Contract Year 2023 Quality Withhold Measures:

Technical Specifications Final

Quality Withhold Measures for MCO Contracts

10/10/2023

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CY 2023 Quality Withhold Measures

Tables 1A, 1B, and 1C list performance and compliance Withhold measures for the Families and Children (abbreviated as F&C) (e.g., PMAP and MinnesotaCare products), Seniors (e.g., MSC+ and MSHO products) and SNBC contracts. For the F&C contract, there are eleven (11) withhold measures of which nine (9) are performance measures and two (2) are compliance measures. The first six (6) performance measures for the contract year 2023 are stratified by Race and Ethnicity (R/E). The last three (3) performance measures are continued from previous contract years (since 2014) and are legislatively mandated. There is an additional compliance measure for 2023, called "F&C/MinnesotaCare Healthcare Equity Stakeholder/Community Engagement", which documents meetings and reporting. For the Seniors contract, there are five (5) withhold measures of which two (2) are performance measures and three (3) are compliance measures. For the SNBC contract, there are four (4) withhold measures of which one (1) is a performance measure and three (3) are compliance measures.

Measurement Technical Specifications

The specifications for the performance measures (e.g., PPC, CIS, W30, WCV, FUH, IET) are based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) 2023 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2023 specifications unless the changes significantly influence this measure's dependability. The calculation of the rates for the HEDIS measures will follow the NCQA technical specifications.

Table 1A: List of Withhold Measures (Performance and Compliance) for F&C Contract and Related Details

Measures for F&C Contract (e.g., PMAP & MinnesotaCare)	Measure Type	Age Group	Points Allocated
Prenatal and Postpartum Care (PPC): Timeliness of Care	Performance (R/E)	All Child-bearing age	7
Prenatal and Postpartum Care (PPC): Postpartum Care	Performance (R/E)	All Child-bearing age	7
Childhood Immunization Status (CIS) - Combo 10	Performance (R/E)	2 years	14
Well Child Visits in First 15 Months (W30): 6 or more visits	Performance (R/E)	0 to 15 months	7
Well Child Visits in First 30 Months (W30): 6 or more visits	Performance (R/E)	15 to 30 months	7
Child & Adolescent Well-Visits (WCV)	Performance (R/E)	All (3 to 21 years)	14

Measures for F&C Contract (e.g., PMAP & MinnesotaCare)	Measure Type	Age Group	Points Allocated
Follow-up After Hospitalization for Mental Illness (FUH): 7-day	Performance (R/E)	All (6 to 65+ years)	7
Follow-up After Hospitalization for Mental Illness (FUH): 30-day	Performance (R/E)	All (6 to 65+ years)	7
Initiation and Engagement of Substance Use Disorder Treatment (IET): Initiation	Performance (R/E)	All (13 to 65+ years)	7
Initiation and Engagement of Substance Use Disorder Treatment (IET): Engagement	Performance (R/E)	All (13 to 65+ years)	7
*Emergency Department Visits (EDV)	Performance	All (0 to 64 years)	1
*Hospital Admission (ADM)	Performance	All (1 to 64 years)	1
*30 Day Readmission (RDM)	Performance	All (1 to 64 years)	1
F&C/MinnesotaCare Healthcare Equity Stakeholder/Community Engagement	Compliance	All	12
No Repeat Deficiencies on the MDH QA/TCA Examination	Compliance	Not Applicable	1

* Measures are mandated by Minnesota Legislature. Not HEDIS measures. Acronyms were developed by DHS.

Table 1B: List of Withhold Measures (Performance and Compliance) for SNBC Contract and Related Details

Measures for SNBC Contract	Measure Type	Age Group	Points Allocated
Annual Dental Visit (ADV)	Performance	18 to 64 years	15
Service Accessibility / Care Plan Audit	Compliance	Not Applicable	15
Stakeholders Group Reporting	Compliance	Not Applicable	15
No Repeat Deficiencies on the MDH QA/TCA Examination	Compliance	Not Applicable	15

Table 1C: List of Withhold Measures (Performance and Compliance) for Seniors Contract and Related Details

Measures for Seniors Contract	Measure Type	Age Group	Points Allocated
Annual Dental Visit	Performance	65+ years	15
Initial Seniors Health Risk Screening or Assessment (SHRA)	Performance	64+ years	30
Service Accessibility / Care Plan Audit	Compliance	Not Applicable	15
Stakeholders Group Reporting	Compliance	Not Applicable	15
No Repeat Deficiencies on the MDH QA/TCA Examination	Compliance	Not Applicable	15

Grouping of Enrollees: Race and Ethnicity

Enrollees for each MCO will be grouped by both race and ethnicity according to the DHS enrollment data and methods. Enrollees selecting more than one race are assigned to one race category beginning with the group of lowest representation based on distribution of race among Minnesota Health Care Program (MHCP) enrollees (Table 2). Data from calendar year 2021, show that the racial composition of state health care program enrollees is Native American (2.4%), Asian/Pacific Islander (7.8%), Black (20.4%), White (55.1%), two or more races (5.7%), and Unknown (8.6%).

Table 2: Hierarchy of Ethnicity and Race Assignments

Ethnicity	**Race (Hierarchy)**	**Two or More races (reporting only, no points)**
Hispanic	Native American/Alaska Native Asian/Pacific Islander Black/African American Non-Hispanic White* Unknown	Multi-racial

*Note: For withhold measure analysis, DHS will compare the Hispanic ethnicity group and other race groups to the reference population. Separating race and ethnicity mean that the reference population cannot include Hispanics; therefore, the reference population will be Non-Hispanic White.

For example, as described in Table 2 above, a person who reports as Hispanic and a race (alone) will be categorized as Hispanic and one race. If a person self-identifies as multiple races, then the person is assigned to one race (e.g., Native American and Black is assigned to Native American; Black and Non-Hispanic White is assigned to Black). This person will also be assigned to the multi-racial group; however, this does not play any role in withhold measures (no points assigned).

Enrollees who report no race (i.e., 'Unknown' race) are counted in the overall rates for measures. They are not reported separately as a category. If possible, DHS will augment the data with race/ethnicity data reported in MAXIS to reduce the number of records missing race/ethnicity values. As reliable data becomes available, DHS will consider modification to the assignment of race, ethnicity, or expanding the list of racial/ethnic groups.

Ethnicity and Race Disparity Gap Measurement

DHS will separate the Hispanic ethnic group from the non-white race groups. To calculate healthcare disparities, note that a person who identifies as non-White and Hispanic will be counted in the non-White group for the race disparity gap and in the Hispanic ethnicity disparity gap.

MCO Baseline Rate Calculations

1. Overall performance rate (all subpopulations and "Unknown" combined, excluding fee-for-service (FFS))
2. Baseline performance rates for each of the five (5) sub-populations listed below:
    a. non-Hispanic White Race – the reference population
    b. Black/African American Race
    c. Native American/Alaskan Native Race
    d. Asian/Pacific Islander Race
    e. Hispanic Ethnicity (all Races)

DHS will assess each measure's overall rate for 2023 against MCO's baseline rate from Contract Year 2021. DHS will calculate the MCO's overall rate and **healthcare disparity gaps** for each measure for both **achievement** and **improvement** (MCOs can receive partial points for partial improvement).

Healthcare Disparity Gap: A Disparity Gap is defined as a lower rate for communities of color (i.e., non-Hispanic White rate is larger than rates for other race populations). It is measured as performance rate difference between the reference population (non-Hispanic White) and each of the following race and ethnicity groups:

1. non-Hispanic White and Black/African American
2. non-Hispanic White and Native American/Alaskan Native
3. non-Hispanic White and Asian/Pacific Islander
4. non-Hispanic White and Hispanic

For example: Suppose the performance rate for non-Hispanic White population and a community of color population are 25% and 20% respectively. Then the baseline disparity gap = 25% (non-Hispanic White population) – 20% (a population of interest) = 5 percentage points (abbreviated as 5% gap).

Points Calculation

The STATE will calculate all performance-based quality withhold measures by the administrative method using encounter data.

Points Calculation for the Six (6) F&C Health Equity Withhold Measures Stratified by Race and Ethnicity (R/E):

1. **CIS** - Childhood Immunization Status (Combo 10)

2. **FUH** - Follow-Up After Hospitalization for Mental Illness (2 sub-measures)
3. **IET** - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (2 sub-measures)
4. **PPC** - Prenatal and Postpartum Care (2 sub-measures)
5. **W30** - Well Child Visits in the first 30 months of life (2 sub-measures)
6. **WCV** – Child & Adolescent Well-Care Visits

Achievement Points

For a given measure, if there is no R/E disparity gap for any of the subgroups in the Reporting Period, then MCO is eligible to earn Achievement Points if it achieves a five (5) percentage point growth or improvement in its overall rate compared to the baseline rate.

Improvement Points

For a given measure, if there is a R/E disparity gap for any of the subgroups in the Reporting Period, then the MCO is eligible to earn Improvement Points if it achieves improvement in the healthcare disparity to reduce the gap between the reference population (e.g., non-Hispanic White) and the population of color (without affecting the drop in the rate for the White population, compared to the baseline rate).

Relative Change Scale

Each measure stratified by race and ethnicity groups (Asian/Pacific Islander, Black/African American, Hispanic, Native American/Native Alaskan, and non-Hispanic White) shall be assessed against a baseline disparity gap with the non-Hispanic White population.

