2018 Health Disparities Report

Managed Care Quality and Monitoring Division
California Department of Health Care Services

February 2020

HSAG HEALTH SERVICES ADVISORY GROUP

DHCS
California Department of
HealthCareServices

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Commonly Used Abbreviations and Acronyms

The following is a list of abbreviations and acronyms used throughout this report.

- **AAB**—*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- **ACE**—angiotensin converting enzyme
- ***AMB–ED***—*Ambulatory Care—Emergency Department Visits*
- ***AMB–OP***—*Ambulatory Care—Outpatient Visits*
- ***AMR***—*Asthma Medication Ratio*
- **ARBs**—angiotensin receptor blockers
- ***BCS***—*Breast Cancer Screening*
- ***CAP–1219***—*Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- ***CAP–1224***—*Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- ***CAP–256***—*Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- ***CAP–711***—*Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- ***CBP***—*Controlling High Blood Pressure*
- ***CCS***—*Cervical Cancer Screening*
- ***CDC–BP***—*Comprehensive Diabetes Care—Blood Pressure Control*
- ***CDC–E***—*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- ***CDC–H8***—*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- ***CDC–H9***—*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- ***CDC–HT***—*Comprehensive Diabetes Care—HbA1c Testing*
- ***CDC–N***—*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- ***CIS–3***—*Childhood Immunization Status—Combination 3*
- **CMS**—Centers for Medicare & Medicaid Services
- **DHCS**—California Department of Health Care Services
- **EAS**—External Accountability Set
- **HbA1c**—hemoglobin A1c
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[1]
- **HIPAA**—Health Insurance Portability and Accountability Act of 1996
- **HSAG**—Health Services Advisory Group, Inc.
- ***IMA–2***—*Immunizations for Adolescents—Combination 2*

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ***LBP***—*Use of Imaging Studies for Low Back Pain*
- **MCP**—managed care health plan
- ***MPM–ACE***—*Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
- ***MPM–Diu***—*Annual Monitoring for Patients on Persistent Medications—Diuretics*
- **N**—number
- **NCQA**—National Committee for Quality Assurance
- **OB/GYN**—obstetrician-gynecologist
- **PCP**—primary care provider
- ***PPC–Pre***—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ***PPC–Pst***—*Prenatal and Postpartum Care—Postpartum Care*
- ***PCR***—*Plan All-Cause Readmissions*
- ***W–34***—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- ***WCC–N***—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
- **WCC–PA**—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*

1. Executive Summary

Background

A health disparity is the difference in health outcomes between groups within a population.[2] To assess and improve health disparities, the California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a health disparities study using the external accountability set (EAS) measures reported by the 25 full-scope Medi-Cal managed care plans (MCPs) for reporting year 2019 with data derived from calendar year 2018.[3] EAS measures reflect clinical quality, timeliness, and access to care provided by MCPs to their beneficiaries, and each MCP is required to report audited EAS results to DHCS annually. This report also includes a trending section with results for reporting years 2017–2019. The goal of the Health Disparities Report is to improve health care for Medi-Cal beneficiaries by evaluating the health care disparities affecting beneficiaries enrolled in Medi-Cal MCPs. This report does not include data for fee-for-service beneficiaries in Medi-Cal.

To identify and understand health disparities affecting Medi-Cal beneficiaries, it is important to consider the population mix of the Medi-Cal managed care program. In 2018, the racial/ethnic distribution of the Medi-Cal managed care population consisted of the following racial/ethnic groups: Hispanic or Latino (49 percent), White (20 percent), Other or Unknown (13 percent), Asian (8 percent), Black or African American (8 percent), and Native Hawaiian or Other Pacific Islander (2 percent). In addition, the Medi-Cal managed care program's age distribution in 2018 was 18-year-olds and younger (42 percent), 19-to-64-year-olds (49 percent), and 65 and older (8 percent).[4] According to the *2003 National Healthcare Quality and Disparities Report*, disparities in access to care and quality of care were identified for the Black or African American group and Hispanic or Latino group when compared to the White group.[5] Although some disparities have narrowed since 2000, disparities continue to persist for these racial/ethnic groups as evidenced by the *2018 National Healthcare Quality and Disparities Report*, which showed that the Black or African American group and the Hispanic or Latino group experienced worse access to care when compared to the White group for 42.9 percent

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[2] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

[3] Aetna Better Health of California and United Healthcare Community Plan were new MCPs for reporting year 2019; therefore, the MCPs were not able to report all reporting year 2019 measures and were not included in the aggregate rates for reporting years 2017 or 2018.

[4] Managed Care Performance Monitoring Dashboard Report, March 28, 2019. Available at: https://www.dhcs.ca.gov/services/Documents/MMCD/March28_2019Release.pdf. Accessed on: Dec 10, 2019.

[5] National Healthcare Disparities Report, 2003. Rockville, MD: Agency for Healthcare Research and Quality; August 2007.

and 75.0 percent, respectively, of access to care indicators.[6] For quality measures, the Black or African American group and the Hispanic or Latino group experienced worse quality of care when compared to the White group for 40.0 percent and 34.7 percent, respectively, of quality care indicators. Given national findings on demographic disparities and to improve health care for Medi-Cal beneficiaries, DHCS requested that HSAG evaluate racial/ethnic health care disparities affecting beneficiaries enrolled in Medi-Cal MCPs.

Medi-Cal Managed Care Program and Health Disparities

DHCS' vision is to preserve and improve the health of all Californians.[7] DHCS focuses on three interconnected goals to advance this strategy:

- Improve the health of all Californians.
- Enhance quality, including the patient care experience, in all DHCS programs.
- Reduce DHCS' per capita health care program costs.

One of the seven priorities for improving and maintaining overall health and well-being of Californians identified by DHCS is the elimination of disparities in health care among Californians. This health disparities report is a step toward reaching that goal by assessing the nature and extent of health disparities across the State and between subdivisions of the Medi-Cal population.

DHCS requested that HSAG evaluate indicator data collected for reporting year 2019 at the statewide level, which consists of data collected during calendar year 2018 also known as Healthcare Effectiveness Data and Information Set (HEDIS) measurement year 2018. Several measures include more than one indicator; therefore, this report will refer to indicators rather than measures. The indicator set for this analysis included a total of 28 indicators. The indicators are grouped into the following domains: Preventive Screening and Children's Health, Preventive Screening and Women's Health, Care for Chronic Conditions, and Appropriate Treatment and Utilization. Please note, HSAG did not include the *Depression Screening and Follow-Up for Adolescents and Adults* indicator in the health disparities analysis due to unreliable data and inconsistent reporting by MCPs. For each indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined by the applicable technical specification, such as the HEDIS specification for the Medicaid population. HSAG

[6] 2018 National Healthcare Quality and Disparities Report. Agency for Healthcare Research and Quality, Oct 2019. Available at: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr18/index.html. Accessed on: Dec 10, 2019.

[7] DHCS Strategy for Quality Improvement in Health Care. California Department of Healthcare Services, Mar 2018. Available at: https://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2018.PDF. Accessed on: Dec 10, 2019.

aggregated results from 25 full-scope MCPs and then stratified these statewide rates by race/ethnicity, primary language, age, and gender.

Although HSAG stratified all indicators by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. To ensure the methodology to identify health disparities aligned with national standards, HSAG used the Centers for Medicare & Medicaid Services' (CMS') *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.[8]

Findings for racial/ethnic health disparities are presented in Section 3 of this report, and trending results for select indicators for reporting years 2017–2019 by racial/ethnic and primary language group are presented in Section 4. The indicator rates by demographic stratification (i.e., primary language, age, and gender) for reporting year 2019 are located in Appendix A. Please note, HSAG uses "majority" throughout the report to refer to at least 50 percent.

Key Findings for Racial/Ethnic Health Disparities

Reporting Year 2019 Findings

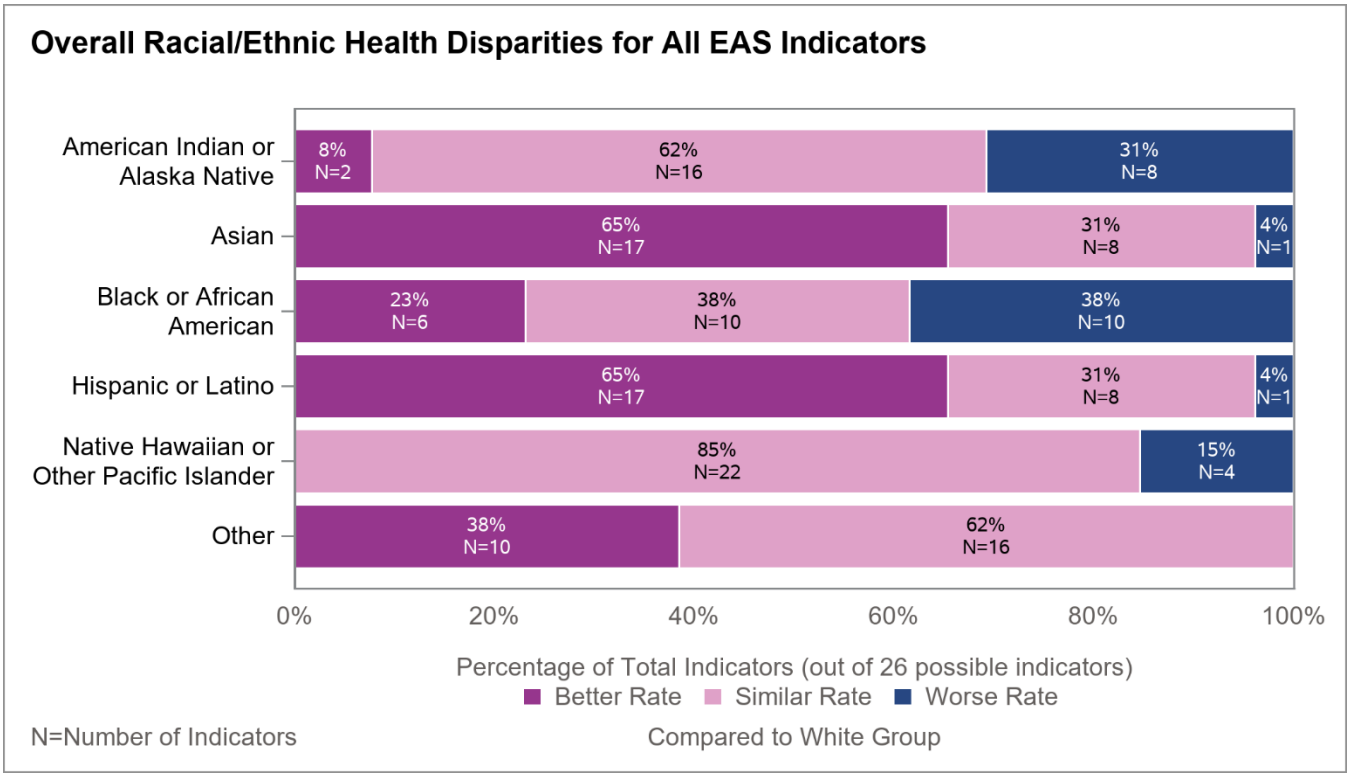
Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 1.1 displays the percentage and number of indicators (out of 26 possible indicators) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

[8] CMS Office of Minority Health and RAND Corporation. *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage*. Baltimore, MD. 2017.

Figure 1.1—Overall Racial/Ethnic Health Disparities for All Indicators

Note: The *Ambulatory Care* indicators were not included in the racial/ethnic health disparities analysis.

Due to rounding, the percentage of total indicators may not equal 100 percent for some racial/ethnic groups.



American Indian or Alaska Native

- For the Appropriate Treatment and Utilization domain, a majority of the indicator rates for the American Indian or Alaska Native group were better than the rates for the White group.
- For the Preventive Screening and Women's Health domain, a majority of the indicator rates for the American Indian or Alaska Native group were worse than the rates for the White group.

Asian

- For the following domains, a majority of the indicator rates for the Asian group were better than the rates for the White group:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
  - Care for Chronic Conditions
- There were no domains where a majority of the indicator rates for the Asian group were worse than the rates for the White group.

Black or African American

- For the Appropriate Treatment and Utilization domain, a majority of the indicator rates for the Black or African American group were better than the rates for the White group.
- For the Preventive Screening and Children's Health domain, a majority of the indicator rates for the Black or African American group were worse than the rates for the White group.

Hispanic or Latino

- For the following domains, a majority of the indicator rates for the Hispanic or Latino group were better than the rates for the White group:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
  - Care for Chronic Conditions
- There were no domains where a majority of the indicator rates for the Hispanic or Latino group were worse than the rates for the White group.

Native Hawaiian or Other Pacific Islander

- There were no domains where a majority of the indicator rates for the Native Hawaiian or Other Pacific Islander group were better than the rates for the White group.
- There were no domains where a majority of the indicator rates for the Native Hawaiian or Other Pacific Islander group were worse than the rates for the White group.

Other

- For the following domains, a majority of the indicator rates for the Other group were better than the rates for the White group:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
- There were no domains where a majority of the indicator rates for the Other group were worse than the rates for the White group.

Reporting Years 2017–2019 Findings

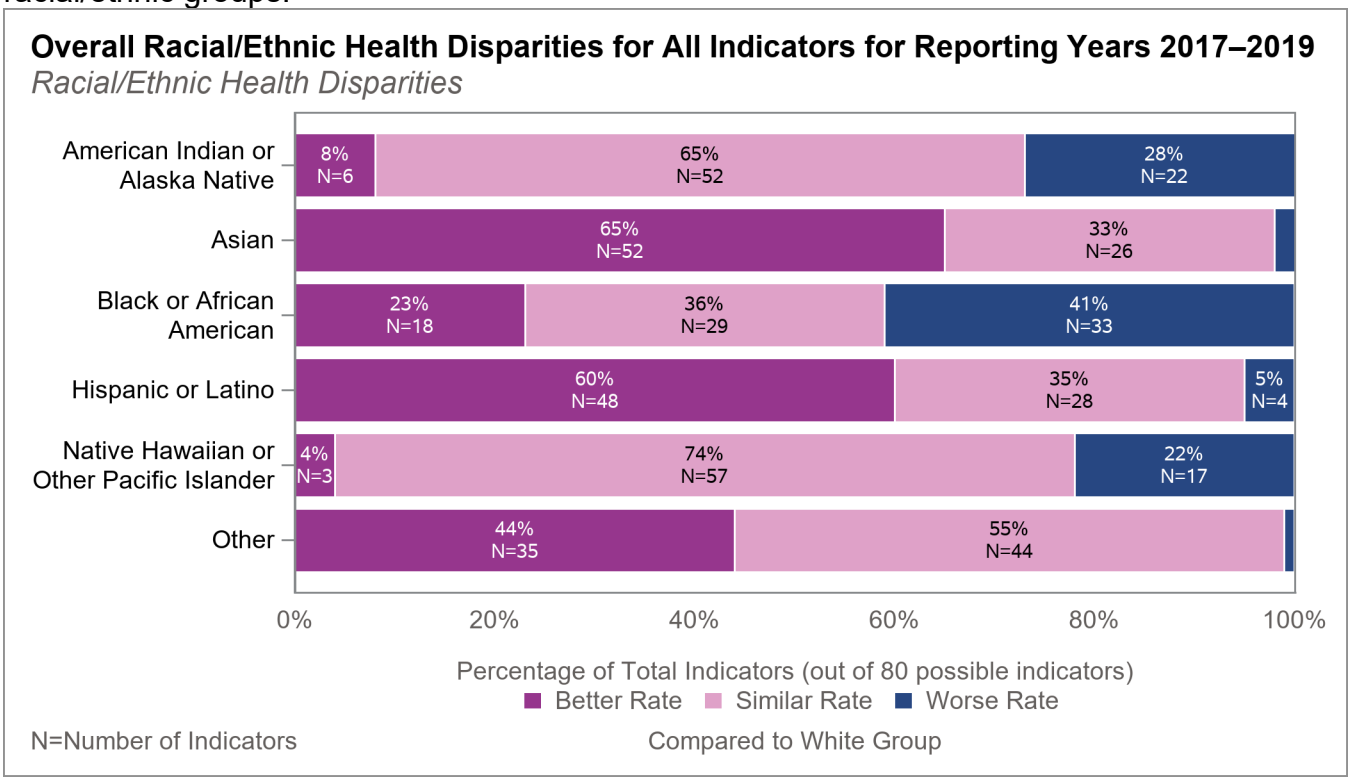
For reporting years 2017–2019, health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 1.2 displays the overall percentage and number of indicators for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group when all three reporting years are combined.

Figure 1.2—Overall Racial/Ethnic Health Disparities for All Indicators for Reporting Years 2017–2019

Note: The *Ambulatory Care* indicators were not included in the racial/ethnic health disparities analysis.

The Native Hawaiian or Other Pacific Islander group had a total of 77 indicators for reporting years 2017–2019.

Due to rounding, the percentage of total indicators may not equal 100 percent for some racial/ethnic groups.



American Indian or Alaska Native

- When all three reporting years were combined, there were no domains where a majority of indicator rates for the American Indian or Alaska Native group were better than the rates for the White group.

- When all three reporting years were combined, a majority of the indicator rates for the American Indian or Alaska Native group in the Preventive Screening and Women's Health domain were worse than the rates for the White group.

Asian

- When all three reporting years were combined, a majority of the indicator rates for the Asian group were better than the rates for the White group for the following domains:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
  - Care for Chronic Conditions
- When all three reporting years were combined, there were no domains where a majority of indicator rates for the Asian group were worse than the rates for the White group.

Black or African American

- When all three reporting years were combined, the majority of indicator rates for the Black or African American group in the Appropriate Treatment and Utilization domain were better than the rates for the White group.
- When all three reporting years were combined, a majority of the indicators rates for the Black or African American group in the Preventive Screening and Women's Health domain were worse than the rates for the White group.

Hispanic or Latino

- When all three reporting years were combined, a majority of the indicator rates for the Hispanic or Latino group were better than the rates for the White group for the following domains:
  - Preventive Screening and Children's Health
  - Preventive Screening and Women's Health
- When all three reporting years were combined, there were no domains where a majority of indicator rates for the Hispanic or Latino group were worse than the rates for the White group.

Native Hawaiian or Other Pacific Islander

- When all three reporting years were combined, there were no domains where a majority of indicator rates for the Native Hawaiian or Other Pacific Islander group were better than or worse than the rates for the White group.

Other

- When all three reporting years were combined, the majority of indicator rates for the Other group in the Preventive Screening and Women's Health domain were better than the rates for the White group.
- When all three reporting years were combined, there were no domains where a majority of indicator rates for the Other group were worse than the rates for the White group.

Overall Conclusions and Items for Consideration

The following are the overall conclusions for the Medi-Cal health disparities analysis for reporting year 2019:

- The rates for the Black or African American group were worse than those for the White group for approximately 38 percent of indicators in the analyses.
  - Indicators for which the rates for the Black or African American group were worse than the rates for the White group were related to access to care and health outcomes. This trend is commonly seen nationally in other state Medicaid programs.[9] Note that the rates for the Black or African American group were better than the rates for the White group for some process measures related to preventive care and appropriate utilization.
- The rates for the American Indian or Alaska Native group and Native Hawaiian or Other Pacific Islander group were worse than those for the White group for approximately 31 percent and 15 percent, respectively, of indicators in the analyses.
- The rates for both the Asian and Hispanic or Latino groups were better than the rates for the White group for approximately 65 percent of indicators in the analyses.

The following are the overall conclusions for the Medi-Cal health disparities analysis for reporting years 2017–2019:

- Overall, for approximately 70 percent of indicators where rates for specific racial/ethnic groups were worse than the White group in reporting year 2017, the health disparities for those indicators continued to exist in reporting year 2019, demonstrating that health disparities are not improving.
- Overall, for approximately 90 percent of indicators where rates for specific racial/ethnic groups were better than the White group in reporting year 2017, the health disparities for those indicators continued to exist in reporting year 2019, demonstrating that health disparities are not improving.

Based on the overall conclusions for the Medi-Cal health disparities analysis, DHCS should consider the following:

- For the racial/ethnic groups with rates that were better than or worse than the rates for the White group for all three reporting years, DHCS should prioritize addressing health disparities related to those select indicators, where possible.
  - For the racial/ethnic groups with rates that were better than the rates for the White group for all three reporting years (i.e., the Asian and Hispanic or Latino groups), DHCS, in collaboration with MCPs, should consider analyzing health disparities further to determine the additional factors that may be associated with higher rates.
  - For the racial/ethnic groups with rates that were worse than the rates for the White group across all three reporting years, DHCS should consider opportunities to increase

[9] Bulger J, Shubrook J, Snow R. Racial Disparities in African Americans with Diabetes: Process and Outcome Mismatch. *Am J Manag Care*. 2012 Aug;18(8):407–13.

MCP member-level engagement to identify contributors to health disparities and strategies to address these disparities where possible.

- Given that the Hispanic or Latino group rates were better than the rates for the White group for a majority of indicators across all three reporting years and that the Hispanic or Latino group is consistently larger than the White group for almost all indicators, DHCS should consider using the Hispanic or Latino group as the reference group in the future. As DHCS continues to analyze health disparities, especially when additional indicators may be included in the analysis, there may be an opportunity to use the Hispanic or Latino group as the reference group in the future.

2. Reader's Guide

Introduction

The "Reader's Guide" is designed to provide supplemental information to the reader that may aid in the interpretation and use of the results presented in this report.

Medi-Cal Managed Care Health Plans

Table 2.1 displays the 25 full-scope Medi-Cal MCPs and the corresponding counties served for which data were aggregated and presented within this report.

Table 2.1—MCPs and Applicable Counties

MCP Name	Counties
Aetna Better Health of California	Sacramento, San Diego
Alameda Alliance for Health	Alameda
Anthem Blue Cross Partnership Plan	Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Inyo, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, San Francisco, Sacramento, San Benito, Santa Clara, Sierra, Sutter, Tehama, Tuolumne, Tulare, Yuba
Blue Shield of California Promise Health Plan (prior to January 1, 2019, known as Care1st Health Plan)	San Diego
California Health & Wellness Plan	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba
CalOptima	Orange
CalViva Health	Fresno, Kings, Madera
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Community Health Group Partnership Plan	San Diego
Contra Costa Health Plan	Contra Costa
Gold Coast Health Plan	Ventura

MCP Name	Counties
Health Net Community Solutions, Inc.	Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare
Health Plan of San Joaquin	San Joaquin, Stanislaus
Health Plan of San Mateo	San Mateo
Inland Empire Health Plan	Riverside, San Bernardino
Kaiser NorCal (KP Cal, LLC)	Amador, El Dorado, Placer, Sacramento
Kaiser SoCal (KP Cal, LLC)	San Diego
Kern Health Systems	Kern
L.A. Care Health Plan	Los Angeles
Molina Healthcare of California Partner Plan, Inc.	Imperial, Riverside, Sacramento, San Bernardino, San Diego
Partnership HealthPlan of California	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
San Francisco Health Plan	San Francisco
Santa Clara Family Health Plan	Santa Clara
UnitedHealthcare Community Plan	San Diego

Summary of Performance Indicators

DHCS selected 28 indicators reported by the 25 full-scope Medi-Cal MCPs for inclusion in the analysis and report. The indicators were grouped into the following domains of care: Preventive Screening and Children's Health, Preventive Screening and Women's Health, Care for Chronic Conditions, and Appropriate Treatment and Utilization. While health disparities are displayed and discussed primarily at the indicator level in this report, grouping these indicators into domains allows Medi-Cal MCPs and DHCS to consider the results as a whole rather than in isolation when developing strategic changes to improve health care for Medi-Cal beneficiaries.

Table 2.2 displays the selected indicators included in the analysis by domain. The indicator set included 28 HEDIS indicators.

Table 2.2—Measure Indicators

Measure Indicator	Indicator
Preventive Screening and Children's Health	
Childhood Immunization Status	*Combination 3*
Children and Adolescents' Access to Primary Care Practitioners	*12 to 24 Months*; *25 Months to 6 Years*; *7 to 11 Years*; *12 to 19 Years*
Immunizations for Adolescents	*Combination 2 (Meningococcal, Tdap, HPV)*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	*Counseling for Nutrition—Total*; *Counseling for Physical Activity—Total*
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
Preventive Screening and Women's Health	
Breast Cancer Screening	*Breast Cancer Screening*
Cervical Cancer Screening	*Cervical Cancer Screening*
Prenatal and Postpartum Care	*Postpartum Care*; *Timeliness of Prenatal Care*
Care for Chronic Conditions	
Annual Monitoring for Patients on Persistent Medications	*Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)*; *Diuretics*
Asthma Medication Ratio	*Asthma Medication Ratio*
Comprehensive Diabetes Care	*Blood Pressure Control (<140/90 mm Hg)*; *Eye Exam (Retinal) Performed*; *Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*; *HbA1c Poor Control (>9.0 Percent)*; *HbA1c Testing*; *Medical Attention for Nephropathy*
Controlling High Blood Pressure	*Controlling High Blood Pressure*
Appropriate Treatment and Utilization	
Ambulatory Care	*Emergency Department Visits*; *Outpatient Visits*
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
Plan All-Cause Readmissions	*Plan All-Cause Readmissions*
Use of Imaging Studies for Low Back Pain	*Use of Imaging Studies for Low Back Pain*

Methodology Overview

For the 2018–19 contract year, HSAG evaluated indicator data collected for reporting year 2019 at the statewide level, which consisted of data collected during calendar year 2018 also known as HEDIS measurement year 2018. HSAG aggregated the results from the 25 full-scope MCPs and then stratified these statewide rates for all indicators by demographic stratifications (i.e., race/ethnicity, primary language, age, and gender).

Although HSAG stratified all indicators by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. To ensure the methodology aligned with national standards, HSAG used CMS' *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.[10]

The information below provides a high-level overview of the health disparities analyses conducted on the reporting year 2019 data for DHCS. For the detailed methodology, please see Appendix B. Methodology.

Data Sources

HSAG received a CA-required patient-level detail file from each MCP for each HEDIS reporting unit containing beneficiary-level information, including the member ID, date of birth, and member months for beneficiaries included in the audited HEDIS rates. Additionally, the patient-level detail files indicated whether a beneficiary was included in the numerator and/or denominator for each applicable HEDIS indicator. HSAG validated the reporting year 2019 patient-level detail files against the audited HEDIS Interactive Data Submission System files to confirm numerator and denominator counts matched for each indicator. Additionally, DHCS provided supplemental files with demographic data (e.g., date of birth, gender, ZIP code, race/ethnicity, primary language) from DHCS' Management Information System/Decision Support System data system.

Statistical Analysis

HSAG combined the demographic files and the measure patient-level detail files to perform a health disparity analysis of the statewide racial/ethnic demographic stratifications using logistic regression. HSAG compared each race/ethnicity group to the White group (i.e., the reference group) for each indicator. The White racial/ethnic group was chosen as the reference group because it is used in most national health disparities reports and has historically been used as a reference point for reporting health care and non-health care disparities.

[10] CMS Office of Minority Health and RAND Corporation. *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage*. Baltimore, MD. 2017.

HSAG performed the logistic regression using SAS® software.[11] The *p*-value of the coefficient from the logistic regression was used to identify statistically significant differences when comparing the racial/ethnic groups to the reference group. For each indicator, HSAG also calculated an absolute difference for each racial/ethnic group by taking the absolute value of the difference between the rate for a racial/ethnic group and the rate for the reference group. For this report, a "health disparity" was defined as a rate for a racial/ethnic group with an absolute difference greater than or equal to 3 percentage points *and* a *p*-value of the coefficient of the logistic regression that is less than 0.05. When analyzing the rate for a racial/ethnic group, HSAG classified the rate in one of the following three categories based on the preceding analyses:

- Better Rate = The absolute difference from the reference group was greater than or equal to 3 percentage points, the *p*-value of the coefficient of the logistic regression was less than 0.05, and the rate for the racial/ethnic group was higher or more favorable than the rate for the reference group. In other words, the reference group showed a health disparity compared to the racial/ethnic group being evaluated.
- Worse Rate = The absolute difference from the reference group was greater than or equal to 3 percentage points, the *p*-value of the coefficient of the logistic regression was less than 0.05, and the rate for the racial/ethnic group was lower or less favorable than the rate for the reference group. In other words, the racial/ethnic group being evaluated showed a health disparity compared to the reference group.
- Similar Rate = The absolute difference from the reference group was less than 3 percentage points or the *p*-value of the coefficient of the logistic regression was greater than or equal to 0.05. This means no health disparities were identified when the racial/ethnic group was compared to the reference group.

For more information on how HSAG displayed the results from the statistical analysis, please refer to the "Evaluating Results" section below.

Evaluating Results

Within Section 3 of this report, indicator results for the current year findings (i.e., reporting year 2019) are grouped and discussed by domain as shown in Table 2.2, starting with an overall domain-level figure. Following each domain-level figure, the narrative is organized by racial/ethnic group and describes indicators for which the rates for the racial/ethnic group were better than or worse than the rates for the White group. The results of the aggregate health disparity analyses for 28 indicators are presented within horizontal bar graphs in Section 3. Of note, due to limitations with the data, HSAG did not perform statistical analyses to identify health disparities for the *Ambulatory Care* indicators; therefore, these indicators are not included in Section 3 and are only presented in Appendix A. Within Appendix A, HSAG also presents indicator rates for the primary language, age, and gender demographic stratifications

[11] SAS® is a registered trademark of the SAS Institute, Inc.

for reporting year 2019; however, statistical analysis was not performed on these demographic stratifications to identify health disparities.

Within Section 4 of this report, HSAG produced three-year rate trending figures (i.e., reporting years 2017–2019) by race/ethnicity and primary language for the following indicators:

- *Childhood Immunization Status—Combination 3*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Breast Cancer Screening*
- *Prenatal and Postpartum Care—Postpartum Care and Timeliness of Prenatal Care*
- *Asthma Medication Ratio*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Controlling High Blood Pressure*

DHCS selected the indicators listed above for the three-year rate trending because they satisfy all of the following criteria: (1) they represent a wide range of health care needs including preventive care for children, women's health, and chronic disease management; (2) they represent areas of interest given the variation in rates among the different racial/ethnic and primary language groups; and (3) there is an expectation of the continuity of measurement (i.e., trends for these indicators can be evaluated in the future).

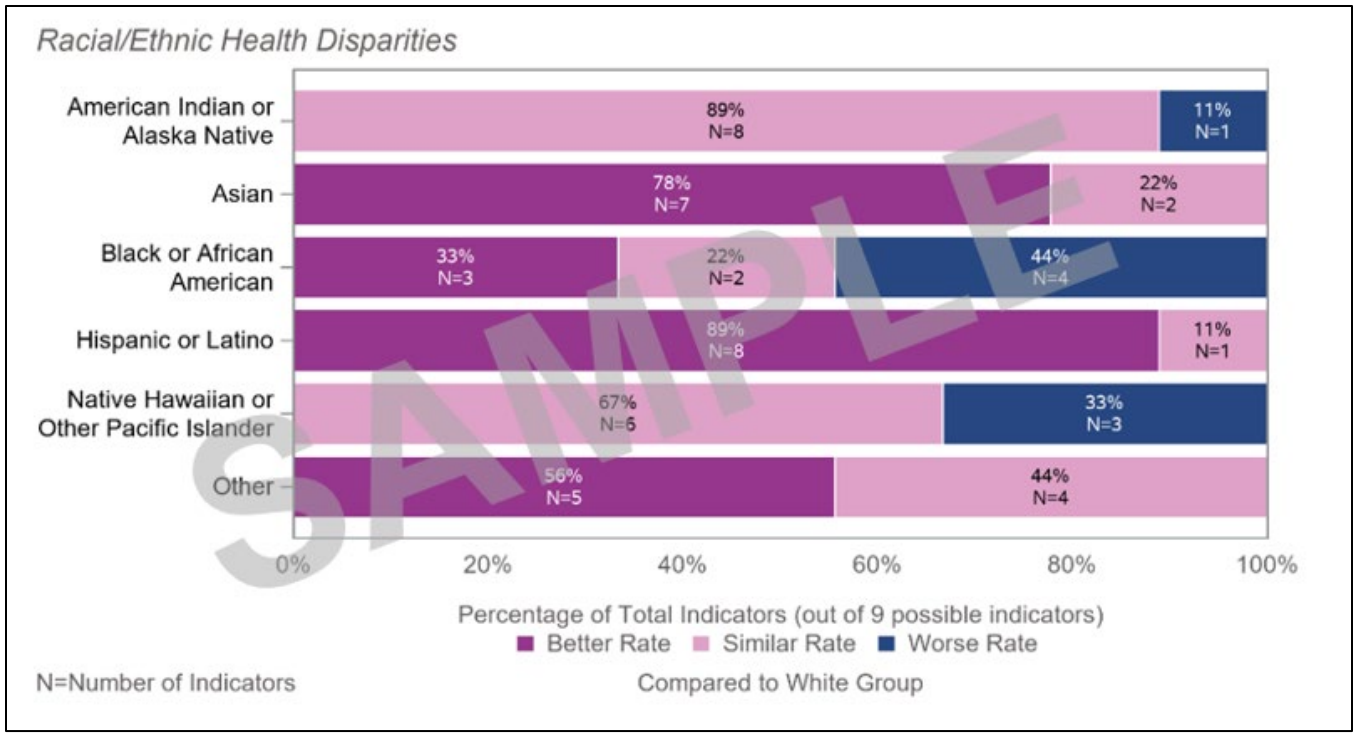
Additionally, Section 5 displays California-wide choropleth maps to show the geographic variability at the county level for four indicators (*Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*, *Breast Cancer Screening*, *Asthma Medication Ratio*, and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*).

Figure Interpretation

Section 3 presents a horizontal stacked bar graph for each domain that displays the percentage of indicators that had a better rate, worse rate, or similar rate to the White group for each racial/ethnic group. In these figures, "N" represents the number of indicators within the domain. Please note, some racial/ethnic stratifications may not have the same number of indicators for a particular domain due to a lack of data (i.e., small numerator or small denominator) for a particular indicator. An example of the horizontal stacked bar graph figure is shown in Figure 2.1. All data in the sample figure are mock data.

Figure 2.1—Sample Domain-Level Horizontal Stacked Bar Graph

FIGURE CONTAINS MOCK DATA



Additionally, the "Executive Summary" includes a similar overall horizontal stacked bar graph that displays the percentage of indicators that had a better rate, worse rate, or similar rate to the White group for each racial/ethnic group across all indicators.

For each indicator presented within Section 3 of this report, horizontal bar graphs display the reporting year 2019 rates for each racial/ethnic group. The indicator three-letter abbreviation is used within the figure (e.g., CBP); however, the abbreviation is defined within the figure title. Health disparities are shown with arrows next to the rate on the bar graph indicating whether the rate for the racial/ethnic group being evaluated was a better rate (indicated by an upward arrow) or a worse rate (indicated by a downward arrow) than the rate for the reference group (i.e., White group). If no arrow is present, no health disparities were identified. "N" represents the total statewide denominator for an indicator for a particular group. A "Note" is included above each figure displaying the statewide denominator and rate for the "Unknown/Missing" racial/ethnic group, if applicable.

Additionally, the figures also display the minimum performance level, when applicable, as established by DHCS, which represents NCQA's Quality Compass® national Medicaid health maintenance organization 25th percentile for HEDIS 2019.[12] Of note, the minimum performance level is displayed not as a statistical benchmark for health disparities but to provide more information about overall performance for a specific indicator. Minimum

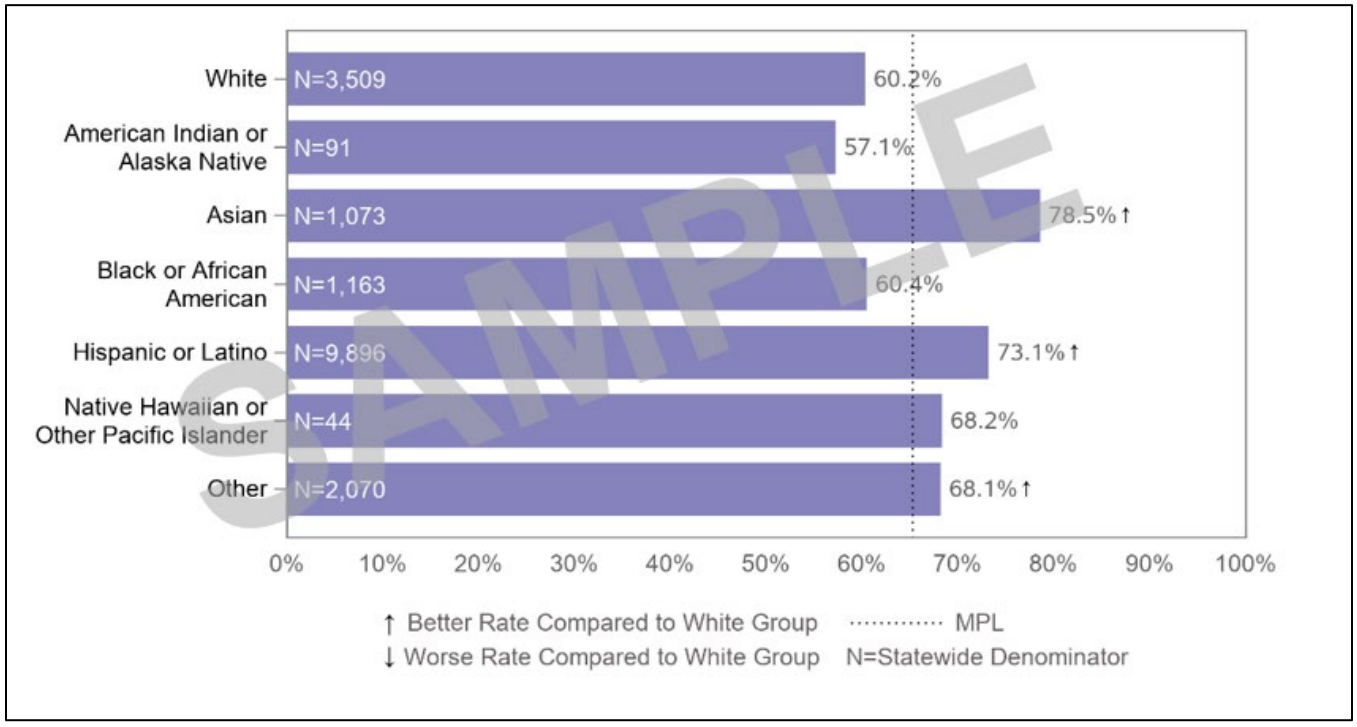
[12] Quality Compass® is a registered trademark of the NCQA.

performance level percentile data (i.e., Quality Compass rates) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to minimum performance levels are illustrated within this report using proxy displays (i.e., the dotted line). Within each applicable figure, "MPL" represents the minimum performance level for an indicator, where applicable. An example of the horizontal bar graph figure is shown in Figure 2.2. All data in the sample figure are mock data.

