular Care: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

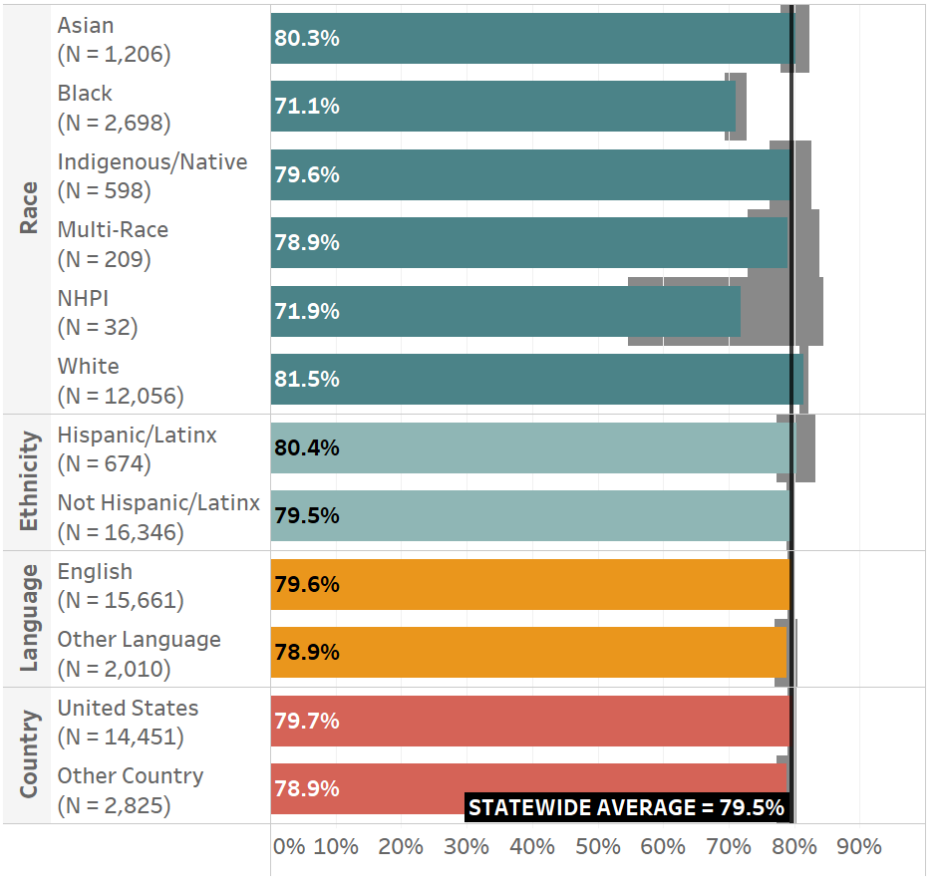
Compared to the MHCP MCO statewide average, **lower** rates of optimal care were observed among Black and Indigenous/Native patients, as well as patients who prefer to speak English, and those born in the United States.

In contrast, **higher** rates of optimal care were observed among Asian patients, Hispanic/Latinx patients, patients who prefer languages other than English, and those born outside of the United States.

OPTIMAL VASCULAR CARE – BP CONTROL:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Vascular Care – BP Control: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

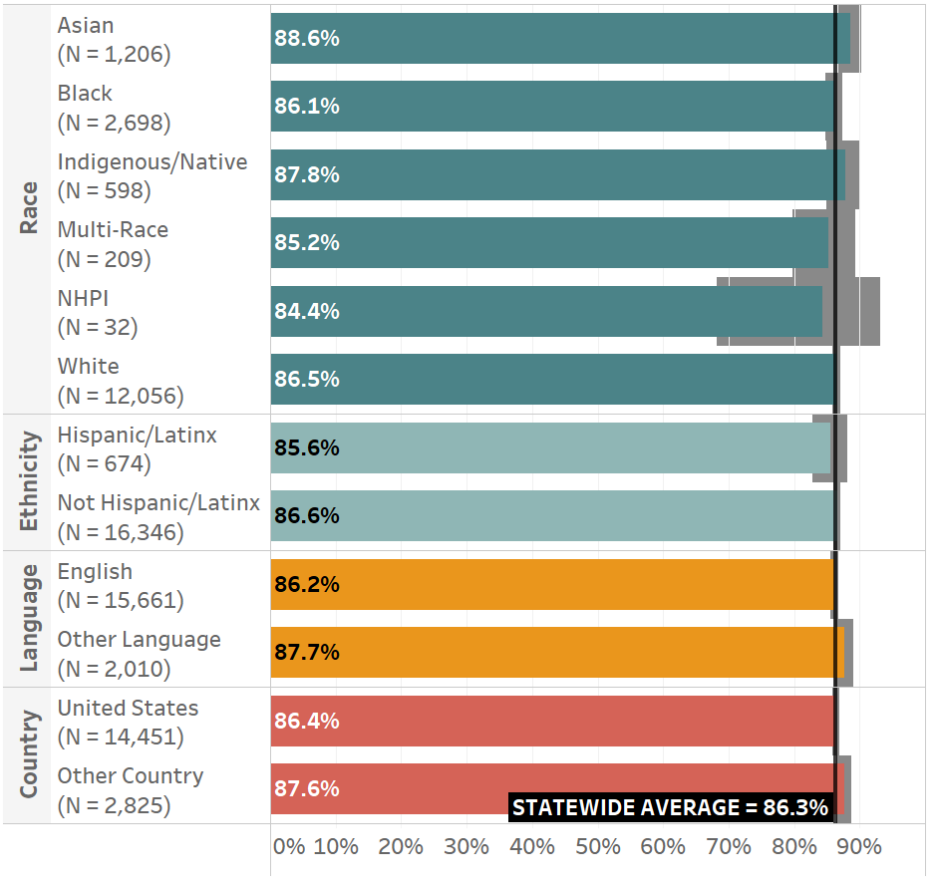
Compared to the MHCP MCO statewide average, a **lower** rate of blood pressure control was observed among patients who are Black.

In contrast, a **higher** rate of blood pressure control was observed among patients who are White.

OPTIMAL VASCULAR CARE – DAILY ASPIRIN USE:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Vascular Care – Daily Aspirin Use: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

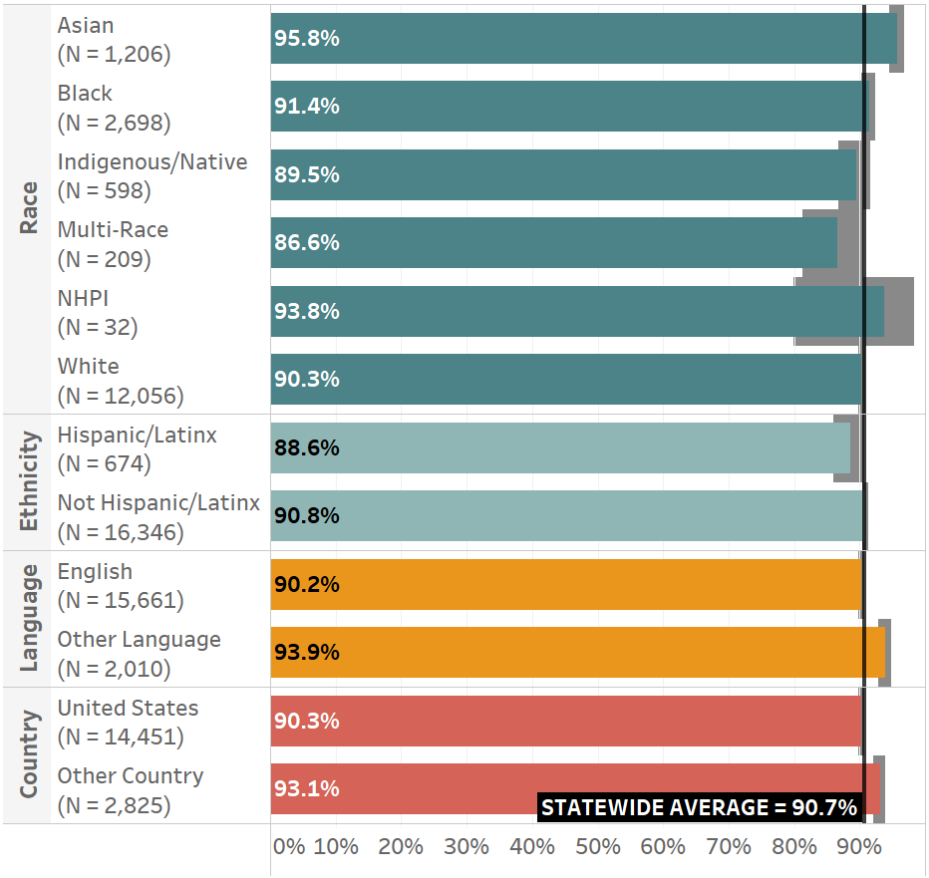
FINDINGS

Compared to the MHCP MCO statewide average, all groups had average rates of daily aspirin use.

OPTIMAL VASCULAR CARE – STATIN USE:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

Measurement year 2024

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Vascular Care – Statin Use: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

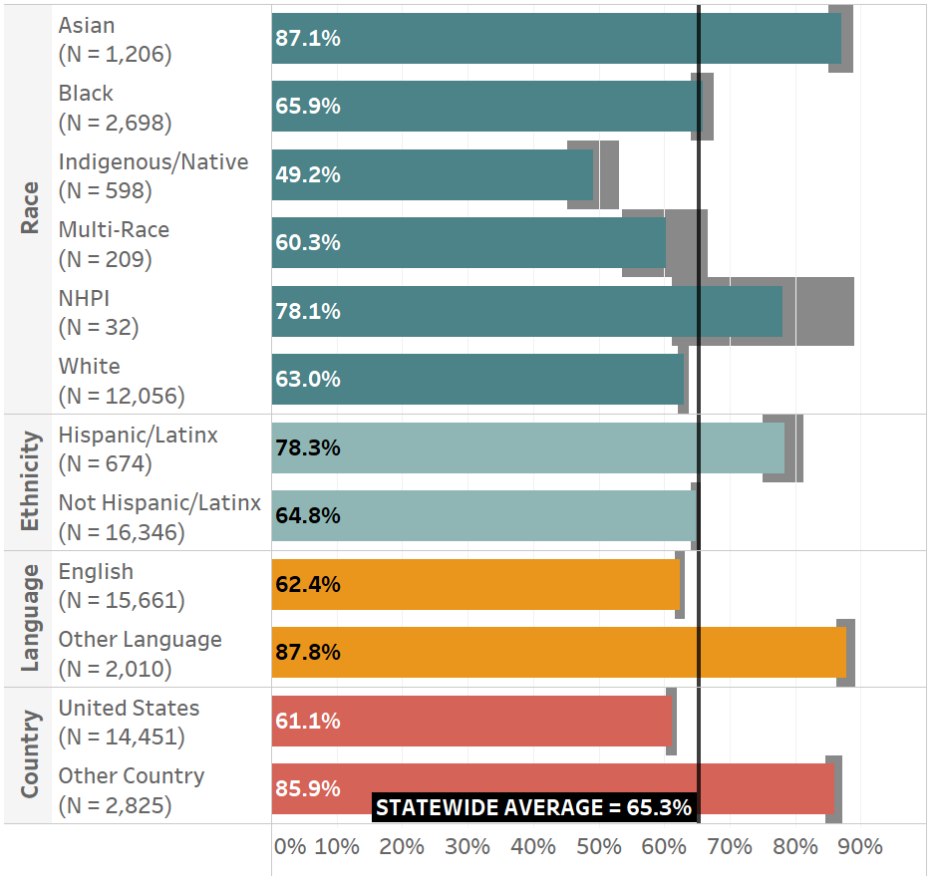
FINDINGS

Compared to the MHCP MCO statewide average, **higher** rates of statin use were observed among Asian patients, patients who prefer languages other than English, and those born outside of the United States.