- For each disparity gap that improves by a net value of fifty percent (50%) or more compared to the baseline-stratified rate, the MCO shall be awarded 1.75 points.
- For each disparity gap that changes in net value between +/- 50% compared to the baseline-stratified rate, between 0 and 1.75 points shall be assigned according to the following ranges:

Table 3A: Points Table for Relative Change Scale

Percent (%) Relative Change	Points Awarded
< -50% to 9.9%	0

Percent (%) Relative Change	Points Awarded
10% to 20%	1.0
20.1 to 30%	1.25
30.1 to 50%	1.5
>50%	1.75

Example Calculation Relative Change Scale

Baseline rate = 25% (Non-Hispanic White population) – 20% (population of interest) = 5% gap

Performance Period rate = 25% (Non-Hispanic White population) – 21% (population of interest) = 4% gap

Gap reduction from 5% to 4%, can be expressed as (5-4)/5 = 0.20 or a 20% net change (i.e., improvement)

Points earned for 20% net improvement on this measure = 1.0

Discrete Scale for Small Population

If an MCO has less than thirty (< 30) non-White enrollees in the denominator for a measure, then DHS will apply a discrete scale for the measure. Each measure stratified by race and ethnicity groups (Asian/Pacific Islander, Black/African American, Hispanic, Native American/Native Alaskan, and non-Hispanic White) shall be assessed against a baseline disparity gap with the non-Hispanic White population. The discrete scale will be applied to the change in the numerator for the population of interest. The denominator in the baseline year determines how many points are available. If a measure qualifies for the discrete scale in one year and the relative change method in the other year, the discrete scale is applied.

Table 3B: Points Table for Discrete Scale

Change in Numerator	Points Awarded
0	0

Change in Numerator	Points Awarded
1 to 9	1.0
10 to 19	1.5
20 to 29	1.75

Example Calculation Discrete Scale

Baseline = Five (5) enrollees in population of interest screened

Performance Period = Seven (7) enrollees in population of interest screened

Gap improvement from Five (5) to Seven (7), net increase of Two (2)

Points earned for Two (2) more enrollees = 1.0 point

Special Case

For a given sub-population, if MCO's performance rate is 100% in the reporting period, then MCO will be awarded the full points allocated to that sub-measure, regardless of the change in the Numerator Count.

Total Points Allocated

Each measure has fourteen (14) points. If a measure has two (2) selected sub-measures, then the total points are equally divided between the two selected sub-measures, or each selected sub-measure will be allocated seven (7) points. For example, *Prenatal and Postpartum Care (PPC)* measure has total fourteen (14) points assigned, then half of the total points or seven (7) points are allocated to the *Timeliness of Prenatal Care* sub-measure and the other half of the total points, or seven (7) points are allocated to the *Postpartum Care* sub-measure.

Calculation of the MCO's Score

The total points earned by the MCO for each measure will consist of the sum of the point calculations for the resulting change in each healthcare disparity gap between the reference group (non-Hispanic White) and each race and ethnicity group as observed from the baseline to performance time periods.

No Points Awarded

As noted in the points tables above (i.e., Table 3A and Table 3B), no points will be awarded for groups for which the healthcare disparity gap does not improve or still exists in the reporting period.

No Points Allocated

As noted in the Points Calculations Decision Tree on page 11, if there is no R/E during the reporting period (or the baseline period), then the points allocated to that sub-group will be re-distributed to remaining other R/E groups.

Points Earned

The MCO's overall performance score will be calculated by taking the sum of earned points and dividing them by the total points available (that is, a score of the percentage of points earned versus points available) for the performance period. Please note that in the relative change scale, 1.75 points are always available to the MCO. In the discrete scale, 1.75 points may not be available depending on the MCO's enrollee numbers in that racial or ethnic group on each measure. However, the sum of the total points available will take that into consideration in the overall performance score.

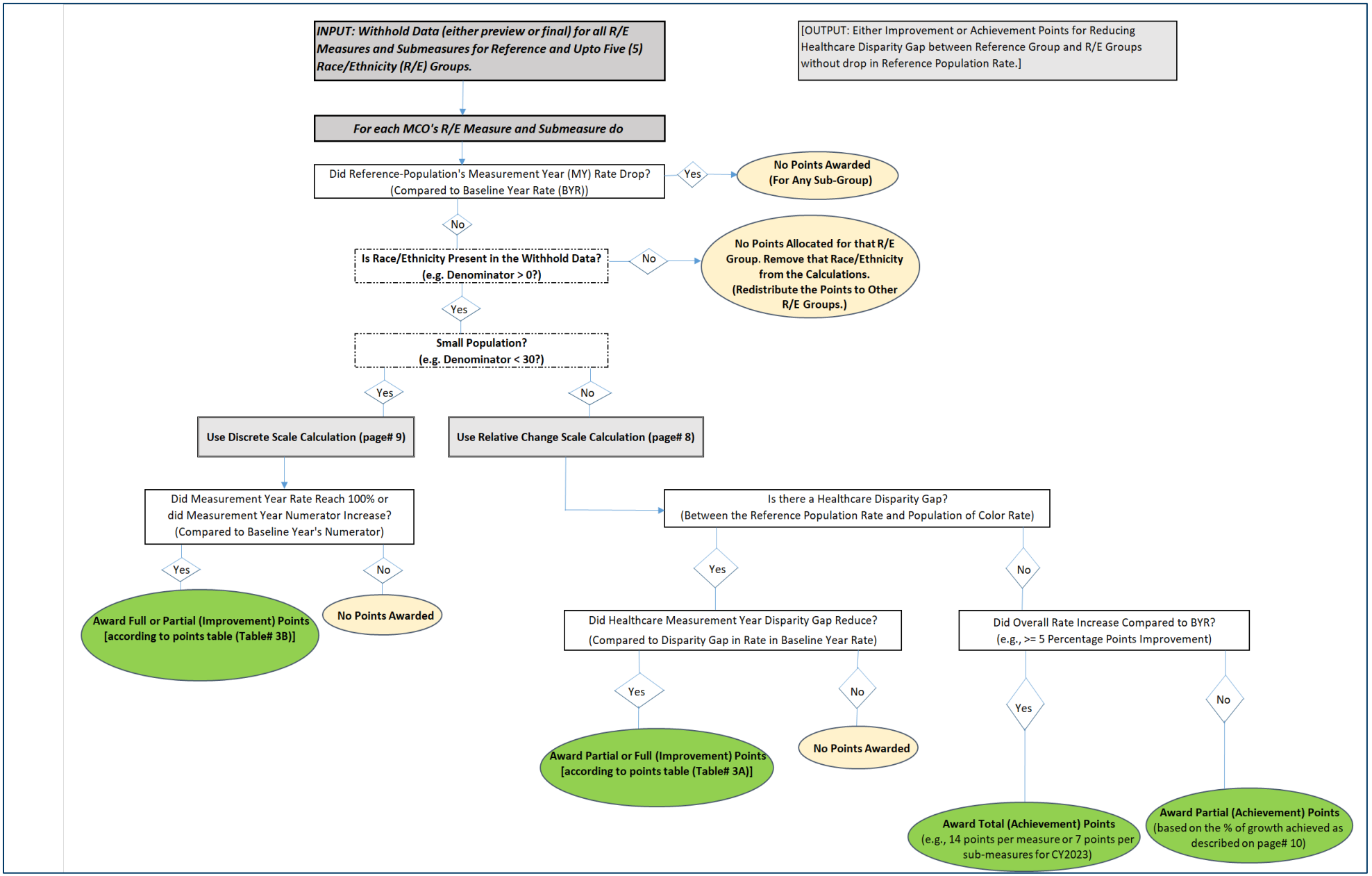
Partial Scoring

A portion of the withheld target points will be awarded commensurate with the achieved improvement less than the targeted amount. The percentage of improvement will be calculated to the first decimal. The number of points will be awarded based on the percentage of improvement achieved.

Measure Specification Changes

If a measure specification changes in a way that would make a year-to-year comparison invalid, such as a change in the clinical target value, then awarding points based on improvement will not be available for that measure.

Table 5: Points Calculations Decision Tree for the F&C MA Health Equity R/E Measures



Withhold Measure Baseline Calculations for New MCOs for Contract Year 2023

For the contract year 2023 F&C (e.g., PMAP and MinnesotaCare products) contract, United Healthcare (UHC) has started serving in eight (8) metro counties now and Medica has started serving in 19 counties, including Hennepin County. Therefore, DHS re-established new 2021 baselines for these two MCOs.

The following approaches are used for baseline-year 2021 rate calculations:

1. The combined healthcare disparities in 2021 for other MCOs with F&C contracts in the metro counties is used. DHS has combined for the relevant county or counties the numbers of enrollees by race or ethnicity to determine the categories of non-Hispanic White (reference population), non-white race populations, and Hispanic population.
   - The combined data for ALL enrollees (excluding FFS) from ALL MCOs, who had enrolled members for 11 out of 12 months in 2021, is used to establish what the healthcare disparities were at that time.
   - This will be the baseline, which the new MCOs will need to improve (decrease) the healthcare disparity gaps.
2. If no healthcare disparities exist for UHC or Medica in their 2023 withhold measure rates, then DHS will use the average measure rate (excluding FFS) for ALL enrollees in the metro counties or other relevant counties, respectively for 2021 as the withhold baseline rates for these MCOs.

Target Improvement

1. The new MCOs will have the same healthcare disparity points awarded for improvement as the existing MCOs.
2. If no healthcare disparities exist for an MCO, then the overall measure rate improvement will be the target. The MCO will have a target of five (5) percentage point improvement over the baseline rate for each measure. The MCOs can receive partial points for partial improvement.

