Contract Year 2025 Quality Withhold Measures:

Technical Specifications

Quality Withhold Measures for MCO Contracts

10/26/2024

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CY 2025 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 Special Needs BasicCare (SNBC) contracts. For the F&C contract, there are thirteen (13) withhold measures (measures, including their sub-measures) of which eleven (11) are performance measures and two (2) are compliance measures. The previously added ten (10) performance measures are stratified by Race and Ethnicity (R/E), however the newly added performance measure in 2025 (e.g., COL) is not stratified by Race and Ethnicity in the first year. The compliance measure, called "F&C/MinnesotaCare Healthcare Equity Community Engagement", documents the meetings and reporting. For the SNBC contract, there are nine (9) withhold measures of which six (6) are performance measures and three (3) are compliance measures. For the Seniors contract, there are seven (7) withhold measures of which four (4) are performance measures and three (3) are compliance measures. Starting from 2025, all performance measures for Seniors and SNBC contracts are stratified by Race and Ethnicity (R/E), except for the SHRA and ADV measures in Seniors and ADV and COL measures in SNBC. The newly added performance measure for SNBC (e.g., COL) is not stratified by Race and Ethnicity in the first year.

Measurement Technical Specifications

The specifications for the performance measures (e.g., ADV, AMB, CIS, COL, FMC, FUH, IET, PPC, WCV, W30) are based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) 2025 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 or baseline rates. 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 / Sub-measures for F&C Contract (e.g., PMAP & MinnesotaCare)	Measure Type	Age Group	Points Allocated
Childhood Immunization Status (CIS): Combo 10	Performance (R/E)	2 years	14
Colorectal Cancer Screening (COL)	Performance	All (46-50; 51-75 years)	4
Follow-up After Hospitalization for Mental Illness (FUH): 7-day	Performance (R/E)	All (6 to 65+ years)	6
Follow-up After Hospitalization for Mental Illness (FUH): 30-day	Performance (R/E)	All (6 to 65+ years)	6
Initiation and Engagement of Substance Use Disorder Treatment (IET): Initiation	Performance (R/E)	All (13 to 65+ years)	6

Measures / Sub-measures for F&C Contract (e.g., PMAP & MinnesotaCare)	Measure Type	Age Group	Points Allocated
Initiation and Engagement of Substance Use Disorder Treatment (IET): Engagement	Performance (R/E)	All (13 to 65+ years)	6
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
Child & Adolescent Well-Visits (WCV)	Performance (R/E)	All (3 to 21 years)	18
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): 2 more visits	Performance (R/E)	15 to 30 months	7
F&C/MinnesotaCare Healthcare Equity Community Engagement	Compliance	All	10
No Repeat Deficiencies on the MDH QA/TCA Examination	Compliance	Not Applicable	2

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	14
Ambulatory Care (AMB): ED Visits	Performance (R/E)	18 to 64 years	14

Measures for SNBC Contract	Measure Type	Age Group	Points Allocated
Colorectal Cancer Screening (COL)	Performance (R/E)	All (46-50; 51-64 years)	10
Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)	Performance (R/E)	18 to 64 years	14
Follow-Up After Hospitalization for Mental Illness (FUH): 7-day	Performance (R/E)	18 to 64 years	7
Follow-Up After Hospitalization for Mental Illness (FUH): 30-day	Performance (R/E)	18 to 64 years	7
Service Accessibility / Care Plan Audit	Compliance	Not Applicable	14
Stakeholders Group Reporting	Compliance	Not Applicable	14
No Repeat Deficiencies on the MDH QA/TCA Examination	Compliance	Not Applicable	6

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 (ADV)	Performance	65+ years	15
Colorectal Cancer Screening (COL)	Performance (R/E)	65+ years	15
Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)	Performance (R/E)	65+ years	15
Initial Seniors Health Risk Screening or Assessment (SHRA) – *DHS developed*	Performance	64+ years	15

Measures for Seniors Contract	Measure Type	Age Group	Points Allocated
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	10

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 2023, show that the racial composition of state health care program enrollees is Native American (2.3%), Asian/Pacific Islander (7.9%), Black (20.7%), White (53.3%), two or more races (5.6%), and Unknown (10.2%).

Table 2: Hierarchy of Ethnicity and Race Assignments

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

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 populations of interest and "Unknown" combined, excluding fee-for-service (FFS))
2. Baseline performance rates for each of the five (5) populations of interest listed below:
    a. Non-Hispanic White
    b. Black/African American
    c. Native American/Alaskan Native
    d. Asian/Pacific Islander
    e. Hispanic Ethnicity (all Races)
3. The "Overall Average Rate" or State Average Rate – serving as the reference group.

DHS will assess each measure's overall rate for 2025 against MCO's baseline State Overall Average Rate from Contract Year 2023. 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 difference in rate for any given population group compared to the reference group (i.e., State Average Rate). Disparity gaps must be calculated for each of the following populations. An example calculation is provided: If the performance rate for a population is 20% while the State Overall Average Rate is 25%, then the disparity gap for that sub-population = 25% – 20% = 5 percentage points (abbreviated as 5% gap).

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

Points Calculation for Race or Ethnicity Measures

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

Points Calculation will be done for all the following Health Equity (H.E.) Withhold Performance Measures, stratified by Race and Ethnicity (R/E), from all contracts:

A. F&C:
   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

      COL – Colorectal Cancer Screening (Not applicable in first year)

B. SNBC:
   1. **AMB** – Ambulatory Care: ED Visits.
   2. **FMC-** Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions
   3. **FUH** - Follow-Up After Hospitalization for Mental Illness

      COL – Colorectal Cancer Screening (Not applicable in first year)

C. Seniors:
   1. **FMC** - Follow-Up After ED Visit for People with Multiple High-Risk Chronic Conditions
   2. **COL** – Colorectal Cancer Screening

Achievement Points

(i) **F&C & SNBC H.E. Measures**: 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 points growth or improvement in its overall rate compared to the baseline rate.

(ii) **Seniors H.E. Measures**: 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 three (3) percentage points 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 groups of interest 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 group (e.g., Overall Average Rate) and the population of color (without affecting the drop in the rate for the Overall Average Rate, compared to the baseline State Overall Average 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 State Overall Average Rate.

- 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 3 A: Points Table for Relative Change Scale

Percent (%) Relative Change	Points Awarded
< -50% to 9.9%	0
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% (State Overall Average Rate) – 20% (population of interest) = 5% gap

Performance Period rate = 25% (State Overall Average Rate) – 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 State Average Rate) shall be assessed against a baseline disparity gap with the State Overall Average Rate. 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 3 B: Points Table for Discrete Scale

Change in Numerator	Points Awarded
0	0
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 population of interest, 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

Suppose 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 (e.g., Overall Average Rate) 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 3 A and Table 3 B), 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 14, if there is no R/E gap during the reporting period (or the baseline period), then the points allocated to that 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.