OPTIMAL VASCULAR CARE – TOBACCO-FREE:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Vascular Care – Tobacco-free: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

Compared to the MHCP MCO statewide average, **lower** rates of being tobacco-free were observed among Indigenous/Native and White patients, as well as patients who prefer to speak English, and those born in the United States.

In contrast, **higher** rates of being tobacco-free were observed among Asian patients, Hispanic/Latinx patients, patients who prefer to languages other than English, and those born outside of the United States.

OPTIMAL ASTHMA CONTROL – ADULTS:
Rates Over Time

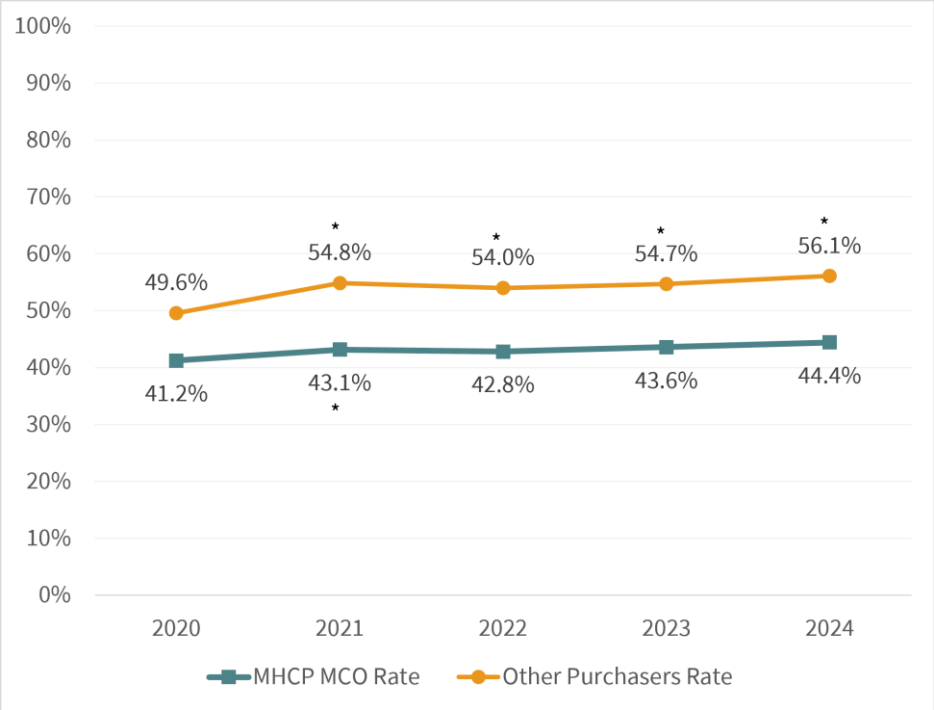
2020 – 2024 measurement years

Measure Definition: The percentage of patients 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:

- Asthma well-controlled as defined by the most recent asthma control tool result
- 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)

NOTES:

- The MHCP population in this graph represents only those with managed care (MCO).
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Optimal Asthma Control – Adults: Rates Over Time

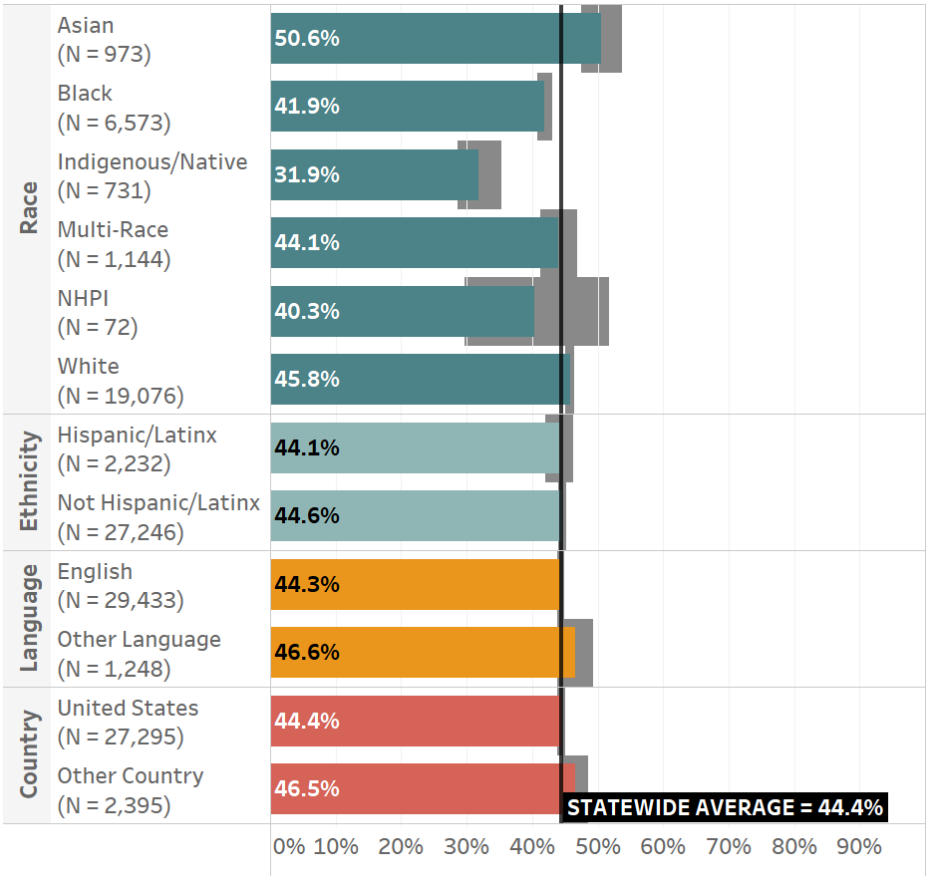
FINDINGS

- From 2023 to 2024, the rate of Optimal Asthma Control – Adults remained stable (no significant change) for the MHCP MCO population.
- In 2024, there was a significant 11.7 percentage point gap in rates between the Other Purchasers population (56.1%) and the MHCP population (44.4%).

OPTIMAL ASTHMA CONTROL – ADULTS:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Asthma Control – Adults: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

Compared to the MHCP MCO statewide average, **lower** rates of optimal control were observed among Black and Indigenous/Native patients.

In contrast, **higher** rates of optimal care were observed among Asian and White patients.

OPTIMAL ASTHMA CONTROL – CHILDREN:
Rates Over Time

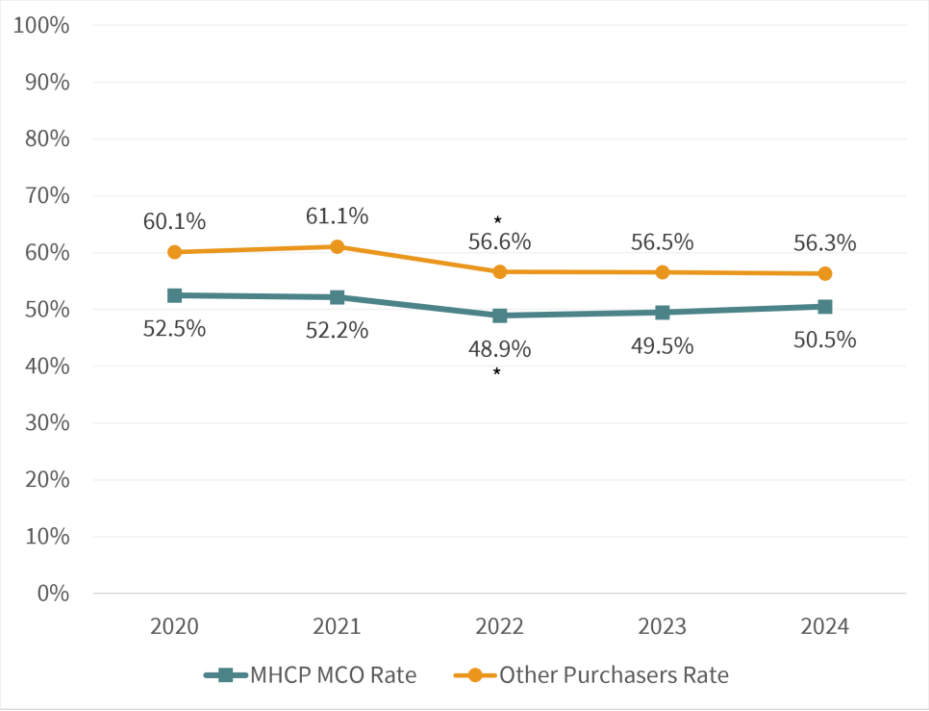
2020 – 2024 measurement years

Measure Definition: The percentage of patients 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:

- Asthma well-controlled as defined by the most recent asthma control tool result
- 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)

NOTES:

- The MHCP population in this graph represents only those with managed care (MCO).
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Optimal Asthma Control – Children: Rates Over Time

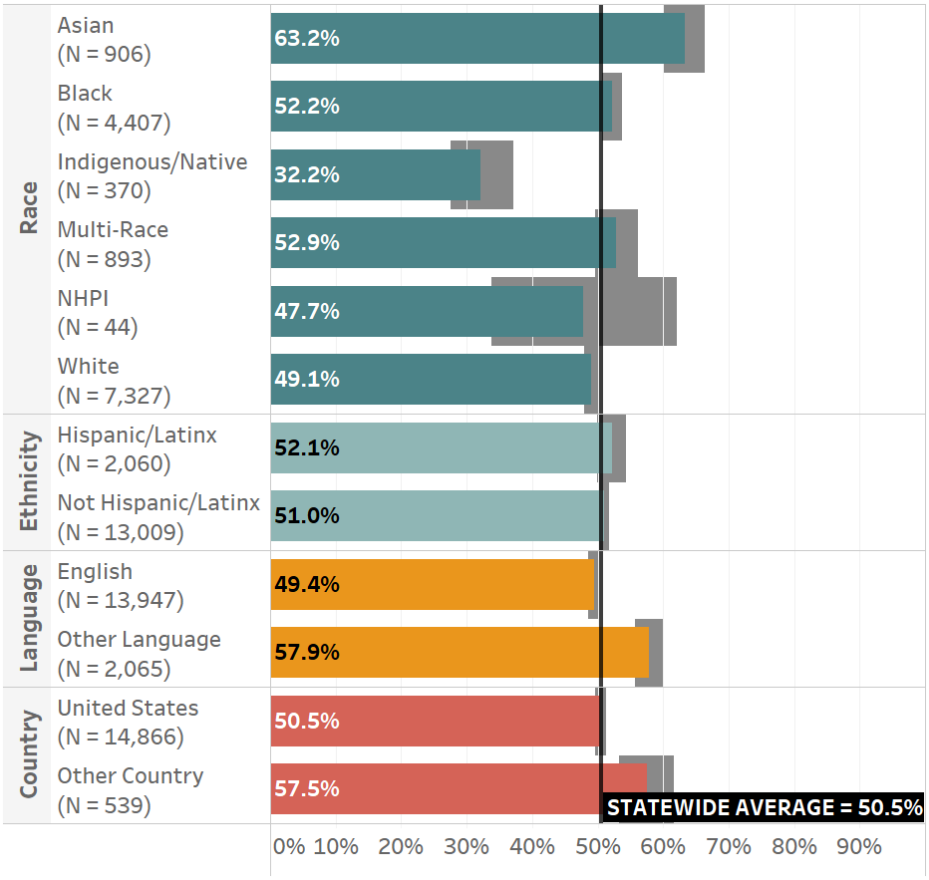
FINDINGS

- From 2023 to 2024, the rate of Optimal Asthma Control – Children remained stable (no significant change) for the MHCP MCO population.
- In 2024, there was a significant 5.8 percentage point gap in rates between the Other Purchasers population (56.3%) and the MHCP population (50.5%).