Statutory Withhold Measures

The Emergency Department Visits (EDV), Hospital Admissions (ADM), and 30-Day Hospital Readmissions (RDM) withhold measures are in effect for the F&C contract. With the recent changes in United Healthcare's (UHC) and Medica's contracts, DHS re-created the new 2021 baseline rates (e.g., average of the rates for ALL enrollees of ALL the MCOs operating in those counties) for each of the three (3) statutory withhold measures for UHC and Medica.

Annual Dental Visits (ADV) Measure for Senior and SNBC:

With the recent changes in United Healthcare's (UHC) SNBC and Seniors contracts from 2023, DHS established a new 2021 baseline data for their Annual Dental Visits (ADV) measure for their SNBC and Seniors population.

Measures for Families and Children (e.g., PMAP & MinnesotaCare) Contract Only

Childhood Immunization Status (CIS) - Combo 10

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polios (IPV); one measles, mumps and rubella (MMR); three haemophiles influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugates (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. We will consider only Combination 10 (or Combo 10) for this measure.

Baseline Year Rate Calculation

The MCOs' calendar year 2021 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 2: Measure Name: Childhood Immunization Status (CIS)
Sub-measure: Combination 10 (or Combo 10)
Total Points: Fourteen (14) points
Age: 2 years old

Measure: CIS – Combo 10	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic**		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	3,843	9,924	38.72	1,285	3,157	40.70	366	1,565	23.39	142	415	34.22	326	664	49.10	359	779	46.08
HealthPartners	1,616	4,118	39.24	329	741	44.40	218	874	24.94	40	127	31.50	140	299	46.82	117	257	45.53
Hennepin Health	124	336	36.90	7	17	41.18	21	103	20.39	<6	15	20.00	<6	<6	50.00	15	34	44.12

Measure: CIS – Combo 10	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic**		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Itasca Medical Care	64	175	36.57	45	119	37.82	<6	<6	25.00	10	25	40.00	0	<6	0.00	0	0	NA
Medica*	3,050	8,784	34.72	740	1,902	38.91	403	1,997	20.18	128	373	34.32	138	332	41.57	276	556	49.64
PrimeWest Health	350	1,054	33.21	185	533	34.71	<6	19	26.32	45	187	24.06	<6	7	28.57	39	95	41.05
SCHA	214	504	42.46	92	212	43.40	7	33	21.21	<6	<6	50.00	<6	<6	40.00	26	65	40.00
UCare	2,993	8,391	35.67	701	1,674	41.88	453	2,095	21.62	53	182	29.12	232	541	42.88	392	769	50.98
	5,220	14,299	36.51	891	2,019	44.13	749	3,602	20.79	125	389	32.13	605	1,302	46.47	499	1,043	47.84

Notes: N = Numerator; D = Denominator; Baseline data calculated in May 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Well Child Visits in First 30 Months of Life (W30)

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.

2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

Baseline Year Rate Calculation

The MCOs' calendar year 2021 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 3 A: Measure Name: Well Child Visits in First 15 Months of Life – (Six or more well-child visits).
Sub-measure: W15
Total Points: Seven (7) points
Age: 0 to 15 months

Measure: W30-W15	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	3,665	6,567	55.81	976	1,690	57.75	448	965	46.42	90	197	45.69	242	407	59.46	309	494	62.55
HealthPartners	1,792	3,051	58.73	243	412	58.98	280	573	48.87	28	68	41.18	115	190	60.53	83	146	56.85
Hennepin Health	125	261	47.89	10	16	62.50	29	68	42.65	<6	9	11.11	<6	<6	33.33	22	34	64.71

Measure: W30-W15	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Itasca Medical Care	46	92	50.00	36	65	55.38	0	0	NA	<6	11	27.27	0	0	NA	0	<6	0.00
Medica*	3,309	6,266	52.81	606	1,056	57.39	551	1,284	42.91	91	204	44.61	96	181	53.04	196	322	60.87
PrimeWest Health	383	758	50.53	188	362	51.93	7	14	50.00	47	115	40.87	<6	<6	50.00	37	72	51.39
SCHA	199	402	49.50	75	138	54.35	<6	25	16.00	<6	<6	25.00	0	<6	0.00	25	57	43.86
UCare	3,119	6,030	51.72	568	918	61.87	540	1,337	40.39	45	105	42.86	169	334	50.60	308	491	62.73
UnitedHealthCare*	5,662	10,612	53.35	700	1,161	60.29	996	2,348	42.42	104	231	45.02	456	826	55.21	410	668	61.38

Notes: N = Numerator; D = Denominator; Baseline data calculated in May 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Table 3 B: Measure Name: Well Child Visits in First 30 Months of Life (2 or more visits)
Sub-measure: W30
Total Points: Seven (7) points
Age: 15 to 30 months

Measure: W30-W30	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/ Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	5,861	9,252	63.35	1,992	3,057	65.16	957	1,575	60.76	195	369	52.85	426	665	64.06	522	776	67.27
HealthPartners	2,434	3,605	67.52	511	692	73.84	508	808	62.87	68	109	62.39	173	254	68.11	181	261	69.35
Hennepin Health	147	287	51.22	9	18	50.00	33	86	38.37	10	18	55.56	<6	8	62.50	23	34	67.65
Itasca Medical Care	85	167	50.90	54	113	47.79	<6	<6	40.00	16	25	64.00	0	0	NA	<6	<6	100.00
Medica*	4,896	8,026	61.00	1,179	1,827	64.53	1,104	1,957	56.41	199	349	57.02	182	321	56.70	407	583	69.81
PrimeWest Health	565	980	57.65	320	506	63.24	12	17	70.59	64	161	39.75	<6	8	62.50	47	87	54.02
SCHA	272	476	57.14	126	208	60.58	11	29	37.93	<6	<6	60.00	<6	<6	25.00	38	63	60.32
UCare	4,620	7,653	60.37	935	1,485	62.96	1,142	2,093	54.56	98	175	56.00	346	567	61.02	475	711	66.81
UnitedHealthCare*	8,216	13,207	62.21	1,336	1,942	68.80	1,981	3,562	55.61	214	369	57.99	815	1,285	63.42	716	1,051	68.13

Notes: N = Numerator; D = Denominator; Baseline data calculated in May 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Child & Adolescent Well Visits (WCV)

The percentage of members 3 - 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. DHS has applied the Child and Adolescent Well-Care Visits (WCV) HEDIS technical specifications to the baseline 2019 data to calculate the rates for this measure.

Baseline Year Rate Calculation

The MCOs' calendar year 2021 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 4: Measure Name: Well Child Visits (1 or more visits)
Total Points: Fourteen (14) points
Age: 3 to 21 years

Measure: WCV	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	79,305	171,892	46.14	35,448	82,029	43.21	17,458	34,267	50.95	3,825	9,623	39.75	7,496	16,611	45.13	10,702	22,455	47.66
HealthPartners	37,311	72,693	51.33	10,676	22,110	48.29	13,030	25,170	51.77	1,430	3,355	42.62	4,423	8,631	51.25	5,484	10,467	52.39
Hennepin Health	2,338	5,246	44.57	161	441	36.51	839	2,111	39.74	191	423	45.15	66	221	29.86	1,024	1,920	53.33
Itasca Medical Care	1,282	3,615	35.46	987	2,782	35.48	40	107	37.38	180	527	34.16	15	41	36.59	23	100	23.00
Medica*	73,135	155,696	46.97	23,159	52,934	43.75	25,633	54,187	47.30	4,019	9,729	41.31	4,330	9,837	44.02	12,251	23,436	52.27
PrimeWest Health	7,692	18,587	41.38	5,080	12,251	41.47	267	653	40.89	910	2,824	32.22	89	245	36.33	994	2,059	48.28
SCHA	4,270	10,652	40.09	2,671	6,887	38.78	427	1,019	41.90	69	211	32.70	76	157	48.41	741	1,859	39.86

Measure: WCV	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
UCare	70,838	146,746	48.27	17,751	39,205	45.28	26,230	55,349	47.39	2,439	5,685	42.90	6,776	15,015	45.13	13,811	25,798	53.54
UnitedHealthCare*	125,135	253,990	49.27	27,874	59,127	47.14	46,161	95,496	48.34	4,924	11,619	42.38	16,402	35,275	46.50	22,521	42,252	53.30

Notes: N = Numerator; D = Denominator; Baseline data calculated in May 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Follow-up after Hospitalization for Mental Illness (FUH)

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Baseline Year Rate Calculation

The MCOs' calendar year 2021 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 5 A: Measure Name: Follow-up after Hospitalization for Mental Illness (30-days)
Sub-measure: 30 Days
Total Points: Seven (7) points
Age: 6 years and older

Measure: FUH - 30 Day	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	1,875	2,818	66.54	1,201	1,698	70.73	241	416	57.93	167	299	55.85	67	105	63.81	217	321	67.60
HealthPartners	746	1,063	70.18	369	520	70.96	191	290	65.86	45	75	60.00	44	59	74.58	102	126	80.95
Hennepin Health	145	266	54.51	62	92	67.39	48	108	44.44	19	37	51.35	<6	8	37.50	12	15	80.00
Itasca Medical Care	37	51	72.55	24	33	72.73	<6	<6	100.00	9	14	64.29	<6	<6	100.00	0	0	NA

Measure: FUH - 30 Day	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Medica*	1,601	2,466	64.92	879	1,266	69.43	349	599	58.26	168	308	54.55	44	71	61.97	182	241	75.52
PrimeWest Health	221	328	67.38	150	207	72.46	<6	9	55.56	48	89	53.93	<6	<6	100.00	15	22	68.18
SCHA	146	231	63.20	113	172	65.70	<6	16	37.50	<6	<6	50.00	<6	7	57.14	13	24	54.17
UCare	1,230	1,851	66.45	662	947	69.90	276	464	59.48	87	160	54.38	57	85	67.06	169	222	76.13
	2,392	3,650	65.53	1,143	1,661	68.81	627	1,061	59.10	190	328	57.93	144	212	67.92	323	432	74.77