Figure 2.2—Sample Indicator-Level Horizontal Bar Graph Figure

Note: The rate for the Unknown/Missing group was 60.9 percent (N=75).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

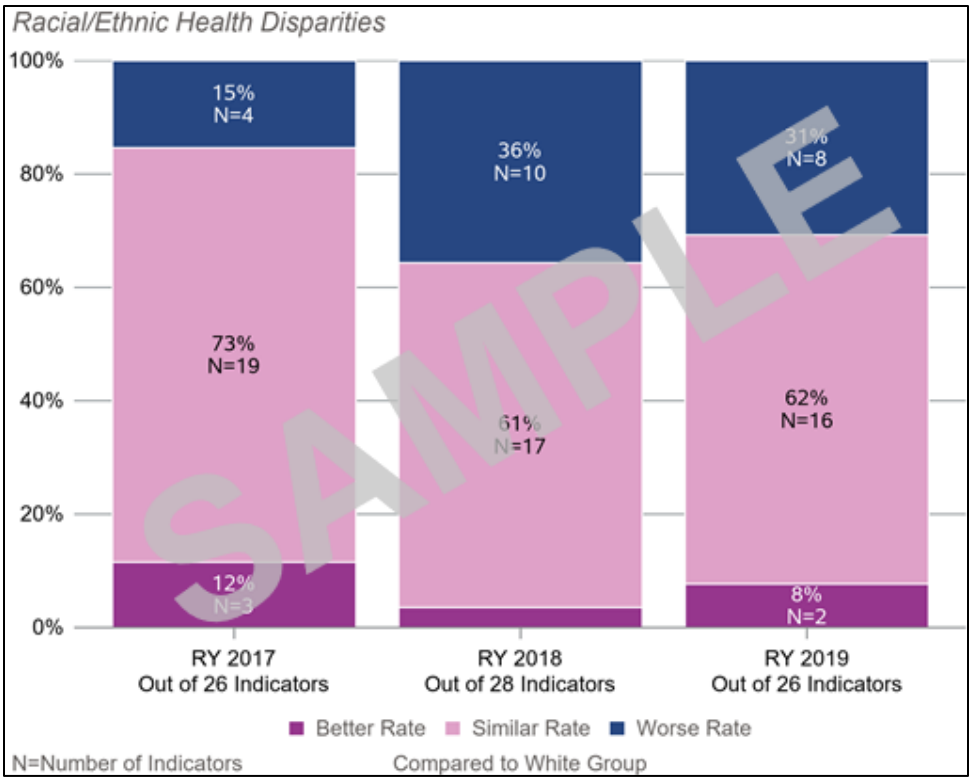
FIGURE CONTAINS MOCK DATA



Section 4 presents stacked column graphs for each racial/ethnic group which display the number of indicators that had a better rate, worse rate, or similar rate when compared to the rate for the reference group (i.e., the White group) for reporting years 2017–2019. In these figures, "N" represents the number of indicators that were better than, similar to, or worse than the reference group for the applicable reporting year. An example of a stacked column graph figure is shown in Figure 2.3. All data in the sample figure are mock data.

Figure 2.3—Sample Racial/Ethnic Group Stacked Column Graph Figure

FIGURE CONTAINS MOCK DATA

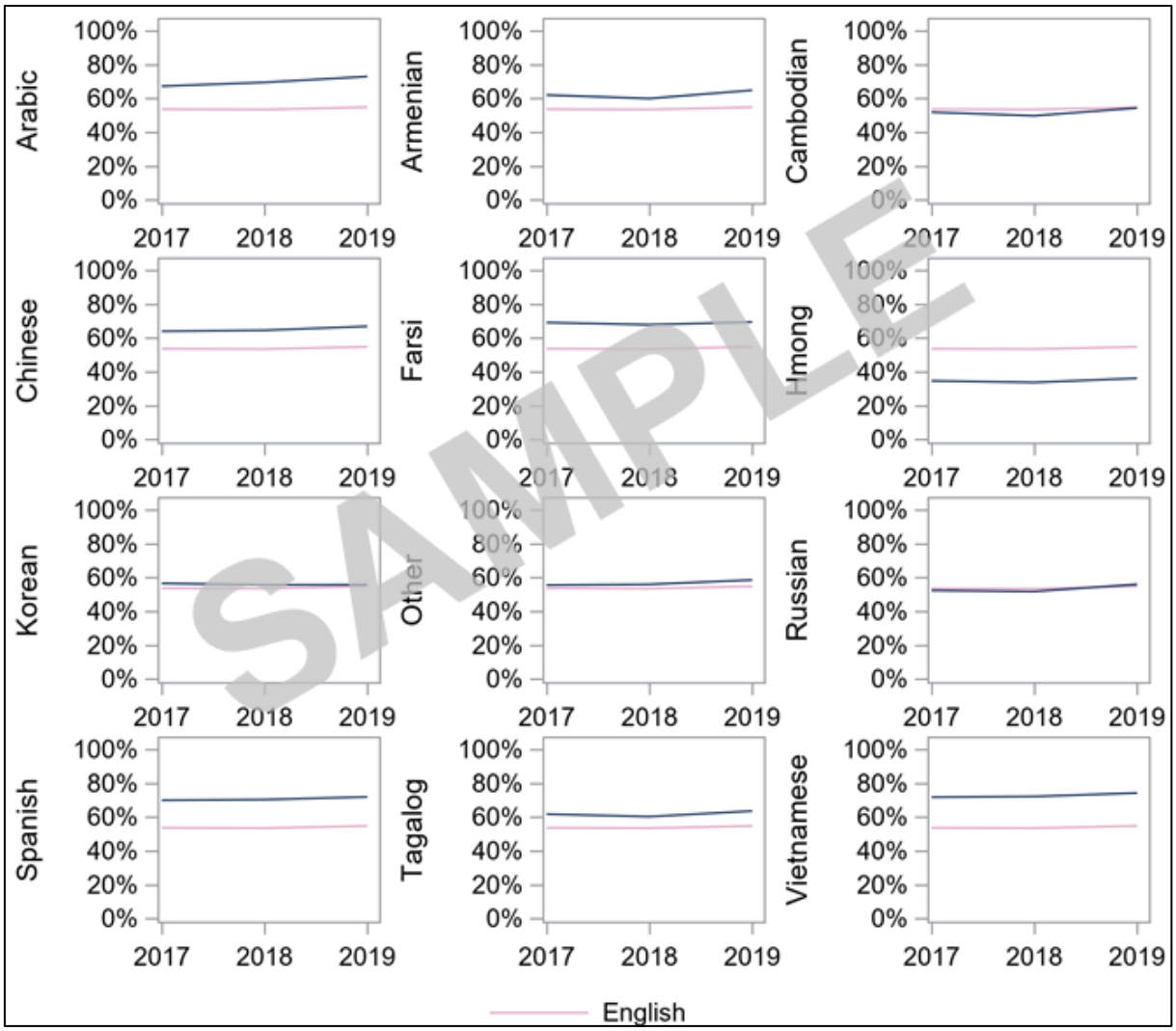


Section 4 also presents three-year rate trending figures by race/ethnicity and primary language for seven indicators. For each indicator, a gridded figure (i.e., a figure that displays separate graphs for each racial/ethnic group and primary language group) was created with a comparison to the reference group (i.e., White or English group) to show the three-year trend line for each racial/ethnic and primary language group. While the actual rates are not presented, these figures demonstrate whether a racial/ethnic group or language group had higher or lower rates than the reference group and whether there was a change in the rates for reporting years 2017–2019.

Any racial/ethnic group or primary language group that had an insufficient numerator or denominator (i.e., less than 11 for the numerator or less than 30 for the denominator) for any reporting year was excluded from the trending graph. A note is included above the figure if any racial/ethnic groups or primary language groups were excluded from the figure due to this criterion. An example of a gridded figure for primary language is shown in Figure 2.4. All data in the sample figure are mock data.

Figure 2.4—Sample Primary Language Group Gridded Figure Graph

FIGURE CONTAINS MOCK DATA

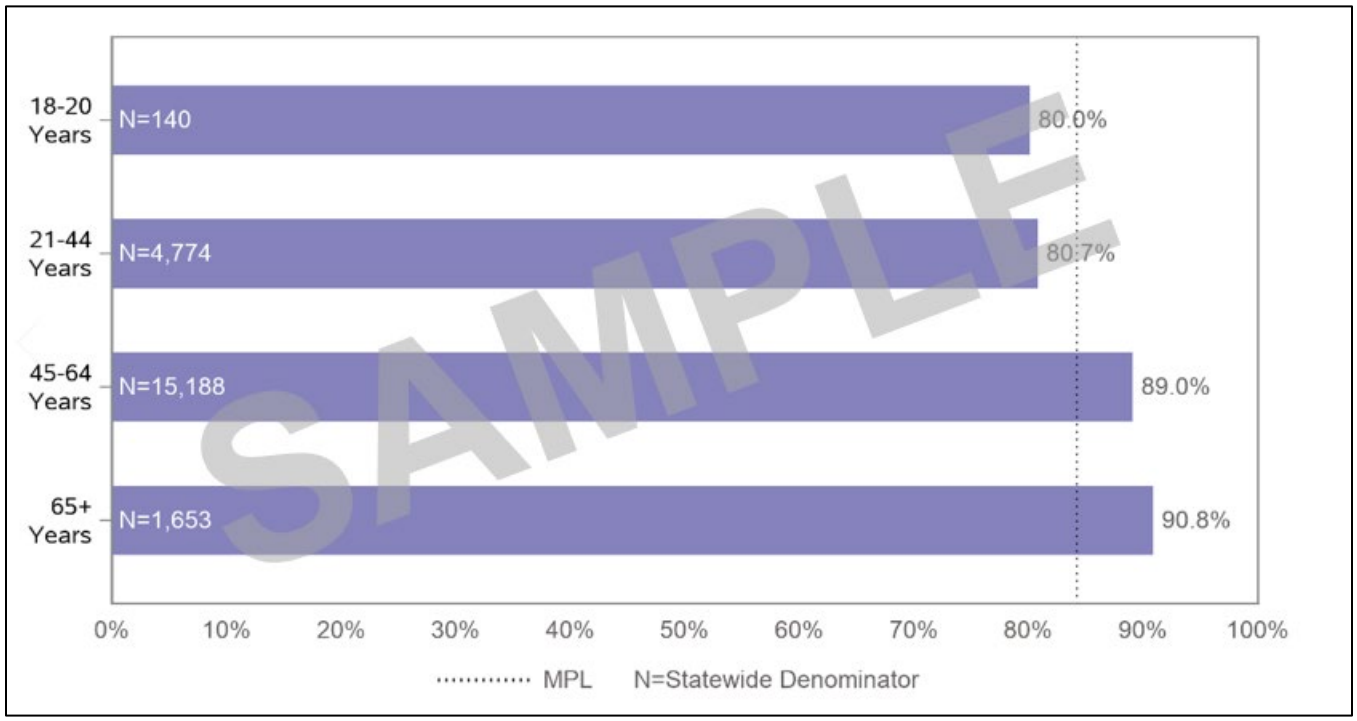


Within Appendix A, horizontal bar graphs display the indicator rates by demographic stratification (primary language, age, and gender) for reporting year 2019 results. Statistical analysis was not performed on these demographic stratifications to identify health disparities; therefore, these rates are for information only. When available, the figures also display the minimum performance level for the corresponding indicator that represents the national Medicaid 25th percentile. As noted previously, the minimum performance level is displayed not as a statistical benchmark for health disparities but to provide more information about overall performance for a specific indicator. "MPL" represents the minimum performance level for an indicator, where applicable. "N" represents the total statewide denominator for an indicator for a particular group. A "Note" is included above each figure displaying the statewide denominator and rate for the "Unknown/Missing" group for the corresponding stratification, where applicable. An example of a horizontal bar graph by age is shown in Figure 2.5. All data in the sample figure are mock data.

Figure 2.5—Sample Horizontal Stacked Bar Graph by Demographic Stratification Figure

Note: The rate for the Unknown/Missing age group was 27.8 percent (N=352).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

FIGURE CONTAINS MOCK DATA



Choropleth Map Interpretation

The choropleth maps highlight regional performance differences for the select indicators. HSAG first assigned a county to each beneficiary based on the county code provided in the DHCS demographic file. If the county code was missing for a beneficiary in the demographic data file, HSAG used the ZIP code to determine the appropriate county. HSAG then calculated county-level rates for each indicator listed previously by summing the numerators and denominators for all beneficiaries within a county. For each indicator, HSAG and DHCS determined cut points (e.g., 60.00 percent, 65.00 percent, 70.00 percent, 80.00 percent) based on the distribution of county-level rates to display the variation of county performance. HSAG then created performance levels (Lowest Performance [darkest blue], Low Performance, Middle/Average Performance, High Performance, and Highest Performance [lightest blue]) based on the cut points for each indicator. Once the performance levels were set for each indicator, each county was shaded the corresponding color of the performance level.

Table 2.3 displays the performance levels and corresponding colors for each indicator. For county rates with a small denominator (i.e., less than 30) or small numerator (i.e., less than 11), HSAG shaded the county white.

Table 2.3—Performance Level and Corresponding Colors

Indicator	Performance Level and Corresponding Colors
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	Below 80.00%
	80.00% to 83.99%
	84.00% to 85.99%
	86.00% to 88.99%
	89.00%+
Breast Cancer Screening	Below 45.00%
	45.00% to 49.99%
	50.00% to 54.99%
	55.00% to 59.99%
	60.00%+
Asthma Medication Ratio	Below 53.00%
	53.00% to 57.99%
	58.00% to 62.99%
	63.00% to 66.99%
	67.00%+
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Below 26.00%
	26.00% to 31.99%
	32.00% to 38.99%
	39.00% to 45.99%
	46.00%+

Cautions and Limitations

Hybrid Indicators

For hybrid indicators, NCQA recommends the submission of a sample of 411 beneficiaries per reporting unit to limit bias and to allow for results from the sample to be generalizable to the entire eligible population. As the rates for individual strata will be based on fewer than 411 beneficiaries, it should be noted that the stratified rates may not be generalizable to the total eligible population. Due to this caveat, the stratified rates produced for hybrid measures should be interpreted with caution. Additionally, HSAG did not weight the statewide rates for hybrid measures by the total eligible population; so, all MCPs, regardless of size, count equally toward the statewide rates. As such, performance may not be representative of actual statewide performance.

Limiting Beneficiaries

To match the age parameters for each indicator, HSAG limited the analysis to beneficiaries whose age was in one of the valid age groups for each indicator. For indicators in the Preventive Screening and Women's Health domain, HSAG only kept beneficiaries who were identified as female in the demographic file. Further, for the *Breast Cancer Screening* indicator and *Cervical Cancer Screening* indicator, the age groups were limited to women 52 to 74 years of age and 24 to 64 years of age, respectively. Additionally, HSAG included the "Unknown/Missing" group for race/ethnicity, primary language, and gender in the report as a note above the figures, where applicable.

3. Current Year Findings

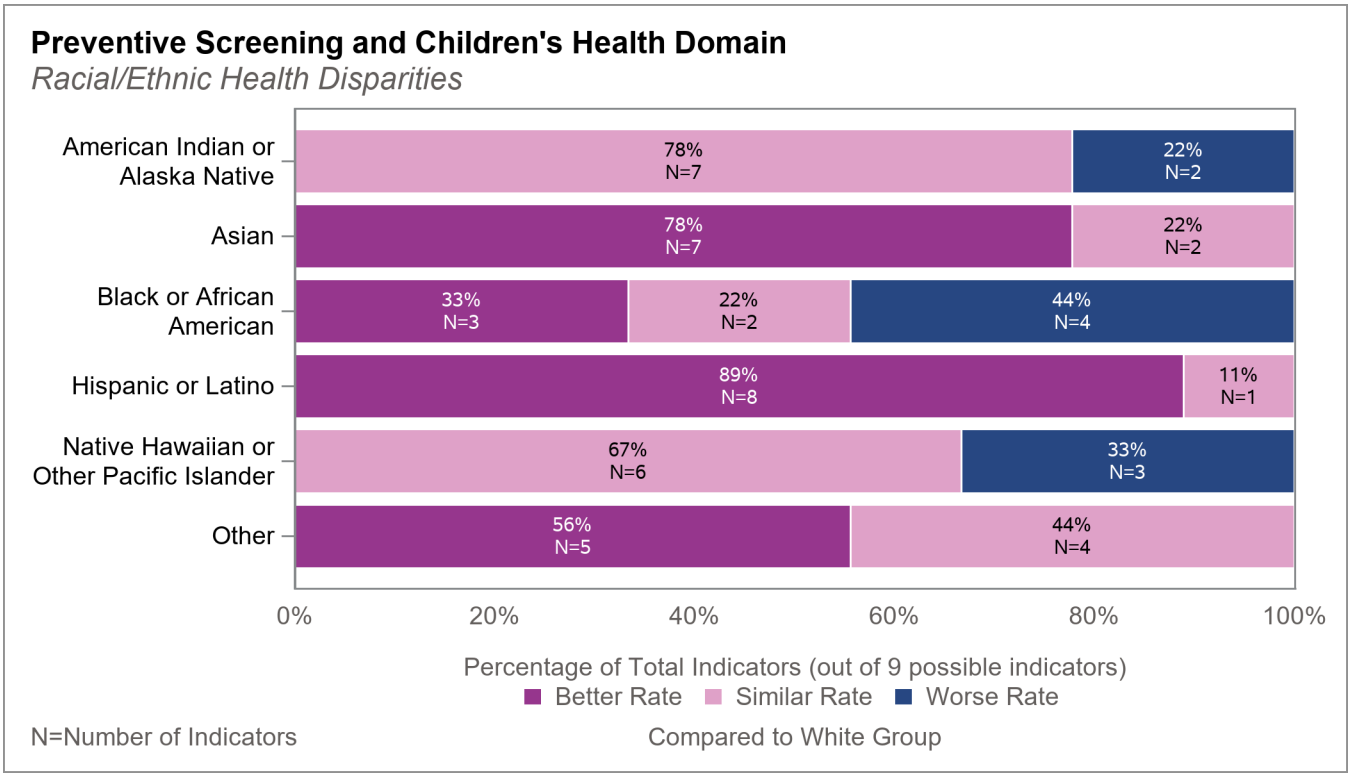
The Findings section presents the racial/ethnic health disparities results for each indicator, where applicable, organized by domain (Preventive Screening and Children's Health, Preventive Screening and Women's Health, Care for Chronic Conditions, and Appropriate Treatment and Utilization).

Racial/Ethnic Health Disparities: Preventive Screening and Children's Health Domain

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 3.1 displays the percentage and number of Preventive Screening and Children's Health domain indicators (out of nine possible indicators) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

Figure 3.1—Racial/Ethnic Health Disparities Summary: Preventive Screening and Children's Health Domain

Note: Due to rounding, the percentage of total indicators may not equal 100 percent for some racial/ethnic groups.



American Indian or Alaska Native

- No rates for the American Indian or Alaska Native group were better than the rates for the White group.
- For the following indicators, the rates for the American Indian or Alaska Native group were worse than the rate for the White group:
  - *Childhood Immunization Status—Combination 3*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*

Asian

- For the following indicators, the rates for the Asian group were better than the rates for the White group:
  - *Childhood Immunization Status—Combination 3*
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - *Immunizations for Adolescents—Combination 2*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- No rates for the Asian group were worse than the rates for the White group.

Black or African American

- For the following indicators, the rates for the Black or African American group were better than the rates for the White group:
  - *Immunizations for Adolescents—Combination 2*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*
- For the following indicators, the rates for the Black or African American group were worse than the rates for the White group:
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Hispanic or Latino

- For the following indicators, the rates for the Hispanic or Latino group were better than the rates for the White group:
  - *Childhood Immunization Status—Combination 3*
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
  - *Immunizations for Adolescents—Combination 2*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- No rates for the Hispanic or Latino group were worse than the rates for the White group.

Native Hawaiian or Other Pacific Islander

- No rates for the Native Hawaiian or Other Pacific Islander group were better than the rates for the White group.
- For the following indicators, the rates for the Native Hawaiian or Other Pacific Islander group were worse than the rates for the White group:
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Other

- For the following indicators, the rates for the Other group were better than the rates for the White group:
  - *Childhood Immunization Status—Combination 3*
  - *Immunizations for Adolescents—Combination 2*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- No rates for the Other group were worse than the rates for the White group.

Racial/Ethnic Health Disparities: Preventive Screening and Children's Health Domain Indicator Results

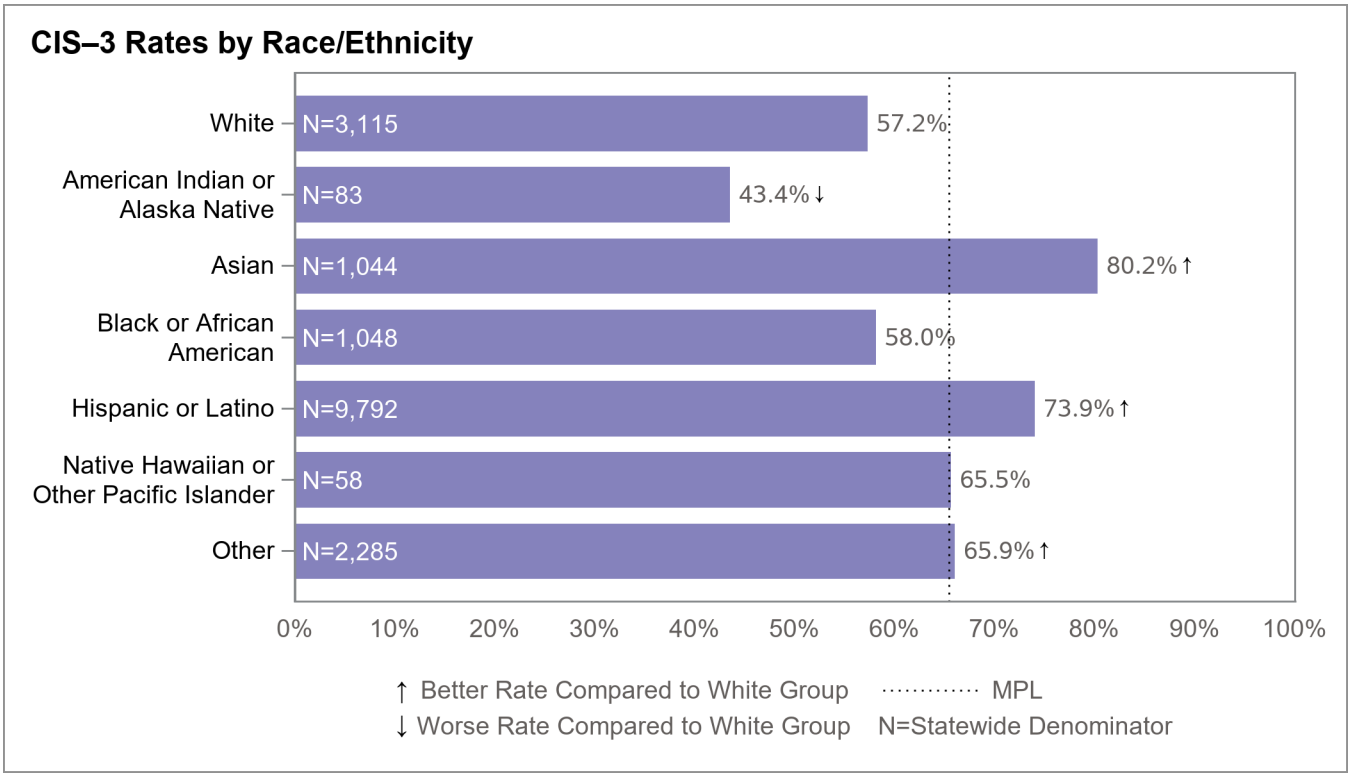
Figure 3.2 through Figure 3.10 display the racial/ethnic health disparities for each indicator included in the Preventive Screening and Children's Health domain. For each figure, the arrows highlight health disparities and indicate when the rates for the specific racial/ethnic groups were better than or worse than the rate for the White group. If the rate for the specific racial/ethnic group was similar to the rate for the White group, then no health disparity was identified and an arrow is not present.

Childhood Immunization Status—Combination 3 (CIS–3)

The *Childhood Immunization Status—Combination 3* (*CIS–3*) indicator measures the percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. Figure 3.2 displays the statewide *Childhood Immunization Status—Combination 3* (*CIS–3*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.2—Childhood Immunization Status—Combination 3 (CIS–3) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 65.2 percent (N=2,156).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



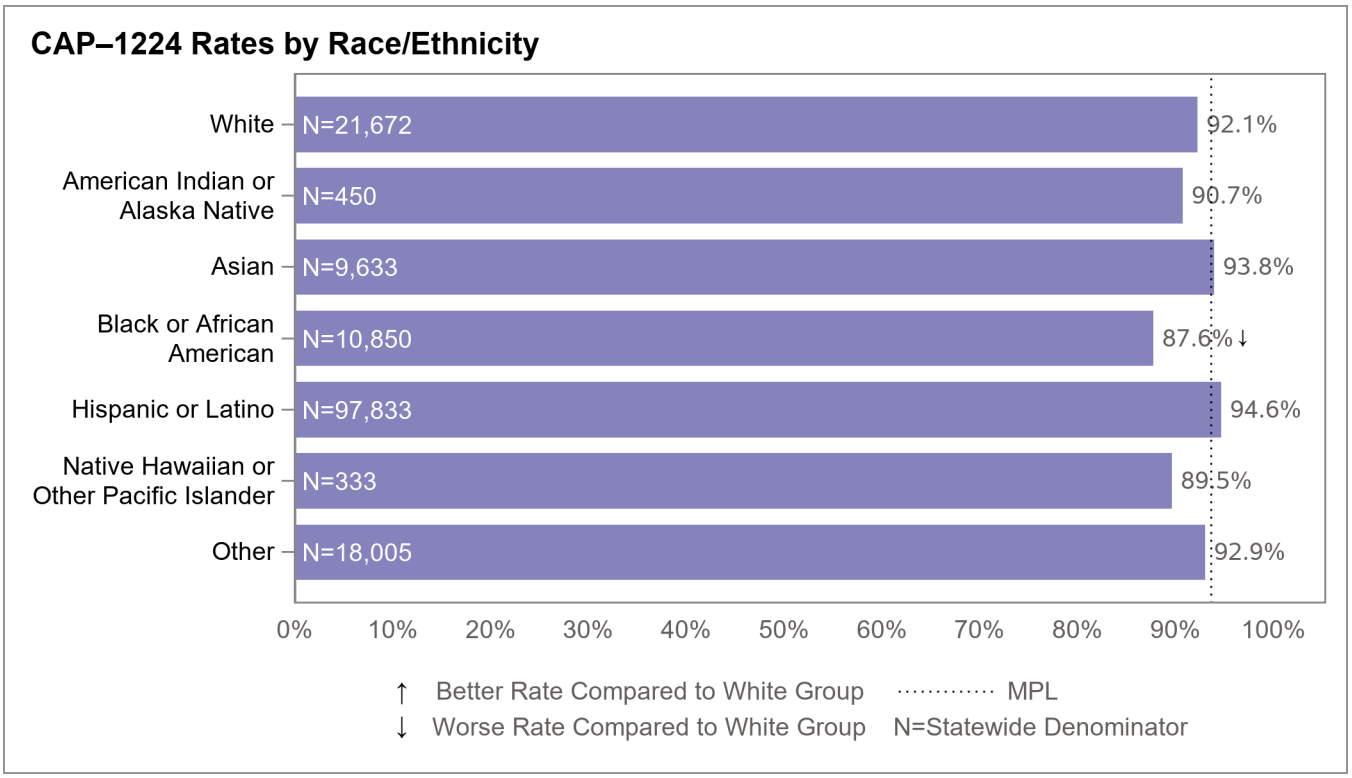
- The rates for all racial/ethnic groups ranged from 43.4 percent for the American Indian or Alaska Native group to 80.2 percent for the Asian group.
- Four health disparities were identified for the *Childhood Immunization Status—Combination 3* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White
  - American Indian or Alaska Native
  - Black or African American

Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months (CAP–1224)

The *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* (*CAP–1224*) indicator measures the percentage of beneficiaries 12 to 24 months of age who had a visit with a PCP. Figure 3.3 displays the statewide *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* (*CAP–1224*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.3—Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months (CAP–1224) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 92.6 percent (N=21,685).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



- The rates for all racial/ethnic groups ranged from 87.6 percent for the Black or African American group to 94.6 percent for the Hispanic or Latino group.
- One health disparity was identified for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* indicator as the rate for the Black or African American group was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - Other

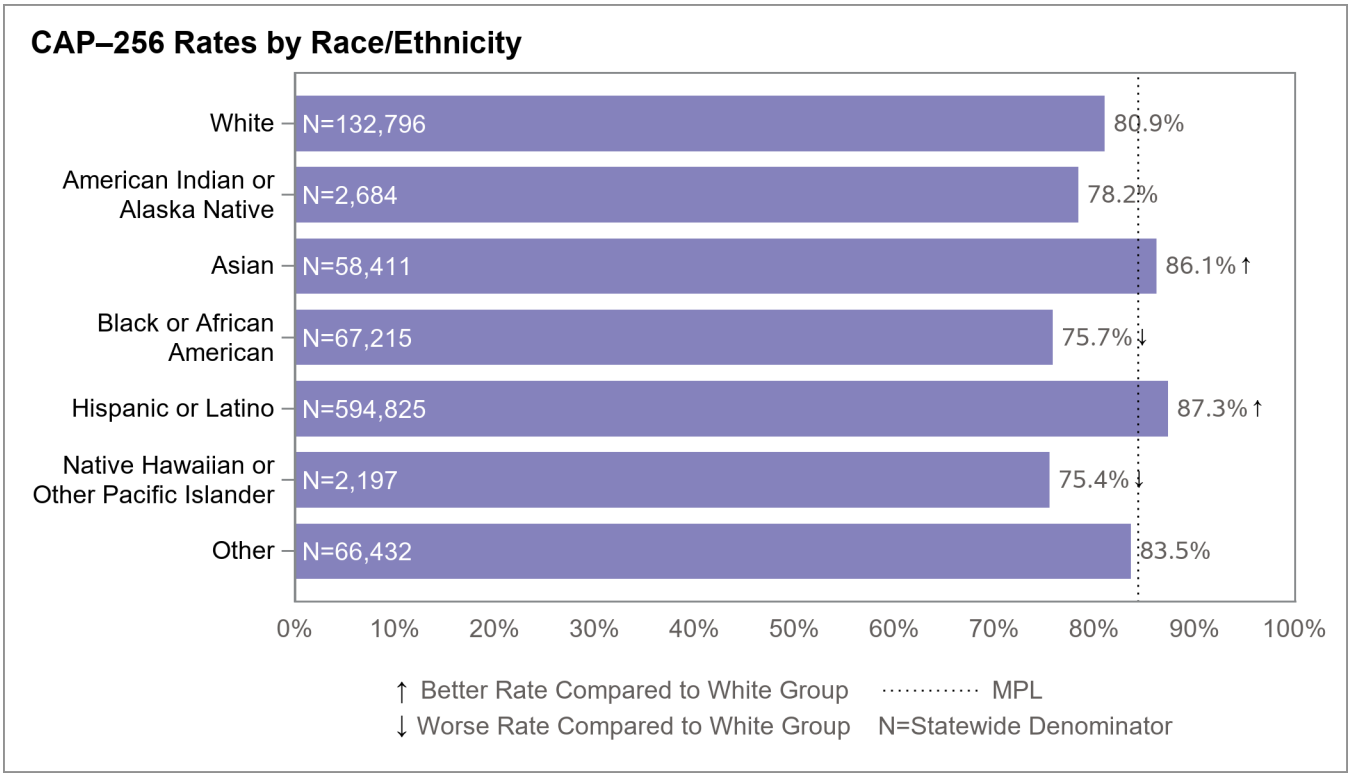
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years (CAP–256)

The *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* (*CAP–256*) indicator measures the percentage of beneficiaries 25 months to 6 years of age who had a visit with a PCP.

Figure 3.4 displays the statewide *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* (*CAP–256*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.4—Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years (CAP–256) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 82.4 percent (N=71,554).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



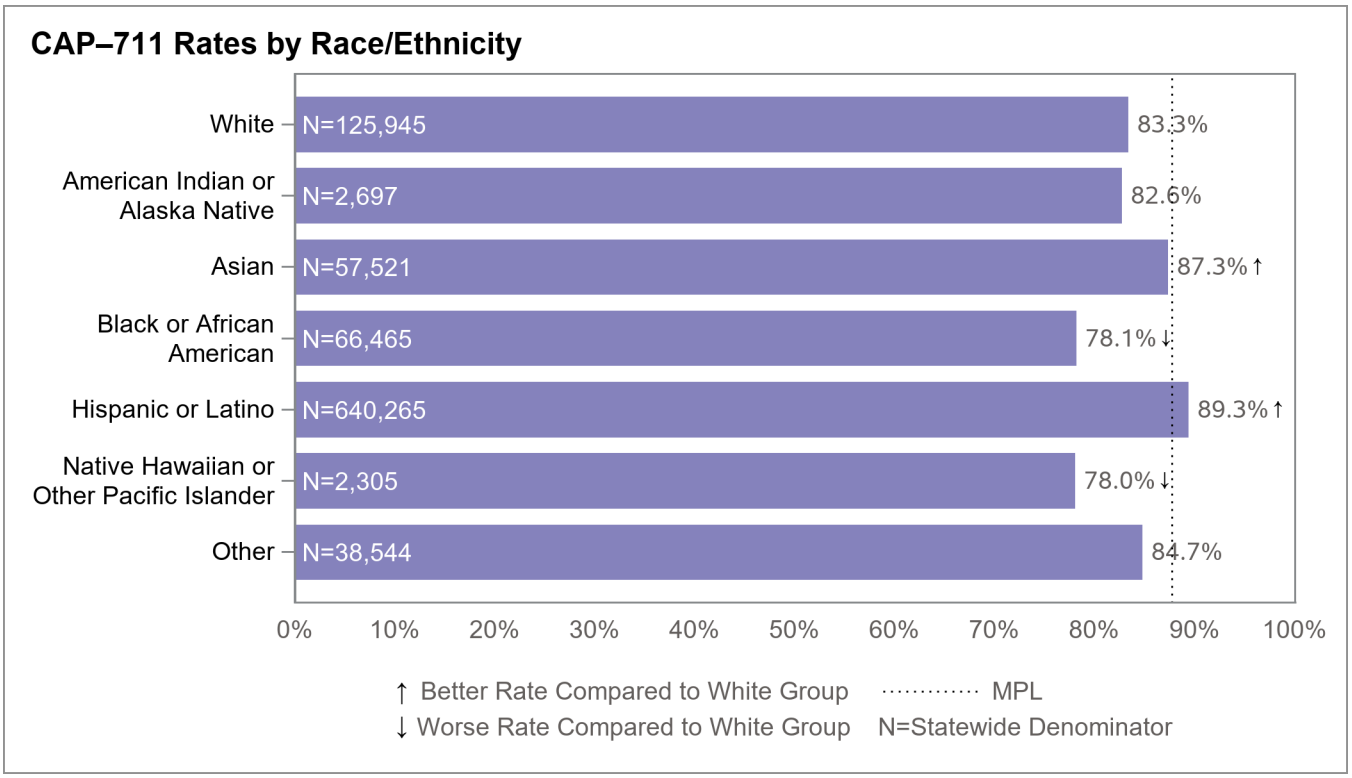
- The rates for all racial/ethnic groups ranged from 75.4 percent for the Native Hawaiian or Other Pacific Islander group to 87.3 percent for the Hispanic or Latino group.
- Four health disparities were identified for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander group was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - Other

Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years (CAP–711)

The *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* (*CAP–711*) indicator measures the percentage of beneficiaries 7 to 11 years of age who had a visit with a PCP. Figure 3.5 displays the statewide *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* (*CAP–711*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.5—Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years (CAP–711) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 83.6 percent (N=31,502).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



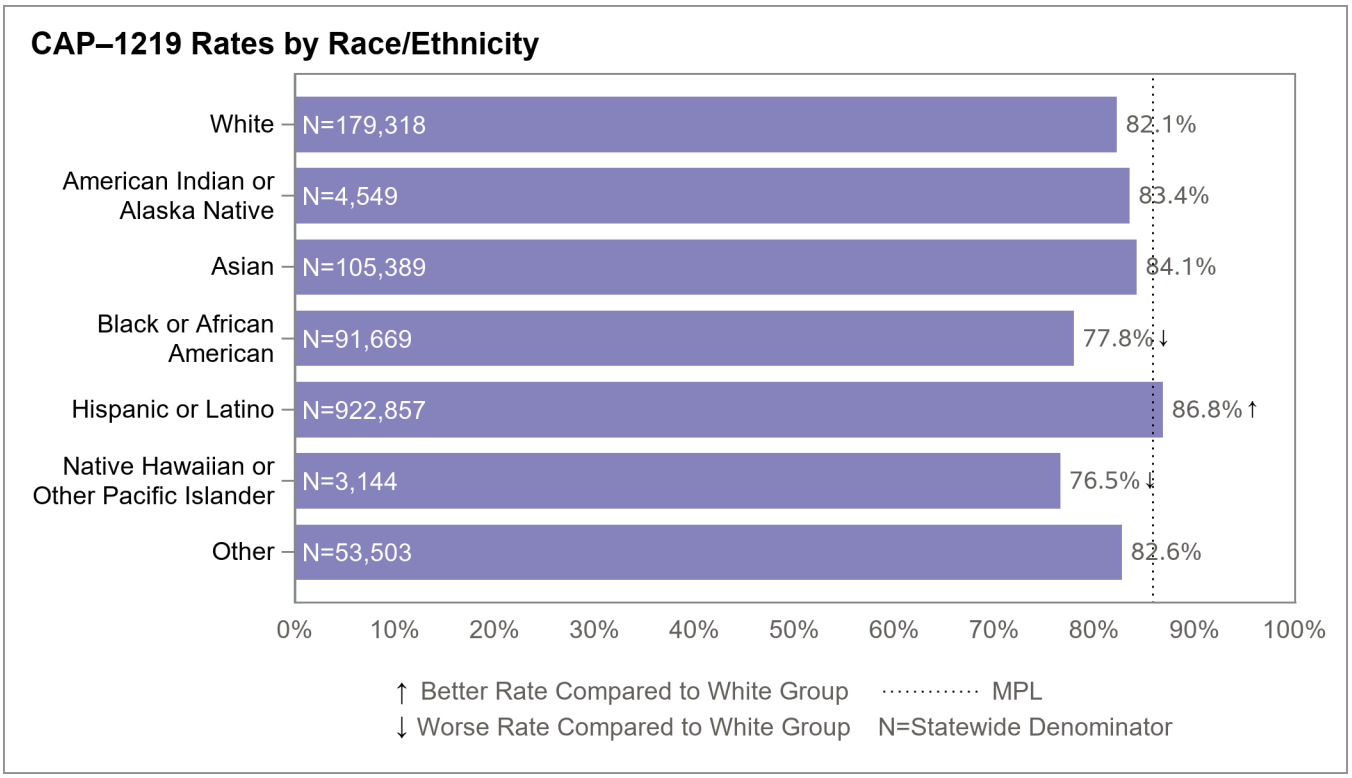
- The rates for all racial/ethnic groups ranged from 78.0 percent for the Native Hawaiian or Other Pacific Islander group to 89.3 percent for the Hispanic or Latino group.
- Four health disparities were identified for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander group was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - Other

Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years (CAP–1219)

The *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* (*CAP–1219*) indicator measures the percentage of beneficiaries 12 to 19 years of age who had a visit with a PCP. Figure 3.6 displays the statewide *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* (*CAP–1219*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.6—Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years (CAP–1219) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 80.4 percent (N=34,342).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