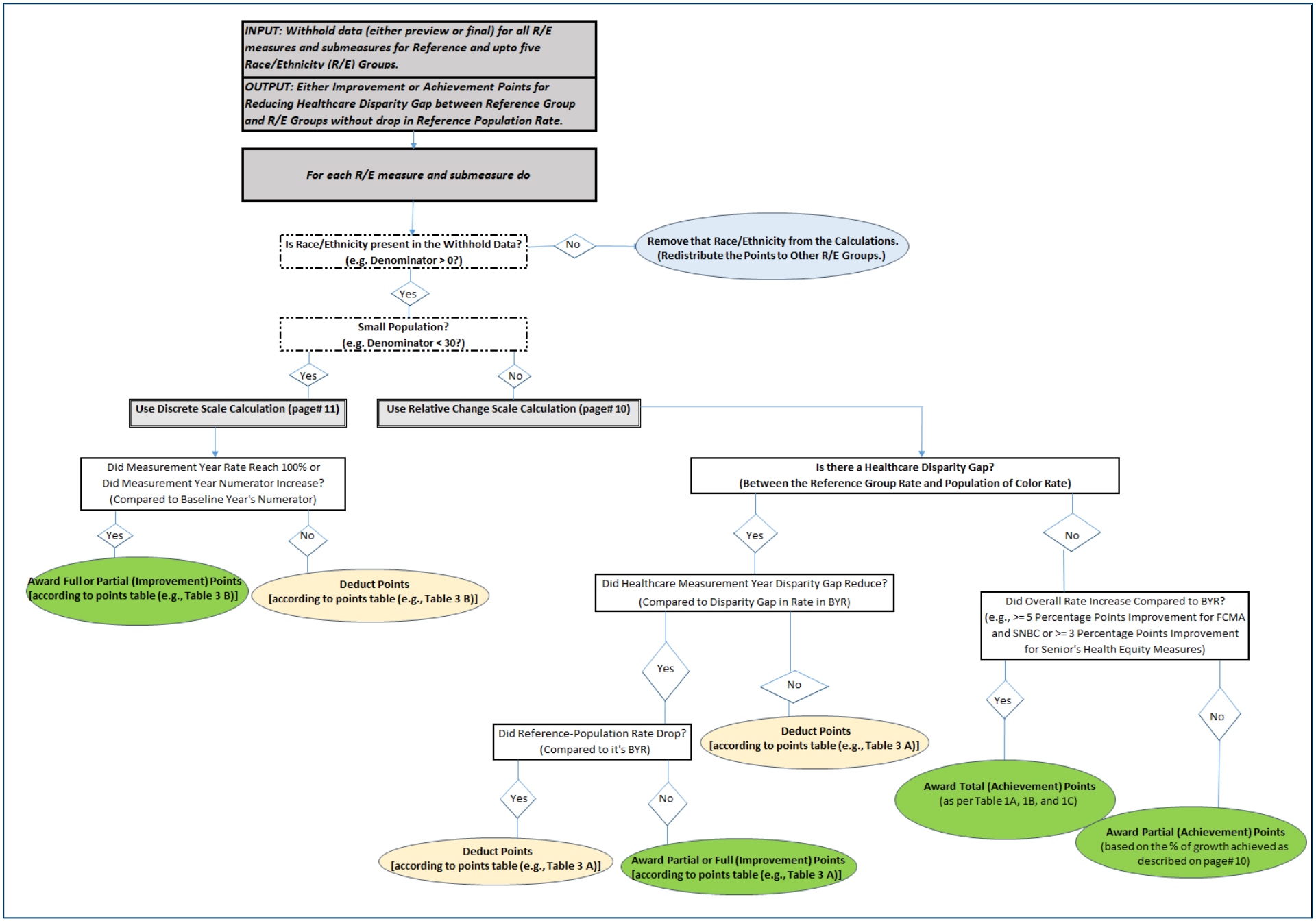
Partial Scoring

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 4: Points Calculation Decision Tree for the Health Equity Race and Ethnicity (R/E) Measures:



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 some separate combination rates. We will consider only Combination 10 (or Combo 10) for this measure.

Baseline Year Rate Calculation

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

Table 5: Measure Name: Childhood Immunization Status (CIS)

Sub-measure: Combination 10 (or Combo 10)

Total Points: Fourteen (14) points

Age: 2 years old

Reference Group = Overall Avg. Rate = 30.2%	2023 Overall Rate (All R/E: Unknown included)			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	2,149	7,270	29.6	731	2,530	28.9	195	891	21.9	72	321	22.4	82	200	41.0	280	666	42.0
HealthPartners	1,341	3,817	35.1	205	513	40.0	167	780	21.4	19	73	26.0	147	296	49.7	120	268	44.8

Reference Group = Overall Avg. Rate = 30.2%	2023 Overall Rate (All R/E: Unknown included)			Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic**		
Hennepin Health	127	338	37.6	7	23	30.4	26	89	29.2	<6	10	20.0	<6	8	50.0	22	45	48.9
Itasca Medical Care	51	156	32.7	36	115	31.3	<6	7	14.3	9	23	39.1	<6	<6	100.0	<6	<6	50.0
Medica	13	44	29.6	<6	9	11.1	<6	10	20.0	<6	<6	0.0	<6	<6	20.0	<6	<6	50.0
PrimeWest Health	223	1,025	21.8	110	494	22.3	7	24	29.2	35	179	19.6	<6	14	35.7	28	91	30.8
SCHA	132	489	27.0	50	216	23.2	9	35	25.7	<6	<6	0.0	<6	<6	0.0	21	52	40.4
UCare	2,431	8,285	29.3	412	1,329	31.0	306	1,848	16.6	43	167	25.8	276	652	42.3	316	743	42.5

Notes: N = Numerator; D = Denominator; Baseline data calculated in June 2024.

**= 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.

Colorectal Cancer Screening (COL)

The percentage of members 46-75 years of age who had appropriate screening for colorectal cancer.

Purpose

This withholds measure applies to the 2025 Minnesota F&C/MNCare contract. Its purpose is to hold managed care organizations accountable for annually increasing the percentage of enrollees with an appropriate colorectal cancer screening.

General Description

This measure evaluates the rate of MCO enrollees who had an annual colorectal cancer screening.

Performance Target

The performance target is five (5) percentage points annual improvement over the baseline year rate for both age groups (e.g., 46-50 and 51-75 years).

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) 2025 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2023 technical 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:** The enrollee is 46-75 years of age, 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 gap in enrollment of up to 45 days during each year of continuous enrollment.

Numerator Details

The numerator (N) is the number of enrollees who meet the denominator criteria and had one or more screenings for colorectal cancer during the measurement year.

Exclusions

In determining the number of screenings for colorectal cancer an enrollee had, the STATE excludes these claims:

- Voided and rejected 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 4 points are available for this measure.