Notes: N = Numerator; D = Denominator; Baseline data calculated in May 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Table 5 B: Measure: Follow-up after Hospitalization for Mental Illness (7-days)

Sub-measure: 7 Days

Total Points: Seven (7) points

Age: 6 years and older

Measure: FUH - 7 Day	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	1,111	2,818	39.43	734	1,698	43.23	126	416	30.29	83	299	27.76	36	105	34.29	140	321	43.61
HealthPartners	478	1,063	44.97	241	520	46.35	119	290	41.03	35	75	46.67	25	59	42.37	66	126	52.38
Hennepin Health	73	266	27.44	32	92	34.78	21	108	19.44	16	37	43.24	<6	8	12.50	<6	15	33.33
Itasca Medical Care	17	51	33.33	10	33	30.30	<6	<6	100.00	<6	14	28.57	0	<6	0.00	0	0	NA
Medica*	948	2,466	38.44	547	1,266	43.21	187	599	31.22	94	308	30.52	25	71	35.21	111	241	46.06
PrimeWest Health	128	328	39.02	89	207	43.00	<6	9	11.11	24	89	26.97	<6	<6	75.00	12	22	54.55
SCHA	84	231	36.36	64	172	37.21	<6	16	18.75	0	<6	0.00	<6	7	28.57	8	24	33.33
UCare	736	1,851	39.76	405	947	42.77	162	464	34.91	46	160	28.75	33	85	38.82	98	222	44.14
UnitedHealthCare*	1,427	3,650	39.10	705	1,661	42.44	352	1,061	33.18	115	328	35.06	74	212	34.91	203	432	46.99

Notes: N = Numerator; D = Denominator; Baseline data calculated in May 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Initiation and Engagement of Alcohol, Opioids, and Other Drug Dependence Treatment (IET)

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- *Initiation of SUD Treatment.* The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.
- *Engagement of SUD Treatment.* The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Baseline Year Rate Calculation

The MCOs' calendar year 2021 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 6 A: Measure Name: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Sub-measure: Initiation (Total)
Total Points: Seven (7) points
Age: 13 years and older

Measure: IET - Initiation	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	5,076	13,766	36.87	3,193	8,728	36.58	707	1,915	36.92	710	1,770	40.11	126	369	34.15	371	1,097	33.82
HealthPartners	1,862	5,242	35.52	1,086	3,072	35.35	410	1,159	35.38	179	468	38.25	67	167	40.12	145	446	32.51
Hennepin Health	942	2,289	41.15	322	736	43.75	405	1,022	39.63	150	381	39.37	24	53	45.28	49	127	38.58
Itasca Medical Care	134	363	36.91	90	275	32.73	<6	<6	50.00	42	78	53.85	<6	<6	NA	<6	7	NA
Medica*	5,112	13,534	37.77	2,660	7,208	36.90	1,279	3,405	37.56	759	1,909	39.76	114	280	40.71	360	932	38.63

Measure: IET - Initiation	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
PrimeWest Health	538	1,459	36.87	305	875	34.86	17	38	44.74	198	489	40.49	<6	7	71.43	20	59	33.90
SCHA	286	829	34.50	232	656	35.37	21	59	35.59	8	33	24.24	<6	<6	80.00	22	83	26.51
UCare	3,473	9,254	37.53	1,932	5,169	37.38	808	2,202	36.69	364	923	39.44	103	274	37.59	297	808	36.76
UnitedHealthCare*	7,438	19,270	38.60	3,753	9,656	38.87	1,995	5,358	37.23	885	2,204	40.15	272	707	38.47	609	1,633	37.29

Notes: N = Numerator; D = Denominator; Baseline data re-calculated in Oct. 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Table 6 B: Measure Name: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Sub-measure: Engagement (Total)
Total Points: Seven (7) points
Age: 13 years and older

Measure: IET - Engagement	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	2,084	13,766	15.14	1,325	8,728	15.18	276	1,915	14.41	290	1,770	16.38	56	369	15.18	150	1,097	13.67
HealthPartners	761	5,242	14.52	450	3,072	14.65	168	1,159	14.50	66	468	14.10	28	167	16.77	57	446	12.78
Hennepin Health	350	2,289	15.29	120	736	16.30	155	1,022	15.17	51	381	13.39	10	53	18.87	18	127	14.17
Itasca Medical Care	49	363	13.50	41	275	14.91	<6	<6	25.00	7	78	8.97	<6	<6	NA	<6	7	NA
Medica*	2,063	13,534	15.24	1,101	7,208	15.27	475	3,405	13.95	310	1,909	16.24	42	280	15.00	167	932	17.92
PrimeWest Health	167	1,459	11.45	108	875	12.34	<6	38	13.16	45	489	9.20	<6	7	28.57	10	59	16.95
SCHA	88	829	10.62	76	656	11.59	6	59	10.17	<6	33	3.03	<6	<6	20.00	<6	83	6.02
UCare	1,370	9,254	14.80	809	5,169	15.65	286	2,202	12.99	137	923	14.84	37	274	13.50	120	808	14.85
UnitedHealthCare*	2,965	19,270	15.39	1,565	9,656	16.21	754	5,358	14.07	332	2,204	15.06	99	707	14.00	248	1,633	15.19

Notes: N = Numerator; D = Denominator Baseline data re-calculated in Oct. 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Prenatal and Postpartum Care (PPC)

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

1. *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
2. *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Baseline Year Rate Calculation

The MCOs' calendar year 2021 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 7 A: Measure Name: Prenatal and Postpartum Care
Sub-measure: Timeliness of Prenatal Care
Total Points: Seven (7) points
Age: All

Measure: PPC - Timeliness of Care	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	4,905	7,786	63.00	2,179	3,647	59.75	1,180	1,709	69.05	298	459	64.92	480	817	58.75	724	1,070	67.66
HealthPartners	2,519	3,459	72.82	782	1,116	70.07	944	1,245	75.82	119	167	71.26	290	428	67.76	345	453	76.16
Hennepin Health	235	349	67.34	26	50	52.00	107	159	67.30	25	36	69.44	9	18	50.00	63	80	78.75
Itasca Medical Care	53	144	36.81	40	117	34.19	<6	<6	33.33	12	22	54.55	<6	<6	0.00	<6	<6	25.00
Medica*	4,862	7,027	69.19	1,656	2,536	65.30	1,878	2,600	72.23	348	490	71.02	271	436	62.16	672	916	73.36

Measure: PPC - Timeliness of Care	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
PrimeWest Health	424	791	53.60	310	536	57.84	13	16	81.25	46	141	32.62	<6	10	50.00	51	88	57.95
SCHA	133	438	30.37	102	309	33.01	6	34	17.65	<6	11	27.27	<6	7	0.00	23	76	30.26
UCare	4,213	6,518	64.64	1,148	1,887	60.84	1,648	2,482	66.40	171	261	65.52	439	713	61.57	719	1,045	68.80
UnitedHealthCare*	8,168	11,569	70.60	2,004	2,884	69.49	3,180	4,467	71.19	404	585	69.06	1,120	1,719	65.15	1,320	1,714	77.01

Notes: N = Numerator; D = Denominator; Baseline data re-calculated in Sept. 2023.

*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Table 7 B: Measure Name: Prenatal and Postpartum Care
Sub-measure: Postpartum Care
Total Points: Seven (7) points
Age: All

Measure: PPC - Postpartum Care	2021 Overall Rate (All R/E: Unknown included)			Reference Population: Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
MCO	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)	N	D	Rate (%)
Blue Plus	4,118	7,786	52.89	1,927	3,647	52.84	843	1,709	49.33	228	459	49.67	381	817	46.63	671	1,070	62.71
HealthPartners	1,680	3,459	48.57	557	1,116	49.91	583	1,245	46.83	74	167	44.31	193	428	45.09	244	453	53.86
Hennepin Health	242	349	69.34	30	50	60.00	106	159	66.67	22	36	61.11	9	18	50.00	69	80	86.25
Itasca Medical Care	82	144	56.94	68	117	58.12	<6	<6	33.33	11	22	50.00	<6	<6	100.00	<6	<6	100.00
Medica*	3,959	7,027	56.34	1,402	2,536	55.28	1,392	2,600	53.54	268	490	54.69	226	436	51.83	628	916	68.56
PrimeWest Health	462	791	58.41	331	536	61.75	6	16	37.50	62	141	43.97	7	10	70.00	57	88	64.77
SCHA	250	438	57.08	183	309	59.22	17	34	50.00	<6	11	36.36	<6	7	28.57	43	76	56.58
UCare	3,616	6,518	55.48	1,059	1,887	56.12	1,306	2,482	52.62	141	261	54.02	343	713	48.11	684	1,045	65.45
UnitedHealthCare*	6,025	11,569	52.08	1,512	2,884	52.43	2,229	4,467	49.90	288	585	49.23	786	1,719	45.72	1,074	1,714	62.66

Notes: N = Numerator; D = Denominator; Baseline data re-calculated in Sept. 2023.
*=Baseline Year Rate is based on the average measure rate for ALL enrollees in the relevant county/counties for 2021.

**= Hispanic population includes all races under Hispanic ethnicity. Black/African American, Native American/Native Alaskan, and Asian American-Pacific Islander races include Hispanic, as well as non-Hispanic ethnicity.