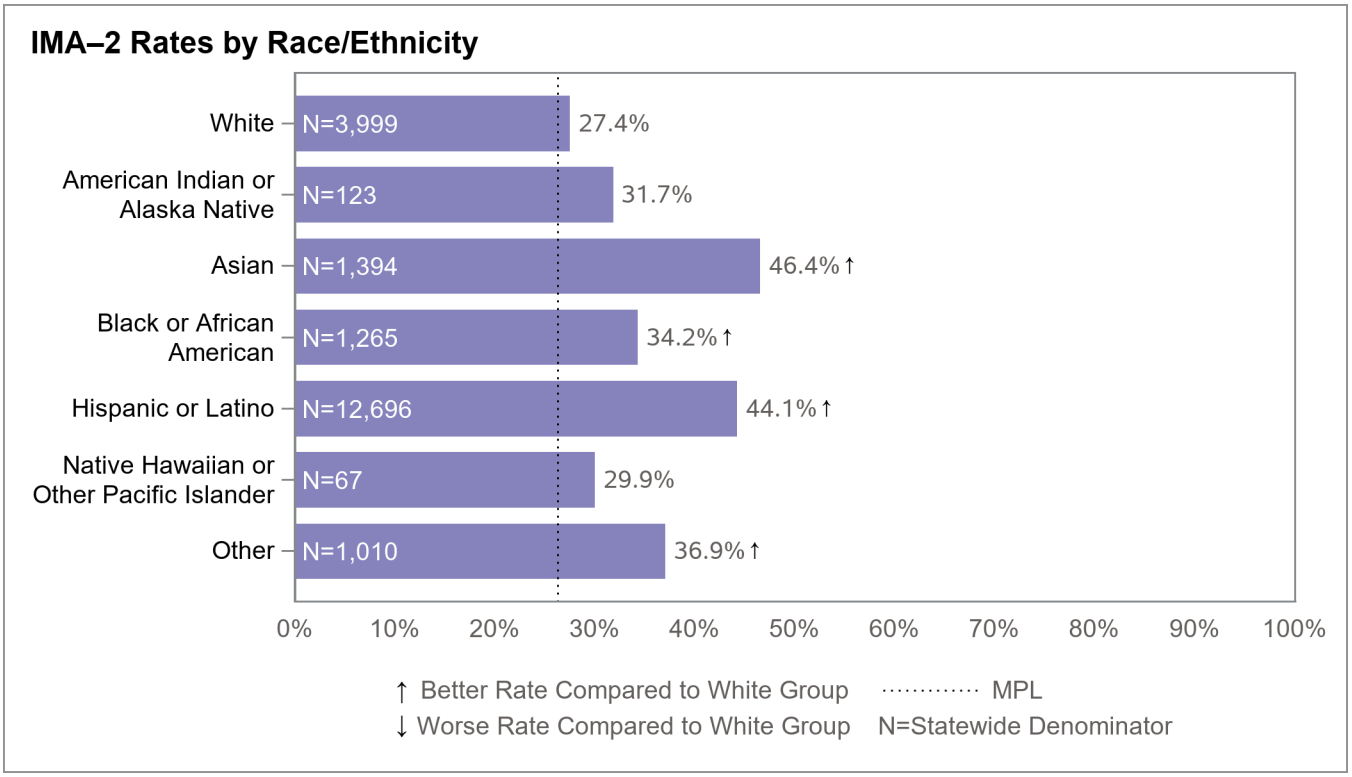
- The rates for all racial/ethnic groups ranged from 76.5 percent for the Native Hawaiian or Other Pacific Islander group to 86.8 percent for the Hispanic or Latino group.
- Three health disparities were identified for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* indicator:
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander group was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
  - Other

Immunizations for Adolescents—Combination 2 (IMA–2)

The *Immunizations for Adolescents—Combination 2* (*IMA–2*) indicator measures the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine; one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine; and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. Figure 3.7 displays the statewide *Immunizations for Adolescents—Combination 2* (*IMA–2*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.7—Immunizations for Adolescents—Combination 2 (IMA–2) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 29.7 percent (N=526).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



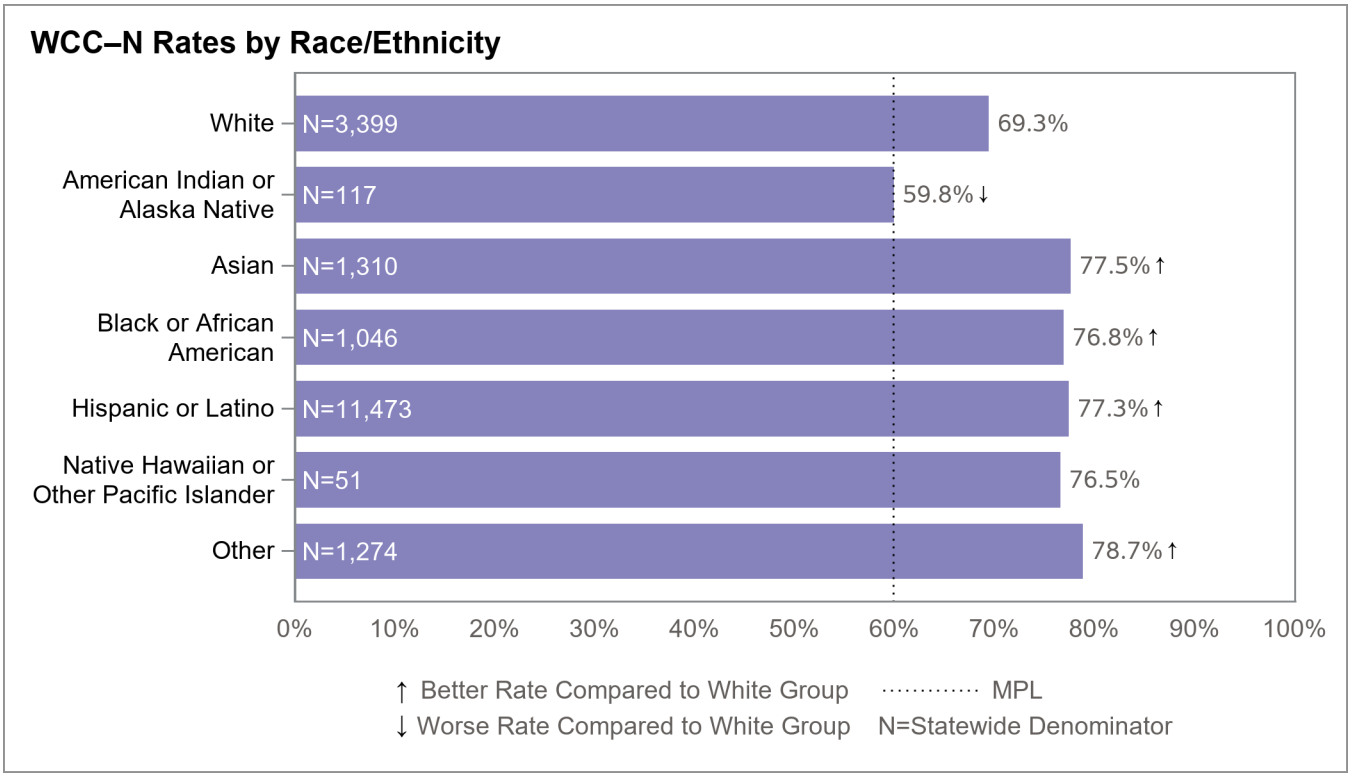
- The rates for all racial/ethnic groups ranged from 27.4 percent for the White group to 46.4 percent for the Asian group.
- Four health disparities were identified for the *Immunizations for Adolescents—Combination 2* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Black or African American group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
- The rates for all racial/ethnic groups were above the minimum performance level for this indicator.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total (WCC–N)

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total* (*WCC–N*) indicator measures the percentage of beneficiaries 3 to 17 years of age who had an outpatient visit with a PCP or obstetrician-gynecologist (OB/GYN) and who had evidence of counseling for nutrition. Figure 3.8 displays the statewide *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total* (*WCC–N*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.8—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total (WCC–N) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 74.8 percent (N=805).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



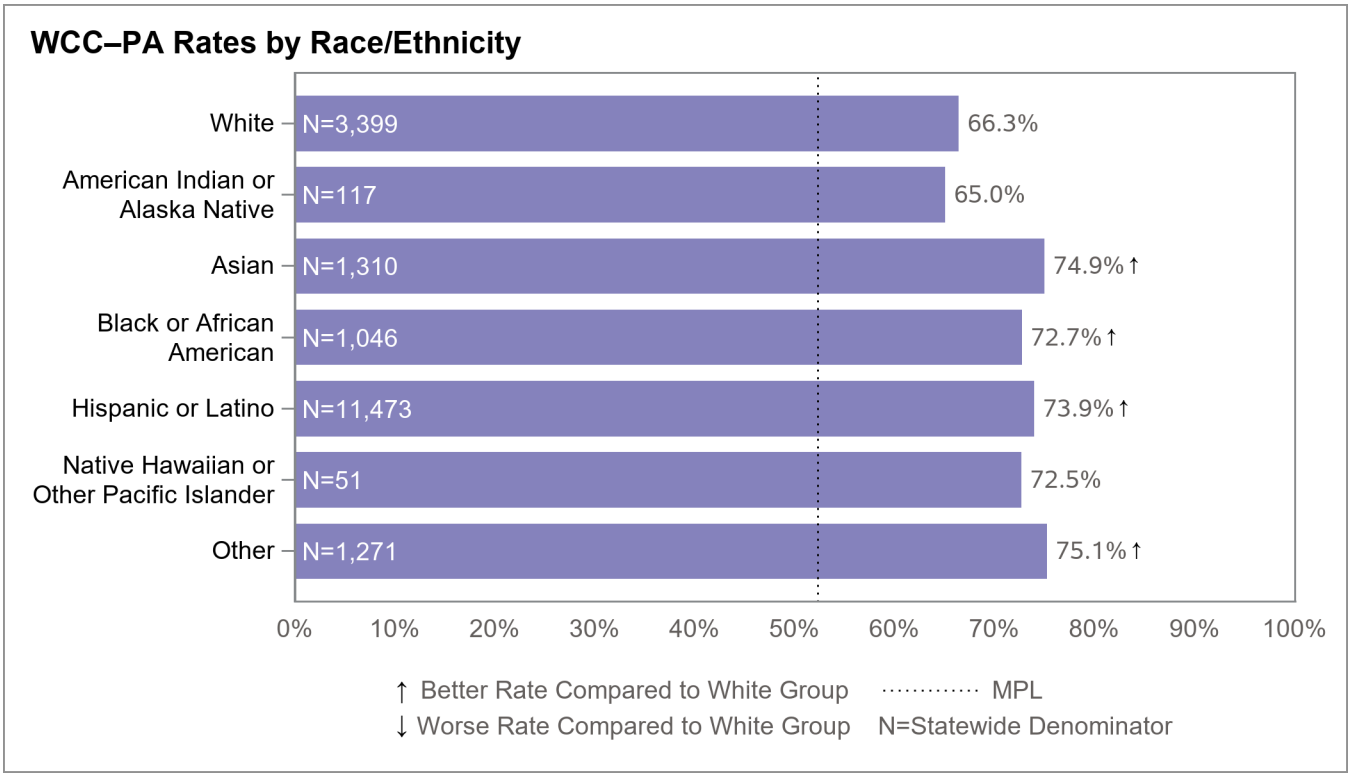
- The rates for all racial/ethnic groups ranged from 59.8 percent for the American Indian or Alaska Native group to 78.7 percent for the Other group.
- Five health disparities were identified for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Black or African American group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
- The rate for the American Indian or Alaska Native group was below the minimum performance level for this indicator.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total (WCC–PA)

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total* (*WCC–PA*) indicator measures the percentage of beneficiaries 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity. Figure 3.9 displays the statewide *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total* (*WCC–PA*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.9—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total (WCC–PA) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 68.7 percent (N=805).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



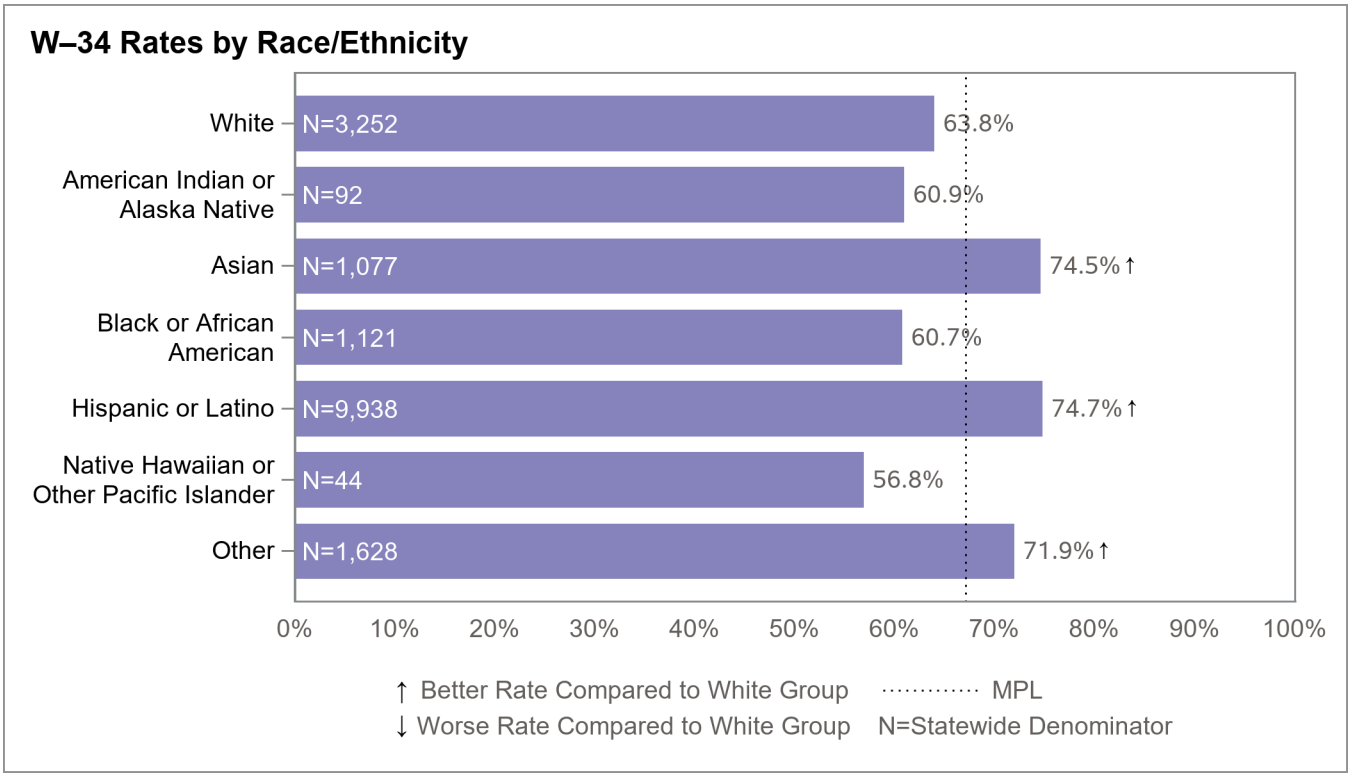
- The rates for all racial/ethnic groups ranged from 65.0 percent for the American Indian or Alaska Native group to 75.1 percent for the Other group.
- Four health disparities were identified for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Black or African American group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
- No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W–34)

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (*W–34*) indicator measures the percentage of beneficiaries 3 to 6 years of age who had one or more well-child visits with a PCP. Figure 3.10 displays the statewide *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (*W–34*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.10—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W–34) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 66.5 percent (N=1,410).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

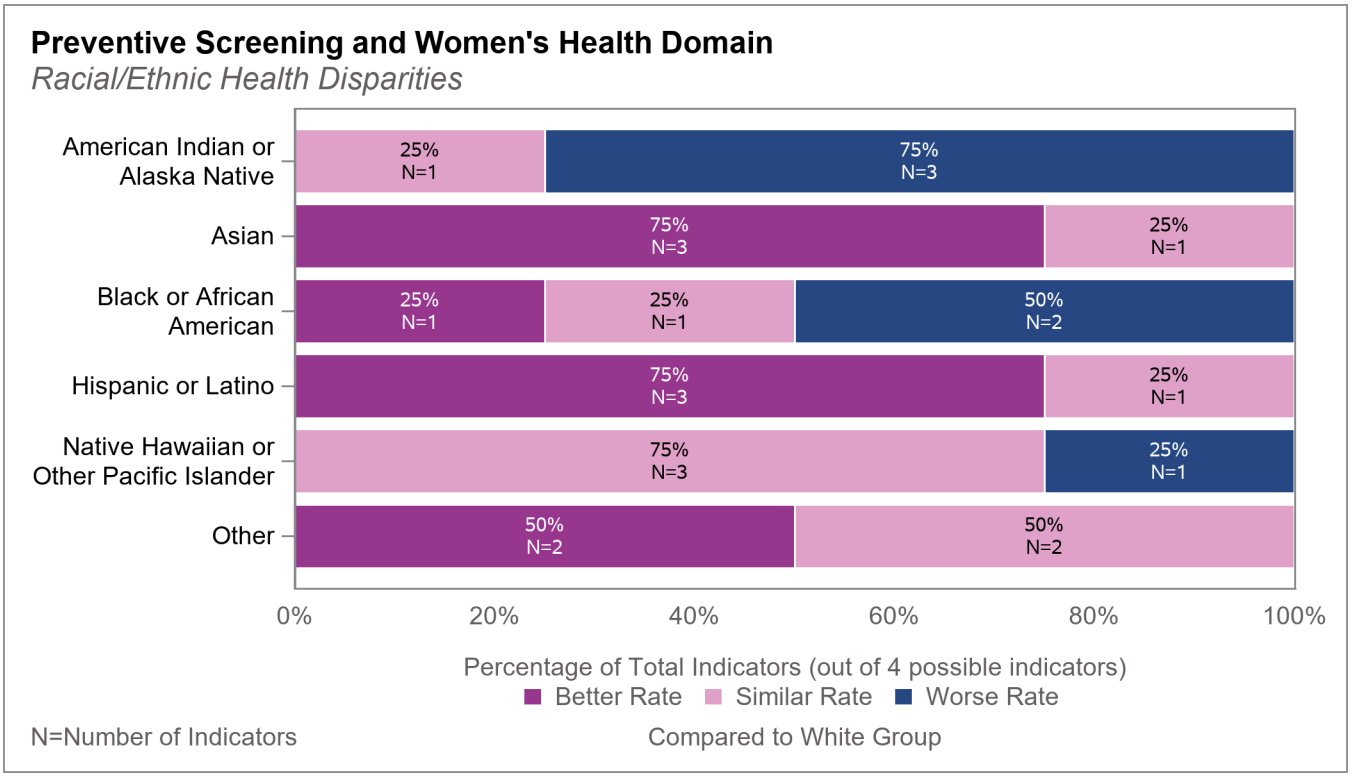


- The rates for all racial/ethnic groups ranged from 56.8 percent for the Native Hawaiian or Other Pacific Islander group to 74.7 percent for the Hispanic or Latino group.
- Three health disparities were identified for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander

Racial/Ethnic Health Disparities: Preventive Screening and Women's Health Domain

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 3.11 displays the percentage and number of Preventive Screening and Women's Health domain indicators (out of four possible indicators) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

Figure 3.11—Racial/Ethnic Health Disparities Summary: Preventive Screening and Women's Health Domain



American Indian or Alaska Native

- No rates for the American Indian or Alaska Native group were better than the rates for the White group.
- For the following indicators, the rates for the American Indian or Alaska Native group were worse than the rates for the White group:
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Asian

- For the following indicators, the rates for the Asian group were better than the rates for the White group:
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Postpartum Care*
- No rates for the Asian group were worse than the rates for the White group.

Black or African American

- For *Cervical Cancer Screening*, the rate for the Black or African American group was better than the rate for the White group.
- For the following indicators, the rates for the Black or African American group were worse than the rates for the White group:
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Hispanic or Latino

- For the following indicators, the rates for the Hispanic or Latino group were better than the rates for the White group:
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Postpartum Care*
- No rates for the Hispanic or Latino group were worse than the rates for the White group.

Native Hawaiian or Other Pacific Islander

- No rates for the Native Hawaiian or Other Pacific Islander group were better than the rates for the White group.
- For *Prenatal and Postpartum Care—Postpartum Care*, the rate for the Native Hawaiian or Other Pacific Islander group was worse than the rate for the White group.

Other

- For the following indicators, the rates for the Other group were better than the rates for the White group:
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
- No rates for the Other group were worse than the rates for the White group.

Racial/Ethnic Health Disparities: Preventive Screening and Women's Health Domain Indicator Results

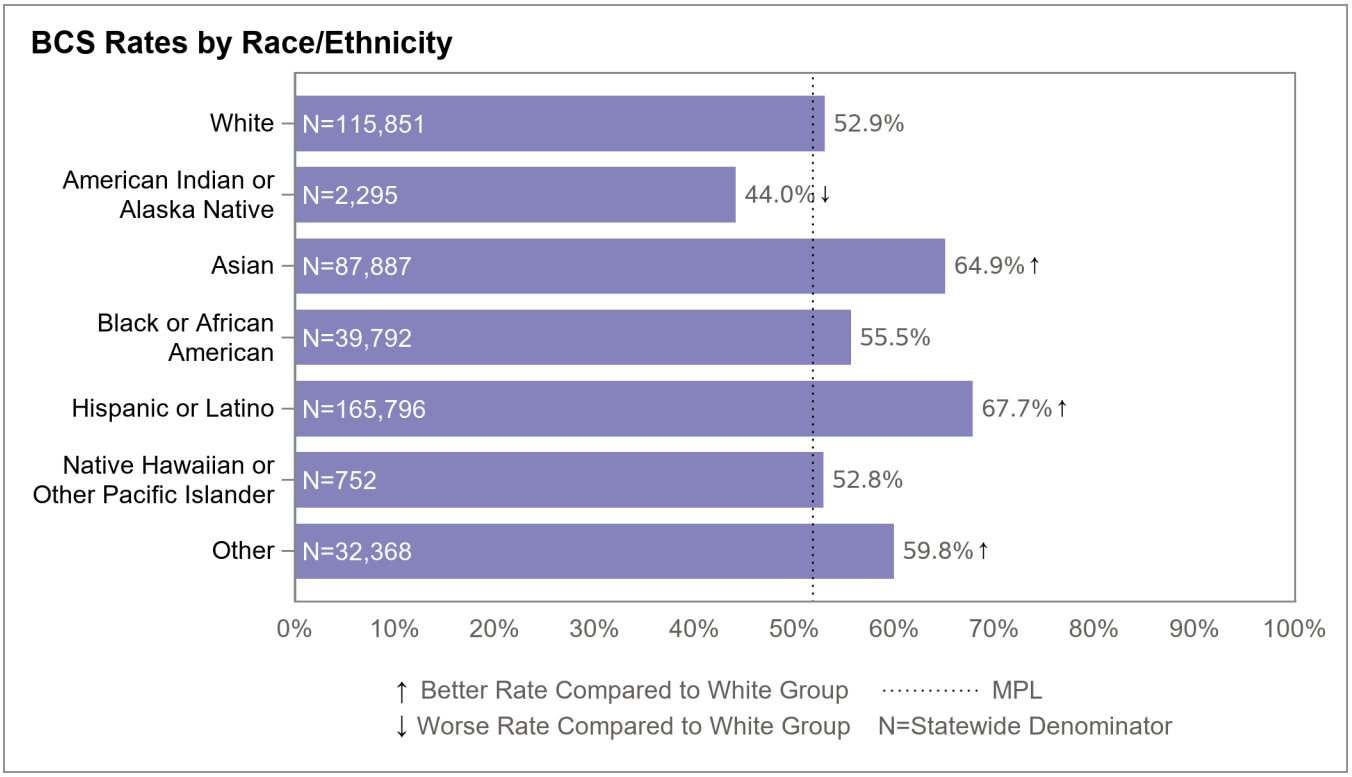
Figure 3.12 through Figure 3.15 display the racial/ethnic health disparities for each indicator included in the Preventive Screening and Women's Health domain. For each figure, the arrows highlight health disparities and indicate when the rates for the specific racial/ethnic groups were better than or worse than the rate for the White group. If the rate for the specific racial/ethnic group was similar to the rate for the White group, then no health disparity was identified, and an arrow is not present.

Breast Cancer Screening (BCS)

The *Breast Cancer Screening* (*BCS*) indicator measures the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer. Figure 3.12 displays the statewide *Breast Cancer Screening* (*BCS*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.12—Breast Cancer Screening (BCS) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 55.6 percent (N=23,399).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



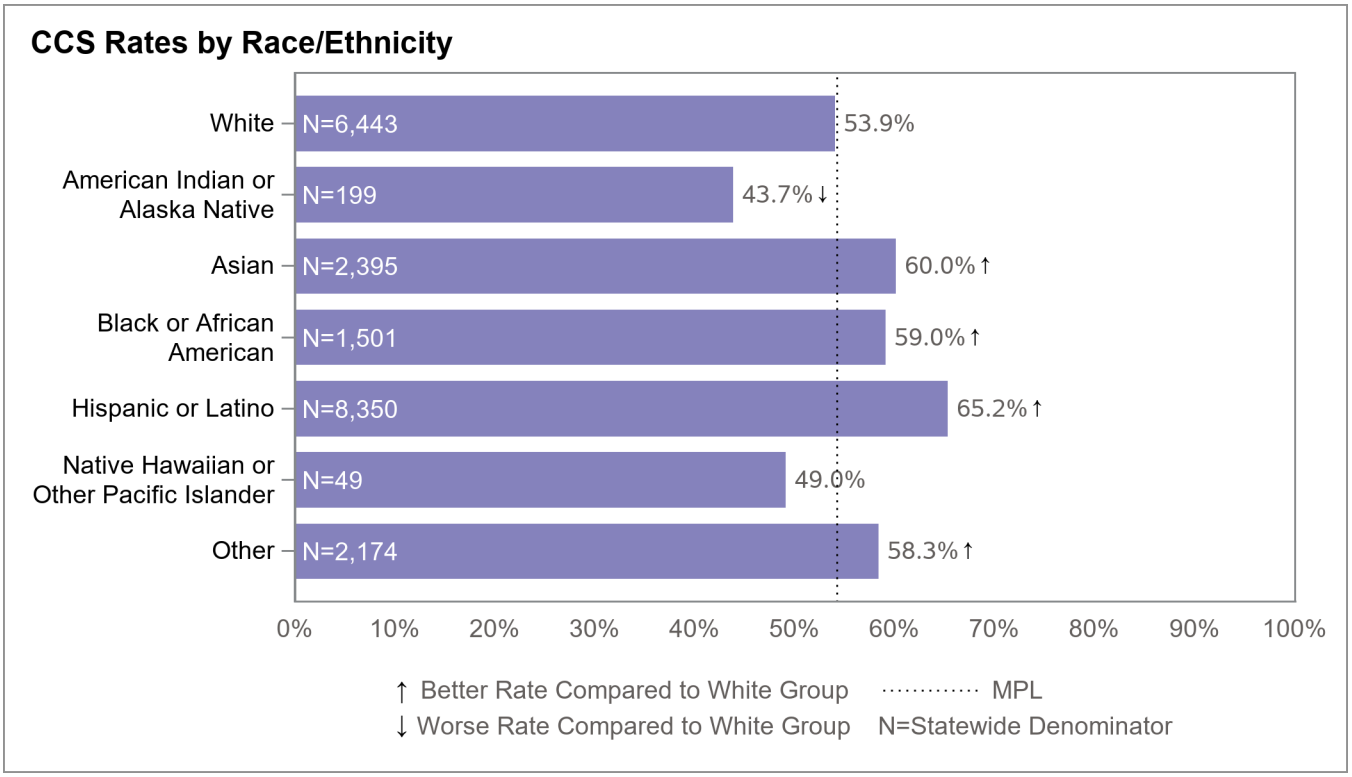
- The rates for all racial/ethnic groups ranged from 44.0 percent for the American Indian or Alaska Native group to 67.7 percent for the Hispanic or Latino group.
- Four health disparities were identified for the *Breast Cancer Screening* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
- The rate for the American Indian or Alaska Native group was below the minimum performance level for this indicator.

Cervical Cancer Screening (CCS)

The *Cervical Cancer Screening* (*CCS*) indicator measures the percentage of women 21 to 64 years of age who were screened for cervical cancer. Figure 3.13 displays the statewide *Cervical Cancer Screening* (*CCS*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.13—Cervical Cancer Screening (CCS) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 53.7 percent (N=665).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



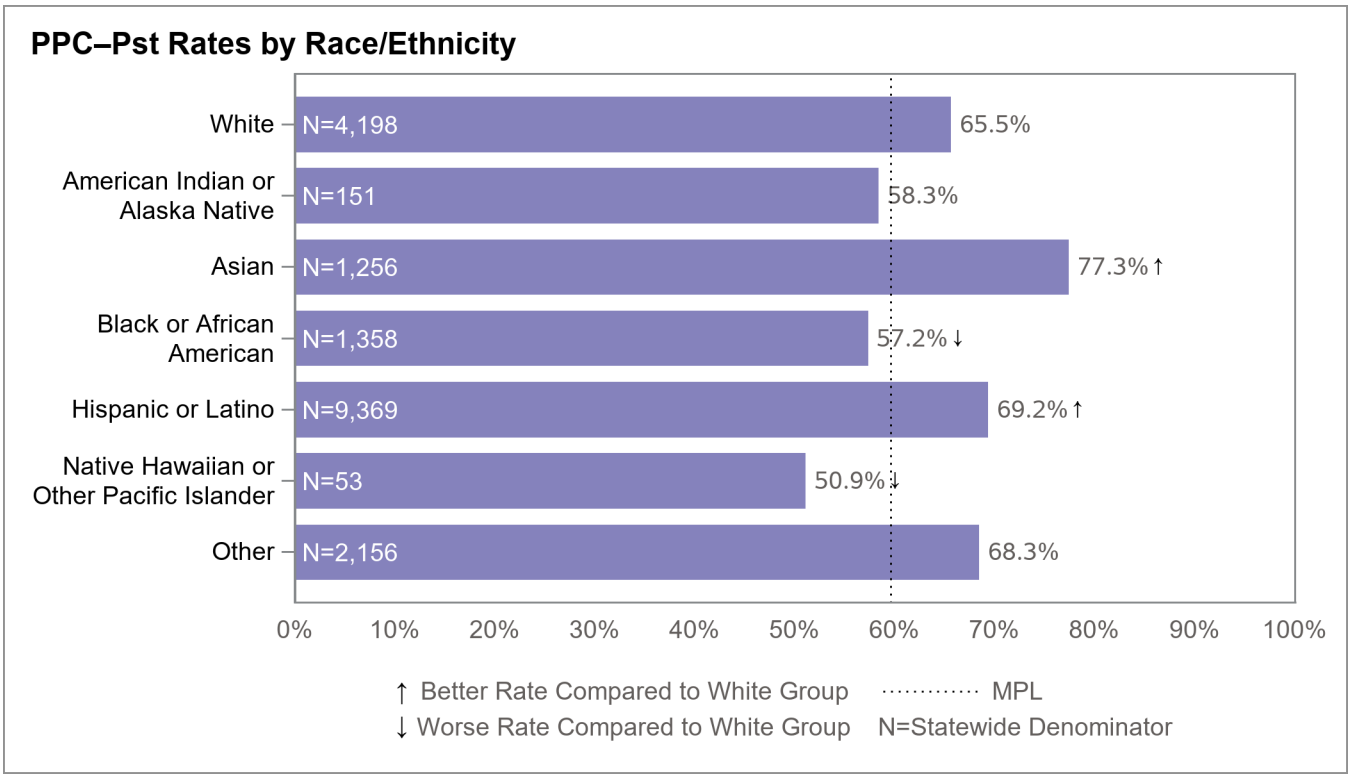
- The rates for all racial/ethnic groups ranged from 43.7 percent for the American Indian or Alaska Native group to 65.2 percent for the Hispanic or Latino group.
- Five health disparities were identified for the *Cervical Cancer Screening* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Black or African American group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White
  - American Indian or Alaska Native
  - Native Hawaiian or Other Pacific Islander

Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)

The *Prenatal and Postpartum Care—Postpartum Care* (*PPC–Pst*) indicator measures the percentage of live birth deliveries that had a postpartum visit on or between 21 and 56 days after delivery. Figure 3.14 displays the statewide *Prenatal and Postpartum Care—Postpartum Care* (*PPC–Pst*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.14—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 69.5 percent (N=407).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



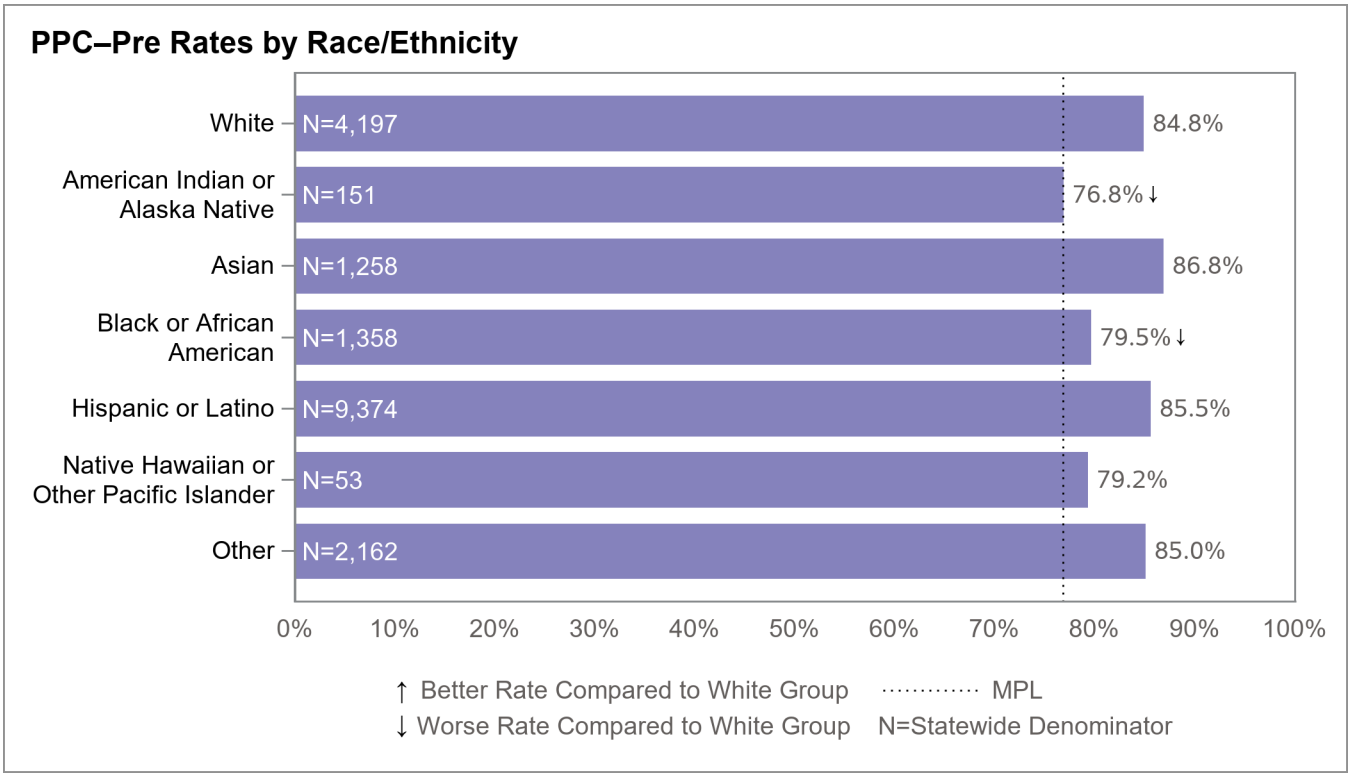
- The rates for all racial/ethnic groups ranged from 50.9 percent for the Native Hawaiian or Other Pacific Islander group to 77.3 percent for the Asian group.
- Four health disparities were identified for the *Prenatal and Postpartum Care—Postpartum Care* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander

Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)

The *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (*PPC–Pre*) indicator measures the percentage of live birth deliveries that received timely prenatal care. Figure 3.15 displays the statewide *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (*PPC–Pre*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.15—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 86.3 percent (N=409).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

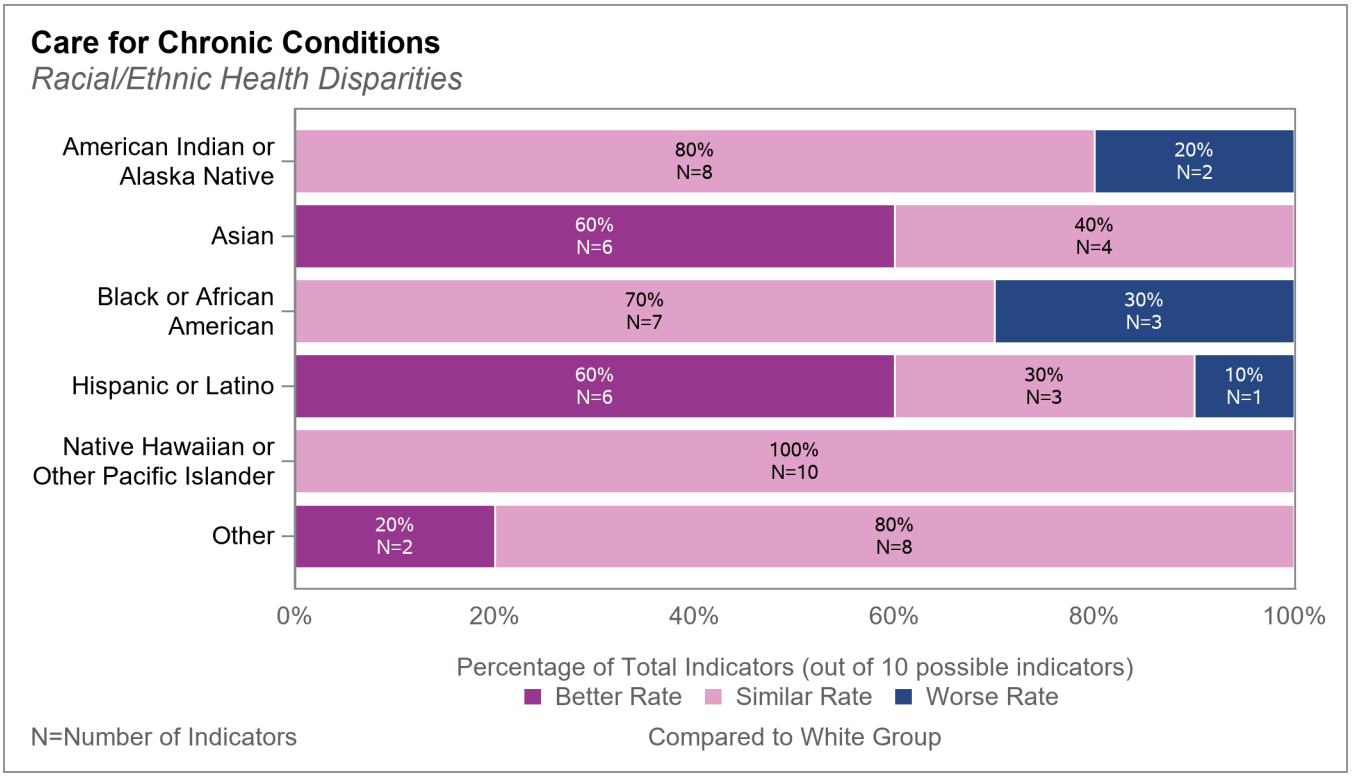


- The rates for all racial/ethnic groups ranged from 76.8 percent for the American Indian or Alaska Native group to 86.8 percent for the Asian group.
- Two health disparities were identified for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator:
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.
- The rate for the American Indian or Alaska Native group was below the minimum performance level for this indicator.

Racial/Ethnic Health Disparities: Care for Chronic Conditions Domain

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 3.16 displays the percentage and number of Care for Chronic Conditions domain indicators (out of 10 possible indicators) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

Figure 3.16—Racial/Ethnic Health Disparities Summary: Care for Chronic Conditions Domain



American Indian or Alaska Native

- No rates for the American Indian or Alaska Native group were better than the rates for the White group.
- For the following indicators, the rates for the American Indian or Alaska Native group were worse than the rates for the White group:
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
  - *Controlling High Blood Pressure*

Asian

- For the following indicators, the rates for the Asian group were better than the rates for the White group:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - *Asthma Medication Ratio*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
  - *Comprehensive Diabetes Care—HbA1c Testing*
- No rates for the Asian group were worse than the rates for the White group.