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

- **4 points:** If the MCO's measurement rate is equal to or greater than the target rate, the MCO gets all 4 points available.
- **Partial points:** If the MCO's contract year rate is greater than the baseline year rate but less than the target rates, the MCO gets part of the available points, commensurate with the percentage increase. The percentage of increase will be calculated to the second decimal. The number of points will be awarded based on the percentage increase achieved.
- **0 points:** If the MCO's measurement rate is below its baseline year rate, the MCO gets 0 points.

Baseline Year Rate Calculation.

The MCOs' calendar year 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in July 2024.

Table 6 A: Calendar Year 2023 Baseline Colorectal Cancer Screening (COL) Rate by MHCP Product and Age Group

Total Points: Four (4) points

Colorectal Cancer Screening (COL) Baseline Year 2023 Rates for F&C:

Ages: 46-50 Years

MCO	Product	Age (years)	Numerator	Denominator	Rate (in %)
Blue Plus	PMAP & MNCare	46-50	3,571	11,910	29.98%
HealthPartners	PMAP & MNCare	46-50	2,218	7,023	31.58%
Hennepin Health	PMAP & MNCare	46-50	283	1,410	20.07%
Itasca Medical Care	PMAP & MNCare	46-50	106	317	33.44%
Medica	PMAP & MNCare	46-50	53	187	28.34%
PrimeWest Health	PMAP & MNCare	46-50	495	1,646	30.07%
South Country Health Alliance	PMAP & MNCare	46-50	223	862	25.87%
UCare	PMAP & MNCare	46-50	3,693	13,899	26.57%

Note: (i) Baseline data as calculated in July 2024.

Table 6 B: Calendar Year 2023 Baseline Colorectal Cancer Screening (COL) Rate by MHCP Product and Age Group

Total Points: Four (4) points

Colorectal Cancer Screening (COL) Baseline Year 2023 Rates for F&C:

Ages: 51-75 Years

MCO	Product	Age (years)	Numerator	Denominator	Rate (in %)
Blue Plus	PMAP & MNCare	51–75	14,405	30,884	46.64%
HealthPartners	PMAP & MNCare	51–75	8,945	18,476	48.41%
Hennepin Health	PMAP & MNCare	51–75	1,339	3,987	33.58%
Itasca Medical Care	PMAP & MNCare	51–75	434	833	52.10%
Medica	PMAP & MNCare	51–75	329	641	51.33%
PrimeWest Health	PMAP & MNCare	51–75	1,833	4,116	44.53%
South Country Health Alliance	PMAP & MNCare	51–75	1,029	2,360	43.60%
UCare	PMAP & MNCare	51–75	14,964	33,273	44.97%

Note: (i) Baseline data as calculated in July 2024.

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 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 7 A: Measure Name: Follow-up after Hospitalization for Mental Illness (30-days)

Sub-measure: 30 Days

Total Points: Six (6) points

Age: 6 years and older

Reference Group = Overall Avg. Rate = 65.64%	2023 Overall Rate (All R/E: Unknown included)			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	1,572	2,341	67.2	1,066	1,506	70.8	150	271	55.4	157	264	59.5	43	62	69.4	150	230	65.2
HealthPartners	613	870	70.5	278	395	70.4	168	244	68.9	41	68	60.3	42	57	73.7	89	116	76.7
Hennepin Health	112	184	60.9	55	74	74.3	33	65	50.8	<6	16	31.3	<6	<6	66.7	13	22	59.1

Reference Group = Overall Avg. Rate = 65.64%	2023 Overall Rate (All R/E: Unknown included)			Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
Itasca Medical Care	43	62	69.4	36	50	72.0	<6	<6	0.0	7	10	70.0	<6	<6	0.0	<6	<6	50.0
Medica	32	53	60.4	23	35	65.7	7	14	50.0	<6	<6	50.0	<6	<6	0.0	<6	<6	0.0
PrimeWest Health	226	352	64.2	143	215	66.5	10	15	66.7	48	83	57.8	<6	<6	83.3	23	35	65.7
SCHA	145	197	73.6	107	138	77.5	15	16	93.8	<6	9	44.4	<6	<6	66.7	20	32	62.5
UCare	1,231	1,995	61.7	649	979	66.3	275	523	52.6	100	174	57.5	61	99	61.6	155	244	63.5

Notes: N = Numerator; D = Denominator; Baseline data calculated in June 2024.

**= 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: Follow-up after Hospitalization for Mental Illness (7-days)

Sub-measure: 7 Days

Total Points: Six (6) points

Age: 6 years and older

Reference Group = Overall Avg. Rate = 40.0%	2023 Overall Rate (All R/E: Unknown included)			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	968	2,341	41.4	670	1,506	44.5	84	271	31.0	84	264	31.8	33	62	53.2	82	230	35.7
HealthPartners	405	870	46.6	194	395	49.1	97	244	39.8	28	68	41.2	25	57	43.9	66	116	56.9
Hennepin Health	58	184	31.5	27	74	36.5	17	65	26.2	<6	16	6.3	<6	<6	33.3	10	22	45.5
Itasca Medical Care	24	62	38.7	20	50	40.0	<6	<6	0.0	<6	10	40.0	<6	<6	0.0	<6	<6	0.0
Medica	20	53	37.7	16	35	45.7	<6	14	21.4	<6	<6	0.0	<6	<6	0.0	<6	<6	0.0
PrimeWest Health	133	352	37.8	85	215	39.5	<6	15	40.0	26	83	31.3	<6	<6	33.3	15	35	42.9
SCHA	92	197	46.7	69	138	50.0	11	16	68.8	<6	9	33.3	<6	<6	33.3	11	32	34.4
UCare	719	1,995	36.0	400	979	40.9	137	523	26.2	55	174	31.6	34	99	34.3	93	244	38.1

Notes: N = Numerator; D = Denominator; Baseline data calculated in June 2024.

**= 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 visits 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 2023baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 8 A: Measure Name: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Sub-measure: Initiation (Total)

Total Points: Six (6) points

Age: 13 years and older

Reference Group = Overall Avg. Rate = 38.3%	2023 Overall Rate (All R/E: Unknown included)			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	4,608	12,162	37.9	3,058	8,057	38.0%	491	1,289	38.0	673	1,739	38.7	82	203	40.4	318	931	34.2
HealthPartners	1,877	5,200	36.1	1,063	2,850	37.3%	458	1,325	37.3	134	392	34.2	90	228	39.5	143	429	33.3
Hennepin Health	947	2,232	42.4	323	695	46.5%	383	988	46.5	164	368	44.6	27	48	56.3	65	161	40.4

Reference Group = Overall Avg. Rate = 38.3%	2023 Overall Rate (All R/E: Unknown included)			Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
Itasca Medical Care	130	358	36.3	91	260	35.0%	<6	<6	35.0	36	91	39.6	<6	<6	100.0	<6	8	37.5
Medica	49	124	39.5	26	67	38.8%	9	22	38.8	<6	17	29.4	<6	<6	25.0	6	13	46.2
PrimeWest Health	632	1,581	40.0	379	942	40.2%	16	44	40.2	202	494	40.9	8	19	42.1	38	110	34.6
SCHA	312	892	35.0	245	705	34.8%	16	40	34.8	8	31	25.8	<6	10	40.0	35	105	33.3
UCare	4,562	11,708	39.0	2,388	6,082	39.3%	1,146	2,969	39.3	453	1,138	39.8	211	513	41.1	421	1,099	38.3

Notes: N = Numerator; D = Denominator; Baseline data as of June 2024.