Three Legislative Statutory Measures (F&C Contract only)

1. Emergency Department Visits (EDV)

This measure summarizes utilization of ambulatory care in the following category: Emergency Department (ED) Visits.

Purpose

This measure applies to the 2023 Families and Children contract. Its purpose is to hold MCOs accountable for decreasing their emergency department (ED) use rate by 10% annually, and eventually by 25% from their baseline year rate. [Minnesota Statutes, section 256B.69, subdivision 5a(e)]

General Description

This measure evaluates the annual decrease in each MCO's rate of ED use.

Performance Target

The annual performance target for this measure is an ED use rate 10% below the MCO's rate for the previous year, until the MCO achieves the final performance target, which is an ED use rate that is 25% below the MCO's baseline year[1] rate.

After an MCO meets or surpasses the final performance target of 25% below the baseline year ED use rate, the STATE will continue to monitor performance to verify that the MCO's ED use rate does not increase more than 10% from the previous year's rate.

Rate Calculation

The rate is calculated by dividing the number of ED visits (numerator) by the number of "enrollee months" (denominator) and then multiplying the result by 1,000 (Rate = [N / D] * 1,000). The rate is calculated to the second decimal (for example, 45.63).

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[1] Baseline Year Rate: For the contract year 2023 calculation, the baseline year rate is calendar year 2009's rate for all MCOs other than Hennepin Health, Medica and UHC. For Hennepin Health, the baseline year rate is calendar year 2012's rate. For the two MCOs starting the F&C contract in 2023, the baseline year is 2021.

The MCO calendar year 2009 (baseline year) rates were calculated as of June 25, 2012. The Hennepin Health calendar year 2012 (baseline year) rate was calculated as of June 5, 2013. For Medica and UHC, the rates were calculated in May 2023.

The specifications for this measure are based on the NCQA HEDIS 2010 technical specifications for the ambulatory care measure. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2010 specifications unless the changes significantly influence this measure's dependability.

Denominator Details

The denominator (D) is the total number of "enrollee months" during the year. An enrollee month is one enrollee's enrollment in the MCO for one month. For an enrollee's enrollee months to be included in the denominator, the enrollee must meet both these criteria:

- **Age:** The enrollee is 0–64 years of age, calculated as of December 31 of the contract year. Enrollees over 64 years of age are excluded.
- **Enrollment:** The enrollee was enrolled in the MCO for at least one month during the calendar year in the Families and Children PMAP or MinnesotaCare program.

One enrollee-month is attributed to the MCO's denominator for each month an enrollee was enrolled in that MCO. Some enrollees may be attributed to multiple MCOs.

Numerator Details

The numerator (N) is the unduplicated number of ED visits during the year for enrollees who meet the denominator criteria. HEDIS 2010 technical specifications are used to identify ED encounters and required exclusions are applied. An ED visit is defined as a visit whose claim has any of the following:

- A CPT code of 99281–99285
- A UB Revenue code of 045x, 0981
- A CPT code of 10040–69979 with a POS (place of service) code of 23

To be included in the numerator, a visit must meet both these criteria:

- The ED visit was provided during the contract year.
- The ED visit occurred during a month that the enrollee was enrolled in the MCO.

Exclusions

These claims and visits are excluded from the numerator calculation:

- Denied claims that result from the implementation of the True Denial Project
- Voided and replaced encounter claims.
- An ED Visit those results in an inpatient stay within one calendar day of the ED Visit.

If an ED visit does not result in an inpatient stay, the ED visit is counted once, regardless of the reason for or duration of the visit.

Multiple ED visits on the same date are counted as only one visit.

Data Source

Denominator and numerator data come from these sources:

- DHS Data Warehouse claims and enrollment data
- Records the STATE gets by May 31 of the year after the contract year.

Points Calculation

A total of 1 point is available for this measure.

The MCO's point for this measure is calculated as follows:

- 1 point: If the MCO's ED use rate is equal to or less than the performance target, the MCO gets the 1 point available. The target rate is the higher of these:
  - An ED use rate 25% below the MCO's baseline year* rate
  - An ED use rate 10% below the MCO's rate for the previous year
- Partial point: If the MCO's ED use rate is less than the MCO's rate for the previous year but not at least 10% below the rate for the previous year, the MCO gets part of the available point, commensurate with the percentage decrease in the difference between 1) the previous year's rate and 2) the rate that is 10% below the previous year's rate.
- 0 points: If the MCO's ED use rate is greater than the previous year's rate, the MCO gets 0 points.

Example of partial point calculation:

- Example MCO's previous year rate is 60 ED visits per 1,000 enrollee months.
- Example MCO's target rate for the contract year is 54 ED visits per 1,000 enrollee months (10% reduction from previous year's rate).
- During the contract year, the MCO achieved a rate of 57 ED visits per 1,000 enrollee months.
- The proportion of the annual reduction achieved is (60 – 57) / (60 – 54) = 3/6 = 0.5 or 50%.
- Because for example MCO achieved a decrease 50% of the difference between its previous year rate of 60 and its target rate of 54, the MCO gets 50% of the available points: 7.5 points.

Point calculation after MCO achieves rate of 25% below baseline year rate:

When an MCO meets or surpasses the final performance target rate of 25% below the baseline year ED use rate for a contract year, the MCO gets all available points for this measure.

In later years, the STATE will continue to monitor performance to verify that the MCO's ED use rate does not increase more than 10% from the previous year's rate. When measuring performance, the STATE must consider the difference in health risk in the MCO's membership in the baseline year compared with the contract year and work with the MCO to account for differences that they agree are significant.

Baseline Year Rate Calculation

The MCO calendar year 2009 (baseline year) rates were calculated as of June 25, 2012. The Hennepin Health calendar year 2012 (baseline year) rate was calculated as of June 5, 2013. For Medica and UHC, the two MCOs starting the F&C contract in 2023 (expanding the service areas), the baseline year is calendar year 2021 (as calculated in May 2023.).

The tables below provide the baseline year rate and final performance target rate for each MCO with **F&C contract.**

Measure Name: **Emergency Department (ED) Visits Utilization**
Total Points: One (1) point
Age: 0 to 64 years

Table 8 A: Calendar Year 2009 (Baseline Year) MCOs' ED Use Rates

MCO	(ED Visits)	(Enrollee Months)	(ED Visits per 1,000 Enrollee Months)	(25% reduction from baseline year)
Blue Plus	61,932	1,253,534	49.41	37.05
HealthPartners	34,631	627,297	55.21	41.41
Itasca Medical Care	4,492	62,704	71.64	53.73
PrimeWest Health	12,653	196,353	64.44	48.33
South Country Health Alliance	21,359	319,542	66.84	50.13
UCare	63,263	1,103,256	57.34	43.01

Table 8 B: Hennepin Health Calendar Year 2012 (Baseline Year) ED Use Rate

MCO	Baseline Year Numerator (ED Visits)	Baseline Year Denominator (Enrollee Months)	Baseline Year ED Use Rate (ED Visits per 1,000 Enrollee Months)	Final Performance Target (25% reduction from baseline year)
Hennepin Health	8,341	62,216	134.07	100.55

Table 8 C: Two New MCOs' Calendar Year 2021 (Baseline Year) ED Visits Rates

MCO	Baseline Year Numerator (ED Visits)	Baseline Year Denominator (Enrollee Months)	Baseline Year ED Use Rate (ED Visits per 1,000 Enrollee Months)	Final Performance Target (25% reduction from baseline year)
*Medica (19 Counties average)	180,457	4,631,952	38.96	29.22
*United Healthcare (8 metros average)	260,903	7,390,854	35.30	26.48

**New 2021 Baseline year rate calculated in May 2023.*

2. Hospital Admission (ADM)

This measure evaluates the annual decrease in each MCO's Inpatient hospital admission rate of members 1 to 64 years of age, who had acute inpatient and observation stays during the measurement year.

Purpose

This measure applies to the 2023 Families and Children contract. Its purpose is to hold managed care organizations accountable for reducing their hospital admission rate by 5% annually, and eventually by 25% from their baseline year rate. [Minnesota Statutes, section 256B.69, subdivision 5a(f)].

General Description

This measure evaluates the annual decrease in each MCO's hospital admission rate.

Performance Target

The MCO's annual performance target for this measure is a hospital admission rate 5% below the rate for the previous year, until the MCO achieves the final performance target, which is a hospital admission rate that is 25% below the MCO's baseline year rate[2].

After an MCO meets or surpasses the final performance target of 25% below the baseline year hospital admission rate, the STATE will continue to monitor performance to verify that the MCO's hospital admission rate does not increase more than 10% from the previous year's rate.

[2] Baseline year rate: For the contract year 2023 calculation, the baseline year rate is calendar year 2011's rate for all MCOs, other than Hennepin Health and the two MCOs (e.g., Medica and UHC). For Hennepin Health, the baseline year rate is from calendar year 2012. For the two MCOs, Medica and UHC, the baseline year is 2021 (*2021 BYR re-calculated in May 2023)*.

The MCO calendar year 2011 (baseline year) rates were calculated as of July 3, 2012. The Hennepin Health calendar year 2012 (baseline year) rate was calculated as of June 4, 2013. Medica and UHC's rates were calculated in May 2023.

Rate Calculation

The rate is calculated by dividing the number of index hospital admissions (numerator) by the number of "enrollee months" (denominator) and then multiplying the result by 1,000 (Rate = [N / D] * 1,000). The rate is calculated to the second decimal (for example, 45.63).