Black or African American

- No rates for the Black or African American group were better than the rates for the White group.
- For the following indicators, the rates for the Black or African American group were worse than the rates for the White group:
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
  - *Controlling High Blood Pressure*

Hispanic or Latino

- For the following indicators, the rates for the Hispanic or Latino group were better than the rates for the White group:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics*
  - *Asthma Medication Ratio*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
  - *Comprehensive Diabetes Care—HbA1c Testing*
  - *Controlling High Blood Pressure*
- For *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent),* the rate for the Hispanic or Latino group was worse than the rate for the White group.

Native Hawaiian or Other Pacific Islander

- No rates for the Native Hawaiian or Other Pacific Islander group were better than or worse than the rates for the White group.

Other

- For the following indicators, the rates for the Other group were better than the rates for the White group:
  - *Asthma Medication Ratio*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- No rates for the Other group were worse than the rates for the White group.

Racial/Ethnic Health Disparities: Care for Chronic Conditions Domain Indicator Results

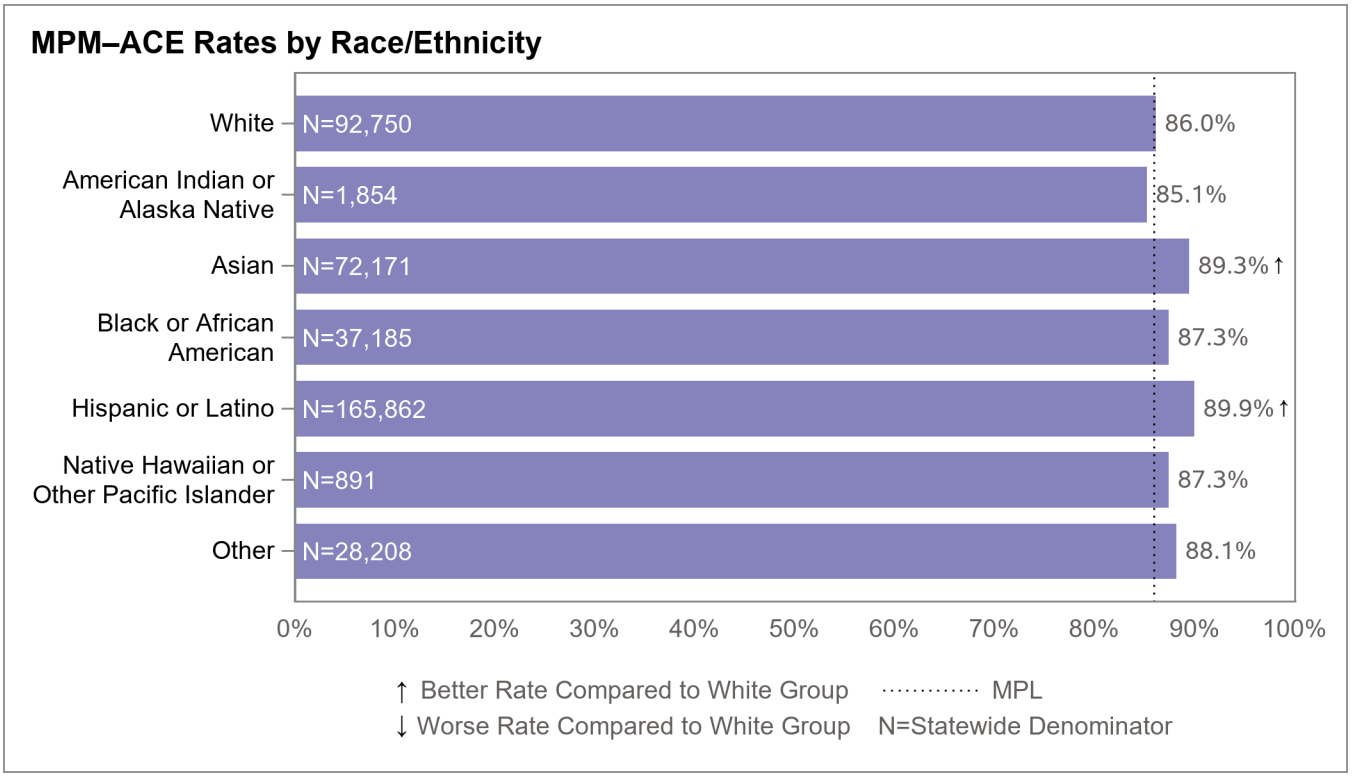
Figure 3.17 through Figure 3.26 display the racial/ethnic health disparities for each indicator included in the Care for Chronic Conditions domain. For each figure, the arrows highlight health disparities and indicate when the rates for the specific racial/ethnic groups were better than or worse than the rate for the White group. If the rate for the specific racial/ethnic group was similar to the rate for the White group, then no health disparity was identified and an arrow is not present.

Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs (MPM–ACE)

The *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* (*MPM–ACE*) indicator measures the percentage of beneficiaries 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs and at least one therapeutic monitoring event for the therapeutic agent. Figure 3.17 displays the statewide *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* (*MPM–ACE*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.17—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs (MPM–ACE) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 88.1 percent (N=19,151).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



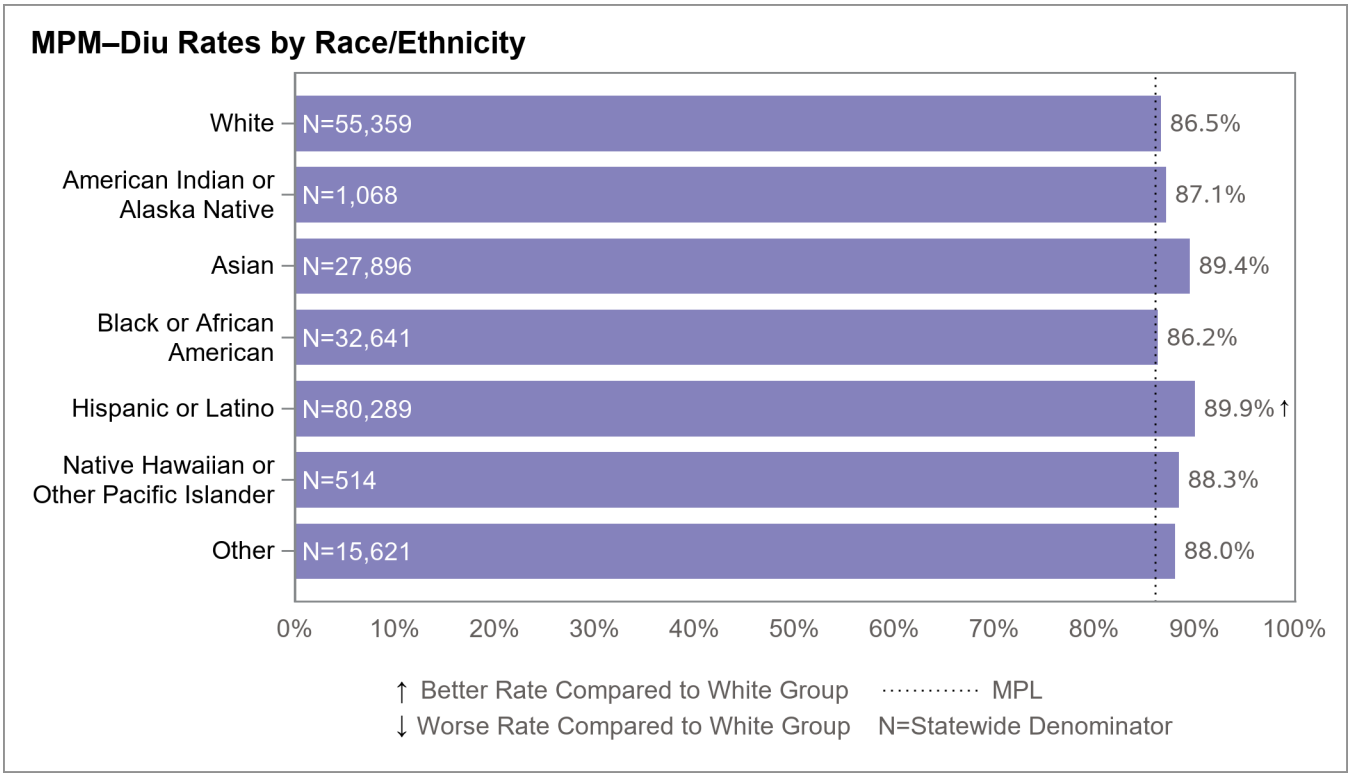
- The rates for all racial/ethnic groups ranged from 85.1 percent for the American Indian or Alaska Native group to 89.9 percent for the Hispanic or Latino group.
- Two health disparities were identified for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
- The rate for the American Indian or Alaska Native group was below the minimum performance level for this indicator.

Annual Monitoring for Patients on Persistent Medications—Diuretics (MPM–Diu)

The *Annual Monitoring for Patients on Persistent Medications—Diuretics* (*MPM–Diu*) indicator measures the percentage of beneficiaries 18 years of age and older who received at least 180 treatment days of diuretics and at least one serum potassium and serum creatinine therapeutic monitoring test. Figure 3.18 displays the statewide *Annual Monitoring for Patients on Persistent Medications—Diuretics* (*MPM–Diu*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.18—Annual Monitoring for Patients on Persistent Medications—Diuretics (MPM–Diu) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 88.0 percent (N=10,588).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



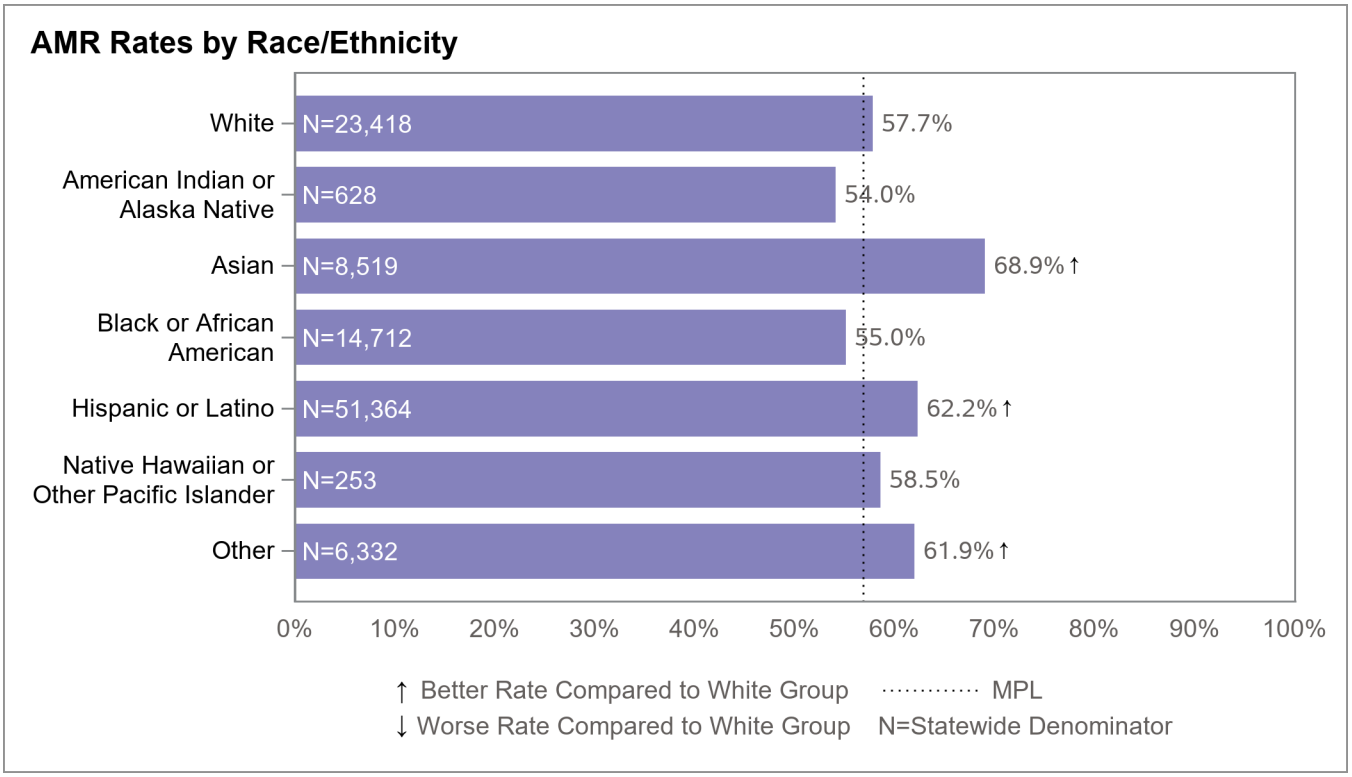
- The rates for all racial/ethnic groups ranged from 86.2 percent for the Black or African American group to 89.9 percent for the Hispanic or Latino group.
- One health disparity was identified for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* indicator as the rate for the Hispanic or Latino group was better than the rate for the White group.
- No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Asthma Medication Ratio (AMR)

The *Asthma Medication Ratio* (*AMR*) indicator measures the percentage of beneficiaries 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater. Figure 3.19 displays the statewide *Asthma Medication Ratio* (*AMR*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.19—Asthma Medication Ratio (AMR) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 62.6 percent (N=4,493).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



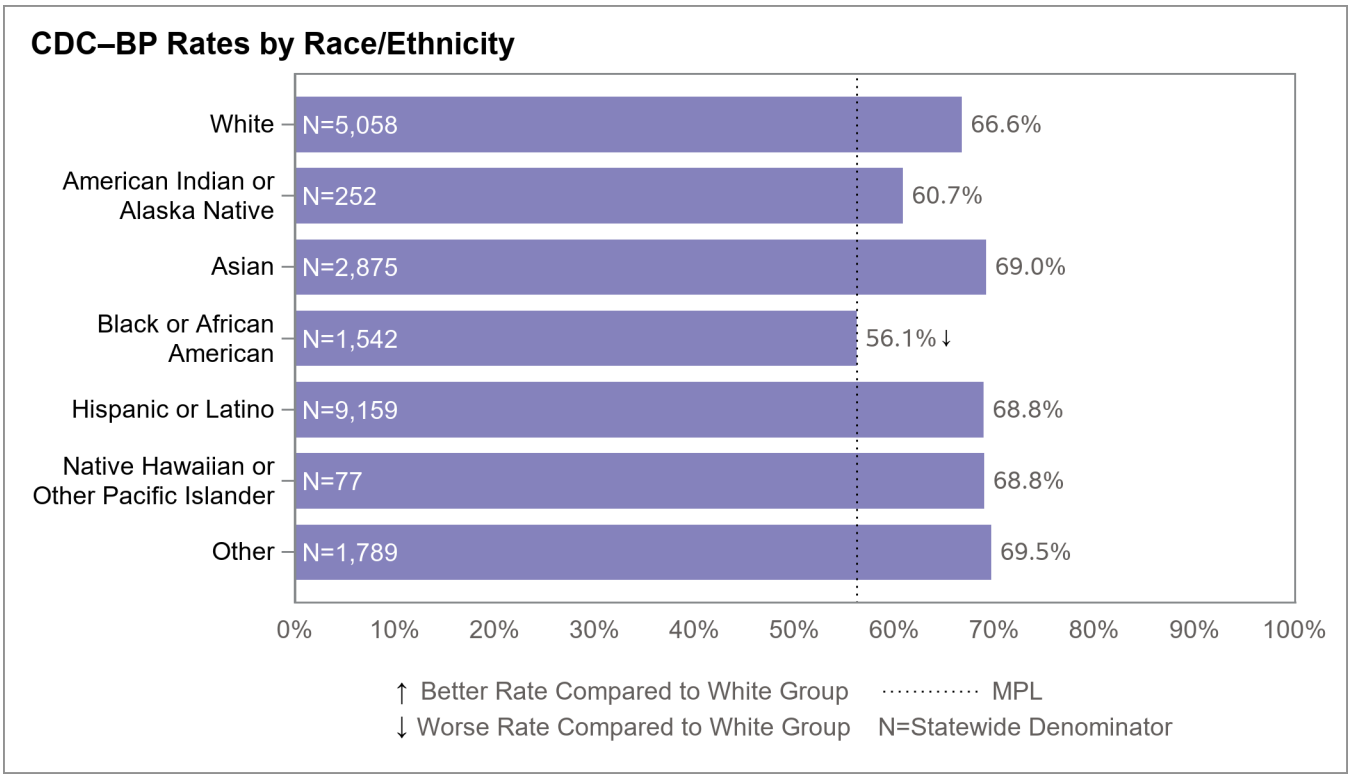
- The rates for all racial/ethnic groups ranged from 54.0 percent for the American Indian or Alaska Native group to 68.9 percent for the Asian group.
- Three health disparities were identified for the *Asthma Medication Ratio* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - American Indian or Alaska Native
  - Black or African American

Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) (CDC–BP)

The *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* (*CDC–BP*) indicator measures the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who had controlled blood pressure (<140/90 mm Hg). Figure 3.20 displays the statewide *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* (*CDC–BP*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.20—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) (CDC–BP) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 66.8 percent (N=892).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



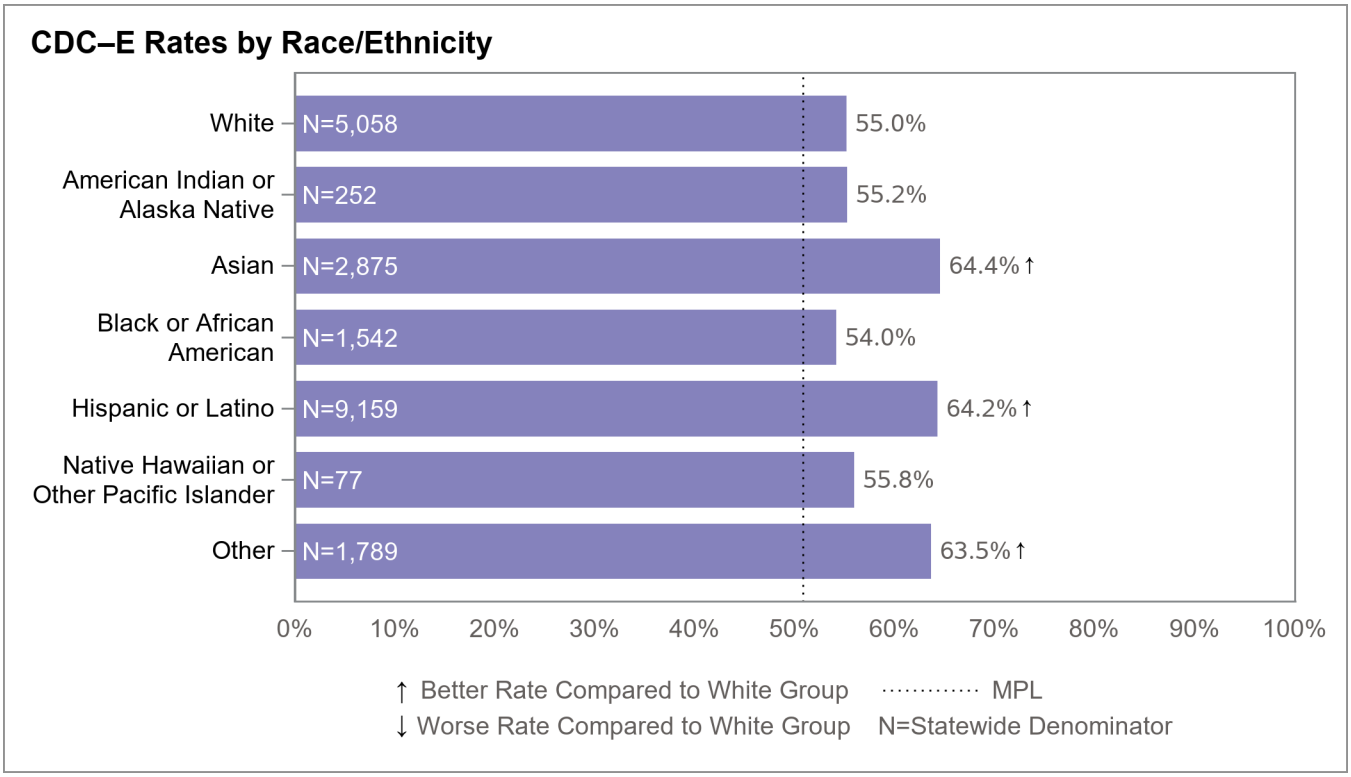
- The rates for all racial/ethnic groups ranged from 56.1 percent for the Black or African American group to 69.5 percent for the Other group.
- One health disparity was identified for the *Comprehensive Diabetes Care—Blood Pressure Control* indicator as the rate for the Black or African American group was worse than the rate for the White group.
- The rate for the Black or African American group was below the minimum performance level for this indicator.

Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E)

The *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* (*CDC–E*) indicator measures the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who had screening or monitoring for diabetic retinal disease. Figure 3.21 displays the statewide *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* (*CDC–E*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.21—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 59.0 percent (N=892).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



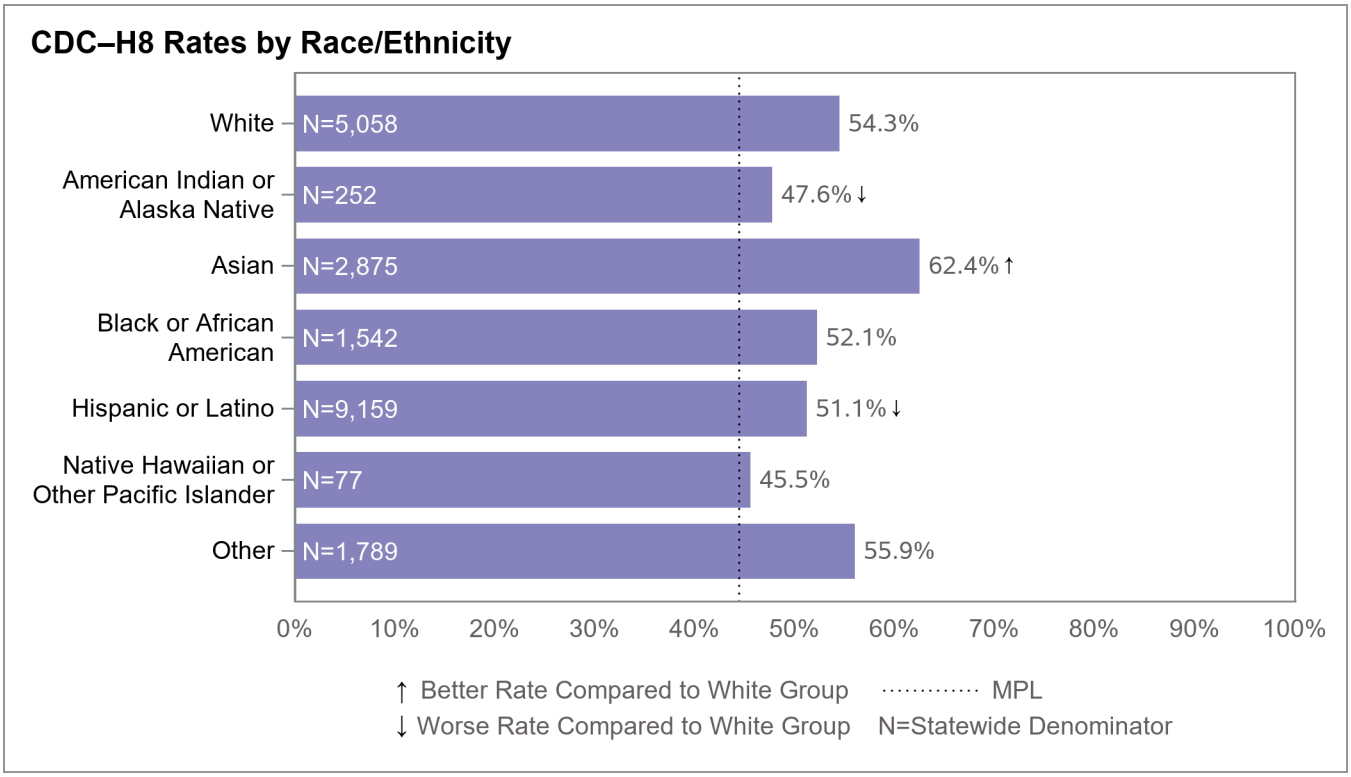
- The rates for all racial/ethnic groups ranged from 54.0 percent for the Black or African American group to 64.4 percent for the Asian group.
- Three health disparities were identified for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
- No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) (CDC–H8)

The *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* (*CDC–H8*) indicator measures the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who had adequately controlled HbA1c levels (<8.0 percent). Figure 3.22 displays the statewide *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* (*CDC–H8*) rates and denominator for each racial/ethnic group.

Figure 3.22—Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) (CDC–H8) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 54.1 percent (N=892).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



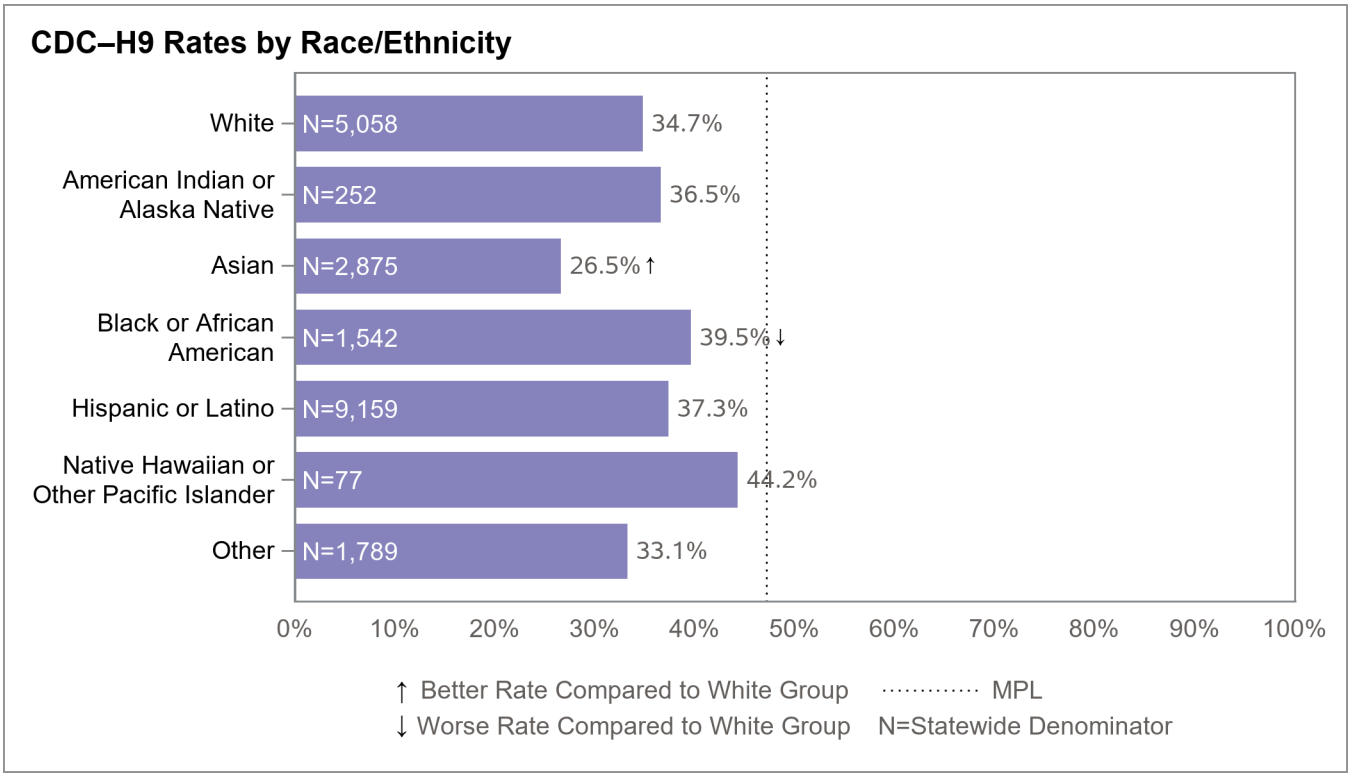
- The rates for all racial/ethnic groups ranged from 45.5 percent for the Native Hawaiian or Other Pacific Islander group to 62.4 percent for the Asian group.
- Three health disparities were identified for the *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
  - The rate for the Hispanic or Latino group was worse than the rate for the White group.
- No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9)

The *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* (*CDC–H9*) indicator measures the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who had poorly controlled HbA1c levels (>9.0 percent). Figure 3.23 displays the statewide *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* (*CDC–H9*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.23—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 34.9 percent (N=892).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.
A lower rate indicates more favorable performance for this indicator.



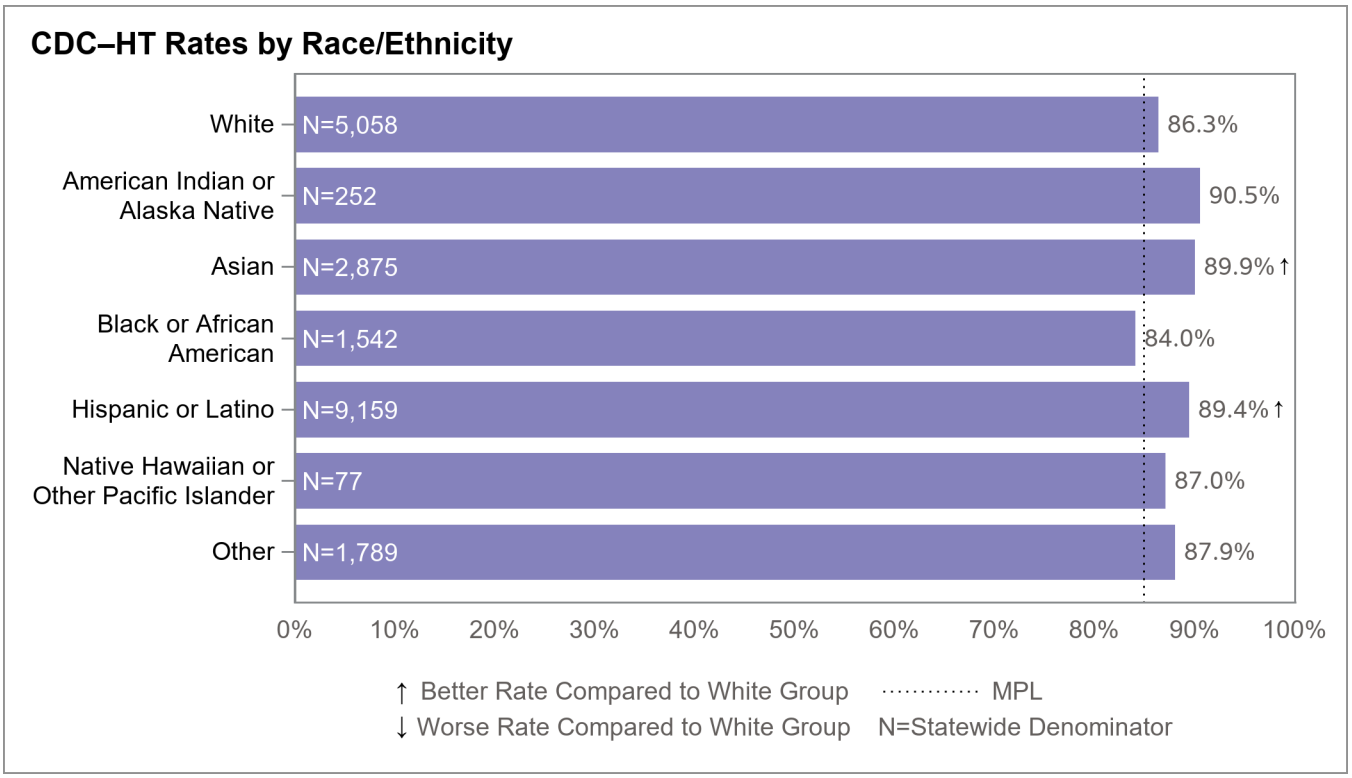
- The rates for all racial/ethnic groups ranged from 44.2 percent for the Native Hawaiian or Other Pacific Islander group to 26.5 percent for the Asian group.
- Two health disparities were identified for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.
- All rates for the racial/ethnic groups were below the minimum performance level for this indicator, indicating more favorable performance.

Comprehensive Diabetes Care—HbA1c Testing (CDC–HT)

The *Comprehensive Diabetes Care—HbA1c Testing* (*CDC–HT*) indicator measures the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who had an HbA1c test performed. Figure 3.24 displays the statewide *Comprehensive Diabetes Care—HbA1c Testing* (*CDC–HT*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.24—Comprehensive Diabetes Care—HbA1c Testing (CDC–HT) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 87.8 percent (N=892).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



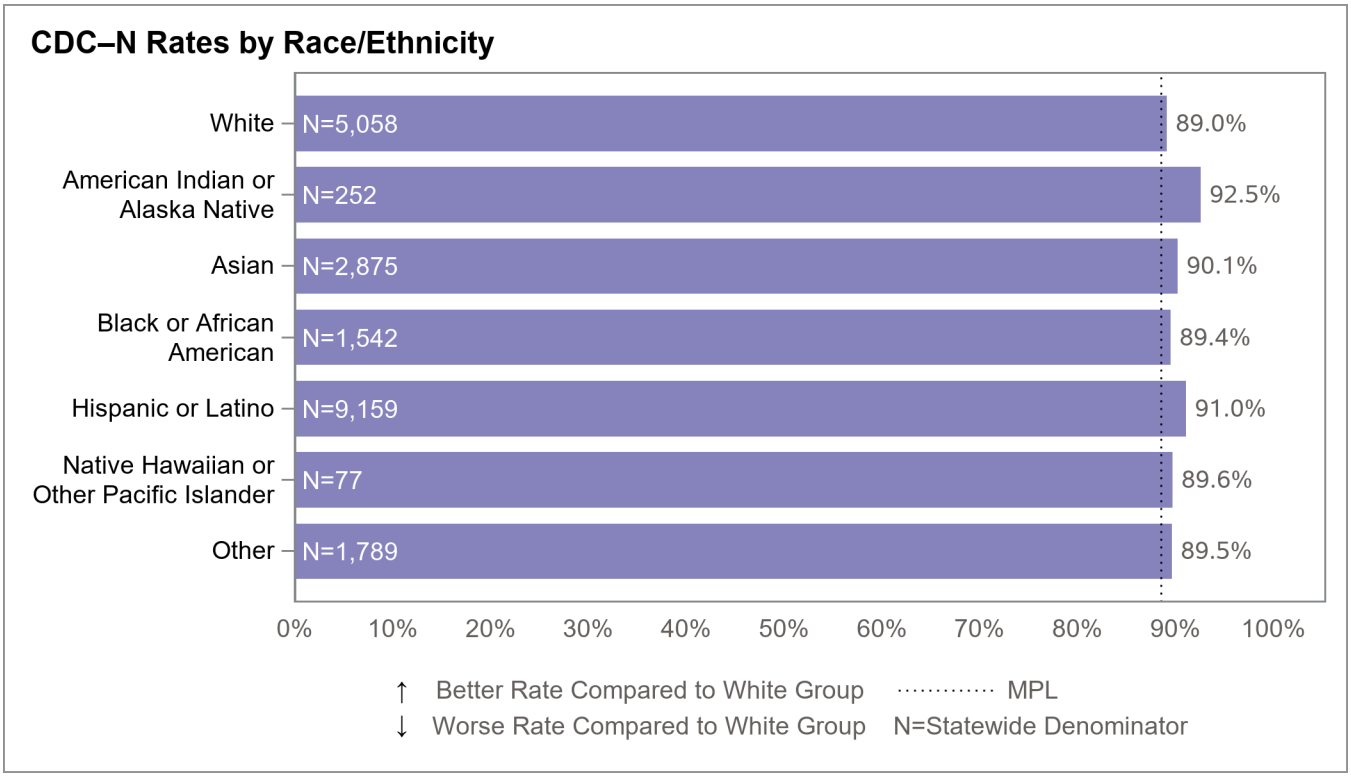
- The rates for all racial/ethnic groups ranged from 84.0 percent for the Black or African American group to 90.5 percent for the American Indian or Alaska Native group.
- Two health disparities were identified for the *Comprehensive Diabetes Care—HbA1c Testing* (*CDC–HT*) indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
- The rate for the Black or African American group was below the minimum performance level for this indicator.

Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N)

The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* (*CDC–N*) indicator measures the percentage of beneficiaries 18 to 75 years of age with diabetes (type 1 and type 2) who received nephropathy screening or monitoring or who had evidence of nephropathy. Figure 3.25 displays the statewide *Comprehensive Diabetes Care—Medical Attention for Nephropathy* (*CDC–N*) rates and denominator for each racial/ethnic group.

Figure 3.25—Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 89.6 percent (N=892).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



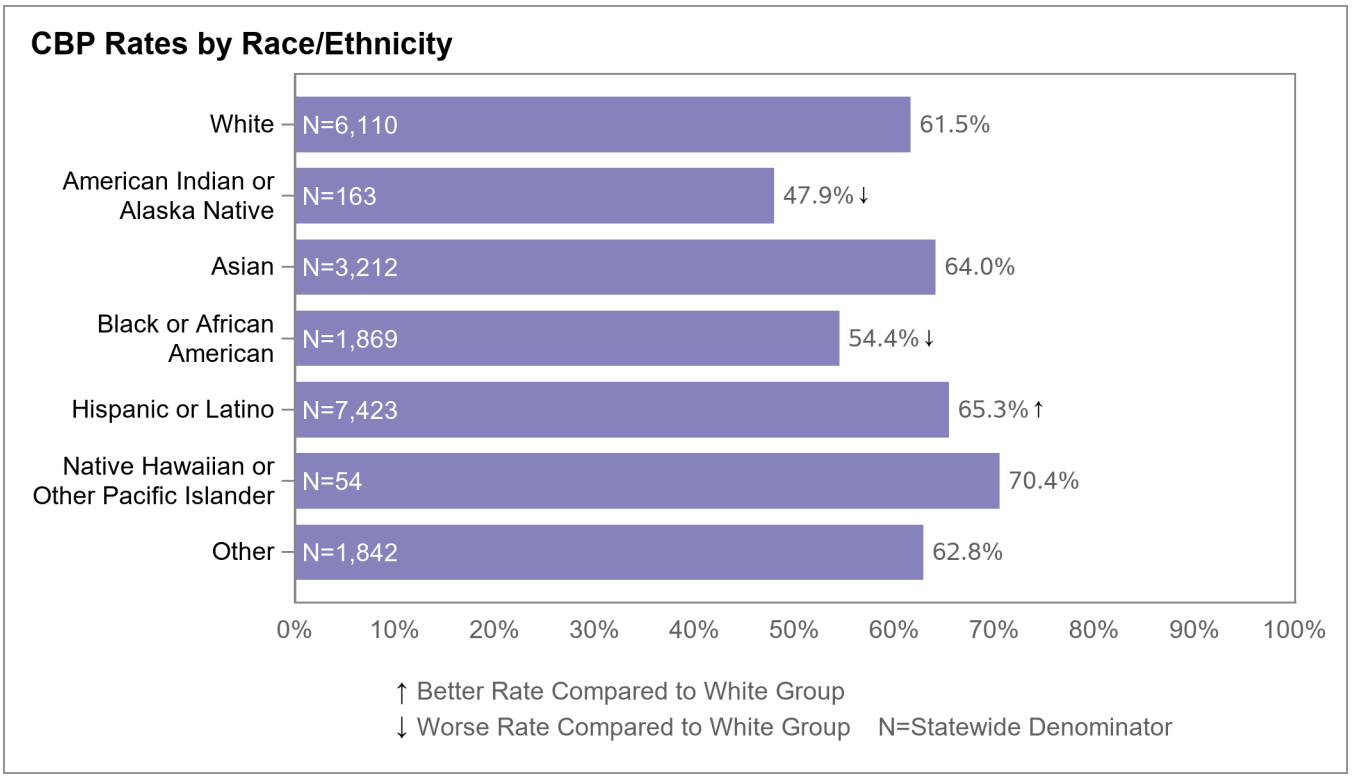
- The rates for all racial/ethnic groups ranged from 89.0 percent for the White group to 92.5 percent for the American Indian or Alaska Native group.
- No health disparities were identified for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* indicator.
- No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Controlling High Blood Pressure (CBP)

The *Controlling High Blood Pressure* (*CBP*) indicator measures the percentage of beneficiaries 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg). Figure 3.26 displays the statewide *Controlling High Blood Pressure* (*CBP*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.26—Controlling High Blood Pressure (CBP) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 62.5 percent (N=1,035).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.
Due to changes in the technical specifications for the *Controlling High Blood Pressure* indicator, NCQA recommended a break in trending between reporting year 2019 and prior years; therefore, the minimum performance level is not displayed.