**= 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 8 B: Measure Name: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Sub-measure: Engagement (Total)

Total Points: Six (6) points

Age: 13 years and older

Reference Group = Overall Avg. Rate = 15.5%	2023 Overall Rate (All R/E: Unknown included)			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	1,922	12,162	15.8	1,266	8,057	15.7	191	1,289	14.8	302	1,739	17.4	40	203	19.7	135	931	14.5
HealthPartners	733	5,200	14.1	412	2,850	14.5	169	1,325	12.8	48	392	12.2	41	228	18.0	67	429	15.6
Hennepin Health	352	2,232	15.8	130	695	18.7	149	988	15.1	53	368	14.4	6	48	12.5	20	161	12.4
Itasca Medical Care	53	358	14.8	44	260	16.9	<6	<6	0.0	8	91	8.8	<6	<6	0.0	<6	8	0.0
Medica	12	124	9.7	7	67	10.5	<6	22	4.6	<6	17	11.8	<6	<6	0.0	<6	13	15.4
PrimeWest Health	248	1,581	15.7	162	942	17.2	<6	44	11.4	60	494	12.2	8	19	42.1	18	110	16.4
SCHA	125	892	14.0	100	705	14.2	7	40	17.5	<6	31	16.1	<6	10	10.0	9	105	8.6

Reference Group = Overall Avg. Rate = 15.5%	2023 Overall Rate (All R/E: Unknown included)			Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
UCare	1,864	11,708	15.9	997	6,082	16.4	464	2,969	15.6	178	1,138	15.6	87	513	17.0	156	1,099	14.2

Notes: N = Numerator; D = Denominator Baseline data as of June 2024.

**= 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 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 9 A: Measure Name: Prenatal and Postpartum Care

Sub-measure: Timeliness of Prenatal Care

Total Points: Seven (7) points

Age: All

Reference Group = Overall Avg. Rate = 63.93%	2023 Overall Rate (All R/E: Unknown included)			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	3,954	6,467	61.1	2,061	3,449	59.8	795	1,197	66.4	246	405	60.7	172	331	52.0	593	952	62.3
HealthPartners	2,538	3,445	73.7	602	847	71.1	931	1,269	73.4	103	134	76.9	373	523	71.3	438	546	80.2

Reference Group = Overall Avg. Rate = 63.93%	2023 Overall Rate (All R/E: Unknown included)			Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
Hennepin Health	255	369	69.1	30	49	61.2	108	155	69.7	24	35	68.6	12	22	54.6	69	96	71.9
Itasca Medical Care	41	137	29.9	35	112	31.3	<6	<6	66.7	<6	18	16.7	<6	<6	33.3	<6	<6	0.0
Medica	94	166	56.6	32	73	43.8	14	25	56.0	<6	8	37.5	<6	7	42.9	32	42	76.2
PrimeWest Health	517	924	56.0	316	560	56.4	33	42	78.6	60	123	48.8	10	27	37.0	91	163	55.8
SCHA	153	429	35.7	103	278	37.1	9	35	25.7	<6	13	30.8	<6	<6	50.0	34	95	35.8
UCare	4,993	7,685	65.0	1,255	2,015	62.3	1,797	2,766	65.0	194	299	64.9	671	1,064	63.1	884	1,286	68.7

Notes: N = Numerator; D = Denominator; Baseline data as of June 2024.

**= 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 9 B: Measure Name: Prenatal and Postpartum Care

Sub-measure: Postpartum Care

Total Points: Seven (7) points

Age: All

Reference Group = Overall Avg. Rate = 59.43%	2023 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	3,966	6,467	61.3	2,132	3,449	61.8	657	1,197	54.9	251	405	62.0	194	331	58.6	645	952	67.8
HealthPartners	1,776	3,445	51.6	424	847	50.1	621	1,269	48.9	80	134	59.7	235	523	44.9	340	546	62.3
Hennepin Health	248	369	67.2	30	49	61.2	100	155	64.5	23	35	65.7	13	22	59.1	68	96	70.8
Itasca Medical Care	88	137	64.2	77	112	68.8	<6	<6	66.7	7	18	38.9	<6	<6	33.3	<6	<6	33.3
Medica	96	166	57.8	35	73	48.0	16	25	64.0	<6	8	62.5	<6	7	42.9	27	42	64.3
PrimeWest Health	644	924	69.7	383	560	68.4	29	42	69.1	70	123	56.9	22	27	81.5	135	163	82.8
SCHA	293	429	68.3	186	278	66.9	25	35	71.4	10	13	76.9	<6	<6	66.7	66	95	69.5
UCare	4,550	7,685	59.2	1,199	2,015	59.5	1,520	2,766	55.0	166	299	55.5	546	1,064	51.3	909	1,286	70.7

Notes: N = Numerator; D = Denominator; Baseline data as of June 2024.

**= 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.

Baseline Year Rate Calculation

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

Table 10: Measure Name: Well Child Visits (1 or more visits)

Total Points: Eighteen (18) points

Age: 3 to 21 years

Reference Group = Overall Avg. Rate = 47.2%	2023 Overall Rate (All R/E: Unknown included)			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	64,885	142,900	45.4	32,827	77,287	42.5	11,295	23,096	48.9	3,415	8,570	39.9	3,039	6,322	48.1	8,593	18,017	47.7
HealthPartners	37,683	72,510	52.0	8,809	18,083	48.7	13,190	25,853	51.0	1,259	2,816	44.7	4,945	9,622	51.4	5,369	10,242	52.4
Hennepin Health	2,164	5,061	42.8	189	499	37.9	733	1,953	37.5	127	377	33.7	84	212	39.6	808	1,683	48.0

Reference Group = Overall Avg. Rate = 47.2%	2023 Overall Rate (All R/E: Unknown included)			Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
Itasca Medical Care	1,343	3,530	38.1	1,051	2,690	39.1	41	106	38.7	168	506	33.2	13	42	31.0	33	110	30.0
Medica	948	2,183	43.4	386	930	41.5	254	553	45.9	51	115	44.4	40	98	40.8	129	288	44.8
PrimeWest Health	9,919	22,210	44.7	5,745	13,181	43.6	736	1,438	51.2	1,090	2,957	36.9	258	631	40.9	1,461	2,961	49.3
SCHA	4,145	10,669	38.9	2,505	6,724	37.3	355	927	38.3	86	228	37.7	63	159	39.6	763	1,859	41.0
UCare	80,038	166,723	48.0	18,205	40,438	45.0	27,997	59,887	46.8	2,672	6,168	43.3	9,662	21,031	45.9	14,035	27,514	51.0

Notes: N = Numerator; D = Denominator; Baseline data as of June 2024.