Denominator Details

The denominator (D) is the total number of "enrollee months" during the year. An enrollee month is one enrollee's enrollment in the MCO for one month. For an enrollee's enrollee months to be included in the denominator, the enrollee must meet both these criteria:

- **Age:** The enrollee is 1–64 years of age, calculated as of December 31 of the contract year. Enrollees under 1 year of age and over 64 years of age are excluded.
- **Enrollment:** The enrollee was enrolled in an MCO for at least one month during the calendar year in the Families and Children PMAP or MinnesotaCare program.

One enrollee month is attributed to the MCO's denominator for each month an enrollee was enrolled in that MCO. Some enrollees may be attributed to multiple MCOs.

Enrollment data is used to identify programs (Families and Children PMAP and MinnesotaCare) and payment system (fee-for-service or managed care).

Numerator Details

The numerator (N) is the unduplicated number of index hospital admissions during the year. Index admissions exclude readmissions as defined for the 30-day readmission percentage, described later in this document.

MCOs must monitor and analyze bimonthly DHS remittance advice and enrollment reports to accurately identify admissions and enrollee months.

A hospital admission is defined as an inpatient stay indicated by:

- either:
  - DHS claim types C (inpatient hospital) and U (Medicare crossover inpatient hospital) with provider type 01 (inpatient hospital) or
  - Provider types 24 (MCO) and 33 (consolidated provider) with general inpatient bill types 110–117
- a beginning date of service during the measurement year; and
- an encounter claim that includes room and board revenue codes.

The admission date is defined as the beginning of the service date on the managed care encounter claim. Admissions less than two days apart for the same enrollee will be "collapsed" into one admission to avoid over counting of admissions due to transfers and multiple claims for an inpatient stay. Inpatient claims that are collapsed may be for the same or for different hospitals.

The admission date is used to correctly assign the responsible MCO for an enrollee who changes MCOs during the admission span.

Exclusions

These claims, admissions and readmissions are excluded from the rate calculation:

- Denied claims that result from the implementation of the True Denial Project
- Voided and replaced encounter claims.
- An admission for which any of the following applies:
  - The admission results in the death of the enrollee during the stay (patient status 20 or 41).
  - The admission has a diagnosis of pregnancy (ICD-10 CM diagnosis codes A34, O00.0–O26.93, O29.011–O9A.53, Z33.1–Z36) in any position on the encounter.
  - The admission has a diagnosis of conditions originating in the perinatal period (ICD-10 CM diagnosis codes A33, P00.0–P08.22, P10.0–P29.2, P29.4–P96.9, Q86.0–Q86.8, R78.81, Z00.2, Z00.3, Z38.00–Z38.8) in any position on the encounter.
- Claims related to mental health and chemical health by APR DRGs (for example, DRG numbers 740–760 or DRG numbers 770–776)
- Readmissions that are within 30 days of a previous discharge (admission ending service date) for the same enrollee. Readmissions may be to the same hospital as for the index admission or a different one. Refer to the specifications for the 30-day readmission percentage, later in this document.

Data Sources

Denominator and numerator data come from these sources:

- DHS Data Warehouse claims and enrollment data
- Records the STATE gets by May 31 of the year after the contract year.

Points Calculation

A total of 1 point is available for this measure.

The MCO's points for this measure are calculated as follows:

- **1 point:** If the MCO's hospital admission rate is equal to or less than the performance target, the MCO gets the 1 point available. The target rate is the is the higher of these:
  - A hospital admission rate 25% below the MCO's baseline year* rate
  - A hospital admission rate 5% below the MCO's rate for the previous year

- **Partial point:** If the MCO's hospital admission rate is less than the MCO's rate for the previous year but not at least 5% below the rate for the previous year, the MCO gets part of the available point, commensurate with the percentage decrease in the difference between 1) the previous year's rate and 2) the rate that is 5% below the previous year's rate.
- **0 points:** If the MCO's hospital admission rate is greater than the previous year's rate, the MCO gets 0 points.

Example of partial point calculation:

- Example MCO's previous year rate is 4.0 hospital admissions per 1,000 enrollee months.
- Example MCO's target rate for the contract year is 3.8 admissions per 1,000 enrollee months (5% reduction from previous year's rate).
- During the contract year, the MCO achieved a rate of 3.9 admissions per 1,000 enrollee months.
- The proportion of the annual reduction achieved is (4.0 – 3.9) / (4.0 – 3.8) = 0.1 / 0.2 = 0.5 or 50%.
- Because for example MCO achieved a decrease of 50% of the difference between its previous year rate of 4.0 and its target rate of 3.8, the MCO gets 50% of the available points: 7.5 points.

Point calculation after MCO achieves rate of 25% below baseline year rate:

When an MCO meets or surpasses the final performance target rate of 25% below the baseline year hospital admission rate for a contract year, the MCO gets all available points for this measure.

In later years, the STATE will continue to monitor performance to verify that the MCO's hospital admission rate does not increase more than 10% from the previous year's rate. When measuring performance, the STATE must consider the difference in health risk in the MCO's membership in the baseline year compared with the contract year and work with the MCO to account for differences that they agree are significant.

Baseline Year Rate Calculation

The MCO calendar year 2011 (baseline year) rates were calculated as of July 3, 2012. The Hennepin Health calendar year 2012 (baseline year) rate was calculated as of June 4, 2013. For Medica and UHC, the baseline year is calendar year 2021 (as re-calculated in May 2023).

The tables below provide the baseline year rate and final performance target rate for each MCO with **F&C contract.**

Measure Name: **Hospital Admission**
Total Points = One (1) point
Age: 1 to 64 years

Table 9 A: Calendar Year 2011 (Baseline Year) MCOs' Hospital Admission Rates

MCO	Baseline Year Numerator (Index Admissions)	Baseline Year Denominator (Enrollee Months)	Baseline Year Hospital Admission Rate (Index Admissions per 1,000 Enrollee Months)	Final Performance Target (25% reduction from baseline year)
Blue Plus	5,006	1,559,793	3.21	2.41
HealthPartners	2,503	752,271	3.33	2.50
Itasca Medical Care	198	66,379	2.98	2.24
PrimeWest Health	738	222,096	3.32	2.49
South Country Health Alliance	822	256,001	3.21	2.41
UCare	4,470	1,379,468	3.24	2.43

Table 9 B: Hennepin Health's Calendar Year 2012 (Baseline Year) Hospital Admission Rate

MCO	Baseline Year Numerator (Index Admissions)	Baseline Year Denominator (Enrollee Months)	Baseline Year Hospital Admission Rate (Index Admissions per 1,000 Enrollee Months)	Final Performance Target (25% reduction from baseline year)
Hennepin Health	587	61,856	9.49	7.12

Table 9 C: Two New MCOs' Calendar Year 2021 (Baseline Year) Hospital Admission Rates

MCO	Baseline Year Numerator (Index Admissions)	Baseline Year Denominator (Enrollee Months)	Baseline Year Hospital Admission Rate (Index Admissions per 1,000 Enrollee Months)	Final Performance Target (25% reduction from baseline year)
Medica (19 counties average)	12,548	4,596,128	2.73	2.05
United Healthcare (8 metros average)	19,564	7,331,457	2.67	2.00

**New 2021 BYR calculated in May 2023.*

3. 30 Day Readmission (RDM)

This measure evaluates the annual decrease in each MCO's 30-day readmission percentage for members 1 to 64 years of age, who had acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.

Purpose

This measure applies to the 2023 Families and Children contract. Its purpose is to hold managed care organizations accountable for reducing the percentage of readmissions that occur within 30 days (the 30-day readmission percentage) by 5% annually, and eventually by 25% from their baseline year rate. [Minnesota Statutes, section 256B.69, subdivision 5a(g)].

General Description

This measure evaluates the annual decrease in each MCO's 30-day readmission percentage.

Performance Target

The MCO's annual performance target for this measure is a 30-day readmission percentage 5% below the rate for the previous year, until the MCO achieves the final performance target, which is a 30-day readmission percentage that is 25% below the MCO's baseline year[3] percentage.

After an MCO meets or surpasses the final performance target of 25% below the baseline year percentage, the STATE will continue to monitor performance to verify that the MCO's 30-day readmission percentage does not increase more than 10% from the previous year's percentage.

[3] Baseline year rate: For the contract year 2023 calculation, the baseline year rate is calendar year 2011's rate for all MCOs, other than Hennepin Health and the two MCOs (e.g., Medica and UHC). For Hennepin Health, the baseline year rate is from calendar year 2012. For Medica and UHC, the baseline year is 2021.

The MCO calendar year 2011 (baseline year) rates were calculated as of July 3, 2012. The Hennepin Health calendar year 2012 (baseline year) rate was calculated as of June 4, 2013. Medica and UHC's rates were re-calculated in May 2023.

Percentage Calculation

The percentage is calculated by dividing the number of 30-day readmissions (numerator) by the total number of admissions (index admissions plus readmissions) (denominator) during the measurement year and then multiplying the result by 100 (Percentage = [N / D] * 100). The percentage is calculated to the second decimal (for example, 45.63%).

Denominator Details

The denominator (D) is the total number of index hospital admissions during the measurement year, as defined in the specifications for the hospital admission rate, plus the number of readmissions during the measurement year, as defined in the "Numerator Details" section below. To be included in the denominator, index hospital admissions must meet the criteria described in the "Numerator Details" section of the specifications for the hospital admission rate, earlier in this document.

Numerator Details

The numerator (N) is the unduplicated number of readmissions that occur within 30 days (30-day readmissions) during the measurement year.

To be included in the numerator, a readmission must have occurred within 30 days of a previous discharge (admission ending service date) for the same enrollee. Readmissions may be to the same hospital as for the index admission or a different one.

Admission date is defined as the beginning service date on the managed care encounter claim.