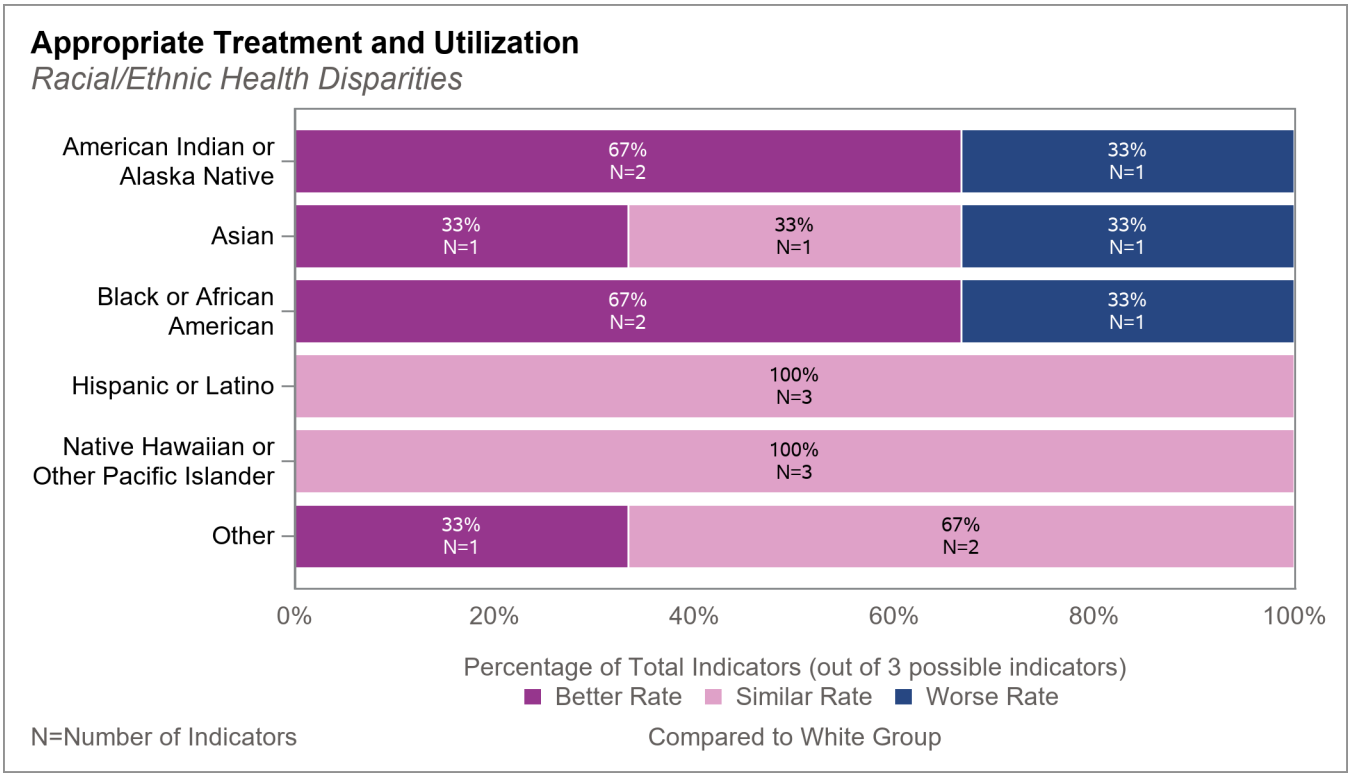


- The rates for all racial/ethnic groups ranged from 47.9 percent for the American Indian or Alaska Native group to 70.4 percent for the Native Hawaiian or Other Pacific Islander group.
- Three health disparities were identified for the *Controlling High Blood Pressure* indicator:
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.

Racial/Ethnic Health Disparities: Appropriate Treatment and Utilization Domain

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 3.27 displays the percentage and number of Appropriate Treatment and Utilization domain indicators (out of three possible indicators) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group. Due to limitations with the data, statistical analyses to identify health disparities were not performed for the *Ambulatory Care* indicators; therefore, these indicators are not included in this section. To see the *Ambulatory Care* statewide rates stratified by race/ethnicity, see Appendix A. Demographic Stratification Results.

Figure 3.27—Racial/Ethnic Health Disparities Summary: Appropriate Treatment and Utilization Domain



American Indian or Alaska Native

- For the following indicators, the rates for the American Indian or Alaska Native group were better than the rates for the White group:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Use of Imaging Studies for Low Back Pain*
- For *Plan All-Cause Readmissions,* the rate for the American Indian or Alaska Native group was worse than the rate for the White group.

Asian

- For *Plan All-Cause Readmissions*, the rate for the Asian group was better than the rate for the White group.
- For *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, the rate for the Asian group was worse than the rate for the White group.

Black or African American

- For the following indicators, the rates for the Black or African American group were better than the rates for the White group:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Use of Imaging Studies for Low Back Pain*
- For *Plan All-Cause Readmissions,* the rate for the Black or African American group was worse than the rate for the White group.

Hispanic or Latino

- No rates for the Hispanic or Latino group were better than or worse than the rates for the White group.

Native Hawaiian or Other Pacific Islander

- No rates for the Native Hawaiian or Other Pacific Islander group were better than or worse than the rates for the White group.

Other

- For *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, the rate for the Other group was better than the rate for the White group.
- No rates for the Other group were worse than the rates for the White group.

Racial/Ethnic Health Disparities: Appropriate Treatment and Utilization Domain Indicator Results

Figure 3.28 through Figure 3.30 display the racial/ethnic health disparities for each indicator included in the Appropriate Treatment and Utilization domain, except for the *Ambulatory Care* indicators. To see the *Ambulatory Care* statewide rates stratified by race/ethnicity group, see Appendix A. Demographic Stratification Results. For each figure, the arrows highlight health disparities and indicate when the rates for the specific racial/ethnic groups were better than or worse than the rate for the White group. If the rate for the specific racial/ethnic group was similar to the rate for the White group, then no health disparity was identified and an arrow is not present.

Plan All-Cause Readmissions (PCR)

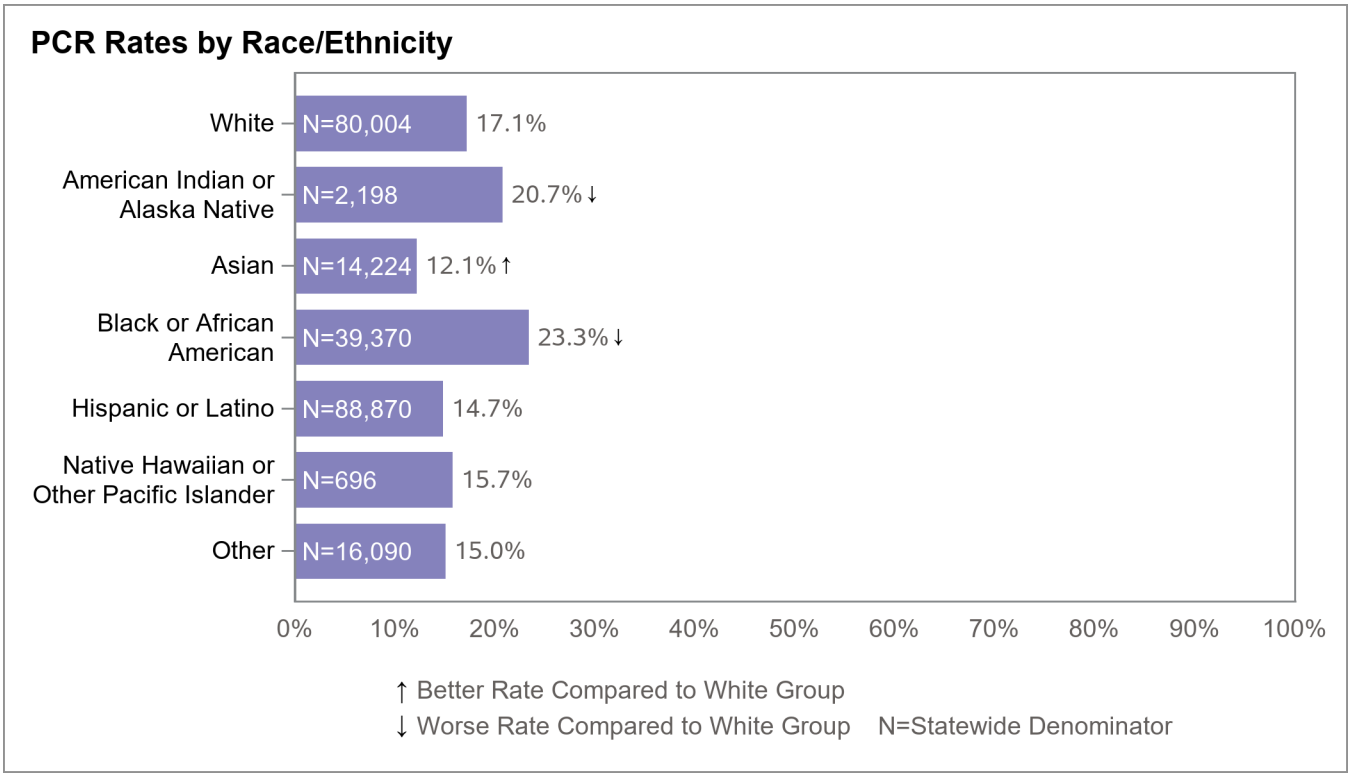
The *Plan All-Cause Readmissions (PCR*) indicator measures the percentage of acute inpatient hospital stays for beneficiaries 18 to 64 years of age and older that were followed by an unplanned acute inpatient readmission for any diagnosis within 30 days of the initial admission. Figure 3.28 displays the statewide *Plan All-Cause Readmissions* (*PCR*) rates and denominator for each racial/ethnic group in addition to identified health disparities. A lower rate indicates more favorable performance for this indicator.

Figure 3.28—Plan All-Cause Readmissions (PCR) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 19.7 percent (N= 11,413).

The *Plan All-Cause Readmissions* indicator does not have an established minimum performance level.

A lower rate indicates more favorable performance for this indicator.



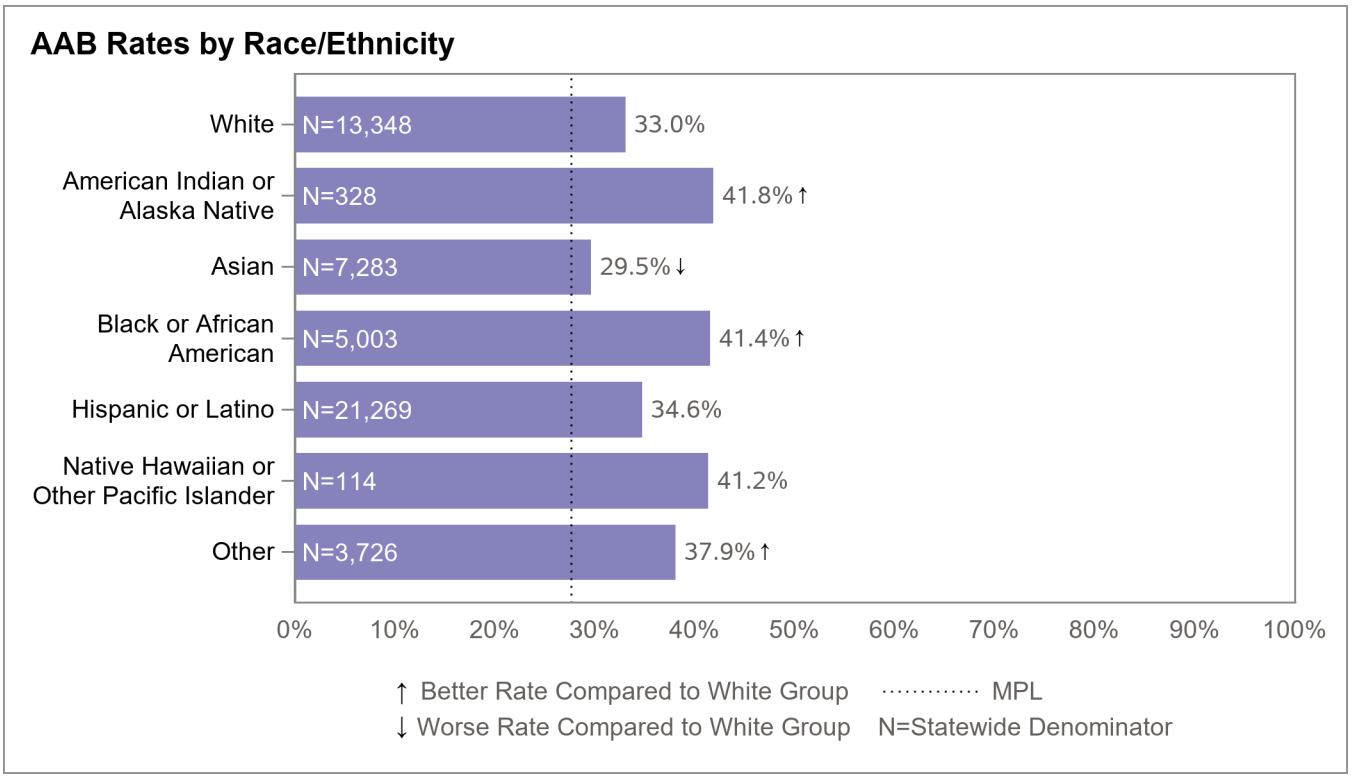
- The rates for all racial/ethnic groups ranged from 23.3 percent for the Black or African American group to 12.1 percent for the Asian group.
- Three health disparities were identified for the *Plan All-Cause Readmissions* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.

Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

The *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* (*AAB*) indicator measures the percentage of adults 18 to 64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or three days after the diagnosis. Figure 3.29 displays the statewide *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* (*AAB*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.29—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 33.6 percent (N=1,907).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



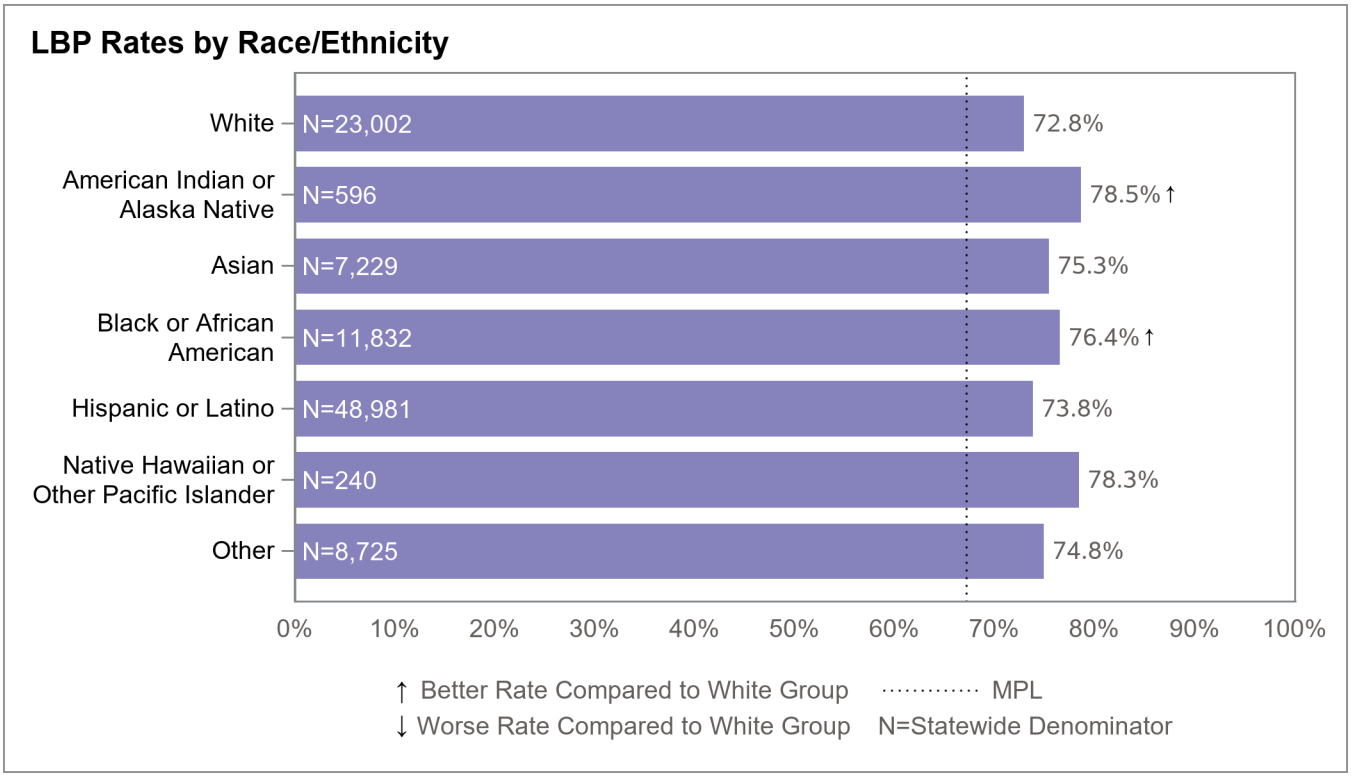
- The rates for all racial/ethnic groups ranged from 29.5 percent for the Asian group to 41.8 percent for the American Indian or Alaska Native group.
- Four health disparities were identified for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* indicator:
  - The rate for the American Indian or Alaska Native group was better than the rate for the White group.
  - The rate for the Black or African American group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
  - The rate for the Asian group was worse than the rate for the White group.
- No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Use of Imaging Studies for Low Back Pain (LBP)

The *Use of Imaging Studies for Low Back Pain* (*LBP*) indicator measures the percentage of beneficiaries with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, magnetic resonance imaging [MRI], or computerized tomography [CT] scan) within 28 days of the diagnosis. Figure 3.30 displays the statewide *Use of Imaging Studies for Low Back Pain* (*LBP*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.30—Use of Imaging Studies for Low Back Pain (LBP) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 73.5 percent (N=3,071).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



- The rates for all racial/ethnic groups ranged from 72.8 percent for the White group to 78.5 percent for the American Indian or Alaska Native group.
- Two health disparities were identified for the *Use of Imaging Studies for Low Back Pain* indicator:
  - The rate for the American Indian or Alaska Native group was better than the rate for the White group.
  - The rate for the Black or African American group was better than the rate for the White group.
- No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

4. Reporting Year 2017–2019 Trending Results

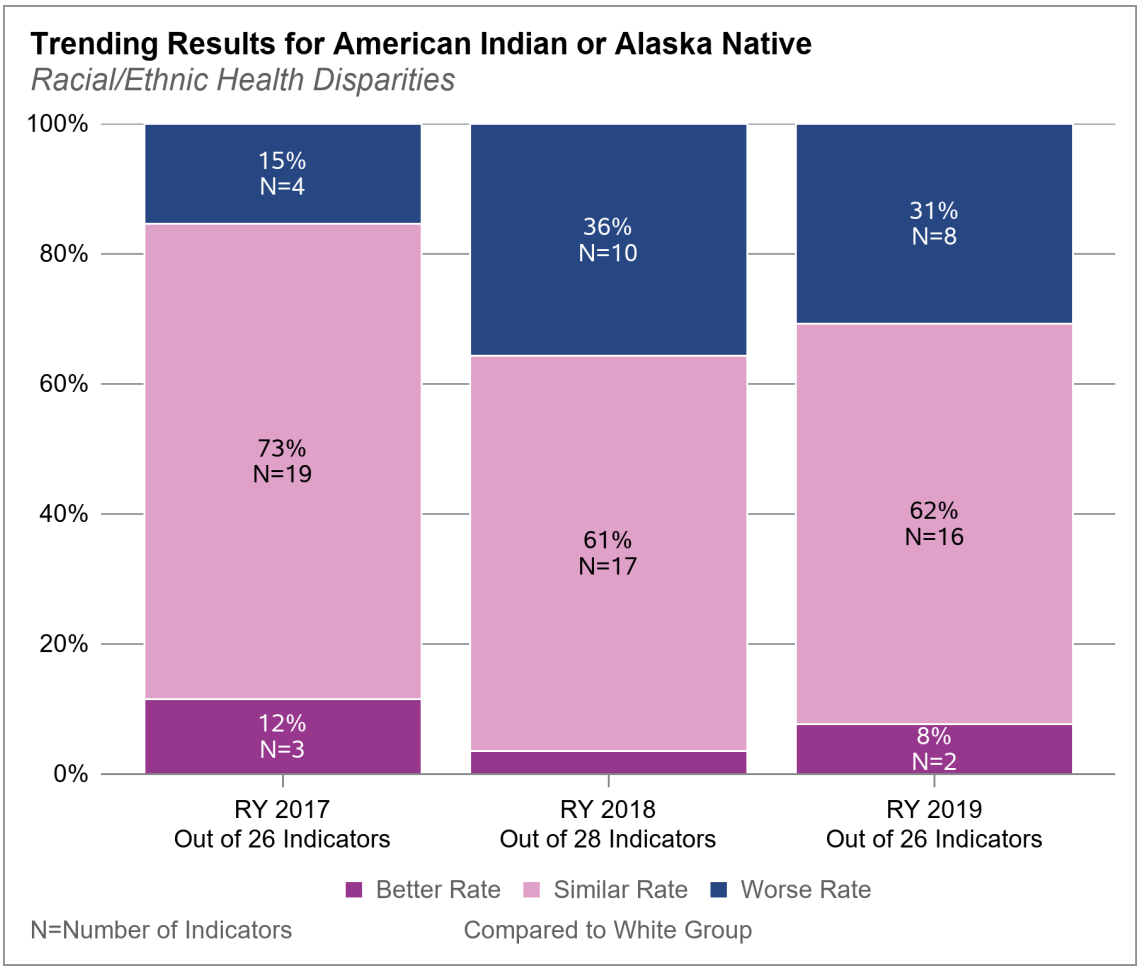
The Reporting Year 2017–2019 Trending Results section first presents the number of indicators for each racial/ethnic group that had a better rate than, similar rate to, or worse rate than the White group (i.e., the reference group). This section also presents three-year rate trending figures (i.e., reporting years 2017–2019) by racial/ethnic group and primary language group for select indicators organized by domain (Preventive Screening and Children's Health, Preventive Screening and Women's Health, and Care for Chronic Conditions).

Racial/Ethnic Trending Health Disparities

American Indian or Alaska Native

Health disparities were identified when indicator rates for the American Indian or Alaska Native group were better than or worse than the rates for the White group (i.e., the reference group). If the American Indian or Alaska Native group's indicator rate was similar to the White group, then no health disparity was identified. Figure 4.1 displays the percentage and number of indicators by reporting year for which the rates for the American Indian or Alaska Native group were worse than, similar to, or better than the rates for the White group.

Figure 4.1—Trending Results for American Indian or Alaska Native

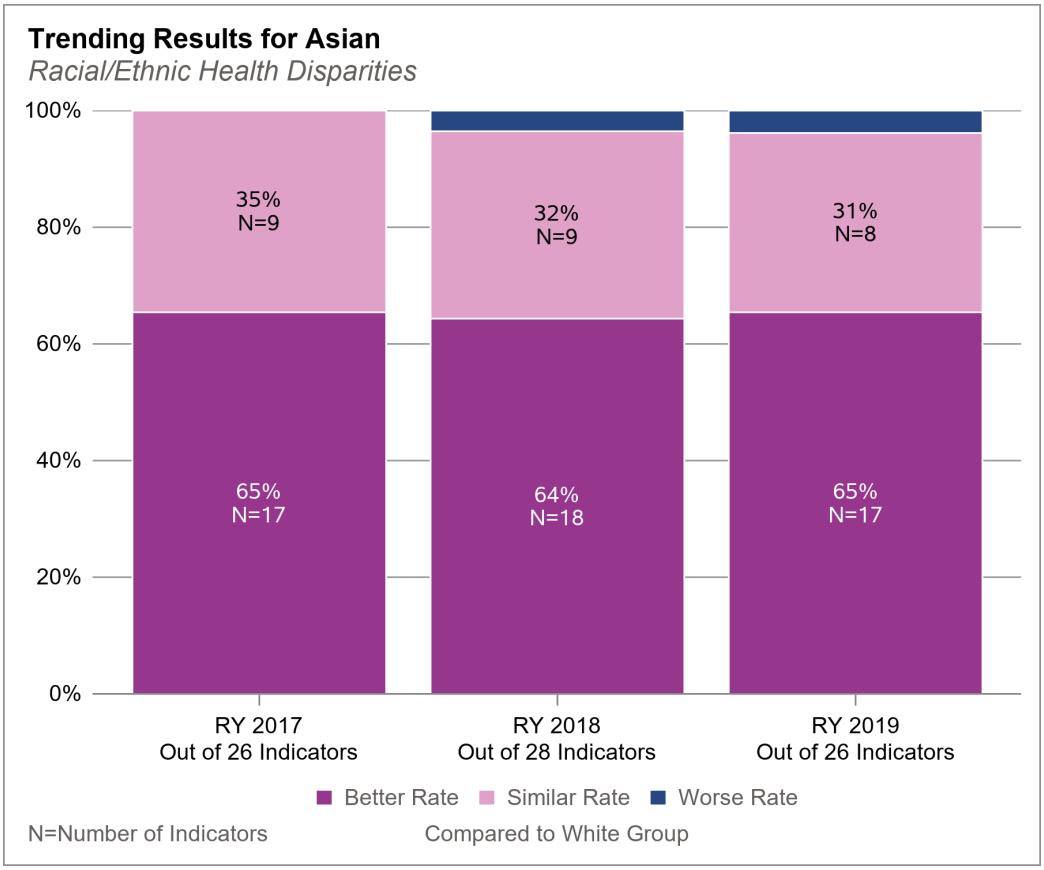


- The number of indicator rates for the American Indian or Alaska Native group that were better than the rates for the White group decreased from reporting years 2017–2019. For the following indicator, the rate for the American Indian or Alaska Native group was better than the rate for the White group for reporting years 2017–2019:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- The number of indicator rates for the American Indian or Alaska Native group that were worse than the rates for the White group increased from reporting years 2017–2019. For the following indicators, the rates for the American Indian or Alaska Native group were worse than the rates for the White group for reporting years 2017–2019:
  - *Breast Cancer Screening*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Asian

Health disparities were identified when indicator rates for the Asian group were better than or worse than the rates for the White group (i.e., the reference group). If the Asian group's indicator rate was similar to the White group, then no health disparity was identified. Figure 4.2 displays the percentage and number of indicators by reporting year for which the rates for the Asian group were worse than, similar to, or better than the rates for the White group.

Figure 4.2—Trending Results for Asian



- The number of indicator rates for the Asian group that were better than the rates for the White group was stable from reporting years 2017–2019. For the following indicators, the rates for the Asian group were better than the rates for the White group for reporting years 2017–2019:
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 3*
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

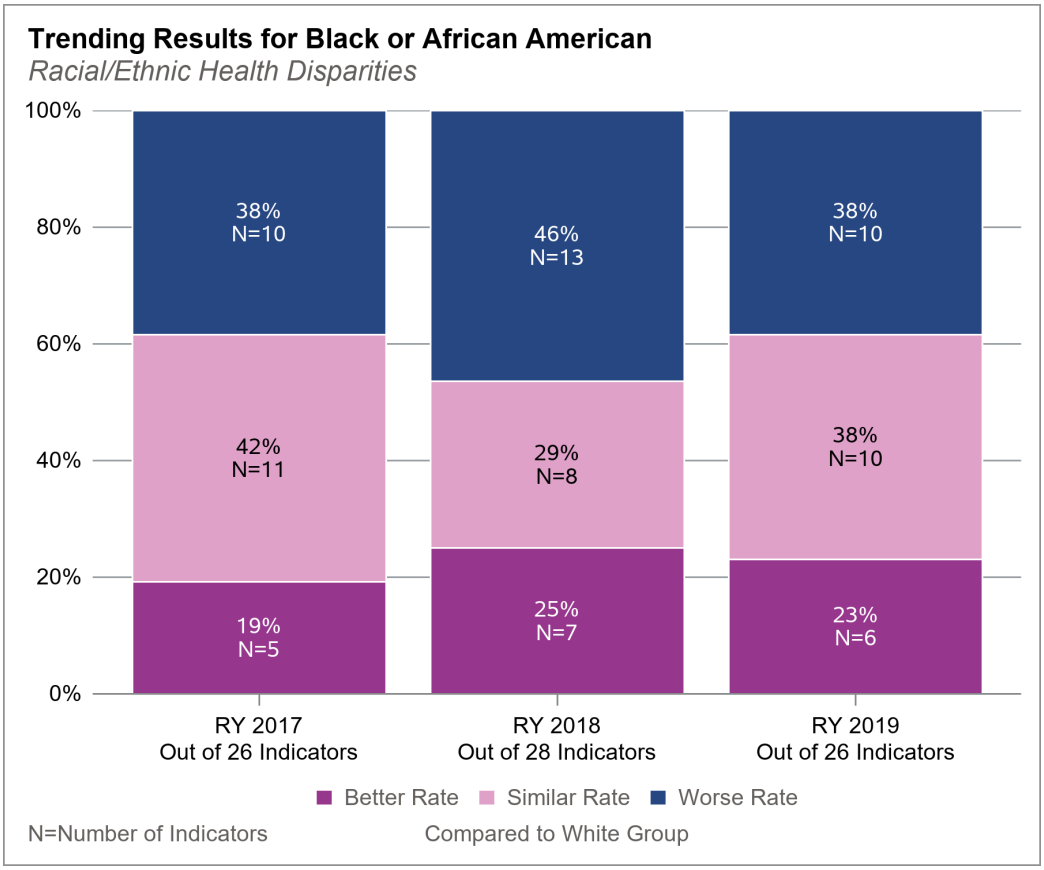
- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Immunizations for Adolescents—Combination 2*
- *Plan All-Cause Readmissions*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

♦ The number of indicator rates for the Asian group that were worse than the rates for the White group increased for reporting years 2017–2019. No indicator rates for the Asian group were worse than the rates for the White group for reporting years 2017–2019.

Black or African American

Health disparities were identified when indicator rates for the Black or African American group were better than or worse than the rates for the White group (i.e., the reference group). If the Black or African American group's indicator rate was similar to the White group, then no health disparity was identified. Figure 4.3 displays the percentage and number of indicators by reporting year for which the rates for the Black or African American group were worse than, similar to, or better than the rates for the White group.

Figure 4.3—Trending Results for Black or African American



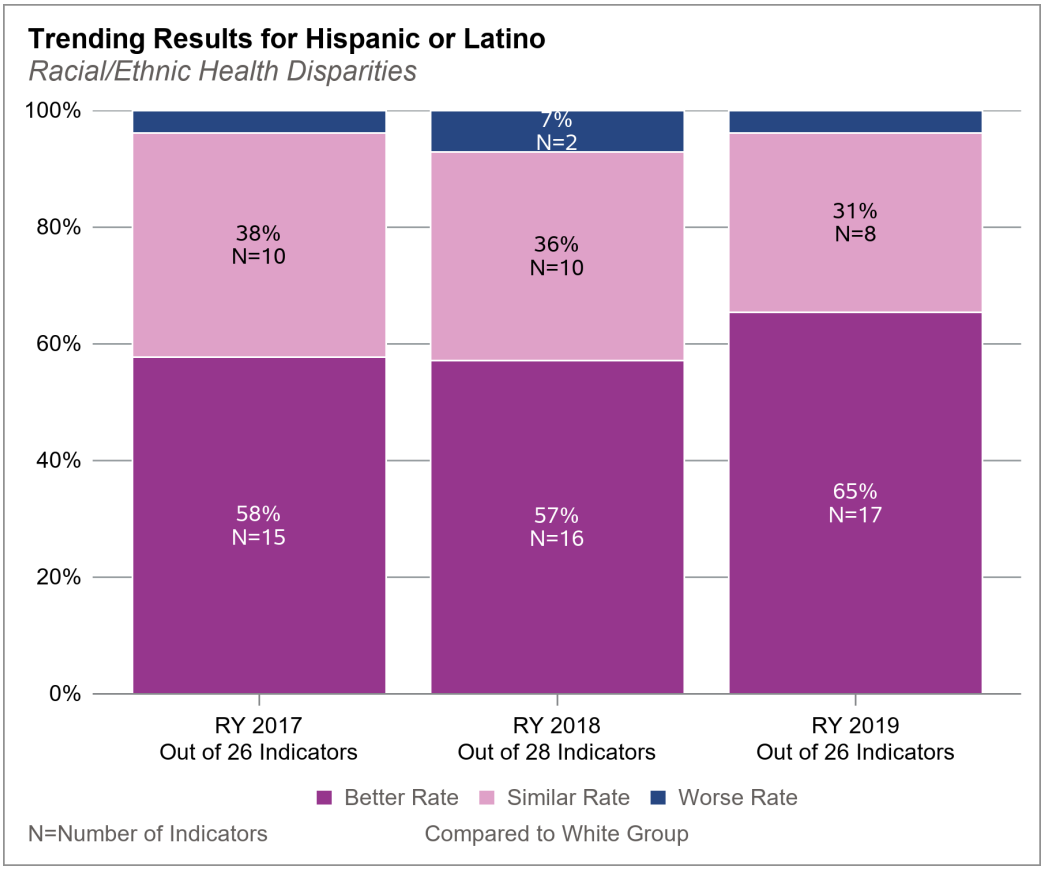
- The number of indicator rates for the Black or African American group that were better than the rates for the White group increased from reporting years 2017–2019. For the following indicators, the rates for the Black or African American group were better than the rates for the White group for reporting years 2017–2019:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Cervical Cancer Screening*
  - *Use of Imaging Studies for Low Back Pain*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*

- The number of indicator rates for the Black or African American group that were worse than the rates for the White group stayed the same from reporting years 2017–2019. For the following indicators, the rates for the Black or African American group were worse than the rates for the White group for reporting years 2017–2019:
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
  - *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
  - *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
  - *Controlling High Blood Pressure*
  - *Prenatal and Postpartum Care—Postpartum Care*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Hispanic or Latino

Health disparities were identified when indicator rates for the Hispanic or Latino group were better than or worse than the rates for the White group (i.e., the reference group). If the Hispanic or Latino group's indicator rate was similar to the White group, then no health disparity was identified. Figure 4.4 displays the percentage and number of indicators by reporting year for which the rates for the Hispanic or Latino group were worse than, similar to, or better than the rates for the White group.

Figure 4.4—Trending Results for Hispanic or Latino



- The number of indicator rates for the Hispanic or Latino group that were better than the rates for the White group increased from reporting years 2017–2019. For the following indicators, the rates for the Hispanic or Latino group were better than the rates for the White group for reporting years 2017–2019:
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*
  - *Annual Monitoring for Patients on Persistent Medications—Diuretics*
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 3*

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Immunizations for Adolescents—Combination 2*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

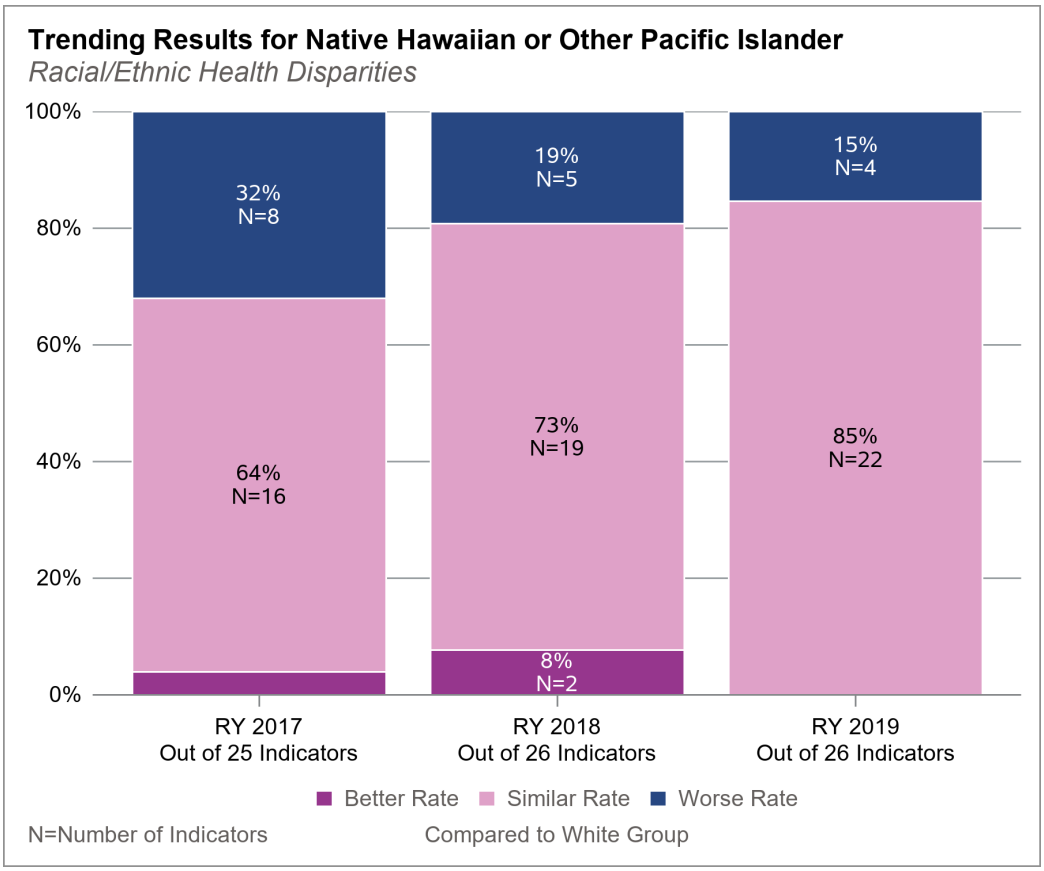
♦ The number of indicator rates for the Hispanic or Latino group that were worse than the rates for the White group stayed the same from reporting years 2017–2019. For the following indicator, the rate for the Hispanic or Latino group was worse than the rate for the White group for reporting years 2017–2019:

- *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*

Native Hawaiian or Other Pacific Islander

Health disparities were identified when indicator rates for the Native Hawaiian or Other Pacific Islander group were better than or worse than the rates for the White group (i.e., the reference group). If the Native Hawaiian or Other Pacific Islander group's indicator rate was similar to the White group, then no health disparity was identified. Figure 4.5 displays the percentage and number of indicators by reporting year for which the rates for the Native Hawaiian or Other Pacific Islander group were worse than, similar to, or better than the rates for the White group.