OPTIMAL ASTHMA CONTROL – CHILDREN:
MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:
- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Optimal Asthma Control – Children: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

Compared to the MHCP MCO statewide average, a **lower** rate of optimal control was observed among Indigenous/Native patients.

In contrast, **higher** rates of optimal control were observed among Asian patients, patients who prefer languages other than English, and those born outside of the United States.

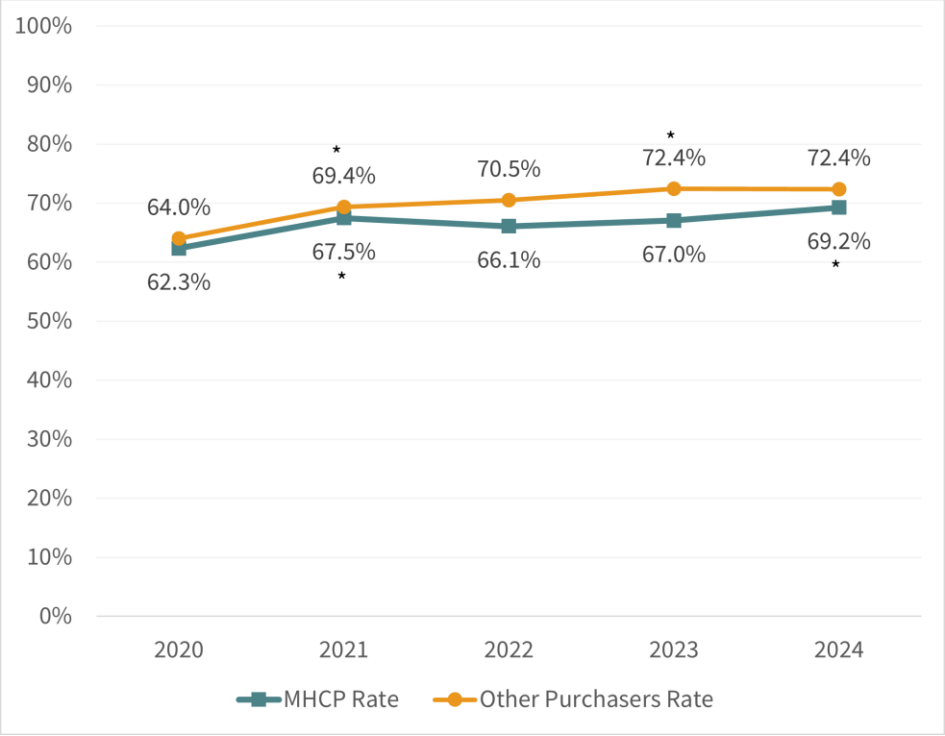
CONTROLLING HIGH BLOOD PRESSURE:
Rates Over Time

2020 – 2024 measurement years

Measure Definition: 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 (NCQA, n.d.-c).

NOTES:

- This measure does not allow the separation of managed care (MCO) and fee-for-service (FFS) for the MHCP population, so the rate includes both.
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Controlling High Blood Pressure: Rates Over Time

FINDINGS

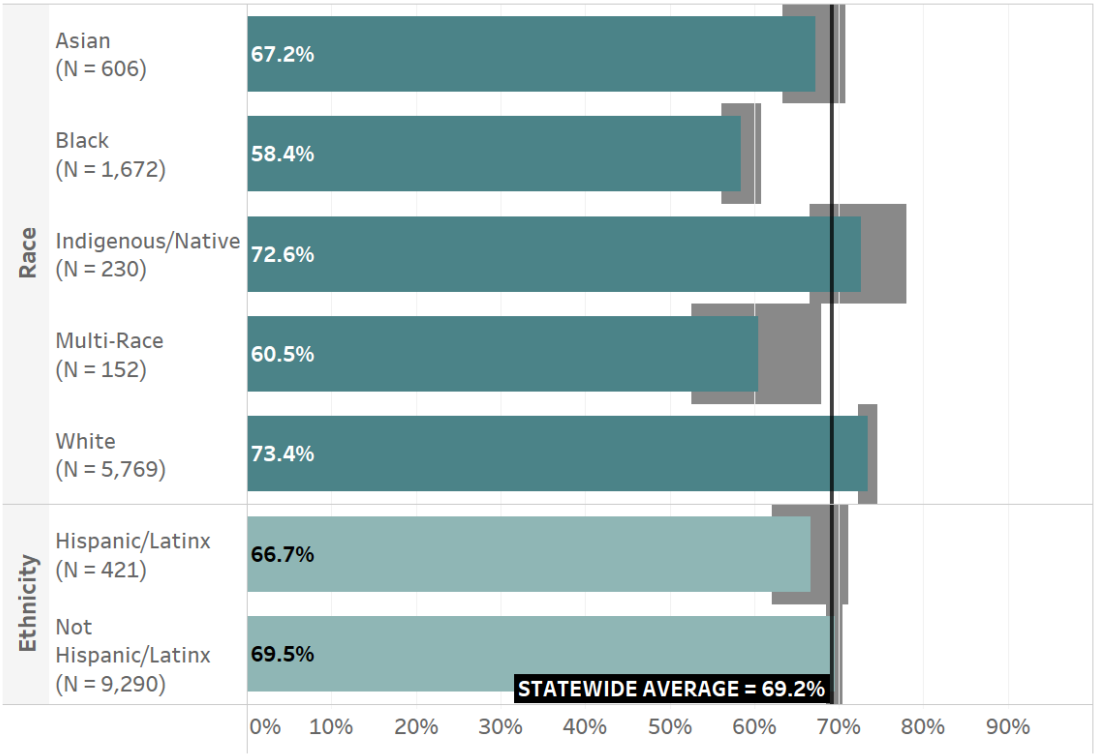
- From 2023 to 2024, the rate of Controlling High Blood Pressure significantly increased by just over 2 percentage points for the MHCP population.
- In 2024, there was a significant 3.2 percentage point gap in rates between the Other Purchasers population (72.4%) and the MHCP population (69.2%).

CONTROLLING HIGH BLOOD PRESSURE:
MHCP Rates by Race/Ethnicity

2024 measurement year

NOTES:

- Stratification by Preferred Language and Country of Origin is not available for this measure. For more information, view the Methodology appendix.
- The "Statewide Average" for this chart refers to the overall rate for the MHCP population only. This measure does not allow the separation of managed care (MCO) and fee-for-service (FFS), so the rate includes both.
- Grey shading next to bars represents 95% confidence interval.
- The Native Hawaiian/Pacific Islander group had less than 60 patients for this measure, which is below the reporting threshold and so have been excluded from the graph.



View data table for Controlling High Blood Pressure: MHCP Rates by Race/Ethnicity

FINDINGS

Compared to the MHCP statewide average, **lower** rates of blood pressure control was observed among Black and Multi-Race patients.

In contrast, a **higher** rate of blood pressure control was observed among White patients.

SECTION 4:
Mental Health

Major depression can affect multiple aspects of an individuals' life and can limit their ability to carry out activities of daily living (National Institute of Mental Health, 2023). In 2021, 21 million adults (8.3% of adult population) and five million adolescents (20% of the adolescent population) experienced at least one major depressive episode in the past year (National Institute of Mental Health, 2023). In Minnesota, a similar pattern was observed in 2023, with approximately 9% of adults and 20% of adolescents had at least one major depressive episode (Substance Abuse and Mental Health Services Administration, n.d.).

This section highlights two critical areas for advancing mental health: mental health screening in adolescents and depression remission in both adolescents and adults.

Measures

All measures featured in this section are stewarded by MN Community Measurement.

Measures Reported by Medical Groups/Clinics:

Adolescent Mental Health and/or Depression Screening

Adolescent Depression: Remission at Six Months

Adult Depression: Remission at Six Months

Note:
For simplicity and alignment with other community reports published by MN Community Measurement, only the Remission at Six Months measures from the Depression Care measure suites have been included in this report.

ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING:

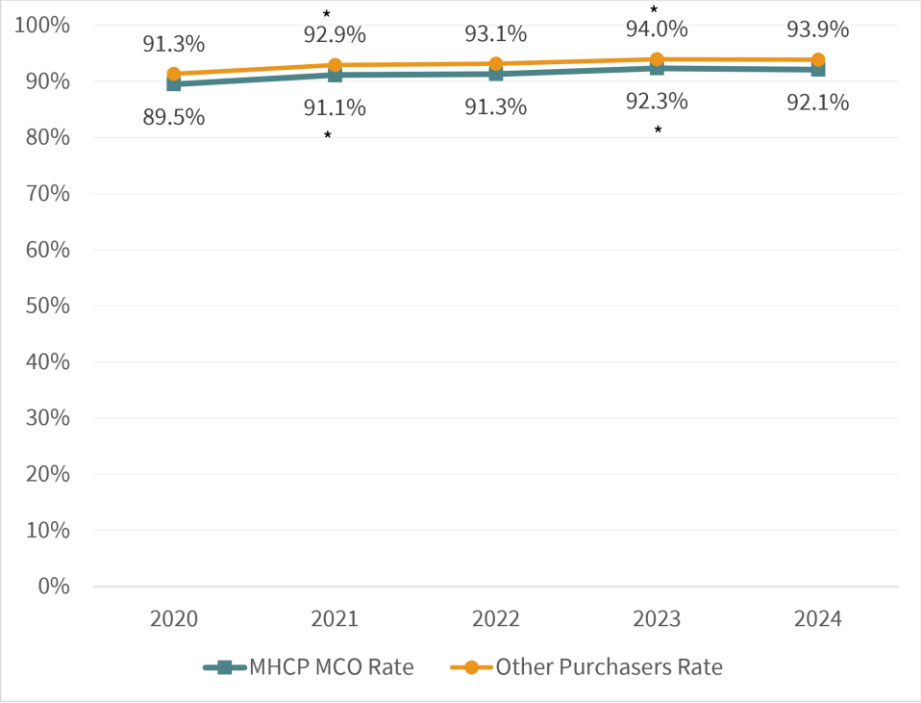
Rates Over Time

2020 – 2024 measurement years

Measure Definition: 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.

NOTES:

- The MHCP population in this graph represents only those with managed care (MCO).
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Adolescent Mental Health Screening: Rates Over Time

FINDINGS

- From 2023 to 2024, the rate of Adolescent Mental Health and/or Depression Screening remained stable (no significant change) for the MHCP MCO population.
- In 2024, there was a significant 1.8 percentage point gap in rates between the Other Purchasers population (93.9%) and the MHCP population (92.1%).