Admissions less than two days apart for the same enrollee will be "collapsed" into one admission to avoid over counting of admissions due to transfers and multiple claims for an inpatient stay. Inpatient claims that are collapsed may be for the same or for different hospitals.

The admission date for the readmission is used to correctly assign the responsible MCO for an enrollee who changes MCOs during the readmission span.

MCOs must monitor and analyze bimonthly DHS remittance advice and enrollment reports to accurately identify admissions and enrollee months.

Exclusions

These claims are excluded from the percentage calculation:

- Denied claims that result from the implementation of the True Denial Project
- Voided and replaced encounter claims.

Data Source

Denominator and numerator data come from these sources:

- DHS Data Warehouse claims and enrollment data
- Records the STATE gets by May 31 of the year after the contract year.

Points Calculation

A total of 1 point is available for this measure.

The MCO's points for this measure are calculated as follows:

- **1 point:** If the MCO's 30-day readmission percentage is equal to or less than the performance target, the MCO gets the 1 point available. The target percentage is the is the higher of these:
    - A 30-day readmission percentage 25% below the MCO's baseline year* percentage
    - A 30-day readmission percentage 5% below the MCO's percentage for the previous year
- **Partial point:** If the MCO's 30-day readmission percentage is less than the MCO's percentage for the previous year but not at least 5% below the percentage for the previous year, the MCO gets part of the available point, commensurate with the percentage decrease in the difference between 1) the previous year's percentage and 2) the percentage that is 5% below the previous year's percentage.
- **0 points:** If the MCO's 30-day readmission percentage is greater than the previous year's percentage, the MCO gets 0 points.

Example of partial point's calculation:

- Example MCO's 30-day readmission percentage for the previous year is 10%.
- Example MCO's target percentage for the contract year is 9.5% (5% reduction from previous year's percentage).
- During the contract year, the MCO achieved a percentage of 9.8%.
- The proportion of the annual reduction achieved is (10 – 9.8) / (10 – 9.5) = 0.2 / 0.5 = 0.4 or 40%.
- Because example MCO achieved a decrease of 40% of the difference between its previous year percentage of 10% and its target percentage of 9.5%, the MCO gets 40% of the available points: 6 points.

Point calculation after MCO achieves percentage 25% below baseline year rate:

When an MCO meets or surpasses the final performance target percentage of 25% below the baseline year 30-day readmission percentage during a contract year, the MCO gets all available points for this measure.

In later years, the STATE will continue to monitor performance to verify that the MCO's 30-day readmission percentage does not increase more than 10% from the previous year's percentage. When measuring performance, the STATE must consider the difference in health risk in the MCO's membership in the baseline year compared with the contract year and work with the MCO to account for differences that they agree are significant.

Small Population

An MCO with a small population may have very few readmissions, which could result in a 30-day readmission percentage insufficiently precise to result in an equitable return of withheld funds. If an MCO does not achieve its annual performance target for this measure, and the measurement year's readmissions are fewer than 100, the STATE will determine that the performance target measure is not dependable. The STATE will eliminate this measure for the MCO and score the MCO using the remaining performance measures.

Baseline Year Percentage Calculation

The MCO calendar year 2011 (baseline year) percentages were calculated as of July 3, 2012. The Hennepin Health calendar year 2012 (baseline year) percentage was calculated as of June 4, 2013. For Medica and UHC the baseline year is calendar year 2021 (as re-calculated in May 2023).

The tables below provide the baseline year rate and final performance target rate for each MCO with **F&C contract.**

Measure Name: **30 Day Readmission**
Total Points: One (1) point
Age: 1 to 64 years

Table 10 A: Calendar Year 2011 (Baseline Year) MCO 30-Day Readmission Percentage

MCO	Baseline Year (Numerator) Readmissions	Baseline Year Index Admissions	Baseline Year Total Admissions (Denominator) [Sum of Index Admissions and Readmissions]	Baseline Year 30-Day Readmission Percentage (Readmissions divided by Total Admissions * 100)	Final Performance Target (25% reduction from baseline year)
Blue Plus	5,006	582	5,588	10.42	7.81
HealthPartners	2,503	261	2,764	9.44	7.08
Itasca Medical Care	198	9	207	4.35	3.26
PrimeWest Health	738	56	794	7.05	5.29
South Country Health Alliance	822	74	896	8.26	6.19
UCare	4,470	468	4,938	9.48	7.11

Table 10 B: Hennepin Health Calendar Year 2012 (Baseline Year) 30-Day Readmission Percentage

MCO	Baseline Year (Numerator) Readmissions	Baseline Year Index Admissions	Baseline Year Total Admissions (Denominator) [Sum of Index Admissions and Readmissions]	Baseline Year 30-Day Readmission Percentage (Readmissions divided by Total Admissions * 100)	Final Performance Target (25% reduction from baseline year)
Hennepin Health	587	97	684	14.18	10.64

Table 10 C: Two New MCOs' Calendar Year 2021 (Baseline Year) 30-Day Readmission Percentage (re-calculated in May 2023)

MCO	Baseline Year (Numerator) Readmissions	Baseline Year Index Admissions	Baseline Year Total Admissions (Denominator) [Sum of Index Admissions and Readmissions]	Baseline Year 30-Day Readmission Percentage (Readmissions divided by Total Admissions * 100)	Final Performance Target (25% reduction from baseline year)
Medica (19 Counties average)	1,633	12,548	14,181	11.52	8.64
United Healthcare (8 Metros average)	2,660	19,564	22,224	11.97	8.98

**New 2021 BYR calculated in May 2023*.

Measures for SNBC and Seniors Contracts Only

Annual Dental Visit (ADV)

The percentage of members, 18-64 years of age (for SNBC) and 65+ years of age (for Senior), who had at least one dental visit during the measurement year.

Purpose

This withholds measure applies to the 2023 Minnesota Seniors[4] (e.g., MSHO[5], MSC+ [6]) and SNBC[7] contracts. Its purpose is to hold managed care organizations accountable for annually increasing the percentage of enrollees with an annual dental visit.

General Description

This measure evaluates the rate of MCO enrollees who had an annual dental visit.

Performance Target

The performance target for this measure is the lesser of these:

- 80%; or
- The MCO's baseline year rate plus 10% of the difference between 80% and the baseline year rate[8].

Note: For the contract year 2023 calculation, the baseline year is calendar year 2021.

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[4] Seniors Contract include MSHO and MSC+ products.

[5] MSHO: Minnesota Senior Health Options (MSHO) means the Minnesota prepaid managed care program that provides integrated Medicare and Medicaid services for Medicaid eligible seniors, age sixty-five (65) and over.

[6] MSC+: Minnesota Senior Care Plus (MSC+) means the mandatory PMAP program for Enrollees ages sixty-five (65) and over.

[7] SNBC: Special Needs Basic Care (SNBC) means the Minnesota prepaid managed care program, that provides Medicaid services and/or integrated Medicare and Medicaid services to Medicaid eligible people with disabilities who are ages eighteen (18) through sixty-five (65).

[8] Baseline Year Rate: For the contract year 2023 calculation, the baseline year is calendar year 2021's rate. DHS created baselines for UHC in May 2023.

Rate Calculation

The rate is calculated using the denominator and numerator described below. It is calculated by dividing the numerator by the denominator (Rate = [N / D]). The rate is calculated to the second decimal (for example, 45.63).

The specifications for this measure are based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) 2018 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2017 specifications unless the changes would significantly influence this measure's dependability.

Denominator Details

The denominator (D) is the number of MCO enrollees who meet all these criteria:

- **Age (SNBC contract):** The enrollee is 18–64 years of age, calculated as of December 31 of the contract year.
- **Age (Senior's contract):** The enrollee is 65 years of age or older, calculated as of December 31 of the contract year.
- **Continuous enrollment:** The enrollee was enrolled in the MCO for the entire measurement year (January 1 through December 31) with no more than a one-month gap in enrollment.

Numerator Details

The numerator (N) is the number of enrollees who meet the denominator criteria and had one or more dental visits with a dental practitioner during the measurement year.

Exclusions

In determining the number of dental visits an enrollee had, the STATE excludes these claims:

- Denied claims that result from the implementation of the True Denial Project
- Voided and replaced encounter claims.

Data Sources

Denominator and numerator data come from these sources:

- DHS Data Warehouse claims and eligibility data
- Records the STATE gets by May 31 of the year after the contract year.

Points Calculation

A total of 15 points are available for this measure.

The MCO's points for this measure are calculated as follows:

- **15 points:** If the MCO's measurement rate is equal to or greater than the target rate, the MCO gets all 15 points available. The target rate is the lesser of these:
    - 80%; or
    - The MCO's baseline year rate plus 10% of the difference between 80% and the baseline year rate[9]
- **Partial points:** If the MCO's contract year rate is greater than the baseline year rate but less than the lesser of the target rates, the MCO gets part of the available points, commensurate with the percentage increase in the difference between 1) the baseline year rate and 2) the baseline year rate plus 10% of the difference between 80% and the baseline year rate.
- **0 points:** If the MCO's measurement rate is below its baseline year rate, the MCO gets 0 points.

Note: For the contract year 2023 calculation, the baseline year is calendar year 2021.

Example of partial points calculation:

- Example MCO's baseline year rate is 40%.
- Example MCO's target rate for the contract year is 44% (baseline year rate plus 10% of the difference [40] between 80% and the MCO's 40% baseline year rate)
- During the contract year, Example MCO achieved a rate of 42%
- Because example MCO achieved an increase of 50% of the difference between its baseline year rate of 40% and its target rate of 44%, the MCO gets 50% of the available points: 7.5 points.