Figure 4.5—Trending Results for Native Hawaiian or Other Pacific Islander

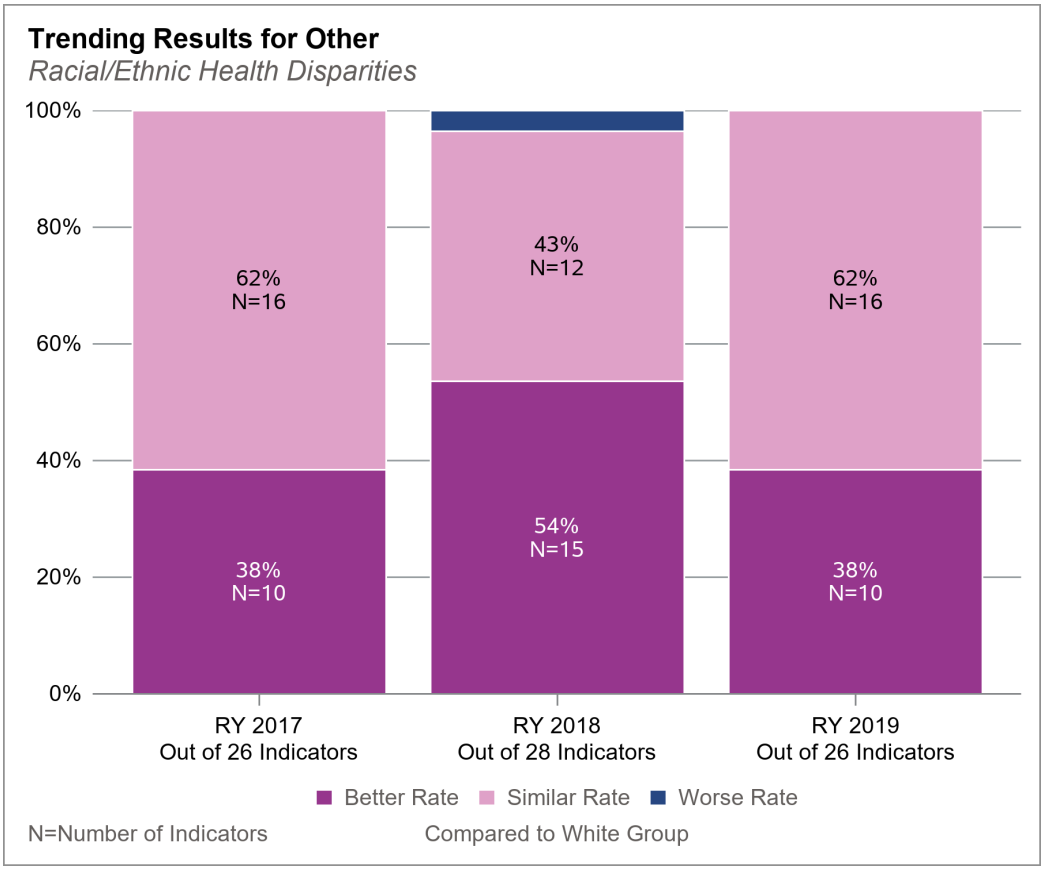


- The number of indicator rates for the Native Hawaiian or Other Pacific Islander group that were better than the rates for the White group decreased from reporting years 2017–2019. No indicator rates for the Native Hawaiian or Other Pacific Islander group were better than the rates for the White group for reporting years 2017–2019.
- The number of indicator rates for the Native Hawaiian or Other Pacific Islander group that were worse than the rates for the White group decreased from reporting years 2017–2019. For the following indicators, the rates for the Native Hawaiian or Other Pacific Islander group were worse than the rates for the White group for reporting years 2017–2019:
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Other

Health disparities were identified when indicator rates for the Other group were better than or worse than the rates for the White group (i.e., the reference group). If the Other group's indicator rate was similar to the White group, then no health disparity was identified. Figure 4.6 displays the percentage and number of indicators by reporting year for which the rates for the Other group were worse than, similar to, or better than the rates for the White group.

Figure 4.6—Trending Results for Other



- The number of indicator rates for the Other group that were better than the rates for the White group stayed the same from reporting years 2017–2019. For the following indicators, the rates for the Other group were better than the rates for the White group for reporting years 2017–2019:
  - *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
  - *Asthma Medication Ratio*
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Childhood Immunization Status—Combination 3*
  - *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- The number of indicator rates for the Other group that were worse than the rates for the White group stayed the same from reporting years 2017–2019. No rates for the Other group were worse than the rates for the White group for reporting years 2017–2019.

Trending for Select Indicators

This section presents three-year rate trending figures (i.e., reporting years 2017–2019) by racial/ethnic group and primary language group for the following indicators:

- *Childhood Immunization Status—Combination 3*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Breast Cancer Screening*
- *Prenatal and Postpartum Care—Postpartum Care and Timeliness of Prenatal Care*
- *Asthma Medication Ratio*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Controlling High Blood Pressure*

DHCS selected the indicators listed above for the three-year rate trending because they satisfy all of the following criteria: (1) they represent a wide range of health care needs including preventive care for children, women's health, and chronic disease management; (2) they represent areas of interest given the variation in rates among the different racial/ethnic and primary language groups; and (3) there is an expectation of the continuity of measurement (i.e., trends for these indicators can be evaluated in the future).

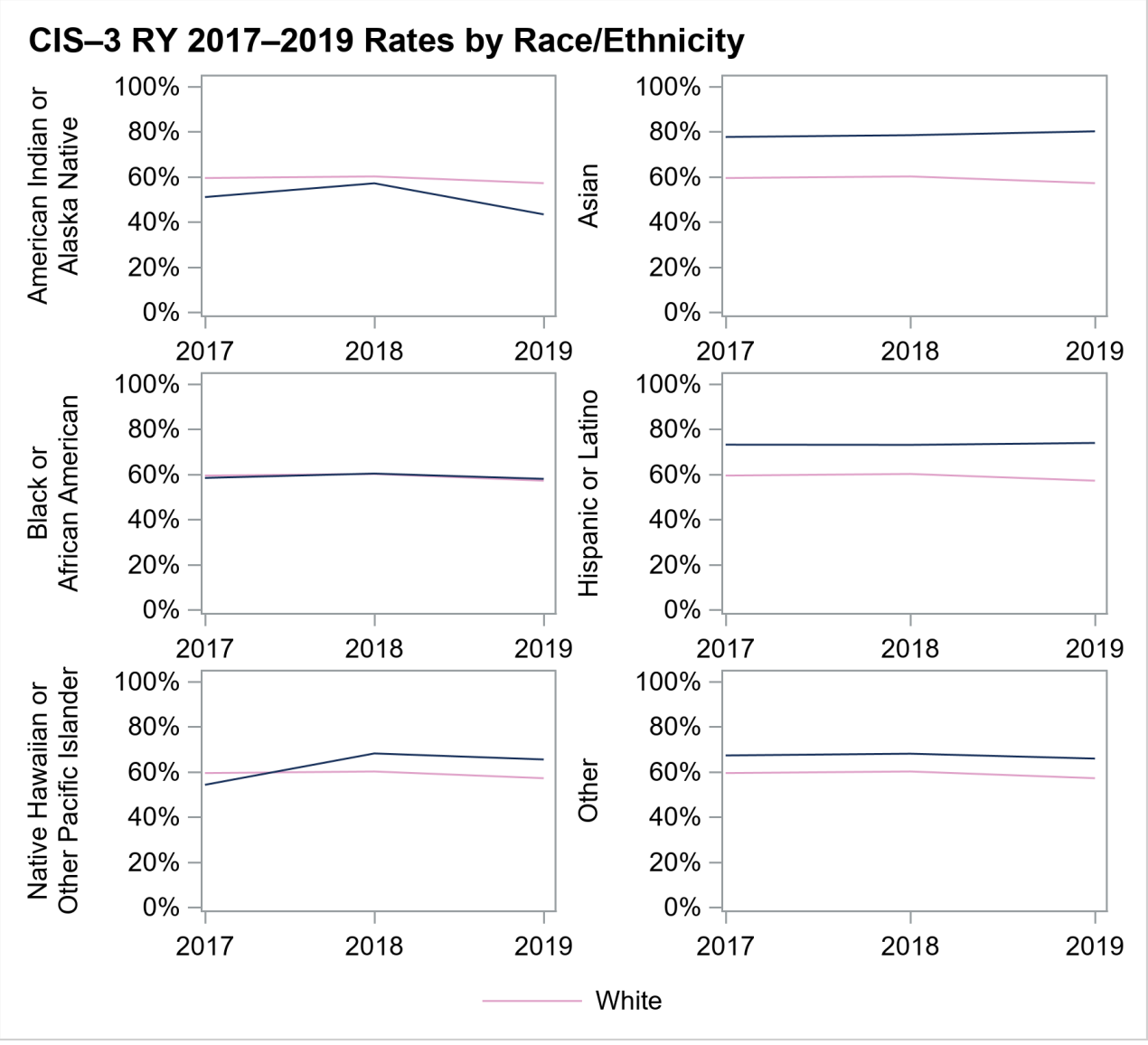
Trending Results for Select Indicators: Preventive Screening and Children's Health Domain

Figure 4.7 through Figure 4.10 display the three-year trend line for each racial/ethnic group and primary language group for the selected indicators in the Preventive Screening and Children's Health domain. For each figure, the racial/ethnic group and primary language group are compared to the applicable reference group (i.e., the White group for the racial/ethnic figures and the English group for the primary language figures).

Childhood Immunization Status—Combination 3 (CIS–3)

Figure 4.7 and Figure 4.8 display the *Childhood Immunization Status—Combination 3 (CIS-3)* rates for reporting years 2017–2019 by racial/ethnic group and primary language group, respectively.

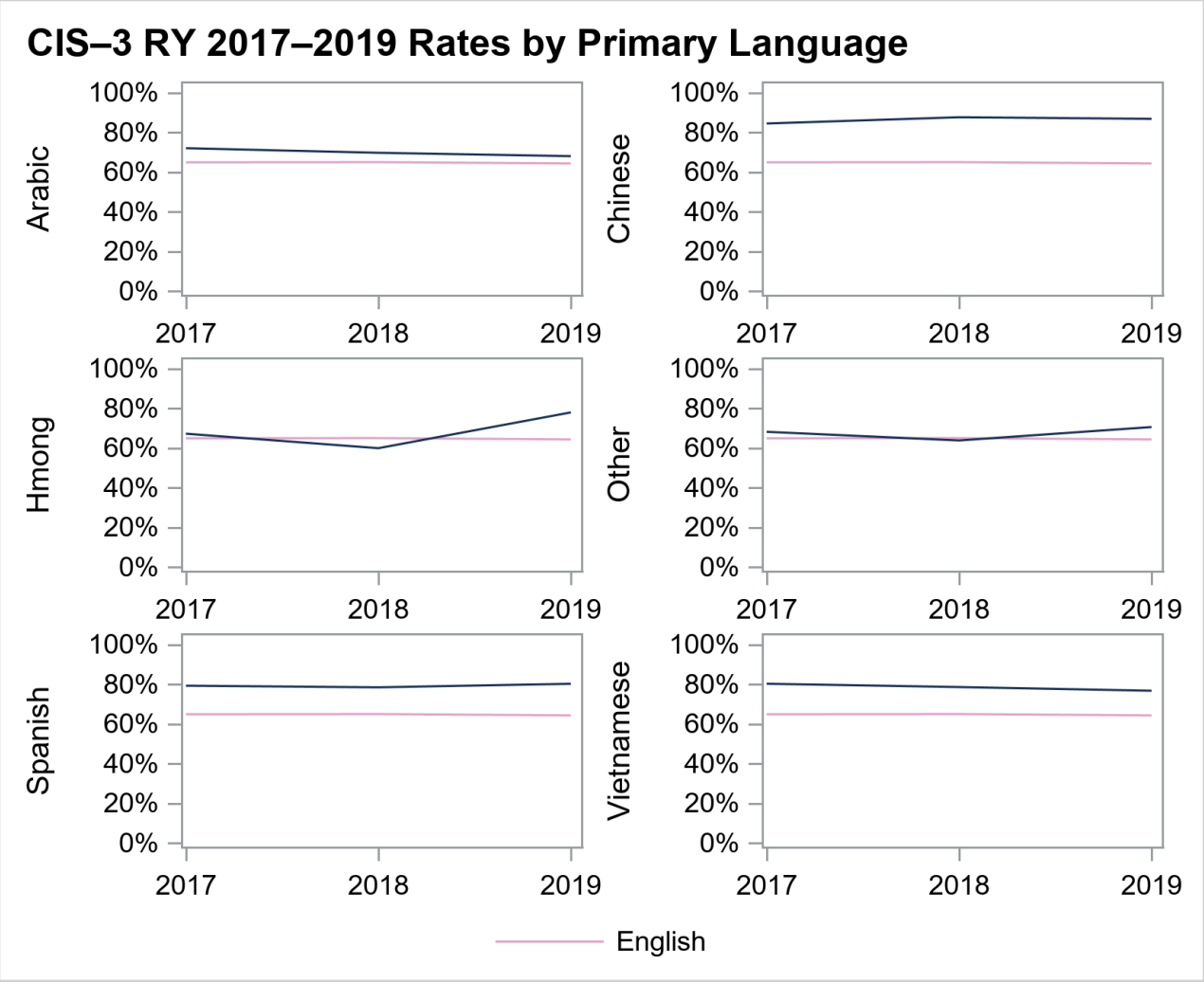
Figure 4.7—Childhood Immunization Status—Combination 3 (CIS–3) Reporting Years 2017–2019 Rates by Race/Ethnicity



- The rates for the following racial/ethnic groups were higher than the rates for the White group for all three reporting years:
  - Asian
  - Hispanic or Latino
  - Other
- The rates for the American Indian or Alaska Native group were lower than the rates for the White group for all three reporting years.
- The rates for the Black or African American group and Native Hawaiian or Other Pacific Islander group were lower than the rates for the White group in reporting year 2017; however, the rates were higher than the rates for the White group in reporting years 2018 and 2019.

Figure 4.8—Childhood Immunization Status—Combination 3 (CIS–3) Reporting Years 2017–2019 Rates by Primary Language

Due to small numerators (i.e., less than 11) or small denominators (i.e., less than 30), the following primary language groups are not presented: Armenian, Cambodian, Farsi, Korean, Russian, and Tagalog.

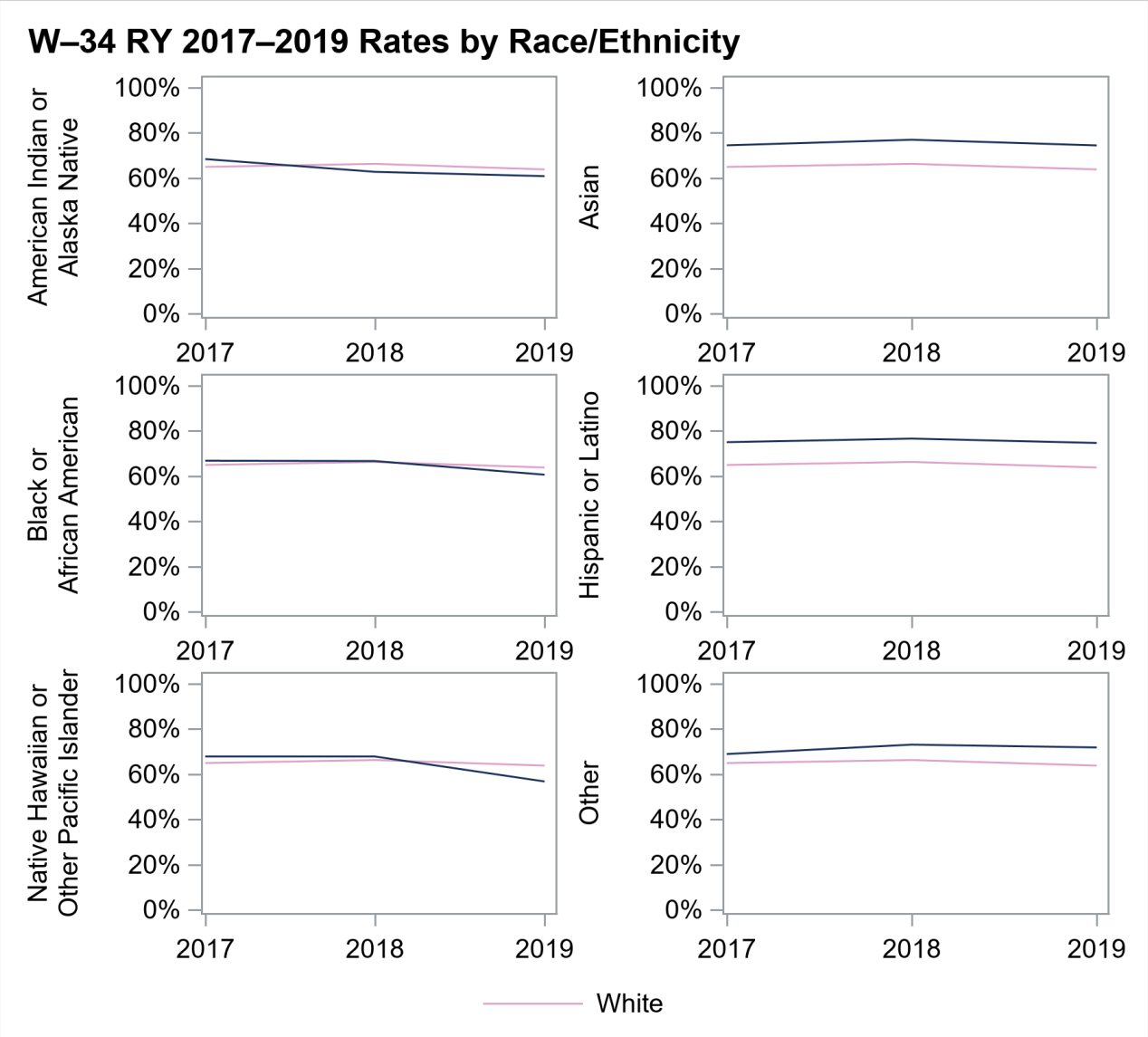


- The rates for the following primary language groups were higher than the rates for the English group for all three reporting years:
  - Arabic
  - Chinese
  - Spanish
  - Vietnamese
- No primary language groups had lower rates than the rates for the English group for all three reporting years.
- The rates for the Hmong group and Other group were higher than the rates for the English group for reporting years 2017 and 2019; however, the rates were lower than the rate for the English group in reporting year 2018, despite the rates for the English group remaining stable for all three reporting years.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W–34)

Figure 4.9 and Figure 4.10 display the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W–34)* rates for reporting years 2017–2019 by racial/ethnic group and primary language group, respectively.

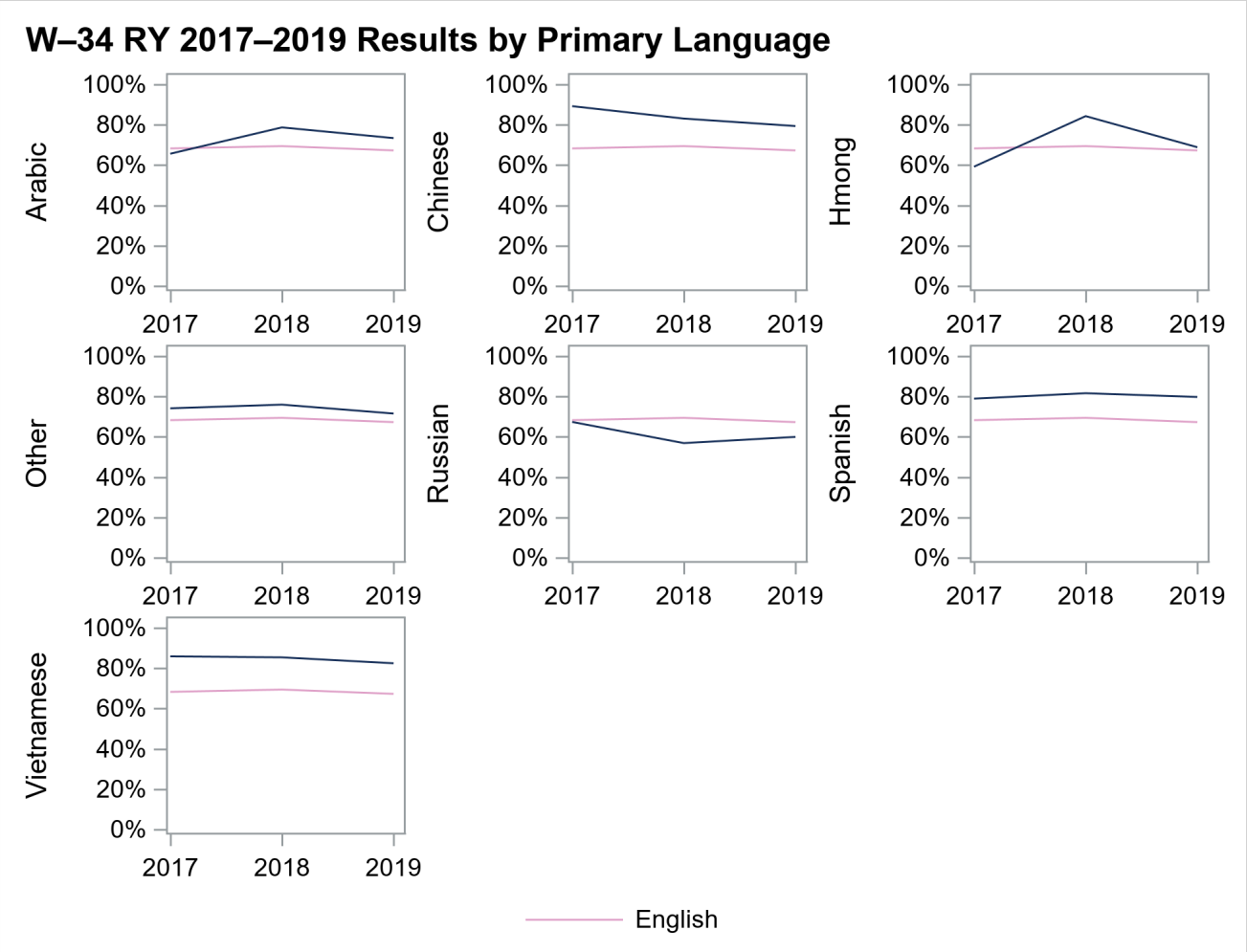
Figure 4.9—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W–34) Reporting Years 2017–2019 Rates by Race/Ethnicity



- The rates for the following racial/ethnic groups were higher than the rates for the White group for all three reporting years:
  - Asian
  - Hispanic or Latino
  - Other
- No racial/ethnic groups had lower rates than the rates for the White group for all three reporting years.
- The rate for the American Indian or Alaska Native group was higher than the rate for the White group in reporting year 2017; however, for reporting years 2018 and 2019, the rates declined to be lower than the rates for the White group, despite the rates for the White group remaining stable for all three reporting years.
- The rates for the Black or African American group and Native Hawaiian or Other Pacific Islander group were higher than the rates for the White group in reporting years 2017 and 2018; however, for reporting year 2019, the rates declined to be lower than the rates for the White group, despite the rates for the White group remaining stable for all three reporting years.

Figure 4.10—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W-34) Reporting Years 2017–2019 Rates by Primary Language

Due to small numerators (i.e., less than 11) or small denominators (i.e., less than 30), the following primary language groups are not presented: Armenian, Cambodian, Farsi, Korean, and Tagalog.



- The rates for the following primary language groups were higher than the rates for the English group for all three reporting years:
  - Chinese
  - Other
  - Spanish
  - Vietnamese
- The rates for the Russian group were lower than the rates for the English group for all three reporting years.
- The rates for the Arabic group and Hmong group were lower than the rates for the English group for reporting year 2017; however, the rates were higher than the rates for the English group in reporting years 2018 and 2019.

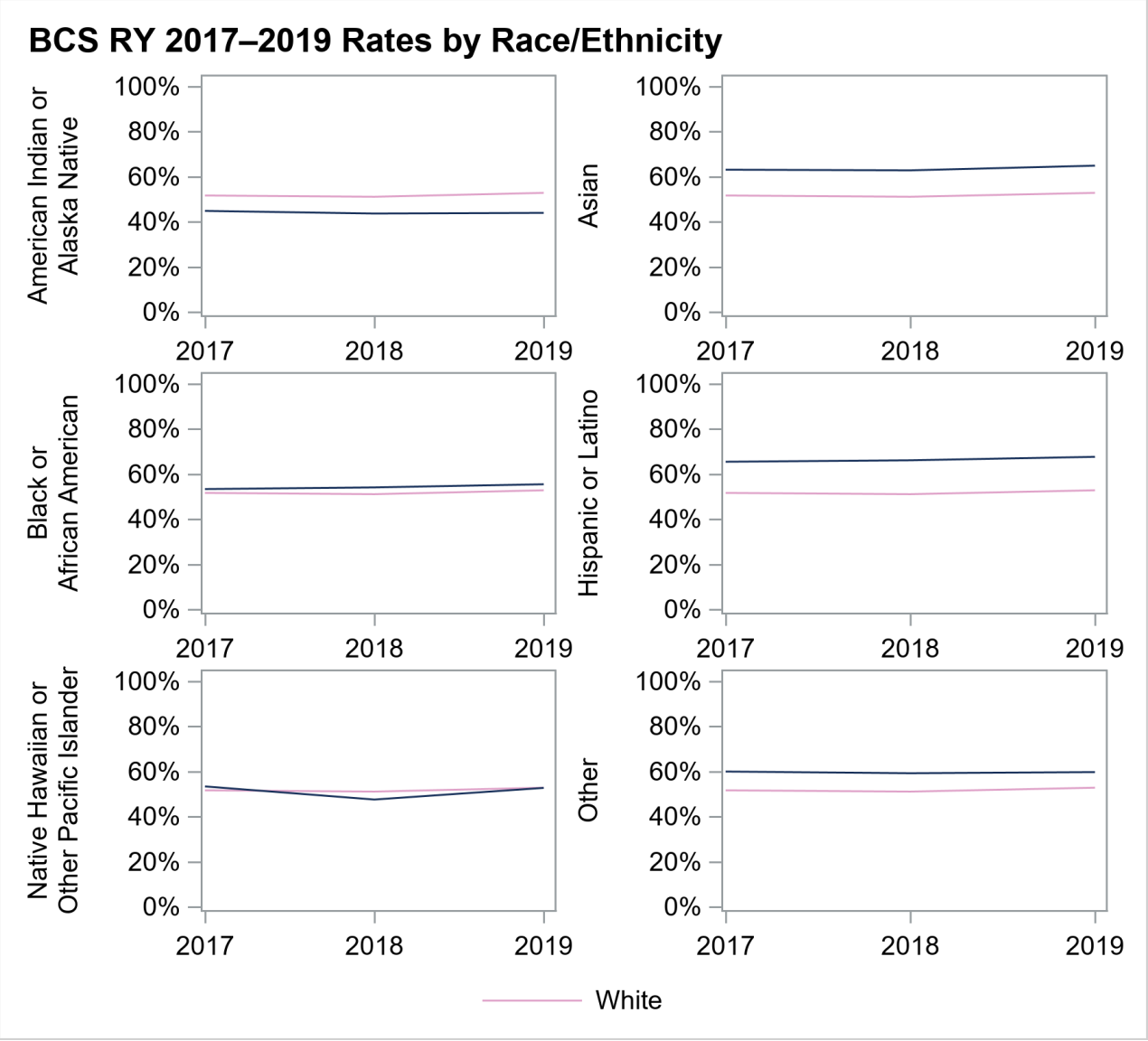
Trending Results for Select Indicators: Preventive Screening and Women's Health Domain

Figure 4.11 through Figure 4.16 display the three-year trend line for each racial/ethnic and primary language group for the select indicators in the Preventive Screening and Women's Health domain. For each figure, the racial/ethnic group and primary language group are compared to the applicable reference group (i.e., White group for the race/ethnicity figures and English group for the primary language figures).

Breast Cancer Screening (BCS)

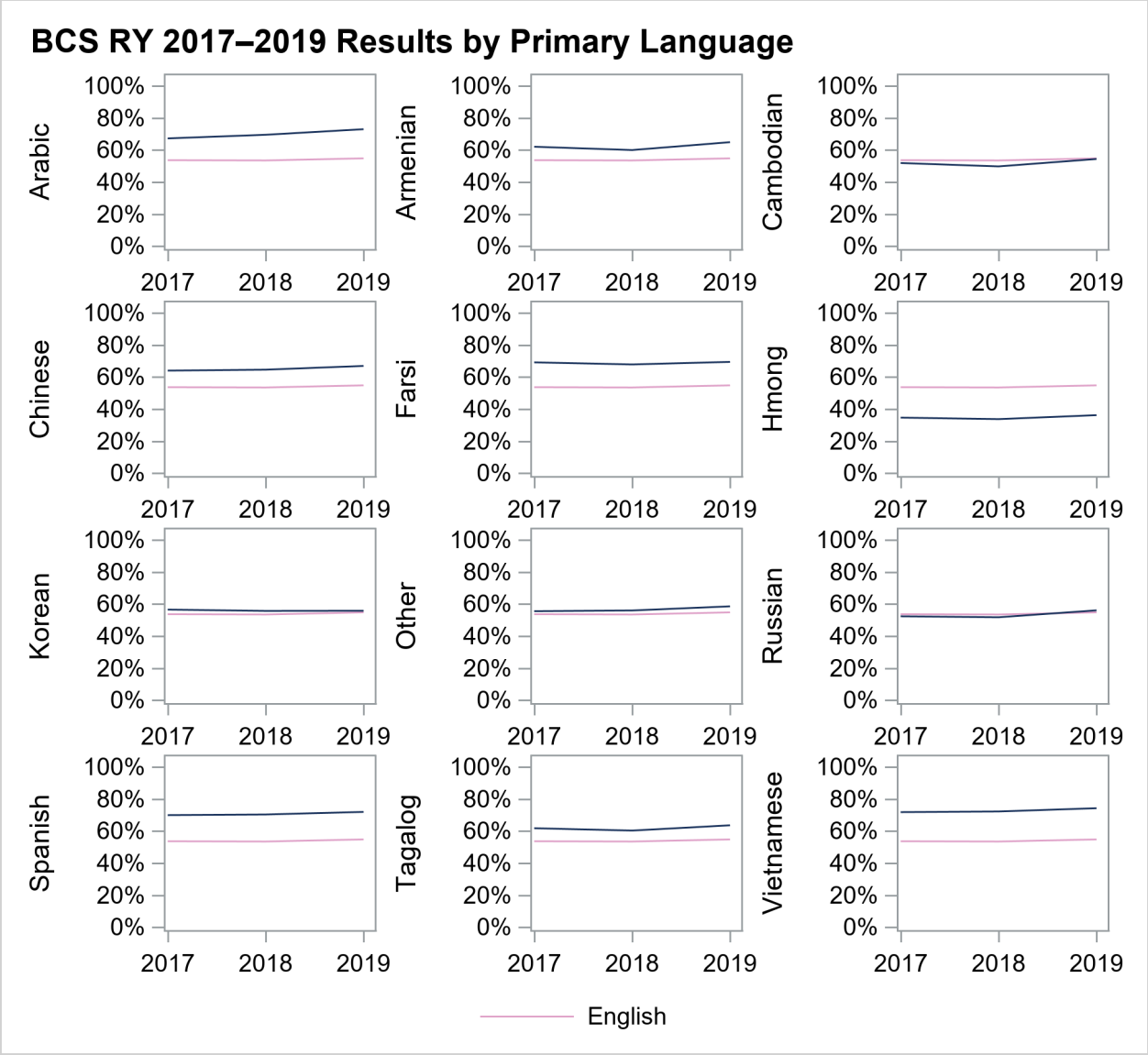
Figure 4.11 and Figure 4.12 display the *Breast Cancer Screening (BCS)* rates for reporting years 2017–2019 by racial/ethnic group and primary language group, respectively.

Figure 4.11—Breast Cancer Screening (BCS) Reporting Years 2017–2019 Rates by Race/Ethnicity



- The rates for the following racial/ethnic groups were higher than the rates for the White group for all three reporting years:
  - Asian
  - Black or African American
  - Hispanic or Latino
  - Other
- The rates for the American Indian or Alaska Native group were lower than the rates for the White group for all three reporting years.
- The rate for the Native Hawaiian or Other Pacific Islander group was higher than the rate for the White group in reporting year 2017; however, for reporting years 2018 and 2019, the rates declined to be lower than the rates for the White group, despite the rates for the White group remaining stable for all three reporting years.

Figure 4.12—Breast Cancer Screening (BCS) Reporting Years 2017–2019 Rates by Primary Language

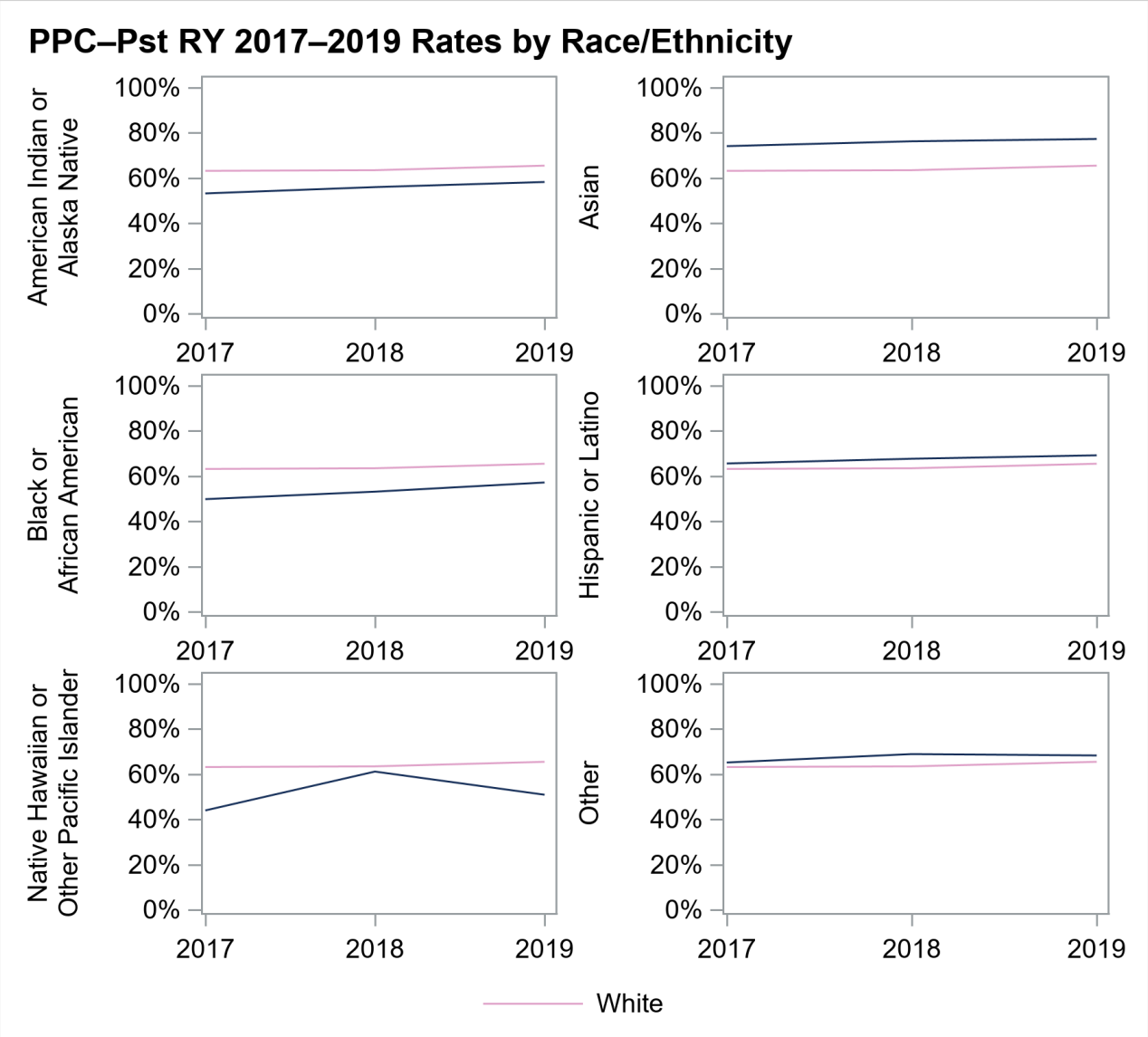


- The rates for the following primary language groups were higher than the rates for the English group for all three reporting years:
  - Arabic
  - Armenian
  - Chinese
  - Farsi
  - Korean
  - Other
  - Spanish
  - Tagalog
  - Vietnamese
- The rates for the following primary language groups were lower than the rates for the English group for all three reporting years:
  - Cambodian
  - Hmong
- The rates for the Russian group were lower than the rates for the English group for reporting years 2017 and 2018; however, for reporting year 2019, the rate increased to be higher than the rate for the English group, despite the rate for the English group remaining stable for all three reporting years.

Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)

Figure 4.13 and Figure 4.14 display the *Prenatal and Postpartum—Postpartum Care (PPC–Pst)* rates for reporting years 2017–2019 by racial/ethnic group and primary language group, respectively.

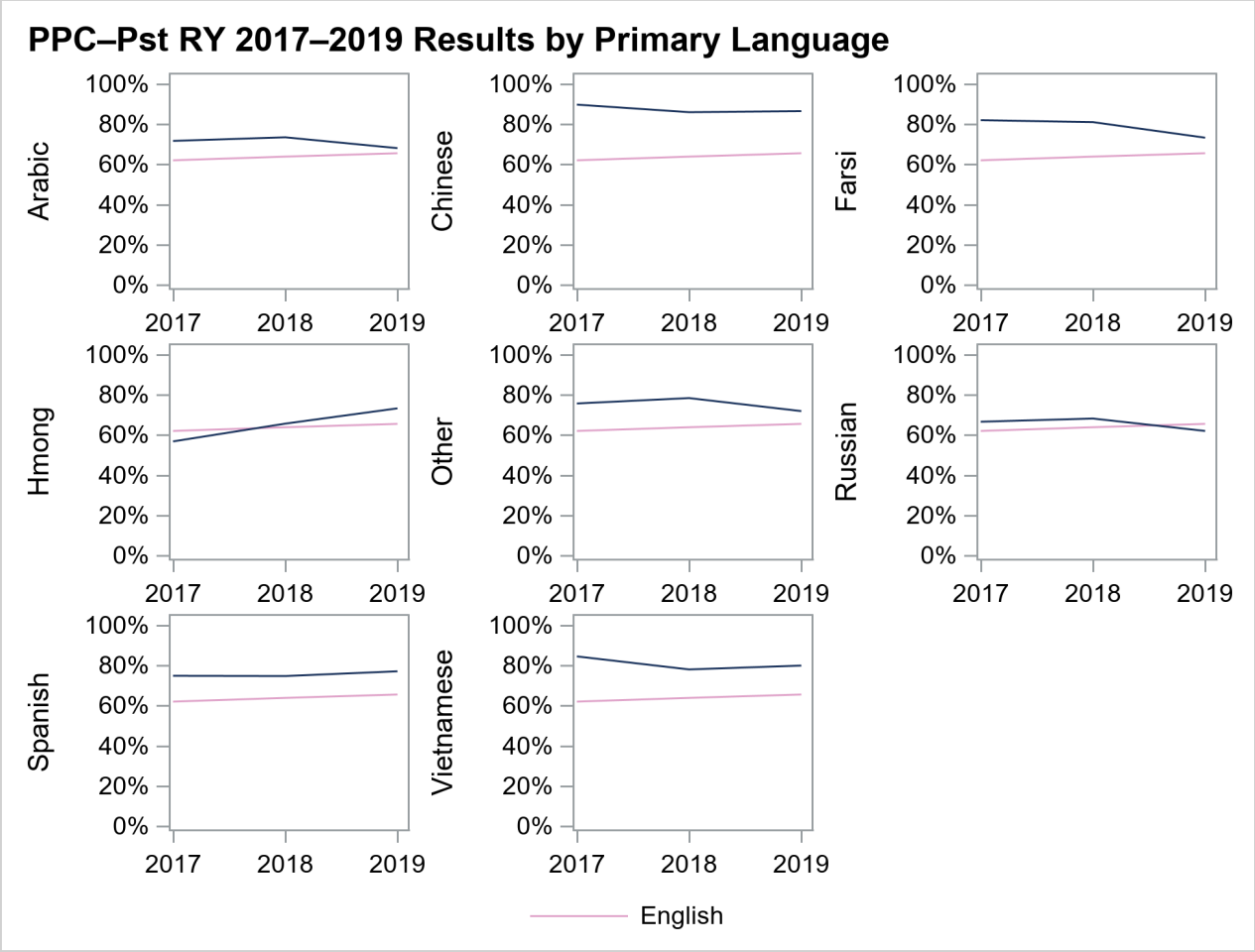
Figure 4.13—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Reporting Years 2017–2019 Rates by Race/Ethnicity



- The rates for the following racial/ethnic groups were higher than the rates for the White group for all three reporting years:
  - Asian
  - Hispanic or Latino
  - Other
- The rates for the following racial/ethnic groups were lower than the rates for the White group for all three reporting years:
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander

Figure 4.14—Prenatal and Postpartum Care (PPC–Pst)—Postpartum Care Reporting Years 2017–2019 Rates by Primary Language

Due to small numerators (i.e., less than 11) or small denominators (i.e., less than 30) the following primary language groups are not presented: Armenian, Cambodian, Korean, and Tagalog.