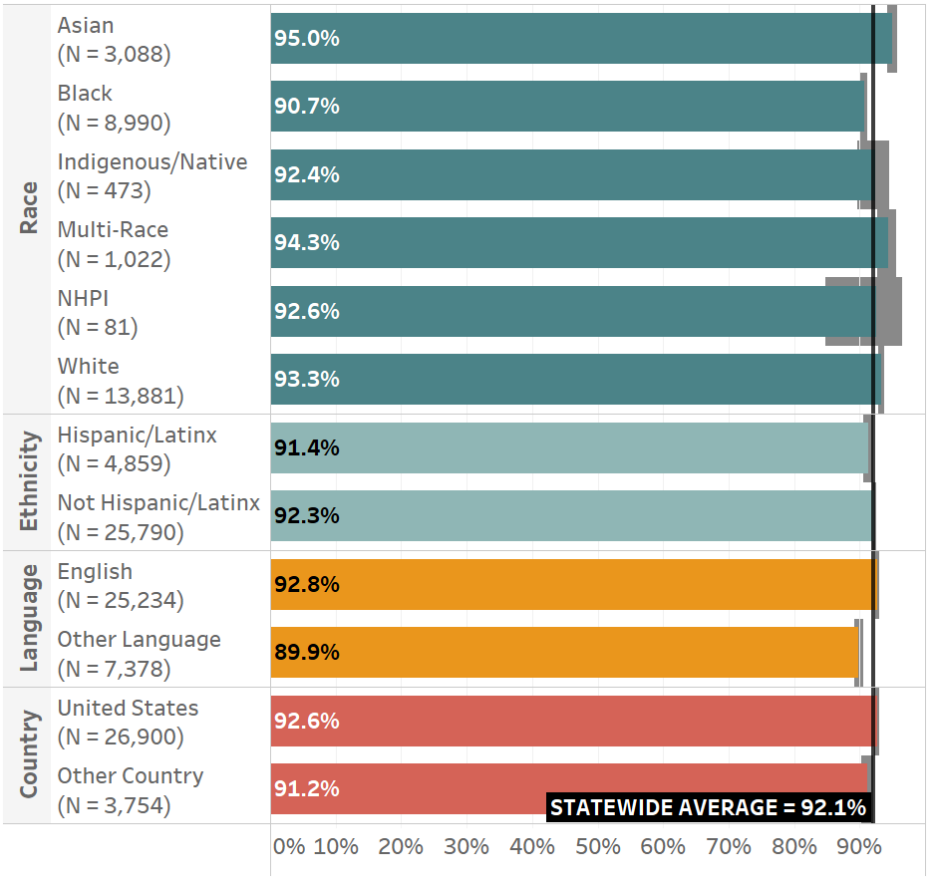
ADOLESCENT MENTAL HEALTH AND/OR DEPRESSION SCREENING:

MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:

- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- NHPI stands for Native Hawaiian/Pacific Islander.



View data table for Adolescent Mental Health Screening: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

Compared to the MHCP MCO statewide average, **lower** rates of screening were observed among Black patients and patients who prefer languages other than English.

In contrast, **higher** rates of screening were observed among Asian, White, and Multi-Race patients and patients who prefer to speak English.

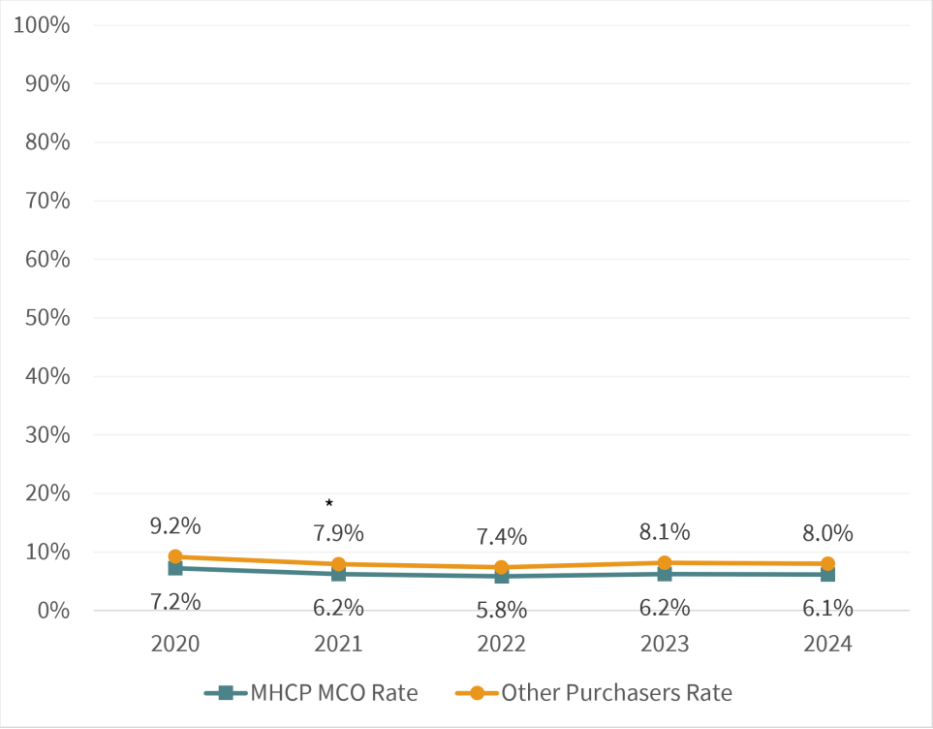
ADOLESCENT DEPRESSION – REMISSION AT SIX MONTHS:
Rates Over Time

2020 – 2024 measurement years

Measure Definition: The percentage of adolescent patients (ages 12-17) with depression who reached remission (PHQ-9/9M score less than 5) within 4 to 8 months of their index event.

NOTES:
- The MHCP population in this graph represents only those with managed care (MCO).
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.

View data table for Adolescent Depression – Remission at Six Months: Rates Over Time



FINDINGS

- From 2023 to 2024, the rate of Adolescent Depression: Remission at Six Months remained stable (no significant change) for the MHCP MCO population.
- In 2024, there was a significant 2 percentage point gap in rates between the Other Purchasers population (8.1%) and the MHCP population (6.1%).

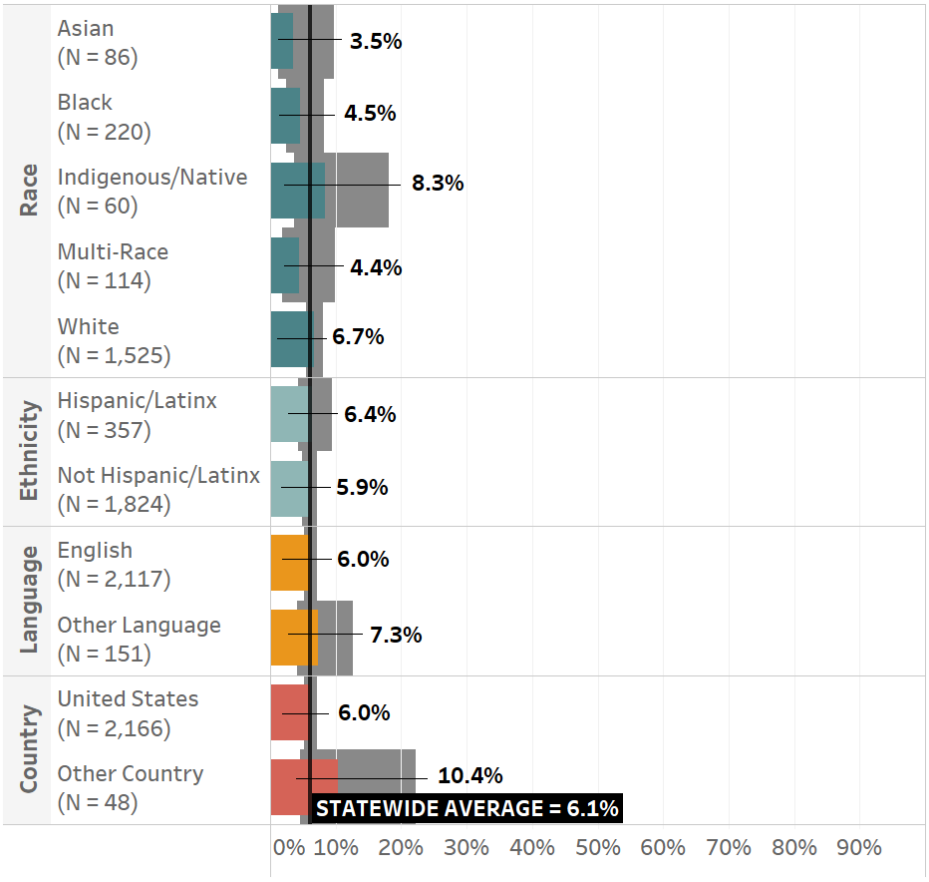
ADOLESCENT DEPRESSION – REMISSION AT SIX MONTHS:

MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:

- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- The Native Hawaiian/Pacific Islander group had less than 30 patients for this measure, which is below the reporting threshold and so have been excluded from the graph.



View data table for Adolescent Depression – Remission at Six Months: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

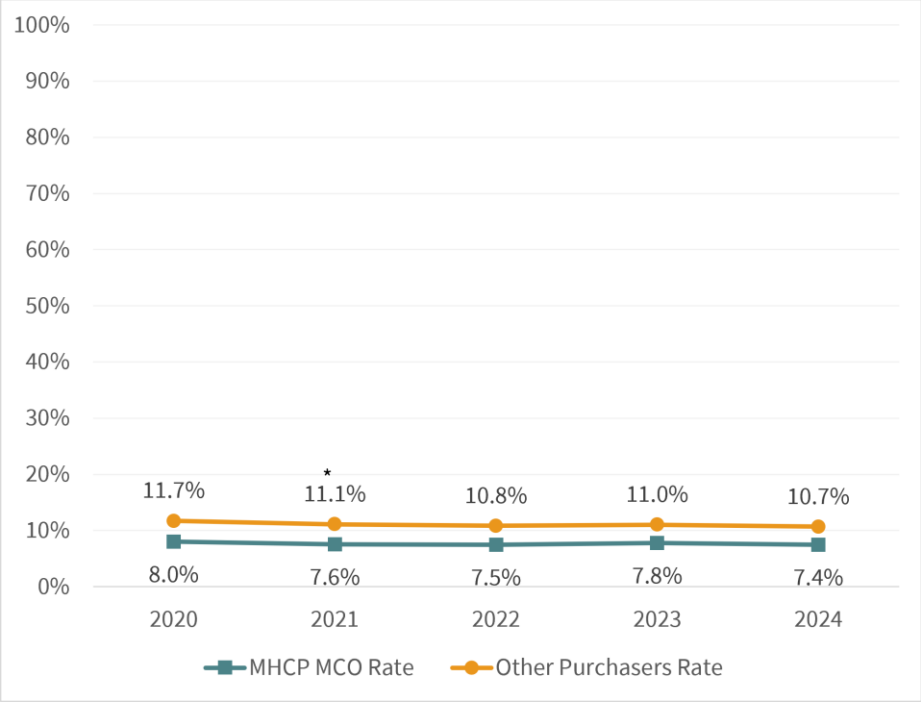
Compared to the MHCP MCO statewide average, all groups had average rates of depression remission at six months.

ADULT DEPRESSION – REMISSION AT SIX MONTHS:
Rates Over Time

2020 – 2024 measurement years

Measure Definition: The percentage of adult patients (ages 18 years and older) with depression who reached remission (PHQ-9/9M score less than 5) within 4 to 8 months of their index event.

NOTES:
- The MHCP population in this graph represents only those with managed care (MCO).
- An asterisk (*) above the rate indicates a statistically significant change from the previous year.



View data table for Adult Depression – Remission at Six Months: Rates Over Time

FINDINGS

- From 2023 to 2024, the rate of Adult Depression: Remission at Six Months remained stable (no significant change) for the MHCP MCO population.
- In 2024, there was a significant 3.3 percentage point gap in rates between the Other Purchasers population (10.7%) and the MHCP population (7.4%).