Point calculation in later years after MCO achieves 80% rate:

Once an MCO achieves a rate of 80% or greater, in later contract years, the MCO must achieve a rate of only 75% or greater to get all points available for this measure. If the MCO's annual rate falls below 75%:

- The MCO will not get all available points for this measure for the year its rate falls below 75%.
- in later years, a new baseline year rate will be established; and

[9] Baseline Year Rate: For the contract year 2023 calculation, the baseline year rate is calendar year 2021's rate. DHS created baselines for UHC.

- To get all available points going forward, the MCO must again reach either 1) the 80% rate or 2) the baseline year rate plus 10% of the difference between 80% and the baseline year rate.

Baseline Year Rate Calculation.

The MCOs' calendar year 2021 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in May 2023.

Table 11: Calendar Year 2021 Baseline Annual Dental Visit (ADV) Rate by MHCP Product and Age Group
Total Points: Fifteen (15) points

Annual Dental Visits (ADV) Baseline Year 2021 Rates for SNBC:

MCO	Product	Age (years)	Numerator	Denominator	Rate (In %)
Health Partners	SNBC	18–64	2,944	7,417	39.69
Hennepin Health	SNBC	18–64	672	1,974	34.04
Medica	SNBC	18–64	4,528	11,109	40.76
PrimeWest Health	SNBC	18–64	957	2,257	42.40
South Country Health Alliance	SNBC	18–64	1,040	2,119	49.08
UCare	SNBC	18–64	12,845	32,093	40.02
UnitedHealthcare*	SNBC	18–64	13,867	35,273	39.31

**New 2021 BYR calculated in May 2023*

Annual Dental Visits (ADV) Baseline Year 2021 Rates for Seniors (e.g., MSHO & MSC+):

MCO	Product	Age (years)	Numerator	Denominator	Rate (In %)
Blue Plus	MSC+/MSHO	65+	3,389	11,378	29.79
HealthPartners	MSC+/MSHO	65+	2,227	6,332	35.17
Itasca Medical Care	MSC+/MSHO	65+	207	600	34.50
Medica	MSC+/MSHO	65+	4,748	13,430	35.35
PrimeWest Health	MSC+/MSHO	65+	883	2,577	34.26
South Country Health Alliance	MSC+/MSHO	65+	684	2,038	33.56
UCare	MSC+/MSHO	65+	6,468	20,065	32.24
UnitedHealthcare*	MSC+/MSHO	65+	10,936	32,077	34.09

**New 2021 BYR calculated in May 2023*

Measure for Seniors Contract Only

Initial Seniors Health Risk Screening or Assessment (SHRA)

The percentage of new MSHO and MSC+ enrollees for whom the MCO performs a timely initial health risk screening or assessment during the contract year.

Purpose

This measure applies to the 2023 Minnesota Seniors (MSHO and MSC+) contract. Its purpose is to hold MCOs accountable for performing timely initial health risk screenings or assessments for new MSHO and MSC+ enrollees who live in the community and do not get Elderly Waiver services.

General Description

This measure evaluates the rate of new MSHO and MSC+ enrollees for whom the MCO performs a timely initial health risk screening or assessment.

Performance Target

The performance target for this measure is 90%, unless MCO has fewer than 100 new Enrollees, then the performance target is 85%.

Rate Calculation

The rate is calculated using the denominator and numerator described below. It is calculated by dividing the numerator by the denominator (Rate = [N / D]). The rate is calculated to the first decimal (for example, 85.8%).

Denominator Details

The denominator (D) is the number of new MSHO and MSC+ enrollees with the MCO. To be included in the denominator, enrollees must meet all these criteria:

- **Continuous enrollment:** The enrollee was continuously enrolled in the MCO for a minimum of 60 days in the MSHO or MSC+ program.
- **Age:** The enrollee was at least 64 years old as of the enrollment month.
- **Living situation:** The enrollee lived in the community without an Elderly Waiver.
- **New enrollment**: The enrollee is identified as a new enrollee because, during the contract year, at least one of the following applied:
    - The enrollee was newly enrolled in MSHO or MSC+.
    - The enrollee selected a new MCO during annual health plan selection or chose a different MCO during the contract year.
    - The enrollee changed his or her program (for example, from MSC+ to MSHO).
    - The enrollee had a gap in enrollment of one or more months.
- Enrollees with valid reasons for not having an initial health risk screening or assessment, such as a waiver opening, are excluded from the denominator.

Numerator Details

The numerator (N) is the combined number of new MSHO and MSC+ enrollees who meet the denominator criteria and for whom an initial health risk screening or assessment was completed within 75 calendar days of the beginning enrollment date, unless an extension for the transition period has been requested and approved by the State. (**Note**: The MCO may request a transition period of up to one hundred and twenty (120) days to change care coordinators to meet this requirement.)

Exclusions

These claims and enrollees are excluded from the calculation:

- Voided and replaced encounter claims.
- Enrollees with retroactive enrollment dates and enrollees who refused an initial health risk screening or assessment.

Data Sources

Denominator and numerator data come from these sources:

- DHS Data Warehouse claims data, enrollment data, and long-term-care screening data
- Records the STATE gets by May 31 of the year after the contract year.

Points Calculation

The MCO's points for this measure are calculated as follows:

- **30 points:** To qualify for the full points allotted to this performance measure, the MCO must show that combined, initial health risk screenings or assessments were completed in a timely manner for:
    - Eighty-five percent (85%) of MSHO and MSC+ new Enrollees if the MCO has fewer than one hundred (100) new Enrollees; or
    - Ninety percent (90%) of MSHO and MSC+ new Enrollees, if the MCO has one hundred (100) or more new Enrollees in the Contract Year.
- **0 points:** If the MCO's measurement rate does not meet the requirements, the MCO gets 0 points. No partial points are available for this measure.

DHS-MCO Contract(s) Compliance-Based Measures (All Contracts)

This section provides a few highlights. Please refer to the relevant contract(s) for details on these measures.

Seniors' Care Plan Audit

Compliance includes timely completion of and submittal to the STATE of the Care Plan audit in section 7.8.3, following the care planning audit data abstraction protocol developed by the Care Plan audit workgroup. No partial whole number of points will be assigned if the MCO fails to completely meet this performance target.

SNBC's Service Accessibility

Compliance with section 6.11 (SNBC Compliance with Service Accessibility Requirements). Compliance means that the MCO will create a process for obtaining updated access information from its provider offices, and the MCO demonstrates that access information continues to be made available to Enrollees and prospective Enrollees as required, and that the MCO provides copies of this information to the STATE.

Seniors and SNBC Stakeholder Group Reporting

MCO Stakeholder Group for MSHO/MSC+ and SNBC members. The MCO will maintain a local or regional stakeholder group as required in section the DHS contract. To qualify for the withhold, the stakeholder group will meet at least twice per Contract Year. The MCO will submit to the STATE twice per Contract Year, on or before December 15th, documentation in the form of stakeholder meeting agendas and meeting minutes that demonstrate the MCO response to significant concerns raised by stakeholder group participants. No partial whole number of points will be assigned if the MCO fails to completely meet this performance target**.**

Families & Children, Seniors, and SNBC - No Repeat Deficiencies on the MDH QA Examinations Meetings

Compliance means complying with the MDH licensing requirements and having no repeated deficiencies related to MHCP that remain after the MCO's corrective action(s) that initially resulted from the MCO's MDH QA Examination. If the MCO is not examined during the Contract Year but remains in compliance with MDH licensing requirements and any corrective actions assigned by MDH, the MCO will receive all points available for this performance target. No partial whole number of points will be assigned if the MCO fails to completely meet this performance target.

Families & Children (e.g., PMAP/MinnesotaCare) Healthcare Equity Community/Stakeholder Meetings and Reporting

The MCO will include as part of its Population Health Management Strategy, a process for engaging and obtaining input to advance health equity from communities in the enrolled population groups who experience disparate outcomes. The MCO will participate in community-led initiatives or other efforts that capture and address stakeholder feedback around health inequities in access to and quality of care.

A summary of the specific engagement activities and the results of the feedback will be provided to the STATE as part of the Population Health Management Annual Report. The report documentation will include agendas, minutes, and other artifacts that demonstrate the capture and connection of the activity to health equity concerns of community participants.

The MCO must develop and execute plans to use the information to respond to issues raised and document the results in the report. Reporting at least four (4) health equity community engagement activities focused on addressing health disparities shall be worth twelve (12) points. The report is due by July 31 of the Contract Year; the STATE will provide feedback on whether the preview includes the needed information.

For the health equity stakeholder/community engagement events meeting minutes, DHS suggests that MCOs remove personal identifiers from the minutes before submitting them to DHS. DHS recommends the organizations that the attendee represents could stand in for their name, or just identify an unaffiliated person as a member of the public. DHS recommends all MCOs follow the same rules about redacting and announce the rule at the start of each meeting, so even if someone in attendance wants their name attached to a comment, no name appears.

Points Calculation

The MCO's points for this measure are calculated as follows:

- **12 points:** To qualify for the full points allotted to this performance measure, the MCO must show that 4 (four) meetings were conducted, and documentation sent to DHS in a timely manner.
- **For each meeting a total of 3 (three) points will be awarded:**
    - **1 point** will be awarded for each meeting held up to a total possible four (4) points.
    - **1 point** will be awarded for submitting report documentation such as agendas, minutes, and other artifacts that demonstrate the capture and connection of the activity to health equity concerns of community participants for each meeting held up to a total possible four (4) points.
    - **1 point** will be awarded for documenting how the MCO develops and executes plans to use the information to respond to issues raised by stakeholders up to a total possible four (4) points.
- Partial points are available for this measure activity.