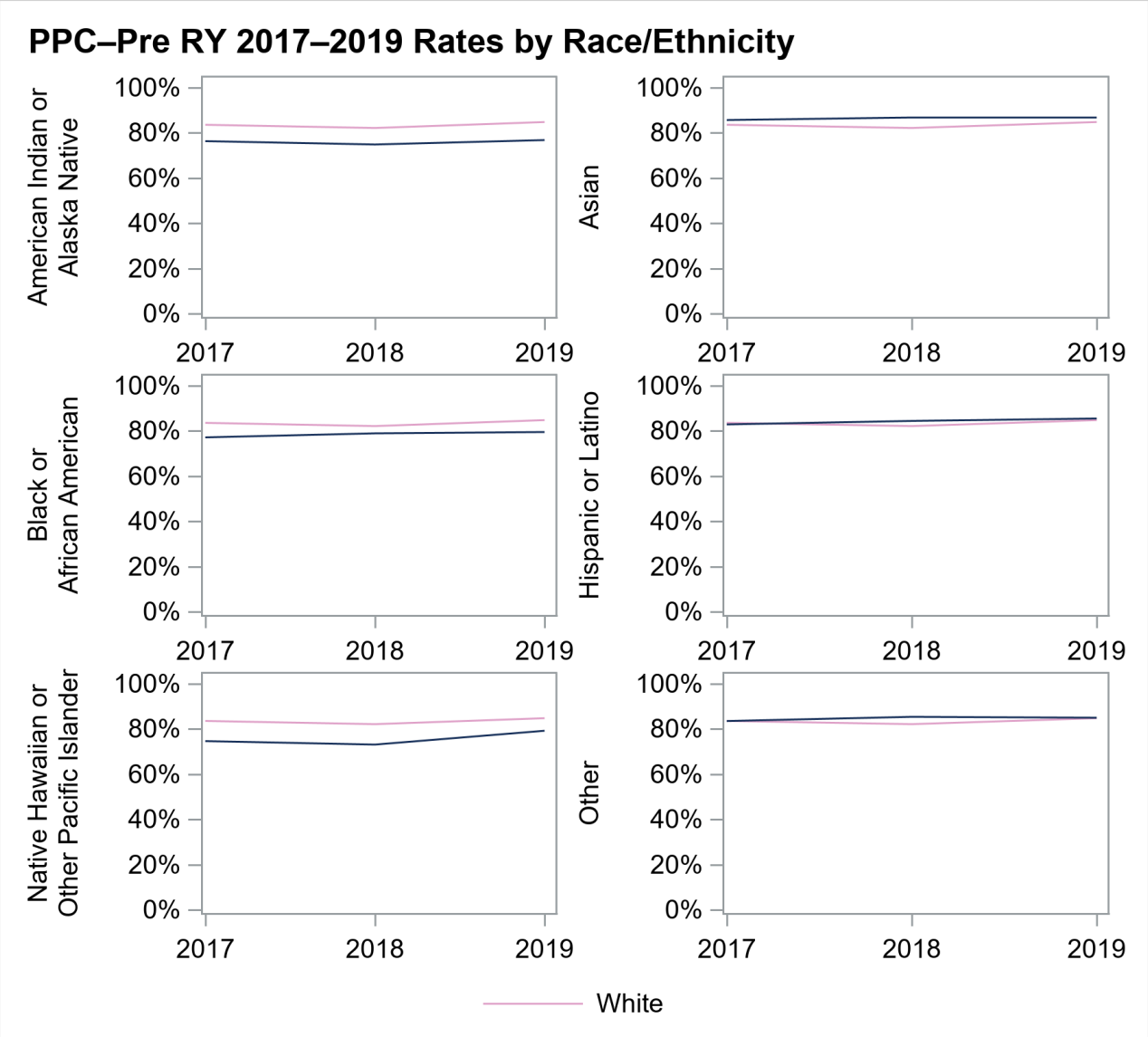


- The rates for the following primary language groups were higher than the rates for the English group for all three reporting years:
  - Arabic
  - Chinese
  - Farsi
  - Other
  - Spanish
  - Vietnamese
- No primary language groups had lower rates than the rates for the English group for all three reporting years.
- The rates for the Russian group were higher than the rates for the English group for reporting years 2017 and 2018; however, the rate was lower than the rate for the English group in reporting year 2019.
- The rate for the Hmong group was lower than the rate for the English group for reporting year 2017; however, the rates were higher than the rates for the English group in reporting years 2018 and 2019.

Prenatal and Postpartum Care—Timelines of Prenatal Care (PPC–Pre)

Figure 4.15 and Figure 4.16 display the *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)* rates for reporting years 2017–2019 by racial/ethnic group and primary language group, respectively.

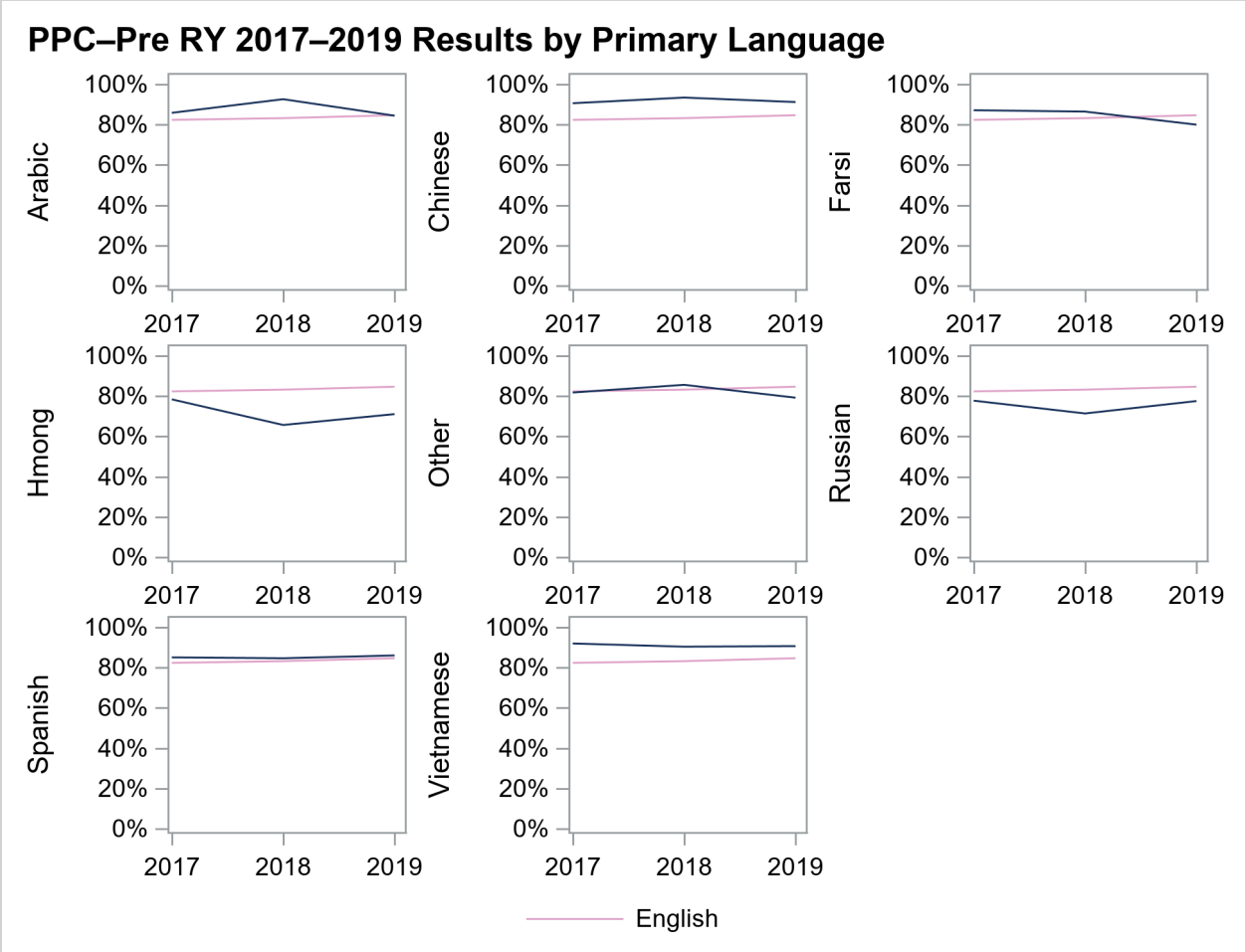
Figure 4.15—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Reporting Years 2017–2019 Rates by Race/Ethnicity



- The rates for the Asian group were higher than the rates for the White group for all three reporting years.
- The rates for the following racial/ethnic groups were lower than the rates for the White group for all three reporting years:
  - American Indian or Alaska Native
  - Black or African American
  - Native Hawaiian or Other Pacific Islander
- The rates for the Hispanic or Latino group and the Other group were lower than the rate for the White group in reporting year 2017; however, the rates were higher than the rates for the White group for reporting years 2018 and 2019.

Figure 4.16—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Reporting Years 2017–2019 Rates by Primary Language

Due to small numerators (i.e., less than 11) or small denominators (i.e., less than 30), the following primary language groups are not presented: Armenian, Cambodian, Korean, and Tagalog.



- The rates for the following primary language groups were higher than the rates for the English group for all three reporting years:
  - Chinese
  - Spanish
  - Vietnamese
- The rates for the following primary language groups were lower than the rates for the English group for all three reporting years:
  - Hmong
  - Russian
- The rates for the Arabic group and Farsi group were higher than the rates for the English group for reporting years 2017 and 2018; however, the rates were lower than the rates for the English group in reporting year 2019.
- The rates for the Other group were lower than the rates for the English group in reporting years 2017 and 2019; however, the rate was higher than the rate for the English group in reporting year 2018.

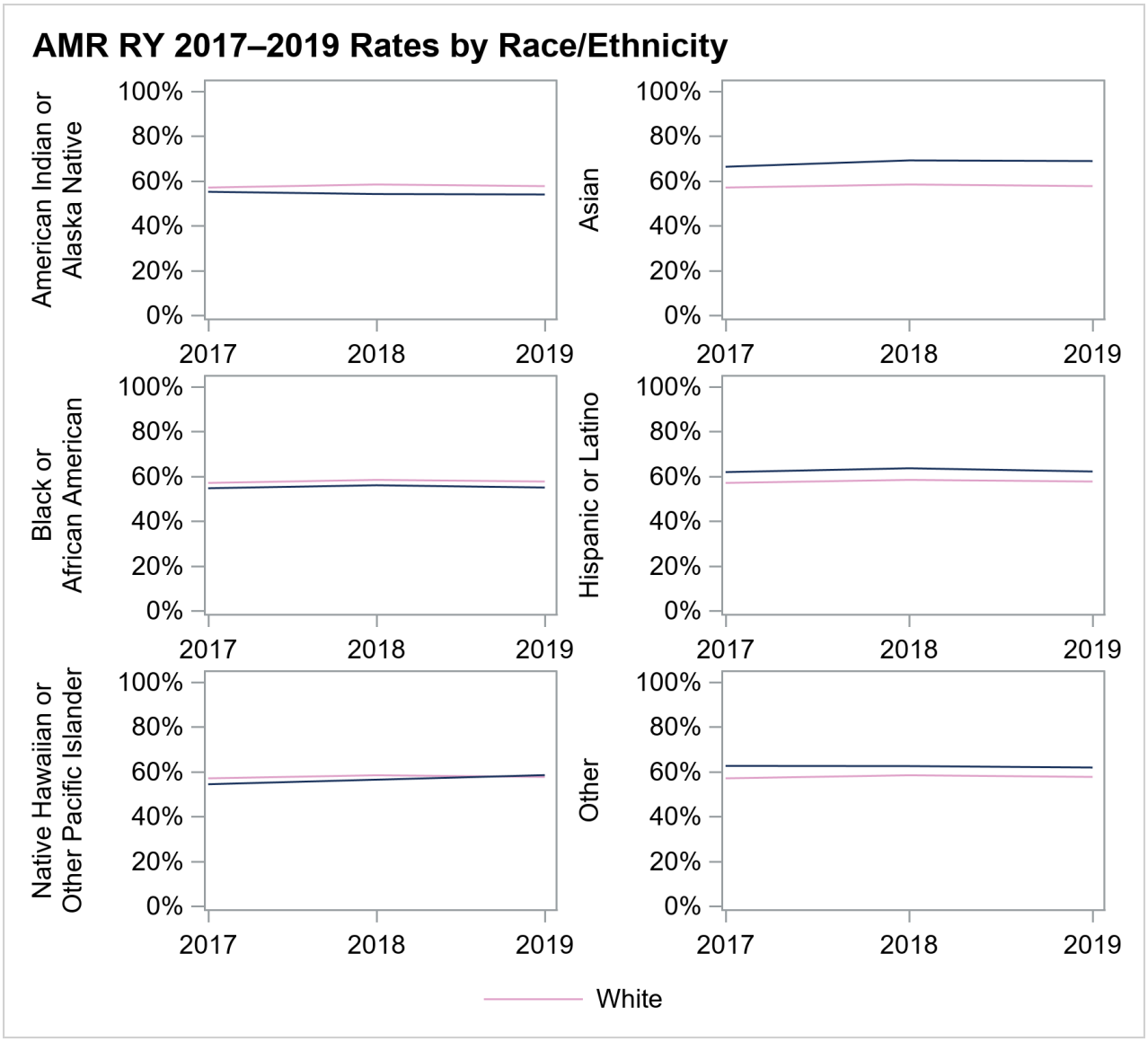
Trending Results for Select Indicators: Care for Chronic Conditions Domain

Figure 4.17 through Figure 4.22 display the three-year trend line for each racial/ethnic group and primary language group for the select indicators in the Care for Chronic Conditions domain. For each figure, the racial/ethnic group and primary language group are compared to the applicable reference group (i.e., White group for the race/ethnicity figures and English group for the primary language figures).

Asthma Medication Ratio (AMR)

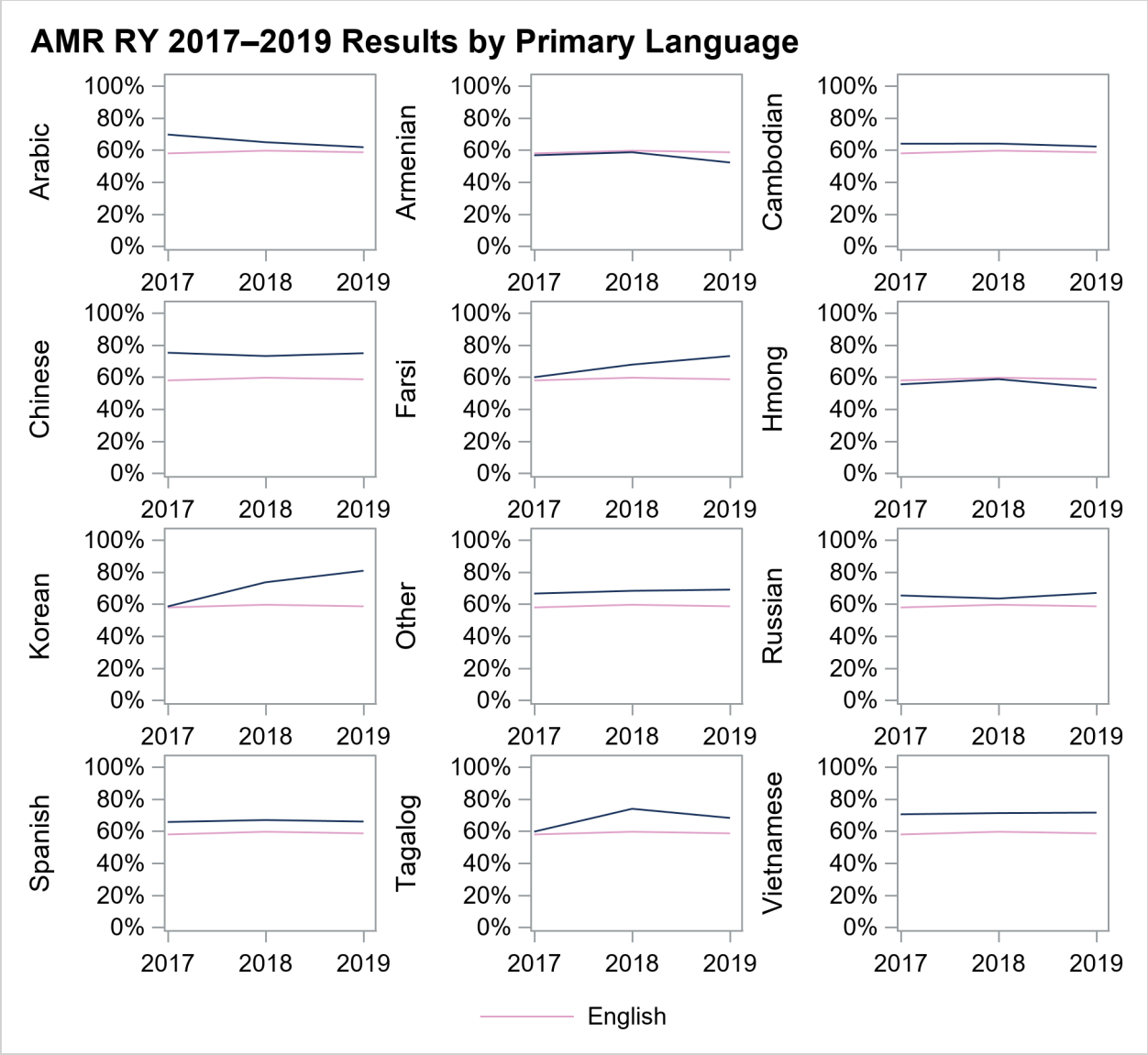
Figure 4.17 and Figure 4.18 display the *Asthma Medication Ratio (AMR)* rates for reporting years 2017–2019 by racial/ethnic group and primary language group, respectively.

Figure 4.17—Asthma Medication Ratio (AMR) Reporting Years 2017–2019 Rates by Race/Ethnicity



- The rates for the following racial/ethnic groups were higher than the rates for the White group for all three reporting years:
  - Asian
  - Hispanic or Latino
  - Other
- The rates for the following racial/ethnic groups were lower than the rates for the White group for all three reporting years:
  - American Indian or Alaska Native
  - Black or African American
- The rates for the Native Hawaiian or Other Pacific Islander group were lower than the rates for the White group in reporting years 2017 and 2018; however, for reporting year 2019, the rate increased to be higher than the rate for the White group, despite the rates for the White group remaining stable for all three reporting years.

Figure 4.18—Asthma Medication Ratio (AMR) Reporting Years 2017–2019 Rates by Primary Language



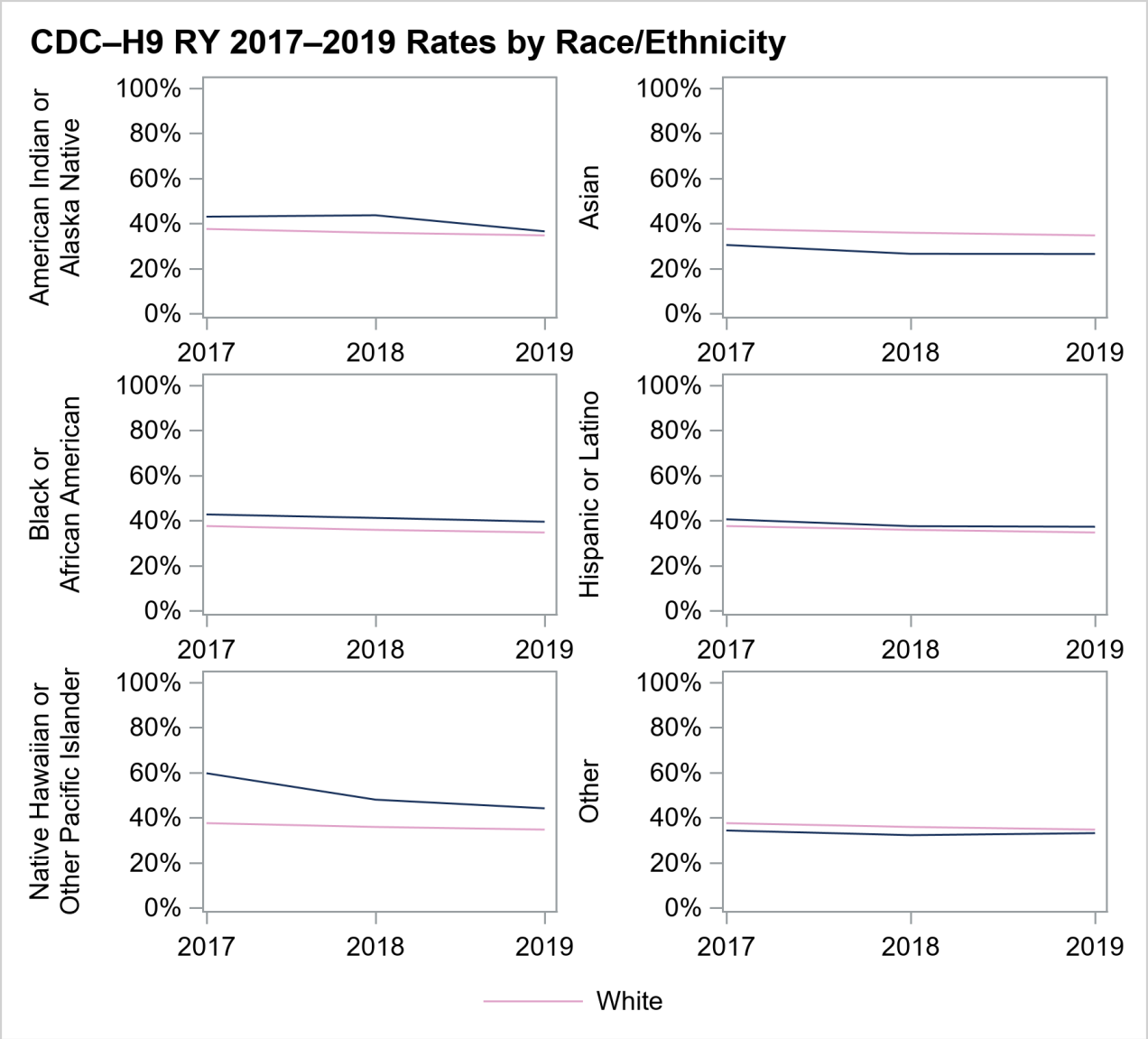
- The rates for the following primary language groups were higher than the rates for the English group for all three reporting years:
  - Arabic
  - Cambodian
  - Chinese
  - Farsi
  - Korean
  - Other
  - Russian
  - Spanish
  - Tagalog
  - Vietnamese
- The rates for the following primary language groups were lower than the rates for the English group for all three reporting years:
  - Armenian
  - Hmong

Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9)

Figure 4.19 and Figure 4.20 display the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9)* rates for reporting years 2017–2019 by racial/ethnic group and primary language group, respectively.

Figure 4.19—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9) Reporting Years 2017–2019 Rates by Race/Ethnicity

A lower rate indicates more favorable performance for this indicator.

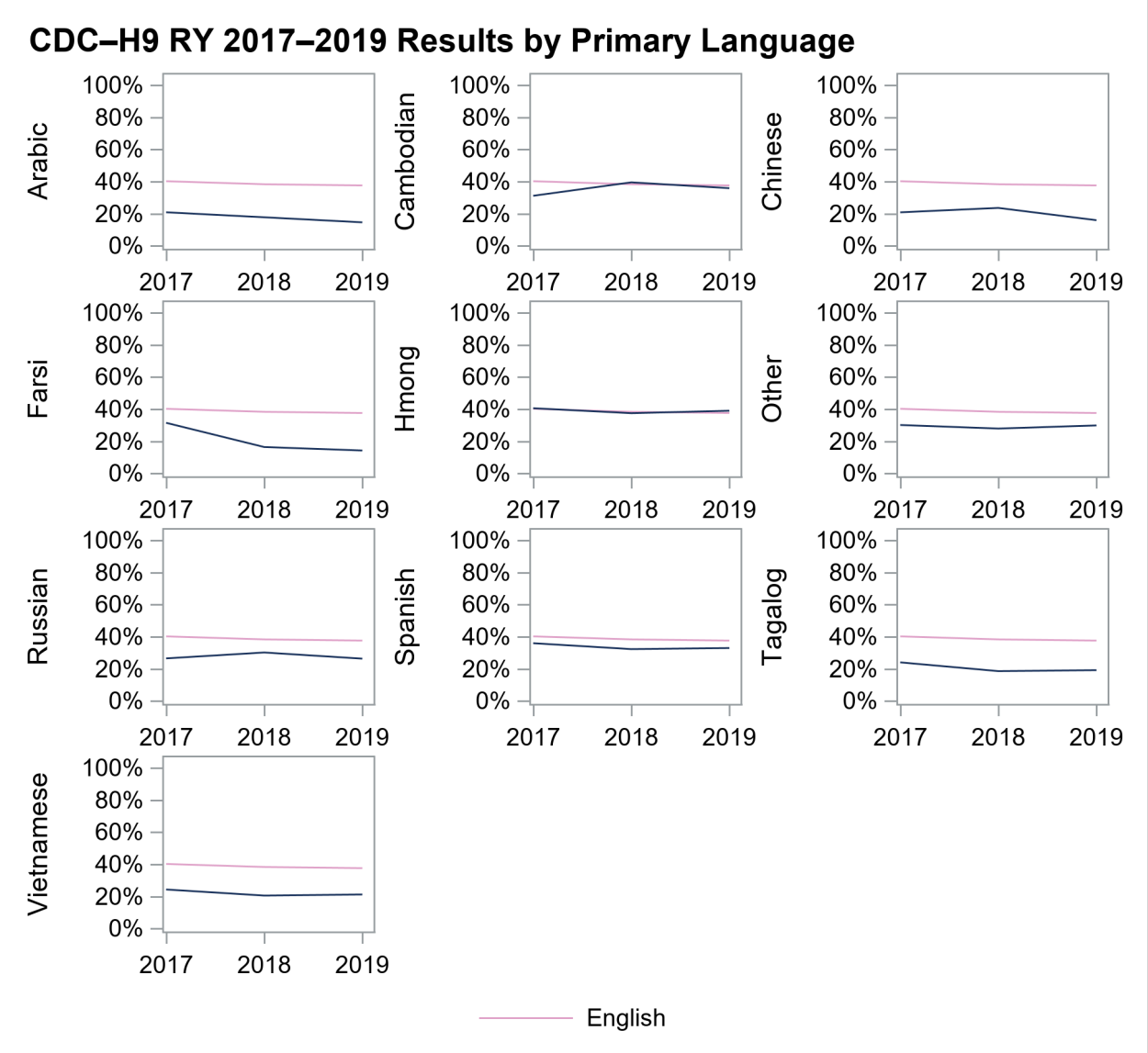


- The rates for the following racial/ethnic groups were lower than the rates for the White group for all three reporting years, indicating more favorable performance:
  - Asian
  - Other
- The rates for the following racial/ethnic groups were higher than the rates for the White group for all three reporting years, indicating less favorable performance:
  - American Indian or Alaska Native
  - Black or African American
  - Hispanic or Latino
  - Native Hawaiian or Other Pacific Islander

Figure 4.20—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9) Reporting Years 2017–2019 Rates by Primary Language

Due to small numerators (i.e., less than 11) or small denominators (i.e., less than 30), the following primary language groups are not presented: Armenian and Korean.

A lower rate indicates more favorable performance for this indicator.

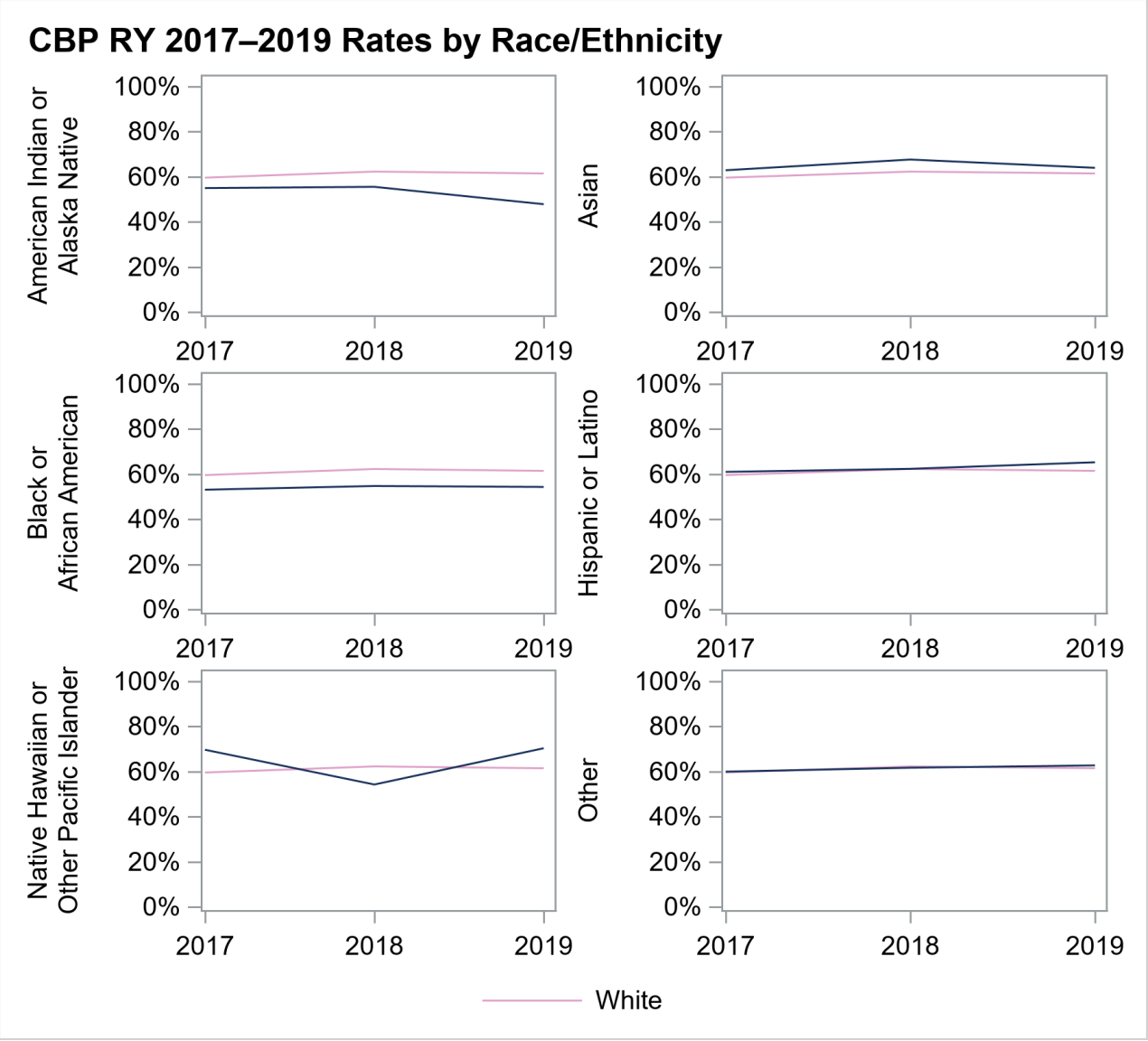


- The rates for the following primary language groups were lower than the rates for the English group for all three reporting years, indicating more favorable performance:
  - Arabic
  - Chinese
  - Farsi
  - Other
  - Russian
  - Spanish
  - Tagalog
  - Vietnamese
- No primary language group had higher rates than the rates for the English group for all three reporting years.
- The rates for the Cambodian group were lower than the rates for the English group for reporting years 2017 and 2019; however, the rates were higher than the rate for the English group in reporting year 2018.
- The rates for the Hmong group were higher than the rates for the English group for reporting years 2017 and 2019; however, the rate was lower than the rate for the English group in reporting year 2018.

Controlling High Blood Pressure (CBP)

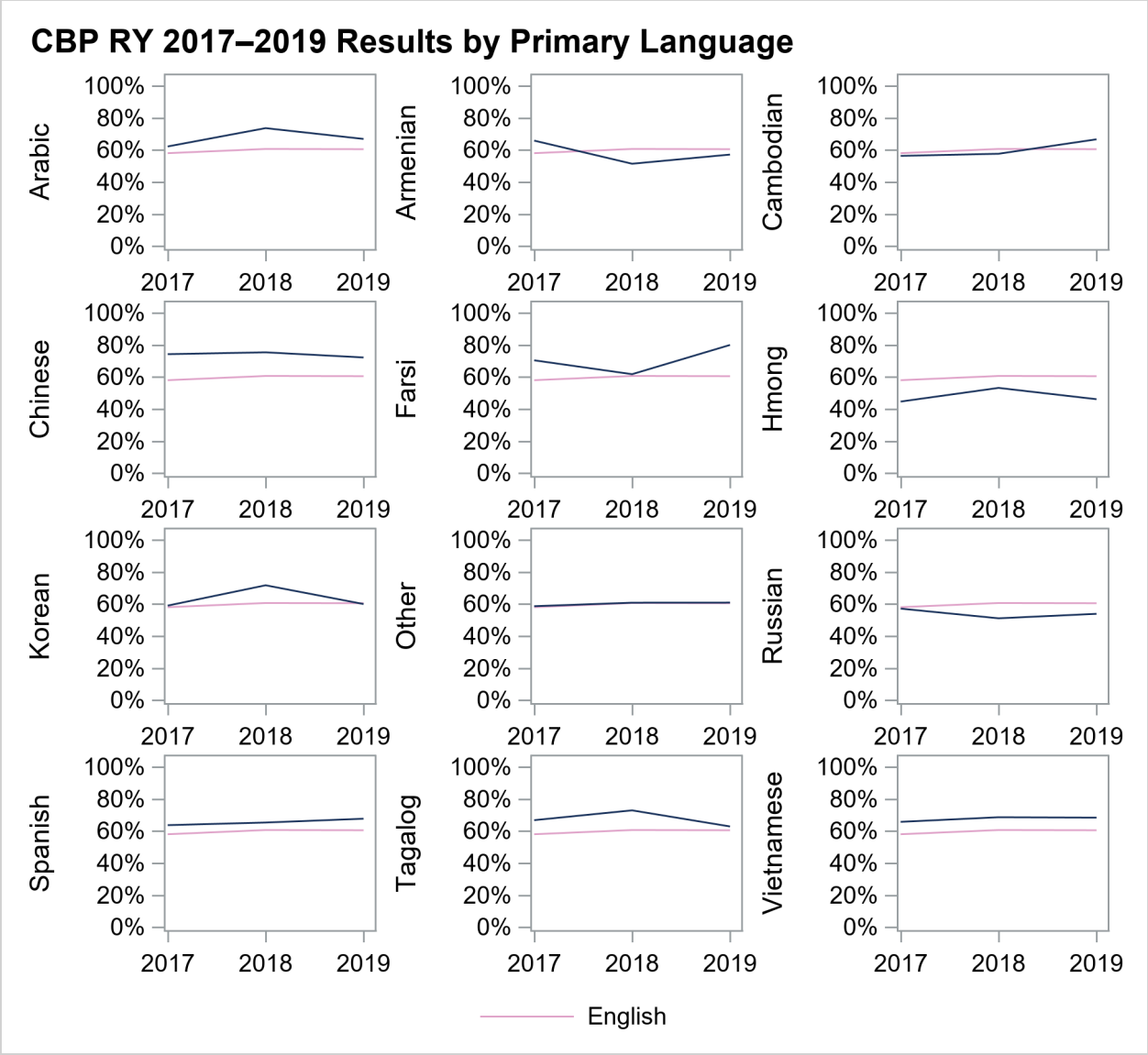
Figure 4.21 and Figure 4.22 display the *Controlling High Blood Pressure (CBP)* rates for reporting years 2017–2019 by racial/ethnic group and primary language group, respectively.

Figure 4.21—Controlling High Blood Pressure (CBP) Reporting Years 2017–2019 Rates by Race/Ethnicity



- The rates for the following racial/ethnic groups were higher than the rates for the White group for all three reporting years:
  - Asian
  - Hispanic or Latino
- The rates for the following racial/ethnic groups were lower than the rates for the White group for all three reporting years:
  - American Indian or Alaska Native
  - Black or African American
- The rates for the Native Hawaiian or Other Pacific Islander group and Other group were higher than the rates for the White group in reporting years 2017 and 2019; however, the rates were lower than the rate for the White group in reporting year 2018.

Figure 4.22—Controlling High Blood Pressure (CBP) Reporting Years 2017–2019 Rates by Primary Language



- The rates for the following primary language groups were higher than the rates for the English group for all three reporting years:
  - Arabic
  - Chinese
  - Farsi
  - Other
  - Spanish
  - Tagalog
  - Vietnamese

- The rates for the following primary language groups were lower than the rates for the English group for all three reporting years:
  - Hmong
  - Russian
- The rates for the Korean group were higher than the rate for the English group in reporting years 2017 and 2018; however, for reporting year 2019, the rate declined to be lower than the rate for the English group, despite the rates for the English group remaining stable for all three reporting years.
- The rate for the Armenian group was higher than the rate for the English group in reporting year 2017; however, the rates were lower than the rates for the English group for reporting years 2018 and 2019.
- The rates for the Cambodian group were lower than the rates for the English group for reporting years 2017 and 2018; however, for reporting year 2019, the rate increased to be higher than the rate for the English group, despite the rates for the English group remaining stable for all three reporting years.

5. Geographic Variability by County for Select Indicators

The Geographic Variability by County for Select Indicators section presents county performance for four indicators identified by DHCS (*Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*, *Breast Cancer Screening*, *Asthma Medication Ratio*, and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*).

As a reference for the Geographic Variability by County figures, Figure 5.1 displays a map of California with all counties labeled.