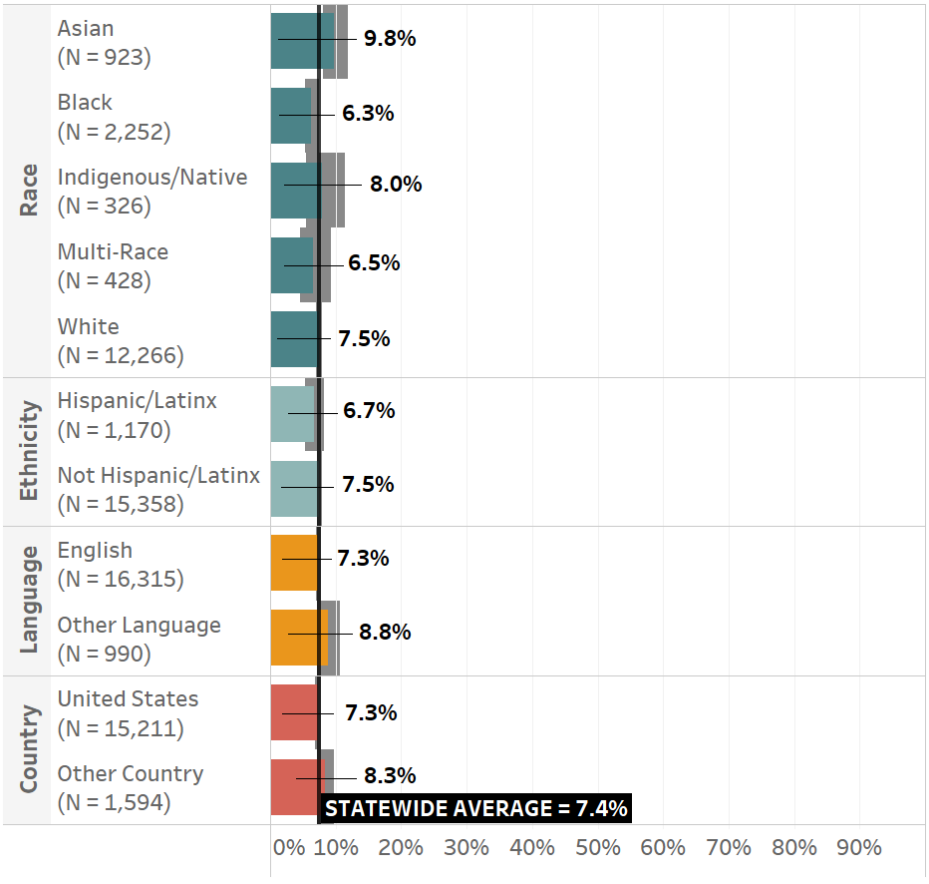
ADULT DEPRESSION – REMISSION AT SIX MONTHS:

MHCP Rates by Race, Ethnicity, Language, & Country of Origin

2024 measurement year

NOTES:

- The "Statewide Average" for this chart refers to the overall rate among submitting medical groups for the MHCP MCO population only.
- Grey shading next to bars represents 95% confidence interval.
- The Native Hawaiian/Pacific Islander group had less than 30 patients for this measure, which is below the reporting threshold and so have been excluded from the graph.



View data table for Adult Depression – Remission at Six Months: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

FINDINGS

Compared to the MHCP MCO statewide average, a **higher** rate of depression remission at six months was observed among Asian patients.

APPENDIX A:
Definitions & Notes

DEFINITIONS

- **95% confidence interval:** The degree of certainty in which the performance rate falls between the specified range of values.
- **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
- **Clinical Data Submission measures:** These measures are calculated using data submitted by medical groups/clinics, which comes from electronic health records or paper-based medical charts. More information on this data collection method can be found in the Methodology section. These measures include:
  - Optimal Diabetes Care
  - Optimal Vascular Care
  - Depression Suite
  - Optimal Asthma Control
  - Colorectal Cancer Screening
  - Adolescent Mental Health and/or Depression Screening
- **Healthcare Effectiveness Data and Information Set (HEDIS) measures:** A national set of performance measures used in the managed care industry and developed and maintain by the National Committee for Quality Assurance (NCQA). Clinical HEDIS measures use data from the administrative or hybrid data collection methodology. More information on this data collection method can be found in the Methodology section. These measures include:
  - Breast Cancer Screening
  - Childhood Immunization Status (Combo 10)
  - Controlling High Blood Pressure
  - Immunizations for Adolescents (Combo 2)
- **Insurance type:** Health care insurance type includes the following categories:
  - Commercial (employer-based and individual coverage)
  - State health care programs (Medical Assistance (Medicaid) and MinnesotaCare)
  - Medicare (federal health care programs for people ages 65 years and older and people who are disabled)
  - Uninsured
- **Measurement year (MY):** The year in which health care services were delivered and the data was recorded.
- **Medical group:** One or more clinic sites operated by a single organization.

- **Minnesota Health Care Programs (MHCP):** These health care programs (i.e., Medical Assistance including dual eligible and MinnesotaCare) provide service under both fee-for-service and managed care delivery systems purchased by DHS. This report only includes performance rates for the managed care (MCO) programs (i.e., Medical Assistance and MinnesotaCare).
- **National Committee for Quality Assurance (NCQA):** A national, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations, as well as produces HEDIS measures.
- **Other Purchasers:** This includes commercial (employer-based insurance coverage) and/or Medicare managed care data.

MEASURE 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:

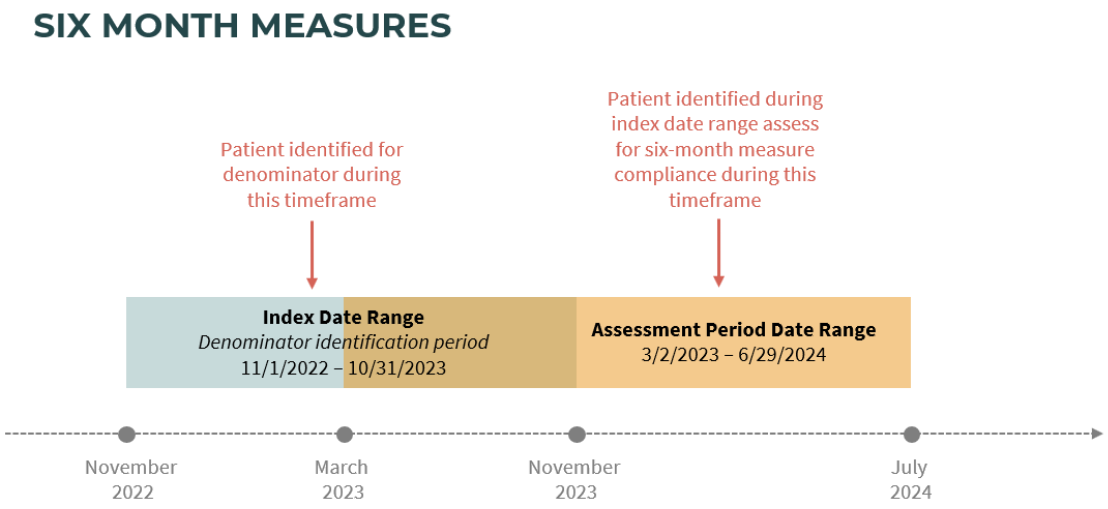
- Patient Health Questionnaire – 9 item version (PHQ-9)
- PHQ-9M Modified for Teens and Adolescents
- Kutcher Depression Scale (KADS)
- Beck Depression Inventory II (BDI-II)
- Beck Depression Inventory Fast Screen (BDI-FS)
- Child Depression Inventory (CDI)
- Child Depression Inventory II (CDI-2)
- Patient 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. The diagnosis of depression does not have to be new for the patient to be included in the denominator.
- **PHQ-9/9M score greater than 9:** The patient completed a PHQ-9/PHQ-9M tool and the score was greater than 9 during the denominator identification period.
- **Age:** The patient was 12 years or older at the time of the encounter.

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



Example: A 23-year-old patient with depression was assessed at an encounter with an eligible provider on 12/2/2022 and had a PHQ-9 score of 20 (index event). Their six-month assessment period would be between 4/3/2023 and 8/1/2023. 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

APPENDIX B: Methodology – Measures reported by medical groups

The measures in this report are collected from two separate data sources: clinics and health plans. Measures reported by medical groups use data from clinics, which enables reporting of results by clinic location as well as by medical group. In contrast, measures reported by payers use claims data from health plans and is limited to reporting of results by medical group.

MEASURES REPORTED BY MEDICAL GROUPS

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

Data Collection

Data submission requirements are specified by MN Community Measurement in our 2024 Measurement Year (MY) PIPE Data File Field Specifications. These documents provide detailed steps and instructions to ensure clinics submit data in a standard format. The most recent version of these documents can be found on MNCM's Knowledge Base in the "PIPE Resources" section.

Data are reported at two levels: by clinic site and medical group. Clinics are defined as single locations where patients received care. Medical groups usually consist of multiple clinics. Often, the medical group provides centralized administrative functions for multiple clinics.

Clinic abstractors collect data from medical records either by extracting the data from an electronic medical record (EMR) via data query or from abstraction of paper-based medical records. Medical groups complete numerous quality checks before data submission. Detailed instructions for medical groups/clinics conducting quality checks are available on MNCM's Knowledge Base. All appropriate Health Insurance Portability and Accountability (HIPAA) requirements are followed.

Data Validation

After clinical quality data is submitted, MNCM completes the following validation of the preliminary results to ensure accuracy and comparability.

Quality Checks

After the medical group submits a data file for numerator calculation, MNCM evaluates the preliminary results for unexpected outcomes and conducts a review of the data file, as necessary. The results are compared to the prior report year. To facilitate the review, the medical group provides information at the time of data submission about any substantial changes to the denominator and numerator from the prior report year.

Audit of the Data Source
All medical groups are subject to an audit of the data source (patient record). MNCM contacts the medical group if selected for audit, and a list of records are shared securely on Home page of the MNCM Data Portal. Other audit details:

The medical group or clinic representative participates in the entire audit process. The audit is conducted via a HIPAA secure, online meeting service. The medical group or clinic representative retrieves and displays the selected records and screens necessary to verify the submitted data. Patient names or other personal information in the patient record may be blinded. MNCM uses date of birth to verify the patient.

The medical group has the following information available for the audit:

- ALL requested patient records.
- The "crosswalk" between the unique patient identifier and the patient's name and date of birth, as necessary.
- Data collection forms and other notes describing where various data elements were located in the patient record.
- List of patients that were excluded.

NCQA 8 and 30 Audit Process
MNCM utilizes the National Committee for Quality Assurance (NCQA) "8 and 30" process for audits.

MNCM randomly selects 33 records from each applicable clinic site for validation. At most, 30 records for each clinic site will be reviewed. The additional three records are oversamples to ensure 30 records will be available on the day of the review.

The MNCM auditor reviews records one through eight in the sample to verify whether the submitted data matches the source data in the medical record.

If no errors are found in these eight records, the compliance rate is 100 percent, and the clinic site is determined to be in high compliance. The MNCM auditor may determine no further record review is necessary. The MNCM auditor communicates results to MNCM staff.

If the auditor identifies one or more errors in these eight records, the auditor will continue auditing records nine through 30 and a compliance rate is calculated (e.g., 27/30 records compliant, 90 percent). If the compliance rate is less than 90 percent, MNCM discusses a corrective action with the medical group.

Two-Week Medical Group Review of the Preliminary Statewide Results
The two-week medical group review is an opportunity for medical groups to review and comment on the preliminary statewide results before final results are published. MNCM provides a data file of the preliminary statewide results to the registered contacts of all participating medical groups. Each medical group is responsible for reviewing their own preliminary results, investigating any concerns and submitting evidence to MNCM if a change in results is requested. In that event, MNCM staff will review the information provided and decide whether to publicly report the results.

Eligible Population Specifications

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

Numerator Specifications

For PIPE measures, the numerator is the number of patients identified from the eligible population who meet the numerator criteria. Clinical quality data the medical group submits is used to calculate the numerator; this data is verified through MNCM's validation process.