**= 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 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs).

Table 11 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

Reference Group = Overall Avg. Rate = 57.18%	2023 Overall Rate (All R/E: Unknown included)			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	3,244	5,425	59.8	957	1,540	62.1	351	661	53.1	91	199	45.7	71	117	60.7	295	470	62.8
HealthPartners	1,936	3,125	62.0	202	299	67.6	287	578	49.7	19	38	50.0	147	203	72.4	140	203	69.0
Hennepin Health	171	315	54.3	10	15	66.7	22	62	35.5	<6	11	18.2	<6	9	44.4	23	39	59.0

Itasca Medical Care	53	93	57.0	38	69	55.1	<6	<6	100.0	<6	8	50.0	<6	<6	100.0	<6	<6	0.0
Medica	42	118	35.6	12	22	54.6	<6	18	27.8	<6	<6	50.0	<6	<6	0.0	<6	10	40.0
PrimeWest Health	374	735	50.9	174	352	49.4	12	16	75.0	43	105	41.0	<6	<6	25.0	47	79	59.5
SCHA	186	366	50.8	66	136	48.5	7	18	38.9	<6	<6	16.7	<6	<6	0.0	26	44	59.1
UCare	3,606	6,633	54.4	505	826	61.1	627	1,367	45.9	49	113	43.4	237	444	53.4	337	587	57.4

Notes: N = Numerator; D = Denominator; Baseline data as of June 2024.

**= 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 11 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

Reference Group = Overall Avg. Rate = 66.14%	2023 Overall Rate (All R/E: Unknown included)			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	4,815	7,160	67.3	1,710	2,608	65.6	657	968	67.9	221	345	64.1	148	210	70.5	494	659	75.0
HealthPartners	2,602	3,751	69.4	377	545	69.2	526	840	62.6	52	79	65.8	244	323	75.5	192	263	73.0
Hennepin Health	186	303	61.4	10	16	62.5	48	83	57.8	<6	11	45.5	<6	<6	50.0	29	43	67.4
Itasca Medical Care	104	162	64.2	86	122	70.5	<6	<6	60.0	13	26	50.0	<6	<6	100.0	<6	<6	50.0
Medica	41	81	50.6	13	26	50.0	<6	9	33.3	<6	8	50.0	<6	<6	75.0	<6	<6	83.3
PrimeWest Health	610	969	63.0	299	461	64.9	9	19	47.4	94	194	48.5	<6	8	62.5	74	99	74.8

SCHA	300	475	63.2	142	221	64.3	26	41	63.4	<6	<6	25.0	<6	<6	100.0	34	53	64.2
UCare	5,263	8,148	64.6	929	1,427	65.1	1,185	2,013	58.9	113	175	64.6	456	657	69.4	527	750	70.3

Notes: N = Numerator; D = Denominator; Baseline data as of June 2024.

**= 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.

Measures for SNBC Contract Only

Annual Dental Visit (ADV)

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

Purpose

This withholds measure applies to the 2025 Minnesota SNBC[1] contract. 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[2].

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).

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[1] 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).

[2] Baseline Year Rate (BYR): For the contract year 2025 calculation, the baseline year is calendar year 2023's rate.

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.
- **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 rejected 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 14 points are available for this measure.

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

- **14 points:** If the MCO's measurement rate is equal to or greater than the target rate, the MCO gets all 14points 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[3]
- **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.

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
- 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 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in June 2024.

[3] Baseline Year Rate (BYR): For the contract year 2025 calculation, the baseline year rate is calendar year 2023's rate.

Table 12: Calendar Year 2023 Baseline Annual Dental Visit (ADV) Rate by MHCP Product and Age Group

Total Points: Fourteen (14) points

Annual Dental Visits (ADV) Baseline Year 2023 Rates for SNBC:

MCO	Product	Age (years)	Numerator	Denominator	Rate (In %)
HealthPartners	SNBC	18–64	2,478	6,401	38.7%
Hennepin Health	SNBC	18–64	668	1,952	34.2%
Medica	SNBC	18–64	4,597	11,453	40.1%
PrimeWest Health	SNBC	18–64	962	2,311	41.6%
South Country Health Alliance	SNBC	18–64	953	1,879	50.7%
UCare	SNBC	18–64	14,493	36,202	40.0%

Note: Baseline data as of June 2024.

Ambulatory Care (AMB) - ED Visits

The annual utilization of emergency department (ED) visits for SNBC members 18-64 years of age.

Purpose

This withholds measure applies to the 2025 Minnesota SNBC contract. Its purpose is to hold managed care organizations accountable for annual reduction in their ED utilization over the baseline year rate.

General Description

This measure evaluates the annual utilization of ED Visits.

Performance Target

The performance target is three (3) percentage points annual decrease over the baseline year rate**.**

Rate Calculation

The rate is calculated as per the 2025 HEDIS Technical Specifications. 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) 2025 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2023 technical specifications unless the changes would significantly influence this measure's dependability.

Exclusions

In determining the ED visit utilization, the STATE excludes these claims:

- Voided and rejected 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 14 points are available for this measure.

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

- **14 points:** If the MCO's measurement rate is equal to or lesser than the target rate, the MCO gets all 14 points available.
- **Partial points:** If the MCO's contract year rate has reduced compared to the baseline year rate but less than the target rates, the MCO gets part of the available points, commensurate with the percentage decrease. The percentage of decrease will be calculated to the second decimal. The number of points will be awarded based on the percentage decrease achieved.
- **0 points:** If the MCO's measurement rate is above its baseline year rate, the MCO gets 0 points.

Example of partial point calculation:

• Example MCO's previous year rate is 118 ED visits per 1,000 enrollee months.
• Example MCO's target rate for the contract year is 115 ED visits per 1,000 enrollee months (3 points reduction from baseline year's rate).
• During the contract year, the MCO achieved a rate of 116 ED visits per 1,000 enrollee months.
• The proportion of the annual reduction achieved is (118 – 116) / (118 – 115) = 2/3 = 0.67 or 67%.
• Because in the example, the MCO achieved a decrease of 67% in the difference between the baseline year rate of 118 and the target rate of 115, the MCO gets 67% of the available points: **9.4 points**
• **0 points**: If the MCO's ED use rate is greater than the baseline year's rate, the MCO gets **0 points**.

Baseline Year Rate Calculation.

The MCOs' calendar year 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in June 2024.

Table 13: Calendar Year 2023 Baseline for Ambulatory Care (AMB) – ED Visits Rate by MHCP Product and Age Group

Total Points: Fourteen (14) points

Ages: 18-64 Years

Reference Group = Overall Avg. Rate = 91.59 Per 1,000 Member Months	2023 Overall Rate (All R/E: Unknown included)			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
HealthPartners	8,281	89,016	93.03	4,297	49,682	86.49	2,767	24,773	111.69	499	3,792	131.59	303	5,600	54.11	415	4,342	95.58
Hennepin Health	3,161	27,458	115.12	742	8,121	91.37	2,023	15,921	127.06	291	1,680	173.21	21	919	22.85	109	949	114.86
Medica	12,742	151,628	84.03	6,705	86,823	77.23	4,296	44,111	97.39	858	5,860	146.42	283	7,649	37.00	593	6,519	90.96
PrimeWest Health	2,877	33,266	86.48	2,187	26,897	81.31	77	1,069	72.03	481	3,852	124.87	12	274	43.80	104	989	105.16
SCHA	2,472	26,163	94.48	2,104	22,645	92.91	172	1,404	122.51	49	442	110.86	9	238	37.82	129	1,324	97.43

Reference Group = Overall Avg. Rate = 91.59 Per 1,000 Member Months	2023 Overall Rate (All R/E: Unknown included)			Non-Hispanic White			Black/ African American			Native American/Native Alaskan			Asian American/ Pacific Islander			Hispanic **		
UCare	44,907	485,202	92.55	27,300	303,514	89.95	11,616	105,320	110.29	2,879	23,217	124.00	1,292	32,944	39.22	1,887	19,033	99.14

Notes: N = Numerator; D = Denominator; Baseline data as of July 2024.

**= 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.

Colorectal Cancer Screening (COL)

The percentage of members 46-64 years of age (for SNBC) who had an appropriate screening for colorectal cancer.

Purpose

This withholds measure applies to the 2025 Minnesota F&C contract. Its purpose is to hold managed care organizations accountable for annually increasing the percentage of enrollees with an appropriate colorectal cancer screening.

General Description

This measure evaluates the rate of MCO enrollees who had an annual colorectal cancer screening.

Performance Target

The performance target is five (5) percentage points annual improvement over the baseline year rate for both age groups (e.g., 46-50 and 51-64 years).

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 NCQA HEDIS 2025 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2023 technical 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 46–64 years of age, 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 gap in enrollment of up to 45 days during each year of continuous enrollment.

Numerator Details

The numerator (N) is the number of enrollees who meet the denominator criteria and had one or more screenings for colorectal cancer during the measurement year.

Exclusions

In determining the number of screenings for colorectal cancer an enrollee had, the STATE excludes these claims:

- Voided and rejected 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 10 points are available for this measure.

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

- **10 points:** If the MCO's measurement rate is equal to or greater than the target rate, the MCO gets all 10 points available.
- **Partial points:** If the MCO's contract year rate is greater than the baseline year rate but less than the target rates, the MCO gets part of the available points, commensurate with the percentage increase. The percentage of increase will be calculated to the second decimal. The number of points will be awarded based on the percentage increase achieved.
- **0 points:** If the MCO's measurement rate is below its baseline year rate, the MCO gets 0 points.

Baseline Year Rate Calculation.

The MCOs' calendar year 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in July 2024.

Table 14 A: Calendar Year 2023 Baseline Colorectal Cancer Screening (COL) Rate by MHCP Product and Age Group

Total Points: Five (5) points

Colorectal Cancer Screening (COL) Baseline Year 2023 Rates for SNBC:

Ages: 46-50 Years

MCO	Product	Age (years)	Numerator	Denominator	Rate (in %)
HealthPartners	SNBC	46-50	166	460	36.09%
Hennepin Health	SNBC	46-50	56	179	31.28%
Medica	SNBC	46-50	356	924	38.53%
PrimeWest Health	SNBC	46-50	94	195	48.21%
South Country Health Alliance	SNBC	46-50	62	152	40.79%
UCare	SNBC	46-50	1,223	3,208	38.12%

Notes: N = Numerator; D = Denominator; Baseline data as of July 2024.

**= 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 14 B: Calendar Year 2023 Baseline Colorectal Cancer Screening (COL) Rate by MHCP Product and Age Group

Total Points: Five (5) points

Colorectal Cancer Screening (COL) Baseline Year 2023 Rates for SNBC:

Ages: 51-64 Years

MCO	Product	Age (years)	Numerator	Denominator	Rate (in %)
HealthPartners	SNBC	51–64	1,079	2,005	53.82%
Hennepin Health	SNBC	51–64	436	888	49.10%
Medica	SNBC	51–64	2,708	4,968	54.51%
PrimeWest Health	SNBC	51–64	573	1,001	57.24%
South Country Health Alliance	SNBC	51–64	472	799	59.07%
UCare	SNBC	51–64	7,953	14,346	55.44%

Notes: N = Numerator; D = Denominator; Baseline data as of July 2024.

**= 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 ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)

The percentage of emergency department (ED) visits for SNBC members 18-64 years of age with multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Purpose

This withholds measure applies to the 2025 Minnesota SNBC contract. Its purpose is to hold managed care organizations accountable for annually increasing the percentage of enrollees with multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

General Description

This measure evaluates the rate of MCO enrollees who had a follow-up service within 7 days of the ED visit.

Performance Target

The performance target is three (3) percentage points annual improvement over the baseline year rate**.**

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) 2025 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 20223technical 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.
- **Continuous enrollment:** The enrollee was enrolled in the MCO for the entire 365 days prior to the ED Visits with no more than a one gap in enrollment of up to 45 days during the 365 days prior to the ED visit and no gap during the 7 days following the ED visit.

Numerator Details

The numerator (N) is the number of enrollees who meet the denominator criteria and had a follow-up service within 7 days after the ED visit (8 total days).

Exclusions

In determining the follow-up service within 7 days after an ED visit an enrollee had, the STATE excludes these claims:

- Voided and rejected 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 14 points are available for this measure.

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

- **14 points:** If the MCO's measurement rate is equal to or greater than the target rate, the MCO gets all 14 points available.
- **Partial points:** If the MCO's contract year rate is greater than the baseline year rate but less than the target rates, the MCO gets part of the available points, commensurate with the percentage increase. The percentage of increase will be calculated to the second decimal. The number of points will be awarded based on the percentage increase achieved.
- **0 points:** If the MCO's measurement rate is below its baseline year rate, the MCO gets 0 points.

Baseline Year Rate Calculation.

The MCOs' calendar year 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in July 2024.