Calculating Rates

Due to the dynamic nature of patient populations, rates and 95 percent confidence intervals are calculated for each measure for each medical group/clinic regardless of whether the full population or a sample is submitted. Rates are first calculated for each medical group/clinic and then a statewide average rate is calculated. The statewide average rate is displayed when comparing a single medical group/clinic to the performance of all medical groups/clinics to provide context. The statewide average is calculated using all data submitted to MNCM for Minnesota residents only.

Thresholds for Public Reporting

MNCM has established minimum thresholds for public reporting to ensure statistically reliable rates. Only medical groups and clinics that meet these thresholds are reported. For PIPE measures included in this report, a minimum threshold of 30 patients per medical group/clinic is required.

Race, Ethnicity, Language, Country Of Origin (RELC) Analysis

For the PIPE measures, the RELC data is submitted by medical groups through MNCM's process. Please refer to the MNCM Handbook on the Collection of Race/Ethnicity/Language Data in Medical Groups available on MNCM's Knowledge Base for more information about this data. For this report, RELC results are reported at a statewide level for the PIPE measures.

Best Practices for RELC Data Collection

RELC data collection undergoes a unique validation process to ensure that medical groups collect these data elements from patients using best practices. Best practices are defined as:

- Patients self-report their race , ethnicity, country of origin and preferred language
- Patients have the option to select one or more categories for race (i.e., medical groups/clinics do not collect data using a multi-racial category).
- Medical groups/clinics have the ability to capture and report more than one race as reported by the patient.

A medical group/clinic must meet all the criteria for each data element to achieve best practice status and to have their data included in the rate calculation. Only validated data, collected using best practices, are used to calculate rates by RELC.

Assigning Insurance Type for Measures Collected by PIPE

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

APPENDIX C: Methodology – Measures reported by payers

The HEDIS measures are a widely used set of performance measures in the managed care industry, developed and maintained by NCQA. There are two types of data collection methods for HEDIS measures: (1) the administrative method that uses only health care claims data; and (2) the hybrid method that uses health care claims data plus medical record review data).

Data Collection

HEDIS technical specifications provide standard definitions for the eligible population for each measure including data elements such as age and continuous enrollment. Continuous enrollment is the minimum amount of time a person must be enrolled in a health plan before becoming eligible for a measure. It ensures that the health plan has enough time to render services. Using continuous enrollment criteria is necessary to standardize measurement, but it can reduce the number of individuals represented in the measure.

For administrative measures, the entire eligible population is the denominator. For the hybrid measures, the eligible population serves as the frame from which to draw a random sample of patients for chart audit and is used as the reference for weighting results.

Eligible Population Specifications

The eligible populations for the administrative and hybrid measures are identified by each participating health plan using its respective administrative claims database. Health plans assign patients to a medical group using a standard medical group definition based on a tax identification number (TIN). Administrative billing codes determine the frequency of a patient's visit to a medical group. For most measures, patients are assigned to the medical group they visited most frequently during the measurement period. Patients who visited two or more medical groups with the same frequency are attributed to the medical group visited most recently in the measurement period. The TIN is used as the common identifier for aggregating data across health plans.

Numerator Specifications

For HEDIS administrative measures, the numerator is the number of patients from the eligible population who met the numerator criteria. For HEDIS hybrid measures, the numerator is the number of patients from the sample who met numerator criteria.

Calculating Rates

HEDIS administrative and hybrid measures are reported at a medical group level and are expressed as percentages. Rates calculated for administrative measures are straightforward; however, rates calculated for hybrid measures require weighting because of sampling procedures. Rates and 95 percent asymmetrical confidence intervals are calculated for each measure for each medical group.

Asymmetrical confidence intervals are used to avoid confidence interval lower bound values less than zero and upper bound values greater than one hundred. Medical group rates are first calculated for each medical group and then a medical group average is calculated. The medical group average is used to compare medical groups for the performance ratings. The statewide average includes attributed and unattributed patients and is displayed in the charts.

Thresholds for Public Reporting

MNCM has established minimum thresholds for public reporting to ensure statistically reliable rates. Only medical groups that meet these thresholds are reported. For the HEDIS administrative measures in this report, a minimum threshold of 30 patients per medical group is required. For the HEDIS hybrid measures in this report, a minimum threshold of 60 patients per medical group is required.

Race and Hispanic Ethnicity Analyses

For the three HEDIS measures, the race and ethnicity data for MHCP is submitted by health plans. Health plans receive this information through the state public program enrollment process. Country of Origin and Preferred Language data are not available for the HEDIS measures.

Data Limitations

Data used to calculate rates for the HEDIS measures reflect patients insured through 10 health plans doing business in Minnesota. Patients who are uninsured, self-pay, or who are served by Medicaid/Medicare fee-for-service are not reflected in the HEDIS results. UnitedHealthcare group is not currently represented in the data for this report.

APPENDIX D:
Data Tables

The following tables contain the data represented in the graphs in this report for each measure, including rates over time and 2024 results stratified by race, ethnicity, and when applicable, language and country of origin.

RATES OVER TIME KEY

For the Rates Over Time tables, the following definitions are assigned to the symbols/text interpretations:

Symbol	Definition
▲ Higher	Rate is significantly higher than the rate from the previous year
● No Diff	Rate is not statistically different than the previous year
▼ Lower	Rate is significantly lower than the rate from the previous year

Colorectal Cancer Screening: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**56.8%**	**58.3%** ▲ Higher	**52.7%** ▼ Lower	**54.8%** ▲ Higher	**56.1%** ▲ Higher
Other Purchasers	**72.4%**	**74.1%** ▲ Higher	**70.0%** ▼ Lower	**72.6%** ▲ Higher	**73.5%** ▲ Higher

Return to Colorectal Cancer Screening Rates section

Colorectal Cancer Screening: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Colorectal Cancer Screening is 56.1%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	10,172	61.6%	60.7%	62.6%
Race	**Black**	23,102	47.1%	46.4%	47.7%
Race	**Indigenous/Native**	2,456	43.4%	41.5%	45.4%
Race	**Multi-Race**	1,230	54.9%	52.1%	57.6%
Race	**Native Hawaiian/ Pacific Islander**	302	47.4%	41.8%	53.0%
Race	**White**	76,557	59.5%	59.2%	59.9%
Ethnicity	**Hispanic/Latinx**	6,493	54.7%	53.4%	55.9%
Ethnicity	**Not Hispanic/Latinx**	110,426	56.6%	56.3%	56.9%
Language	**English**	101,422	57.1%	56.8%	57.4%
Language	**Other Language**	21,446	51.6%	51.0%	52.3%
Country	**United States**	88,892	57.9%	57.6%	58.2%
Country	**Other Country**	29,255	52.9%	52.3%	53.5%

Return to Colorectal Cancer Screening section

Breast Cancer Screening: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**56.9%**	**54.4%** ▼ Lower	**57.4%** ▲ Higher	**58.1%** ● No Diff	**62.8%** ▲ Higher
Other Purchasers	**74.5%**	**75.6%** ▲ Higher	**78.4%** ▲ Higher	**79.7%** ▲ Higher	**81.4%** ▲ Higher

Return to Breast Cancer Screening Rates section

Breast Cancer Screening: MHCP Rates by Race/Ethnicity

The 2024 MHCP statewide average for Breast Cancer Screening is 62.8%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	3,844	64.4%	62.8%	65.9%
Race	**Black**	6,448	57.9%	56.7%	59.1%
Race	**Indigenous/Native**	1,021	49.1%	46.0%	52.1%
Race	**Multi-Race**	510	62.7%	58.5%	66.8%
Race	**Native Hawaiian/ Pacific Islander**	98	58.2%	48.3%	67.4%
Race	**White**	25,472	65.6%	65.0%	66.2%
Ethnicity	**Hispanic/Latinx**	1,813	70.8%	68.6%	72.8%
Ethnicity	**Not Hispanic/Latinx**	42,341	63.0%	62.5%	63.4%

Return to Breast Cancer Screening by Race/Ethnicity section

Childhood Immunization Status: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**46.6%**	**41.0%** ▼ Lower	**34.9%** ▼ Lower	**30.2%** ▼ Lower	**25.7%** ▼ Lower
Other Purchasers	**65.7%**	**67.6%** ● No Diff	**61.7%** ▼ Lower	**57.7%** ▼ Lower	**52.5%** ▼ Lower

Return to Childhood Immunization Statuts Rates section

Childhood Immunization Status: MHCP Rates by Race/Ethnicity

The 2024 MHCP statewide average for Childhood Immunization Status is 25.7%. The Native Hawaiian/Pacific Islander group had less than 60 patients for this measure, which is below the reporting threshold and so have been excluded from the table.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	89	38.2%	28.8%	48.6%
Race	**Black**	389	14.9%	11.7%	18.8%
Race	**Indigenous/Native**	237	17.3%	13.0%	22.6%
Race	**Multi-Race**	234	24.4%	19.3%	30.2%
Race	**White**	2,182	24.7%	22.9%	26.5%
Ethnicity	**Hispanic/Latinx**	860	37.7%	34.5%	41.0%
Ethnicity	**Not Hispanic/Latinx**	5,306	23.9%	22.7%	25.0%

Return to Childhood Immunization Status by Race/Ethnicity section

Immunizations for Adolescents: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**30.5%**	**30.6%** ● No Diff	**30.9%** ● No Diff	**29.1%** ● No Diff	**29.5%** ● No Diff
Other Purchasers	**38.5%**	**39.4%** ● No Diff	**38.4%** ● No Diff	**37.3%** ● No Diff	**37.2%** ● No Diff

Return to Immunizations for Adolescents Rates section

Immunizations for Adolescents: MHCP Rates by Race/Ethnicity

The 2024 MHCP statewide average for Immunizations for Adolescents is 29.5%. The Native Hawaiian/Pacific Islander group had less than 60 patients for this measure, which is below the reporting threshold and so have been excluded from the table.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	201	41.3%	34.7%	48.2%
Race	**Black**	783	30.4%	27.3%	33.7%
Race	**Indigenous/Native**	238	25.6%	20.5%	31.5%
Race	**Multi-Race**	477	32.7%	28.6%	37.0%
Race	**White**	3,939	29.0%	27.6%	30.5%
Ethnicity	**Hispanic/Latinx**	1,004	38.8%	35.9%	41.9%
Ethnicity	**Not Hispanic/Latinx**	7,041	28.3%	27.2%	29.3%

Return to Immunizations for Adolescents by Race/Ethnicity section

Optimal Diabetes Care: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**31.4%**	**33.2%** ▲ Higher	**34.9%** ▲ Higher	**36.2%** ▲ Higher	**36.1%** ● No Diff
Other Purchasers	**42.1%**	**46.1%** ▲ Higher	**46.9%** ▲ Higher	**48.7%** ▲ Higher	**49.2%** ▲ Higher

Return to Optimal Diabetes Care Rates section

Optimal Diabetes Care: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Diabetes Care is 36.1%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	4,278	43.9%	42.4%	45.3%
Race	**Black**	10,004	33.7%	32.8%	34.6%
Race	**Indigenous/Native**	1,204	18.6%	16.5%	20.9%
Race	**Multi-Race**	554	30.9%	27.2%	34.8%
Race	**Native Hawaiian/ Pacific Islander**	149	32.2%	25.2%	40.1%
Race	**White**	20,589	36.8%	36.2%	37.5%
Ethnicity	**Hispanic/Latinx**	3,218	36.5%	34.8%	38.2%
Ethnicity	**Not Hispanic/Latinx**	35,184	36.1%	35.6%	36.6%
Language	**English**	32,026	34.7%	34.2%	35.2%
Language	**Other Language**	8,274	41.8%	40.7%	42.9%
Country	**United States**	27,534	33.9%	33.4%	34.5%
Country	**Other Country**	11,523	41.8%	40.9%	42.7%