Table 15: Calendar Year 2023 Baseline for Follow Up After Emergency Department Visits for People with Multiple High-risk Chronic Conditions (FMC) Rate by MHCP Product and Age Group

Total Points: Fourteen (14) points

Follow Up After Emergency Department Visits for People with Multiple High-risk Chronic Conditions (FMC) Baseline Year 2023 Rates for SNBC:

Reference Group = Overall Avg. Rate = 73.12%	2023 Overall Rate (All R/E: Unknown included)			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 (%)
HealthPartners	1,180	1,586	74.4	718	921	78.0	321	468	68.6	65	80	81.3	32	52	61.5	43	60	71.7
Hennepin Health	404	553	73.1	67	87	77.0	276	381	72.4	44	54	81.5	<6	<6	50.0	15	17	88.2
Medica	2,264	2,918	77.6	1,307	1,636	79.9	751	1,000	75.1	111	151	73.5	43	54	79.6	60	86	69.8
PrimeWest Health	436	620	70.3	329	452	72.8	16	23	69.6	76	121	62.8	<6	<6	100.0	10	15	66.7
SCHA	409	598	68.4	374	529	70.7	11	27	40.7	<6	8	12.5	<6	<6	100.0	21	31	67.7
UCare	6,887	9,561	72.0	4,380	6,009	72.9	1,601	2,240	71.5	456	654	69.7	212	319	66.5	235	340	69.1

Notes: N = Numerator; D = Denominator; Baseline data as of July 2024.

**= 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 SNBC members 18-64 years of age 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.

Purpose

This withholds measure applies to the 2025 Minnesota SNBC contract. Its purpose is to hold managed care organizations accountable for annually increasing the percentage of discharges for which the member received follow-up within 7 days or 30 days.

General Description

This measure evaluates the rate of MCO enrollees who had a follow-up service after hospitalization for mental illness.

Performance Target

The performance target is three (3) percentage points annual improvement over the baseline year rate**.**

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) 2025 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2023 technical 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.
- **Continuous enrollment:** The enrollee was enrolled in the MCO for the entire 365 days prior to the ED Visits with no more than a one gap in enrollment of up to 45 days during the 365 days prior to the ED visit and no gap during the 7 days following the ED visit.

Numerator Details

The numerator (N) is the number of enrollees who meet the denominator criteria and had a follow-up service within 7 days after the ED visit (8 total days).

Exclusions

In determining the follow-up service within 7 days after an ED visit an enrollee had, the STATE excludes these claims:

- Voided and rejected 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 14 points are available for this measure.

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

- **14 points:** If the MCO's measurement rate is equal to or greater than the target rate, the MCO gets all 14 points available.
- **Partial points:** If the MCO's contract year rate is greater than the baseline year rate but less than the target rates, the MCO gets part of the available points, commensurate with the percentage increase. The percentage of increase will be calculated to the second decimal. The number of points will be awarded based on the percentage increase achieved.
- **0 points:** If the MCO's measurement rate is below its baseline year rate, the MCO gets 0 points.

Baseline Year Rate Calculation.

The MCOs' calendar year 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in July 2024.

Table 16: Calendar Year 2023 Baseline for Follow-up after Hospitalization for Mental Illness (FUH) – 30 Day Rate by MHCP Product and Age Group

Total Points: Seven (7) points

Follow-up after Hospitalization for Mental Illness (FUH) – 30 Day Baseline Year 2023 Rates for SNBC:

Reference Group = Overall Avg. Rate = 65.13%	2023 Overall Rate (All R/E: Unknown included)			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 (%)
HealthPartners	186	278	66.9	120	164	73.2	44	78	56.4	8	10	80.0	9	15	60.0	<6	11	54.5
Hennepin Health	43	69	62.3	18	23	78.3	16	35	45.7	<6	8	75.0	<6	<6	100.0	<6	<6	100.0
Medica	269	412	65.3	154	231	66.7	68	117	58.1	18	28	64.3	16	19	84.2	12	17	70.6
PrimeWest Health	61	85	71.8	56	69	81.2	<6	<6	0.0	<6	13	38.5	<6	<6	0.0	<6	<6	0.0
SCHA	33	46	71.7	28	36	77.8	<6	<6	60.0	<6	<6	100.0	<6	<6	0.0	<6	<6	25.0
UCare	874	1,361	64.2	610	878	69.5	160	296	54.1	47	95	49.5	16	39	41.0	39	54	72.2

Notes: N = Numerator; D = Denominator; Baseline data as of July 2024.

**= 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 17: Calendar Year 2023 Baseline for Follow-up after Hospitalization for Mental Illness (FUH) – 7 Day Rate by MHCP Product and Age Group

Total Points: Seven (7) points

Follow-up after Hospitalization for Mental Illness (FUH) – 7 Day Baseline Year 2023 Rates for SNBC:

Reference Group = Overall Avg. Rate = 35.50%	2023 Overall Rate (All R/E: Unknown included)			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 (%)
HealthPartners	100	278	36.0	67	164	40.9	19	78	24.4	<6	10	30.00%	6	15	30.0	<6	11	36.4
Hennepin Health	23	69	33.3	7	23	30.4	10	35	28.6	<6	8	62.50%	<6	<6	62.5	<6	<6	50.0
Medica	144	412	35.0	92	231	39.8	27	117	23.1	7	28	25.00%	11	19	25.0	6	17	35.3
PrimeWest Health	36	85	42.4	33	69	47.8	<6	<6	0.0	<6	13	23.08%	<6	<6	23.1	<6	<6	0.0
SCHA	21	46	45.7	18	36	50.0	<6	<6	40.0	<6	<6	0.00%	<6	<6	0.0	<6	<6	25.0
UCare	475	1,361	34.9	365	878	41.6	69	296	23.3	16	95	16.84%	9	39	16.8	15	54	27.8

Notes: N = Numerator; D = Denominator; Baseline data as of July 2024.

**= 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.

Measures for Seniors Contract Only

Annual Dental Visit (ADV)

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

Purpose

This withholds measure applies to the 2025 Minnesota Seniors[4] (e.g., MSHO[5], MSC+[6]) contract. 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[7].

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).

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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] Baseline Year Rate (BYR): For the contract year 2025 calculation, the baseline year is calendar year 2023's rate.

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 (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 rejected 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[8]
- **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.

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
- 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 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in June 2024.

[8] Baseline Year Rate (BYR): For the contract year 2025 calculation, the baseline year rate is calendar year 2023's rate.

Table 18: Calendar Year 2023 Baseline Annual Dental Visit (ADV) Rate by MHCP Product and Age Group

Total Points: Fifteen (15) points

Annual Dental Visits (ADV) Baseline Year 2023 Rates for Seniors (e.g., MSHO & MSC+):

MCO	Product	Age (years)	Numerator	Denominator	Rate (In %)
Blue Plus	MSC+/MSHO	65+	3,863	12,722	30.4%
HealthPartners	MSC+/MSHO	65+	2,801	7,933	35.3%
Itasca Medical Care	MSC+/MSHO	65+	213	606	35.2%
Medica	MSC+/MSHO	65+	4,902	13,555	36.2%
PrimeWest Health	MSC+/MSHO	65+	900	2,797	32.2%
South Country Health Alliance	MSC+/MSHO	65+	681	1,905	35.8%
UCare	MSC+/MSHO	65+	8,249	24,286	34.0%

Notes: (i) Baseline data as of June 2024.