Return to Optimal Diabetes Care section

Optimal Diabetes Care: HbA1c Control

MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Diabetes Care: HbA1c Control is 66.5%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	4,278	65.9%	64.4%	67.3%
Race	**Black**	10,004	64.5%	63.6%	65.4%
Race	**Indigenous/Native**	1,204	51.4%	48.6%	54.2%
Race	**Multi-Race**	554	60.8%	56.7%	64.8%
Race	**Native Hawaiian/ Pacific Islander**	149	58.4%	50.4%	66.0%
Race	**White**	20,589	68.7%	68.1%	69.4%
Ethnicity	**Hispanic/Latinx**	3,218	59.6%	57.9%	61.3%
Ethnicity	**Not Hispanic/Latinx**	35,184	66.7%	66.2%	67.2%
Language	**English**	32,026	66.7%	66.1%	67.2%
Language	**Other Language**	8,274	64.6%	63.5%	65.6%
Country	**United States**	27,534	66.7%	66.2%	67.3%
Country	**Other Country**	11,523	65.2%	64.3%	66.1%

Return to Optimal Diabetes Care: HbA1c Control section

Optimal Diabetes Care: BP Control

MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Diabetes Care: BP Control is 79.8%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	4,278	82.6%	81.4%	83.7%
Race	**Black**	10,004	75.0%	74.2%	75.8%
Race	**Indigenous/Native**	1,204	77.9%	75.5%	80.2%
Race	**Multi-Race**	554	76.5%	72.8%	79.9%
Race	**Native Hawaiian/ Pacific Islander**	149	75.2%	67.7%	81.4%
Race	**White**	20,589	81.2%	80.6%	81.7%
Ethnicity	**Hispanic/Latinx**	3,218	80.2%	78.8%	81.6%
Ethnicity	**Not Hispanic/Latinx**	35,184	79.4%	79.0%	79.8%
Language	**English**	32,026	78.9%	78.5%	79.4%
Language	**Other Language**	8,274	81.6%	80.7%	82.4%
Country	**United States**	27,534	78.7%	78.2%	79.2%
Country	**Other Country**	11,523	81.3%	80.6%	82.0%

Return to Optimal Diabetes Care: BP Control section

Optimal Diabetes Care: Daily Aspirin Use

MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Diabetes Care: Daily Aspirin Use is 98.7%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	4,278	98.9%	98.6%	99.2%
Race	**Black**	10,004	98.9%	98.7%	99.1%
Race	**Indigenous/Native**	1,204	98.3%	97.4%	98.9%
Race	**Multi-Race**	554	98.7%	97.4%	99.4%
Race	**Native Hawaiian/ Pacific Islander**	149	98.7%	95.2%	99.6%
Race	**White**	20,589	98.6%	98.4%	98.8%
Ethnicity	**Hispanic/Latinx**	3,218	99.0%	98.6%	99.3%
Ethnicity	**Not Hispanic/Latinx**	35,184	98.7%	98.6%	98.8%
Language	**English**	32,026	98.6%	98.5%	98.7%
Language	**Other Language**	8,274	99.1%	98.8%	99.2%
Country	**United States**	27,534	98.5%	98.4%	98.7%
Country	**Other Country**	11,523	99.1%	98.9%	99.3%

Return to Optimal Diabetes Care: Daily Aspirin Use section

Optimal Diabetes Care: Statin Use

MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Diabetes Care: Statin Use is 87.7%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	4,278	92.1%	91.3%	92.9%
Race	**Black**	10,004	85.8%	85.1%	86.5%
Race	**Indigenous/Native**	1,204	83.2%	81.0%	85.2%
Race	**Multi-Race**	554	86.6%	83.6%	89.2%
Race	**Native Hawaiian/ Pacific Islander**	149	89.3%	83.3%	93.3%
Race	**White**	20,589	88.2%	87.7%	88.6%
Ethnicity	**Hispanic/Latinx**	3,218	88.3%	87.2%	89.4%
Ethnicity	**Not Hispanic/Latinx**	35,184	87.8%	87.4%	88.1%
Language	**English**	32,026	87.4%	87.0%	87.8%
Language	**Other Language**	8,274	89.1%	88.4%	89.7%
Country	**United States**	27,534	88.0%	87.7%	88.4%
Country	**Other Country**	11,523	87.5%	86.9%	88.1%

Return to Optimal Diabetes Care: Statin Use section

Optimal Diabetes Care: Tobacco-free
MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Diabetes Care: Tobacco-free is 74.3%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	4,278	86.4%	85.4%	87.4%
Race	**Black**	10,004	78.3%	77.5%	79.1%
Race	**Indigenous/Native**	1,204	49.3%	46.5%	52.2%
Race	**Multi-Race**	554	68.6%	64.6%	72.3%
Race	**Native Hawaiian/ Pacific Islander**	149	78.5%	71.3%	84.4%
Race	**White**	20,589	71.2%	70.6%	71.8%
Ethnicity	**Hispanic/Latinx**	3,218	84.5%	83.2%	85.7%
Ethnicity	**Not Hispanic/Latinx**	35,184	74.1%	73.7%	74.6%
Language	**English**	32,026	71.2%	70.7%	71.7%
Language	**Other Language**	8,274	89.2%	88.5%	89.9%
Country	**United States**	27,534	68.8%	68.2%	69.3%
Country	**Other Country**	11,523	89.2%	88.6%	89.8%

Return to Optimal Diabetes Care: Tobacco-free section

Optimal Vascular Care: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**42.9%**	**43.2%** ● No Diff	**43.3%** ● No Diff	**43.7%** ● No Diff	**42.9%** ● No Diff
Other Purchasers	**55.0%**	**58.7%** ▲ Higher	**57.6%** ▼ Lower	**57.7%** ● No Diff	**56.8%** ▼ Lower

Return to Optimal Vascular Care Rates section

Optimal Vascular Care: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Vascular Care is 42.9%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	1,206	61.0%	58.2%	63.7%
Race	**Black**	2,698	39.0%	37.2%	40.9%
Race	**Indigenous/Native**	598	33.6%	29.9%	37.5%
Race	**Multi-Race**	209	38.3%	32.0%	45.0%
Race	**Native Hawaiian/ Pacific Islander**	32	43.8%	28.2%	60.7%
Race	**White**	12,056	42.2%	41.3%	43.0%
Ethnicity	**Hispanic/Latinx**	674	50.7%	47.0%	54.5%
Ethnicity	**Not Hispanic/Latinx**	16,346	42.7%	42.0%	43.5%
Language	**English**	15,661	40.9%	40.1%	41.7%
Language	**Other Language**	2,010	58.2%	56.0%	60.3%
Country	**United States**	14,451	40.1%	39.3%	40.9%
Country	**Other Country**	2,825	57.3%	55.4%	59.1%

Return to Optimal Vascular Care section

Optimal Vascular Care: BP Control

MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Vascular Care: BP Control is 79.5%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	1,206	80.3%	77.9%	82.4%
Race	**Black**	2,698	71.1%	69.4%	72.8%
Race	**Indigenous/Native**	598	79.6%	76.2%	82.6%
Race	**Multi-Race**	209	78.9%	72.9%	83.9%
Race	**Native Hawaiian/ Pacific Islander**	32	71.9%	54.6%	84.4%
Race	**White**	12,056	81.5%	80.8%	82.1%
Ethnicity	**Hispanic/Latinx**	674	80.4%	77.3%	83.2%
Ethnicity	**Not Hispanic/Latinx**	16,346	79.5%	78.9%	80.2%
Language	**English**	15,661	79.6%	79.0%	80.3%
Language	**Other Language**	2,010	78.9%	77.0%	80.6%
Country	**United States**	14,451	79.7%	79.0%	80.4%
Country	**Other Country**	2,825	78.9%	77.3%	80.3%

Return to Optimal Vascular Care: BP

Optimal Vascular Care: Daily Aspirin Use
MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Vascular Care: Daily Aspirin Use is 86.3%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	1,206	88.6%	86.7%	90.3%
Race	**Black**	2,698	86.1%	84.8%	87.4%
Race	**Indigenous/Native**	598	87.8%	84.9%	90.2%
Race	**Multi-Race**	209	85.2%	79.7%	89.3%
Race	**Native Hawaiian/ Pacific Islander**	32	84.4%	68.2%	93.1%
Race	**White**	12,056	86.5%	85.8%	87.1%
Ethnicity	**Hispanic/Latinx**	674	85.6%	82.8%	88.1%
Ethnicity	**Not Hispanic/Latinx**	16,346	86.6%	86.0%	87.1%
Language	**English**	15,661	86.2%	85.6%	86.7%
Language	**Other Language**	2,010	87.7%	86.2%	89.1%
Country	**United States**	14,451	86.4%	85.8%	86.9%
Country	**Other Country**	2,825	87.6%	86.4%	88.8%

Return to Optimal Vascular Care: Daily Aspirin Use section

Optimal Vascular Care: Statin Use

MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Vascular Care: Statin Use is 90.7%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	1,206	95.8%	94.5%	96.8%
Race	**Black**	2,698	91.4%	90.3%	92.4%
Race	**Indigenous/Native**	598	89.5%	86.7%	91.7%
Race	**Multi-Race**	209	86.6%	81.3%	90.6%
Race	**Native Hawaiian/ Pacific Islander**	32	93.8%	79.9%	98.3%
Race	**White**	12,056	90.3%	89.7%	90.8%
Ethnicity	**Hispanic/Latinx**	674	88.6%	86.0%	90.8%
Ethnicity	**Not Hispanic/Latinx**	16,346	90.8%	90.4%	91.3%
Language	**English**	15,661	90.2%	89.8%	90.7%
Language	**Other Language**	2,010	93.9%	92.8%	94.9%
Country	**United States**	14,451	90.3%	89.8%	90.8%
Country	**Other Country**	2,825	93.1%	92.1%	94.0%

Return to Optimal Vascular Care: Statin Use section

Optimal Vascular Care: Tobacco-free
MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Vascular Care: Tobacco-free is 65.3%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	1,206	87.1%	85.1%	88.8%
Race	**Black**	2,698	65.9%	64.1%	67.6%
Race	**Indigenous/Native**	598	49.2%	45.2%	53.2%
Race	**Multi-Race**	209	60.3%	53.5%	66.7%
Race	**Native Hawaiian/ Pacific Islander**	32	78.1%	61.2%	89.0%
Race	**White**	12,056	63.0%	62.1%	63.8%
Ethnicity	**Hispanic/Latinx**	674	78.3%	75.1%	81.3%
Ethnicity	**Not Hispanic/Latinx**	16,346	64.8%	64.1%	65.5%
Language	**English**	15,661	62.4%	61.6%	63.2%
Language	**Other Language**	2,010	87.8%	86.3%	89.2%
Country	**United States**	14,451	61.1%	60.3%	61.9%
Country	**Other Country**	2,825	85.9%	84.6%	87.2%

Return to Optimal Vascular Care: Tobacco-free section

Optimal Asthma Control – Adults: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**41.2%**	**43.1%** ▲ Higher	**42.8%** ● No Diff	**43.6%** ● No Diff	**44.4%** ● No Diff
Other Purchasers	**49.6%**	**54.8%** ▲ Higher	**54.0%** ▼ Lower	**54.7%** ▲ Higher	**56.1%** ▲ Higher