Colorectal Cancer Screening (COL)

The percentage of members 65+ years of age who had an appropriate screening for colorectal cancer.

Purpose

This withholds measure applies to the 2025 Minnesota Seniors (e.g., MSHO, MSC+) contract. Its purpose is to hold managed care organizations accountable for annually increasing the percentage of enrollees with an annual screening for colorectal cancer.

General Description

This measure evaluates the rate of MCO enrollees who had an annual colorectal cancer screening.

Performance Target

The performance target is three (3) percentage points annual improvement over the baseline year rate**.**

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) 2025 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2023 technical 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 (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 gap in enrollment of up to 45 days during each year of continuous enrollment.

Numerator Details

The numerator (N) is the number of enrollees who meet the denominator criteria and had one or more screenings for colorectal cancer during the measurement year.

Exclusions

In determining the number of screenings for colorectal cancer an enrollee had, the STATE excludes these claims:

- Voided and rejected 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.
- **Partial points:** If the MCO's contract year rate is greater than the baseline year rate but less than the target rates, the MCO gets part of the available points, commensurate with the percentage increase. The percentage of increase will be calculated to the second decimal. The number of points will be awarded based on the percentage increase achieved.
- **0 points:** If the MCO's measurement rate is below its baseline year rate, the MCO gets 0 points.

Baseline Year Rate Calculation.

The MCOs' calendar year 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in July 2024.

Table 19: Calendar Year 2023 Baseline for Colorectal Cancer Screening (COL) Rate by MHCP Product and Age Group

Total Points: Fifteen (15) points

Colorectal Cancer Screening (COL) Rate Baseline Year 2023 Rates for Seniors (e.g., MSHO & MSC+):

Reference Group = Overall Avg. Rate = 55.08%	2023 Overall Rate (All R/E: Unknown included)			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	2,335	4,248	55.0	1,801	3,219	55.9	150	308	48.7	56	127	44.1	202	346	58.4	99	195	50.8
HealthPartners	1,518	2,612	58.1	688	1,257	54.7	338	599	56.4	27	48	56.3	372	535	69.5	83	139	59.7
IMCare	115	213	54.0	107	196	54.6	<6	<6	0.0	8	15	53.3	<6	<6	0.0	<6	<6	0.0
Medica	1,962	3,559	55.1	1,241	2,218	56.0	342	679	50.4	62	122	50.8	218	368	59.2	98	161	60.9
Prime West Health	390	706	55.2	344	610	56.4	<6	9	44.4	24	53	45.3	<6	<6	40.0	12	19	63.2
SCHA	284	509	55.8	258	461	56.0	<6	13	46.2	<6	<6	100.0	<6	<6	66.7	12	21	57.1
UCare	3,640	6,750	53.9	1,819	3,283	55.4	804	1,749	46.0	68	129	52.7	740	1,230	60.2	178	317	56.2

Notes: N = Numerator; D = Denominator; Baseline data as of July 2024.

**= 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 ED Visit for People with Multiple High-Risk Chronic Conditions (FMC)

The percentage of emergency department (ED) visits for members 65 years of age and older with multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

Purpose

This withholds measure applies to the 2024 Minnesota Seniors (e.g., MSHO, MSC+) contract. Its purpose is to hold managed care organizations accountable for annually increasing the percentage of enrollees with multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit.

General Description

This measure evaluates the rate of MCO enrollees who had a follow-up service within 7 days of the ED visit.

Performance Target

The performance target is three (3) percentage points annual improvement over the baseline year rate**.**

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) 2024 technical specifications. To preserve the validity of comparisons between years, the STATE will not consider changes to the HEDIS 2022 technical 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 (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 365 days prior to the ED Visits with no more than a one gap in enrollment of up to 45 days during the 365 days prior to the ED visit and no gap during the 7 days following the ED visit.

Numerator Details

The numerator (N) is the number of enrollees who meet the denominator criteria and had a follow-up service within 7 days after the ED visit (8 total days).

Exclusions

In determining the follow-up service within 7 days after an ED visit an enrollee had, the STATE excludes these claims:

- Voided and rejected 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.
- **Partial points:** If the MCO's contract year rate is greater than the baseline year rate but less than the target rates, the MCO gets part of the available points, commensurate with the percentage increase. The percentage of increase will be calculated to the second decimal. The number of points will be awarded based on the percentage increase achieved.
- **0 points:** If the MCO's measurement rate is below its baseline year rate, the MCO gets 0 points.

Baseline Year Rate Calculation.

The MCOs' calendar year 2023 baseline year rates were calculated (and de-duplicated to remove potential multiple Recipient IDs or PMIs) in July 2024.

Table 20: Calendar Year 2023 Baseline for Follow Up After Emergency Department Visits for People with Multiple High-risk Chronic Conditions (FMC) Rate by MHCP Product and Age Group

Total Points: Fifteen (15) points

Follow Up After Emergency Department Visits for People with Multiple High-risk Chronic Conditions (FMC) Baseline Year 2023 Rates for Seniors:

Reference Group = Overall Avg. Rate = 62.17%	2023 Overall Rate (All R/E: Unknown included)			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	1,871	2,769	67.6	1,623	2,378	68.3	64	109	58.7	41	69	59.4	63	100	63.0	54	80	67.50%
HealthPartners	652	1,099	59.3	382	607	62.9	141	273	51.6	8	18	44.4	91	143	63.6	47	73	64.38%
IMCare	126	173	72.8	119	160	74.4	<6	<6	0.0	7	13	53.8	<6	<6	0.0	<6	<6	0.00%
Medica	1,596	2,682	59.5	1,117	1,863	60.0	291	476	61.1	57	104	54.8	78	142	54.9	50	92	54.35%
Prime West Health	388	537	72.3	348	475	73.3	<6	<6	100.0	31	52	59.6	<6	<6	0.0	<6	<6	100.00%
SCHA	278	452	61.5	252	412	61.2	<6	7	57.1	<6	<6	0.0	<6	<6	50.0	20	31	64.52%
UCare	2,247	3,802	59.1	1,354	2,271	59.6	572	904	63.3	48	82	58.5	199	395	50.4	57	117	48.72%

Notes: N = Numerator; D = Denominator; Baseline data as of July 2024.

**= 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.

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 2025 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 rejected 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:

- **15 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) Health Equity Community 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 ten (10) 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:

- **10 points:** To qualify for the full points allotted to this performance measure, the MCO must show that four (4) meetings were conducted, and documentation sent to DHS in a timely manner.
- **For each meeting a total of 2.5 (two and a half) points will be awarded:**
    - **1/2 point** will be awarded for each meeting held up to a total possible two (2) 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.