Return to Optimal Asthma Control - Adults Rates section

Optimal Asthma Control – Adults: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Asthma Control – Adult is 44.4%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	973	50.6%	47.4%	53.7%
Race	**Black**	6,573	41.9%	40.7%	43.1%
Race	**Indigenous/Native**	731	31.9%	28.6%	35.3%
Race	**Multi-Race**	1,144	44.1%	41.2%	46.9%
Race	**Native Hawaiian/ Pacific Islander**	72	40.3%	29.7%	51.8%
Race	**White**	19,076	45.8%	45.1%	46.5%
Ethnicity	**Hispanic/Latinx**	2,232	44.1%	42.1%	46.2%
Ethnicity	**Not Hispanic/Latinx**	27,246	44.6%	44.0%	45.2%
Language	**English**	29,433	44.3%	43.8%	44.9%
Language	**Other Language**	1,248	46.6%	43.8%	49.3%
Country	**United States**	27,295	44.4%	43.8%	45.0%
Country	**Other Country**	2,395	46.5%	44.5%	48.5%

Return to Optimal Asthma Control - Adults section

Optimal Asthma Control – Children: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**52.5%**	**52.2%** ● No Diff	**48.9%** ▼ Lower	**49.5%** ● No Diff	**50.5%** ● No Diff
Other Purchasers	**60.1%**	**61.1%** ● No Diff	**56.6%** ▼ Lower	**56.5%** ● No Diff	**56.3%** ● No Diff

Return to Optimal Asthma Control - Children Rates section

Optimal Asthma Control – Children: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Optimal Asthma Control – Children is 50.5%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	906	63.2%	60.1%	66.3%
Race	**Black**	4,407	52.2%	50.7%	53.7%
Race	**Indigenous/Native**	370	32.2%	27.6%	37.1%
Race	**Multi-Race**	893	52.9%	49.6%	56.1%
Race	**Native Hawaiian/ Pacific Islander**	44	47.7%	33.8%	62.1%
Race	**White**	7,327	49.1%	47.9%	50.2%
Ethnicity	**Hispanic/Latinx**	2,060	52.1%	50.0%	54.3%
Ethnicity	**Not Hispanic/Latinx**	13,009	51.0%	50.1%	51.8%
Language	**English**	13,947	49.4%	48.6%	50.3%
Language	**Other Language**	2,065	57.9%	55.7%	60.0%
Country	**United States**	14,866	50.5%	49.6%	51.3%
Country	**Other Country**	539	57.5%	53.3%	61.6%

Return to Optimal Asthma Control - Children section

Controlling High Blood Pressure: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**62.3%**	**67.5%** ▲ Higher	**66.1%** ● No Diff	**67.0%** ● No Diff	**69.2%** ▲ Higher
Other Purchasers	**64.0%**	**69.4%** ▲ Higher	**70.5%** ● No Diff	**72.4%** ▲ Higher	**72.4%** ● No Diff

Return to Controlling High Blood Pressure Rates section

Controlling High Blood Pressure: MHCP Rates by Race/Ethnicity

The 2024 MHCP statewide average for Controlling High Blood Pressure is 69.2%. The Native Hawaiian/Pacific Islander group had less than 60 patients for this measure, which is below the reporting threshold and so have been excluded from the table.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	606	67.2%	63.3%	70.8%
Race	**Black**	1,672	58.4%	56.1%	60.8%
Race	**Indigenous/Native**	230	72.6%	66.5%	78.0%
Race	**Multi-Race**	152	60.5%	52.6%	67.9%
Race	**White**	5,769	73.4%	72.3%	74.6%
Ethnicity	**Hispanic/Latinx**	421	66.7%	62.1%	71.1%
Ethnicity	**Not Hispanic/Latinx**	9,290	69.5%	68.5%	70.4%

Return to Controlling High Blood Pressure section

Adolescent Mental Health Screening: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**89.5%**	**91.1%** ▲ Higher	**91.3%** ● No Diff	**92.3%** ▲ Higher	**92.1%** ● No Diff
Other Purchasers	**91.3%**	**92.9%** ▲ Higher	**93.1%** ● No Diff	**94.0%** ▲ Higher	**93.9%** ● No Diff

Return to Adolescent Mental Health Screening Rates section

Adolescent Mental Health Screening: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Adolescent Mental Health Screening is 92.1%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	3,088	95.0%	94.2%	95.7%
Race	**Black**	8,990	90.7%	90.0%	91.2%
Race	**Indigenous/Native**	473	92.4%	89.6%	94.5%
Race	**Multi-Race**	1,022	94.3%	92.7%	95.6%
Race	**Native Hawaiian/ Pacific Islander**	81	92.6%	84.8%	96.6%
Race	**White**	13,881	93.3%	92.9%	93.7%
Ethnicity	**Hispanic/Latinx**	4,859	91.4%	90.6%	92.2%
Ethnicity	**Not Hispanic/Latinx**	25,790	92.3%	91.9%	92.6%
Language	**English**	25,234	92.8%	92.4%	93.1%
Language	**Other Language**	7,378	89.9%	89.2%	90.5%
Country	**United States**	26,900	92.6%	92.3%	92.9%
Country	**Other Country**	3,754	91.2%	90.2%	92.0%

Return to Adolescent Mental Health Screening section

Adolescent Depression – Remission at Six Months: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**7.2%**	**6.2%** ● No Diff	**5.8%** ● No Diff	**6.2%** ● No Diff	**6.1%** ● No Diff
Other Purchasers	**9.2%**	**7.9%** ▼ Lower	**7.4%** ● No Diff	**8.1%** ● No Diff	**8.0%** ● No Diff

Return to Adolescent Depression - Remission at Six Months Rates section

Adolescent Depression – Remission at Six Months: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Adolescent Depression – Remission at Six Months is 6.1%. The Native Hawaiian/Pacific Islander group had less than 30 patients for this measure, which is below the reporting threshold and so have been excluded from the table.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	86	3.5%	1.2%	9.8%
Race	**Black**	220	4.5%	2.5%	8.2%
Race	**Indigenous/Native**	60	8.3%	3.6%	18.1%
Race	**Multi-Race**	114	4.4%	1.9%	9.9%
Race	**White**	1,525	6.7%	5.5%	8.1%
Ethnicity	**Hispanic/Latinx**	357	6.4%	4.3%	9.5%
Ethnicity	**Not Hispanic/Latinx**	1,824	5.9%	4.9%	7.1%
Language	**English**	2,117	6.0%	5.1%	7.1%
Language	**Other Language**	151	7.3%	4.1%	12.6%
Country	**United States**	2,166	6.0%	5.1%	7.1%
Country	**Other Country**	48	10.4%	4.5%	22.2%

Return to Adolescent Depression - Remission at Six Months section

Adult Depression – Remission at Six Months: Rates Over Time

Population	2020	2021	2022	2023	2024
MHCP	**8.0%**	**7.6%** ● No Diff	**7.5%** ● No Diff	**7.8%** ● No Diff	**7.4%** ● No Diff
Other Purchasers	**11.7%**	**11.1%** ▼ Lower	**10.8%** ● No Diff	**11.0%** ● No Diff	**10.7%** ● No Diff

Return to Adult Depression - Remission at Six Months Rates section

Adult Depression – Remission at Six Months: MHCP Rates by Race, Ethnicity, Language, and Country of Origin

The 2024 MHCP statewide average for Adult Depression – Remission at Six Months is 7.4%.

Category	Demographic	Denominator	Rate	95% CI Lower	95% CI Upper
Race	**Asian**	923	9.8%	8.0%	11.8%
Race	**Black**	2,252	6.3%	5.4%	7.4%
Race	**Indigenous/Native**	326	8.0%	5.5%	11.4%
Race	**Multi-Race**	428	6.5%	4.6%	9.3%
Race	**White**	12,266	7.5%	7.0%	7.9%
Ethnicity	**Hispanic/Latinx**	1,170	6.7%	5.4%	8.2%
Ethnicity	**Not Hispanic/Latinx**	15,358	7.5%	7.1%	7.9%
Language	**English**	16,315	7.3%	7.0%	7.8%
Language	**Other Language**	990	8.8%	7.2%	10.7%
Country	**United States**	15,211	7.3%	6.9%	7.7%
Country	**Other Country**	1,594	8.3%	7.1%	9.8%

Return to Adult Depression - Remission at Six Months section

APPENDIX E:
Sources

Borsky, A. E., Zhan, C., Miller, T., Ngo-Metzger, Q., Bierman, A. S., & Meyers, D. J. (2018). *Few Americans receive all high-priority, appropriate clinical preventive services. Health Affairs, 37*(6), 925–928.
Link: Health Affairs article on preventive services — https://doi.org/10.1377/hlthaff.2017.1248

Hacker, K. (2024). *The burden of chronic disease*. *Mayo Clinic Proceedings: Innovations, Quality & Outcomes, 8*(1), 112–119.
Link: Mayo Clinic Proceedings article on chronic disease burden — https://pmc.ncbi.nlm.nih.gov/articles/PMC10830426/

Minnesota Department of Human Services. (2023). *Medicaid matters: We're all healthier when we're all covered (DHS-8665A-ENG)* [PDF].
Link: Minnesota DHS Medicaid Matters report (PDF) — https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8665A-ENG

Minnesota Statutes § 256B.072. (2025). *Performance reporting and quality improvement system*.
Link: Minnesota Statute 256B.072 — https://www.revisor.mn.gov/statutes/cite/256B.072

National Committee for Quality Assurance. (n.d.). *Controlling high blood pressure (CBP)*.
Link: NCQA controlling high blood pressure (CBP) measure — https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/controlling-high-blood-pressure-cbp/

National Committee for Quality Assurance. (n.d.-a). *Breast cancer screening (BCS-E)*.
Link: NCQA breast cancer screening (BCS-E) measure — https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/breast-cancer-screening-bcs-e/

National Committee for Quality Assurance. (n.d.-b). *Childhood immunization status (CIS-E)*.
Link: NCQA childhood immunization status (CIS-E) measure — https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/childhood-immunization-status-cis-e/

National Committee for Quality Assurance. (n.d.-c). *Immunizations for adolescents (IMA-E)*.
Link: NCQA immunizations for adolescents (IMA-E) measure — https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/immunizations-for-adolescents-ima-e/

National Institute of Mental Health. (2023). *Major depression*.
Link: NIMH statistics on major depression — https://www.nimh.nih.gov/health/statistics/major-depression

Sabatino, S. A., Thompson, T. D., White, M. C., Shapiro, J. A., de Moor, J. S., Doria-Rose, V. P., Klabunde, C. N., & Richardson, L. C. (2015a). *Cancer screening test receipt — United States, 2013*. *Morbidity and Mortality Weekly Report, 64*(17), 464–468.
Link: CDC MMWR cancer screening receipt (2013) https://pmc.ncbi.nlm.nih.gov/articles/PMC5309146/

Sabatino, S. A., White, M. C., Thompson, T. D., & Klabunde, C. N. (2015b). *Cancer screening test use—United States, 2013*. *Morbidity and Mortality Weekly Report, 64*(17), 464–468.
Link: CDC MMWR cancer screening use (2013) — https://pmc.ncbi.nlm.nih.gov/articles/PMC5309146/

Substance Abuse and Mental Health Services Administration. (n.d.). *State estimates of substance use and mental disorders*.
Link: SAMHSA state estimates dashboard — https://datatools.samhsa.gov/saes/state

Watson, K. B., Wiltz, J. L., Nhim, K., Kaufmann, R. B., Thomas, C. W., & Greenlund, K. J. (2025). *Trends in multiple chronic conditions among US adults, by life stage, Behavioral Risk Factor Surveillance System, 2013–2023*. *Preventing Chronic Disease, 22*, E15.
Link: CDC Preventing Chronic Disease article — https://www.cdc.gov/pcd/issues/2025/24_0539.htm