Figure 5.1—California Map by County

Figure 5.2—Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years (CAP–256) Geographic Variability by County

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

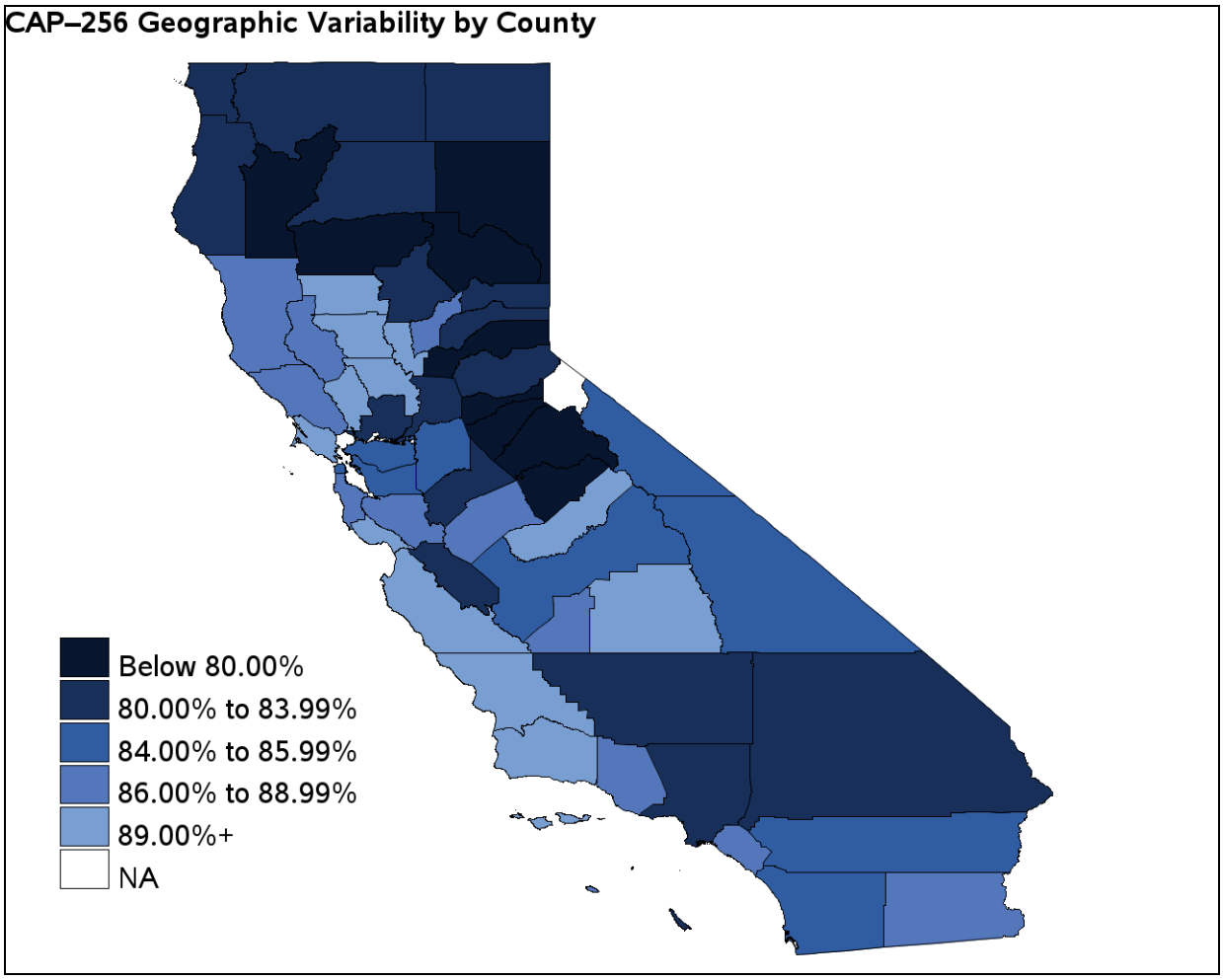


Figure 5.3—Breast Cancer Screening (BCS) Geographic Variability by County

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

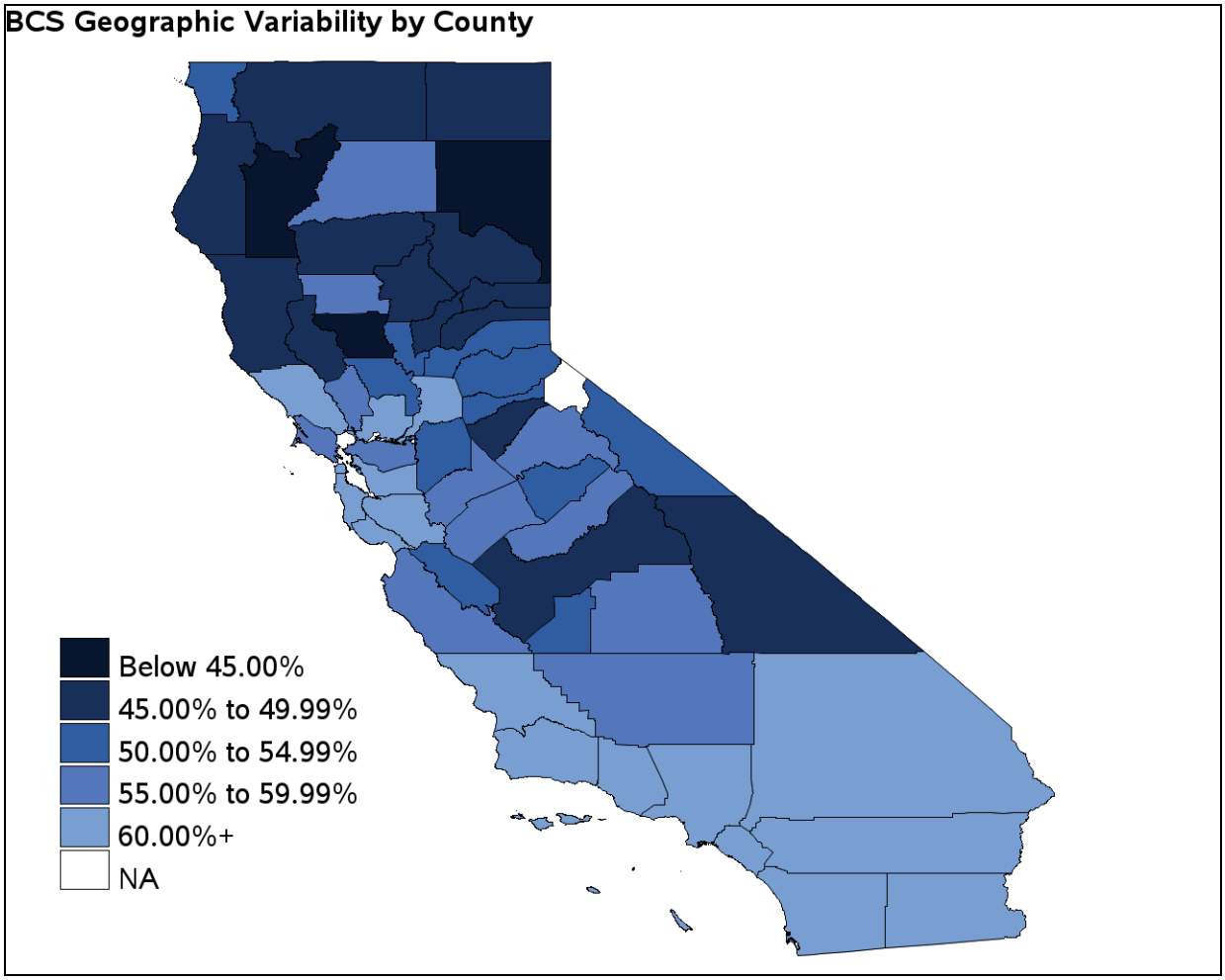


Figure 5.4—Asthma Medication Ratio (AMR) Geographic Variability by County

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

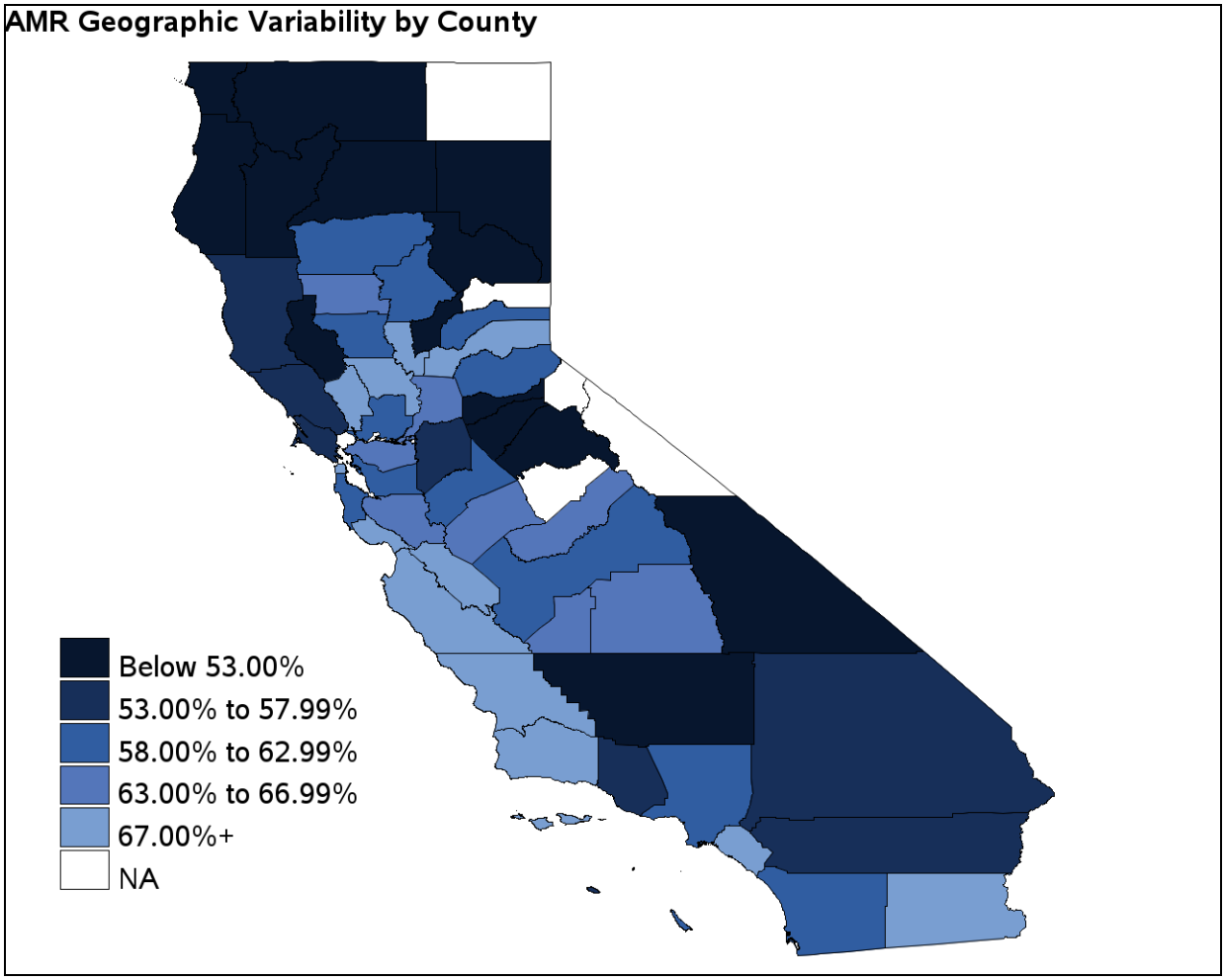
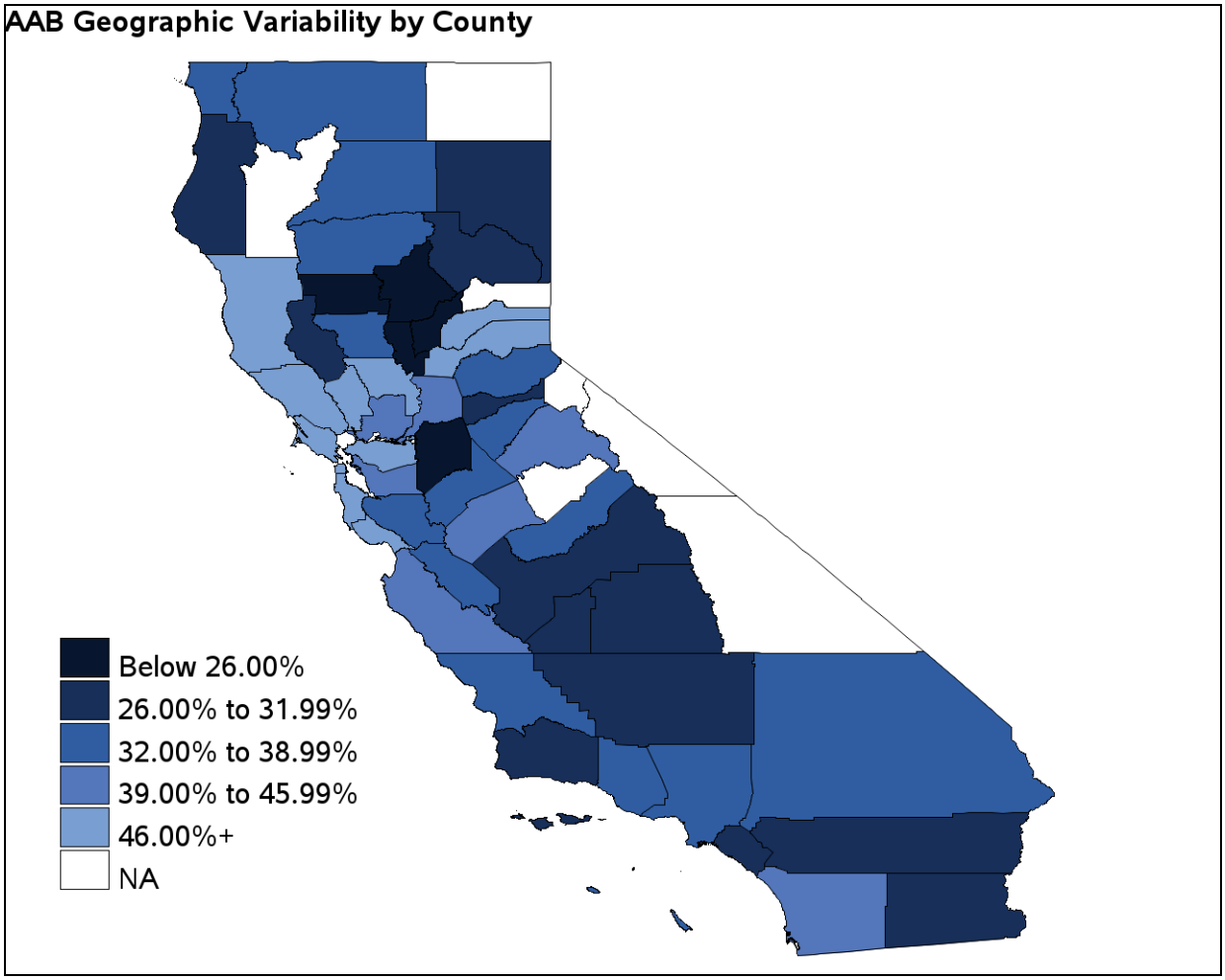


Figure 5.5—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) Geographic Variability by County

NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).



Appendix A. Demographic Stratification Results

Appendix A presents the racial/ethnic stratification results for the *Ambulatory Care* (*AMB*) indicators and the primary language, age, and gender stratification results for each indicator where appropriate, organized by domain (Preventive Screening and Children's Health, Preventive Screening and Women's Health, Care for Chronic Conditions, and Appropriate Treatment and Utilization).

Race/Ethnicity

Figure A.1 and Figure A.2 display the statewide rates by racial/ethnic group for the *Ambulatory Care* (*AMB*) indicators. Due to limitations with the data, HSAG did not perform analyses to identify health disparities for the *Ambulatory Care* (*AMB*) indicators.

Appropriate Treatment and Utilization Domain

Figure A.1 and Figure A.2 display the statewide Appropriate Treatment and Utilization indicator rates and denominator for each racial/ethnic group.

Ambulatory Care (AMB)

The *Ambulatory Care* (*AMB*) indicators summarize utilization of ambulatory care for Emergency Department Visits and Outpatient Visits.

Figure A.1—Ambulatory Care—Emergency Department Visits (AMB–ED) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 42.7 emergency department visits per 1,000 member months (N=5,084,431).

The *Ambulatory Care—Emergency Department Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

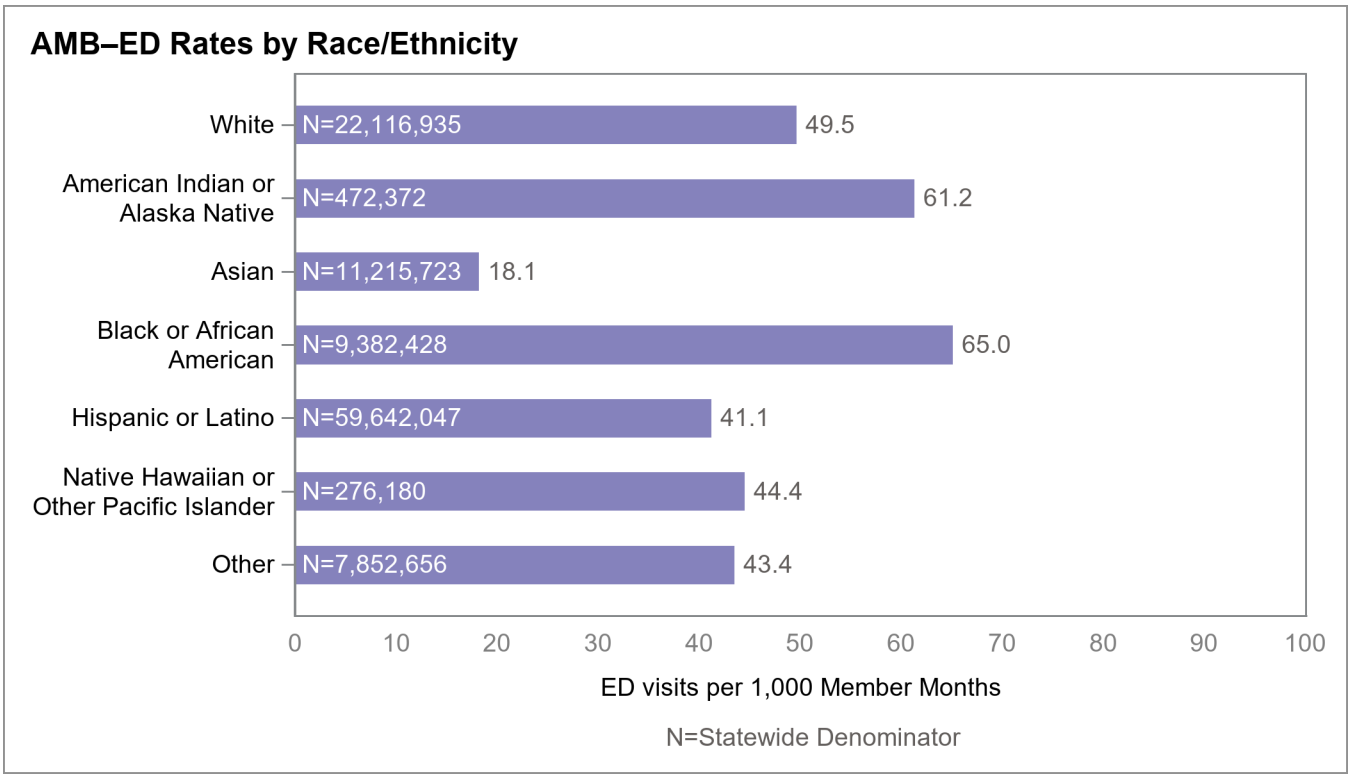
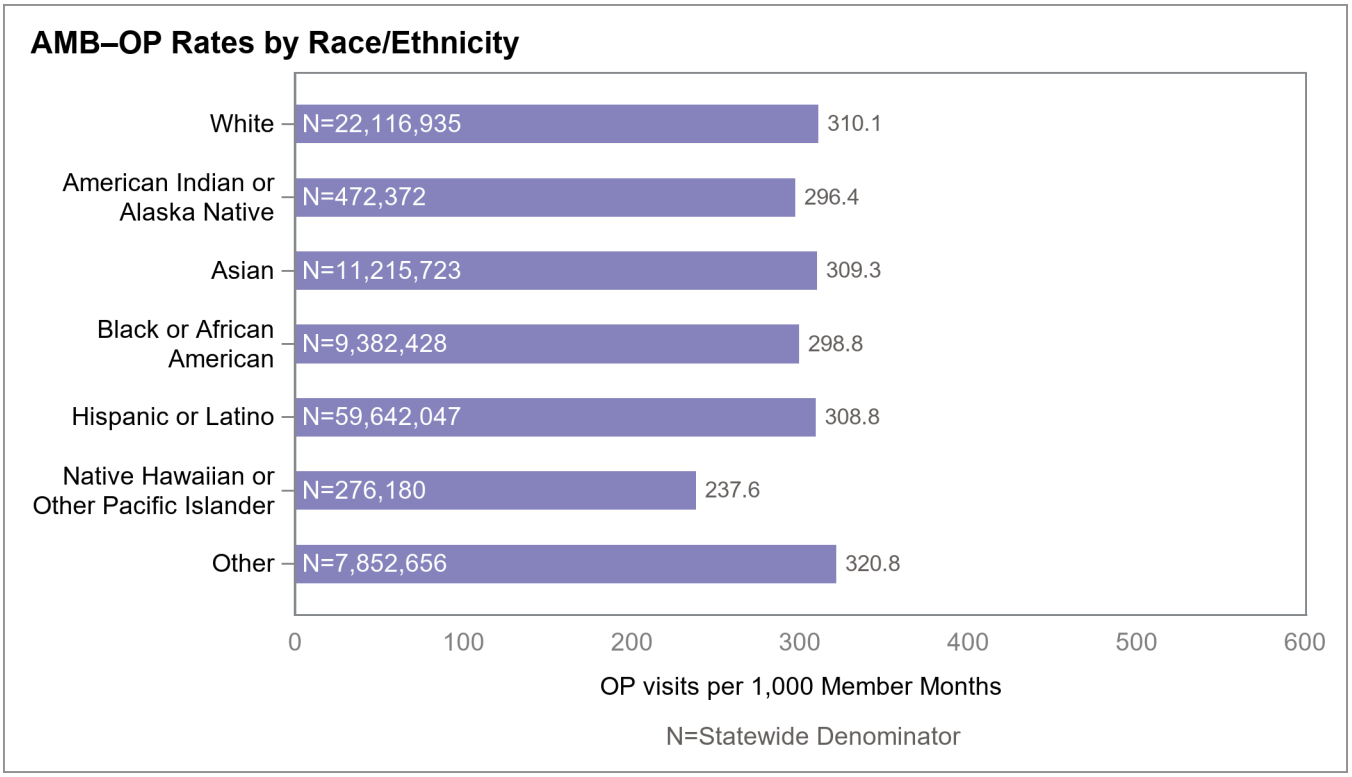


Figure A.2—Ambulatory Care—Outpatient Visits (AMB–OP) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 315.3 outpatient visits per 1,000 member months (N=5,084,431).

The *Ambulatory Care—Outpatient Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.



Primary Language

Figure A.3 through Figure A.30 display the statewide rates by each primary language group for each indicator. Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of June 2017. Please note, the rate for the Unknown/Missing group is only included as a note if the rate met the minimum denominator (i.e., 30 or more) and minimum numerator (i.e., 11 or more) requirements.

Preventive Screening and Children's Health Domain

Figure A.3 through Figure A.11 display the statewide Preventive Screening and Children's Health indicator rates and denominator for each primary language group.

Figure A.3—Childhood Immunization Status—Combination 3 (CIS–3) Rates by Primary Language

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
S indicates fewer than 11 cases exist in the numerator for the primary language group; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard.
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

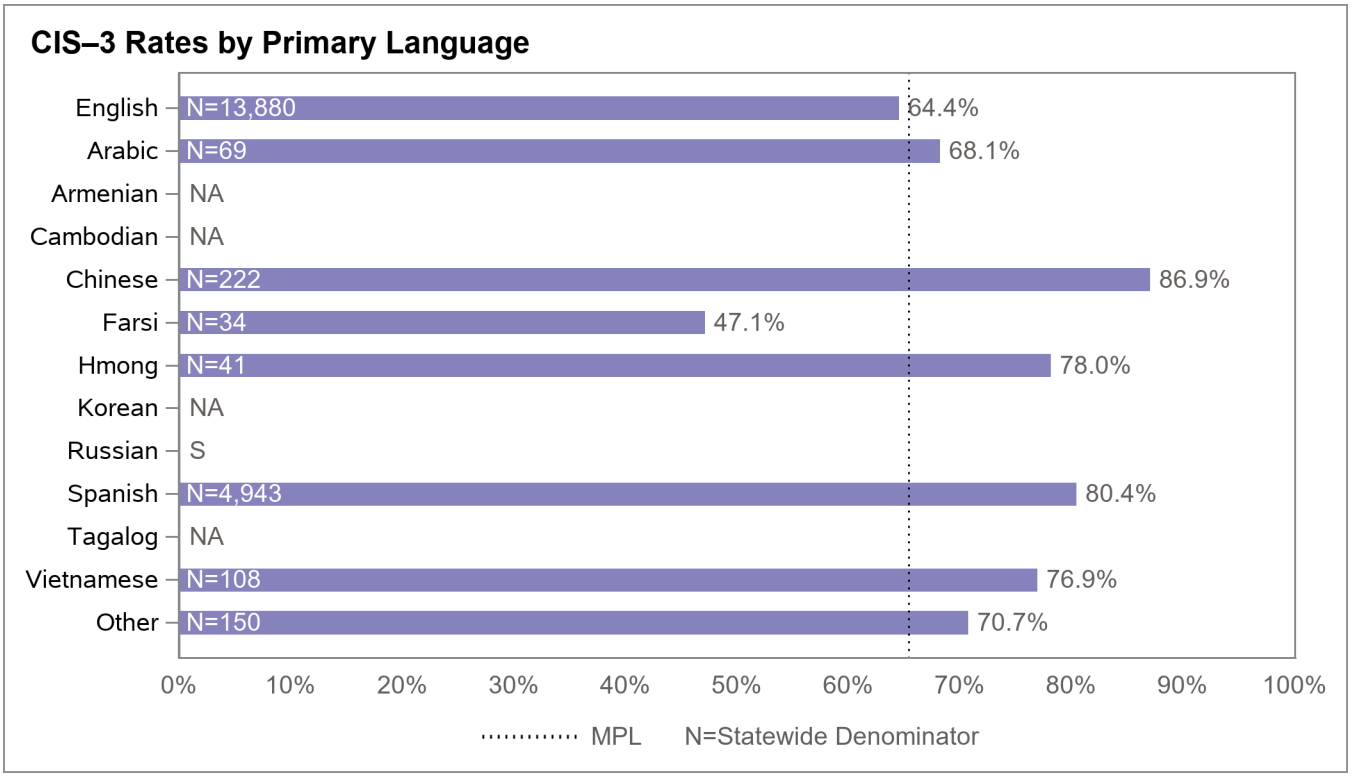


Figure A.4—Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months (CAP–1224) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 68.2 percent (N=245).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

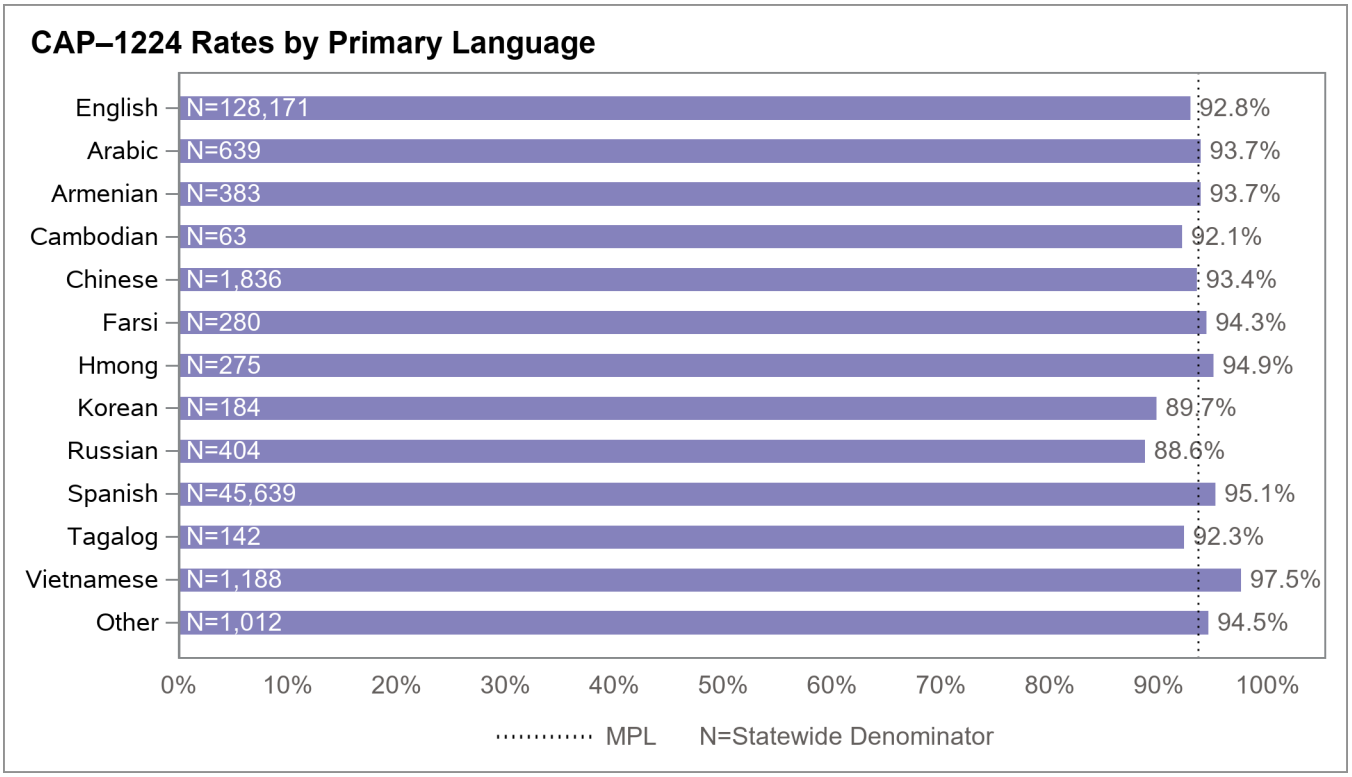


Figure A.5—Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years (CAP–256) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 60.6 percent (N=1,283).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

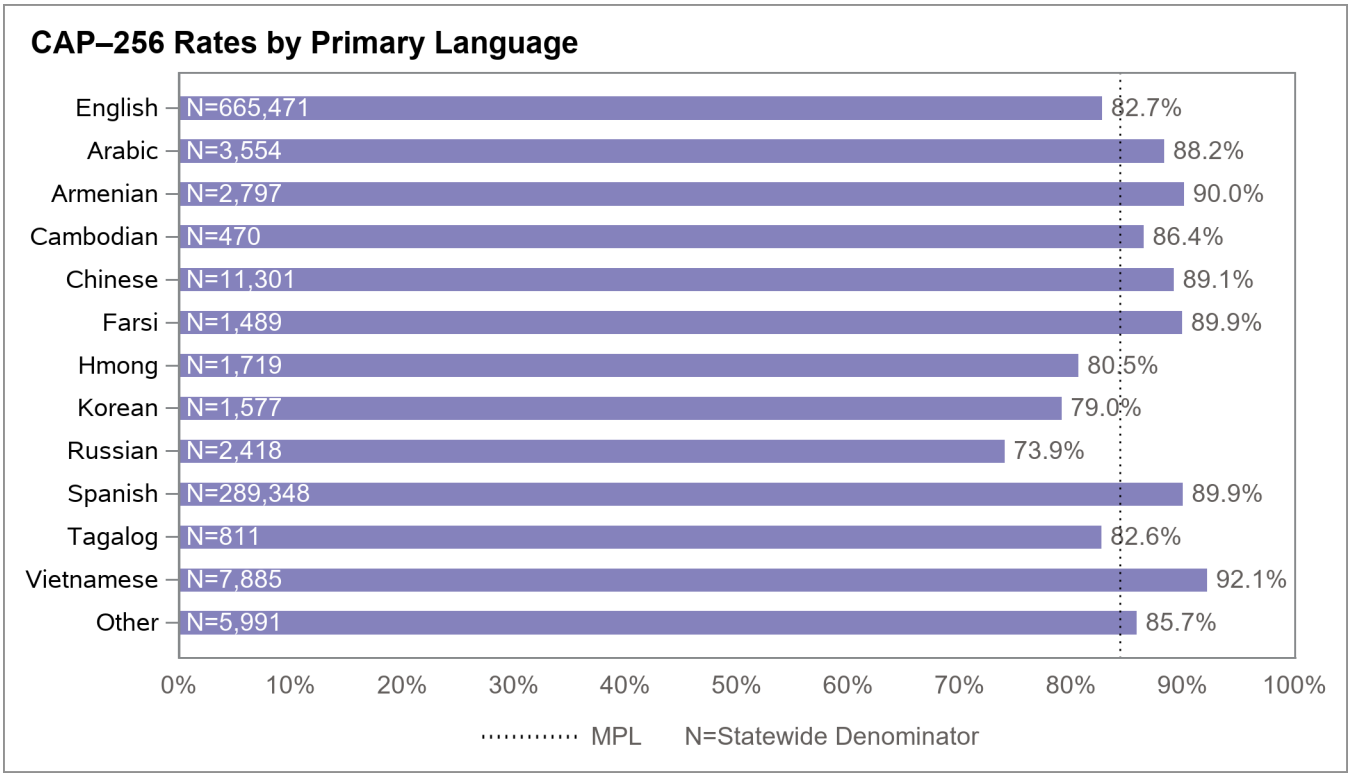


Figure A.6—Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years (CAP–711) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 63.5 percent (N=521).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

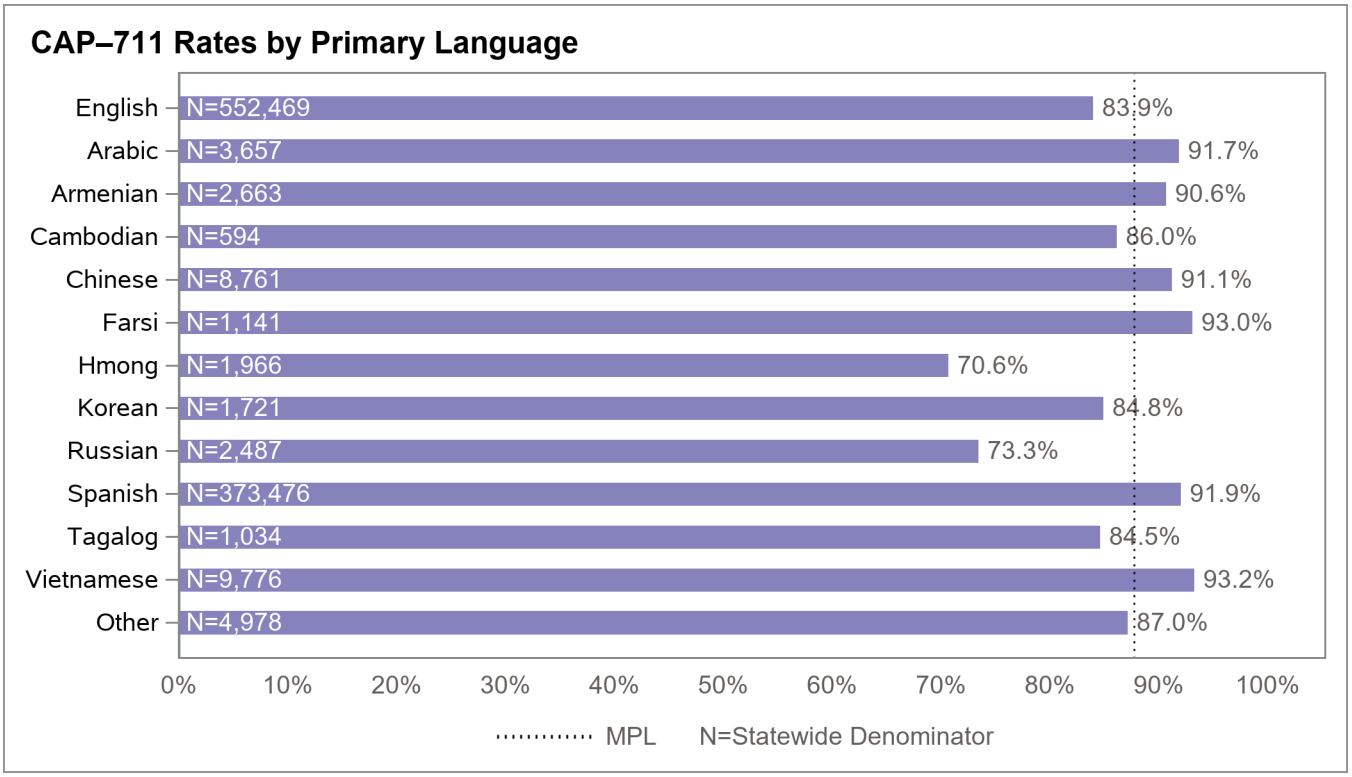


Figure A.7—Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years (CAP–1219) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 63.4 percent (N=705).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

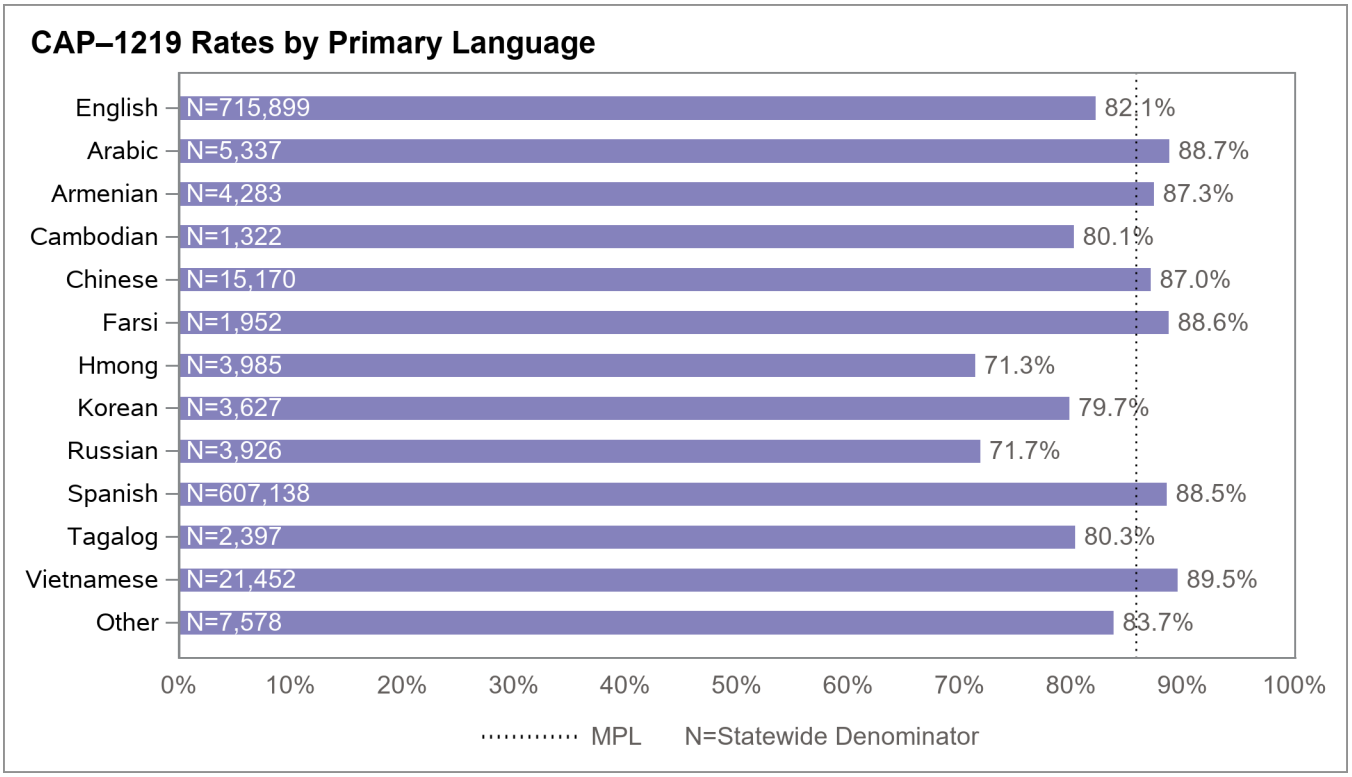


Figure A.8—Immunizations for Adolescents—Combination 2 (IMA–2) Rates by Primary Language

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
S indicates fewer than 11 cases exist in the numerator for the primary language group; therefore, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard.
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

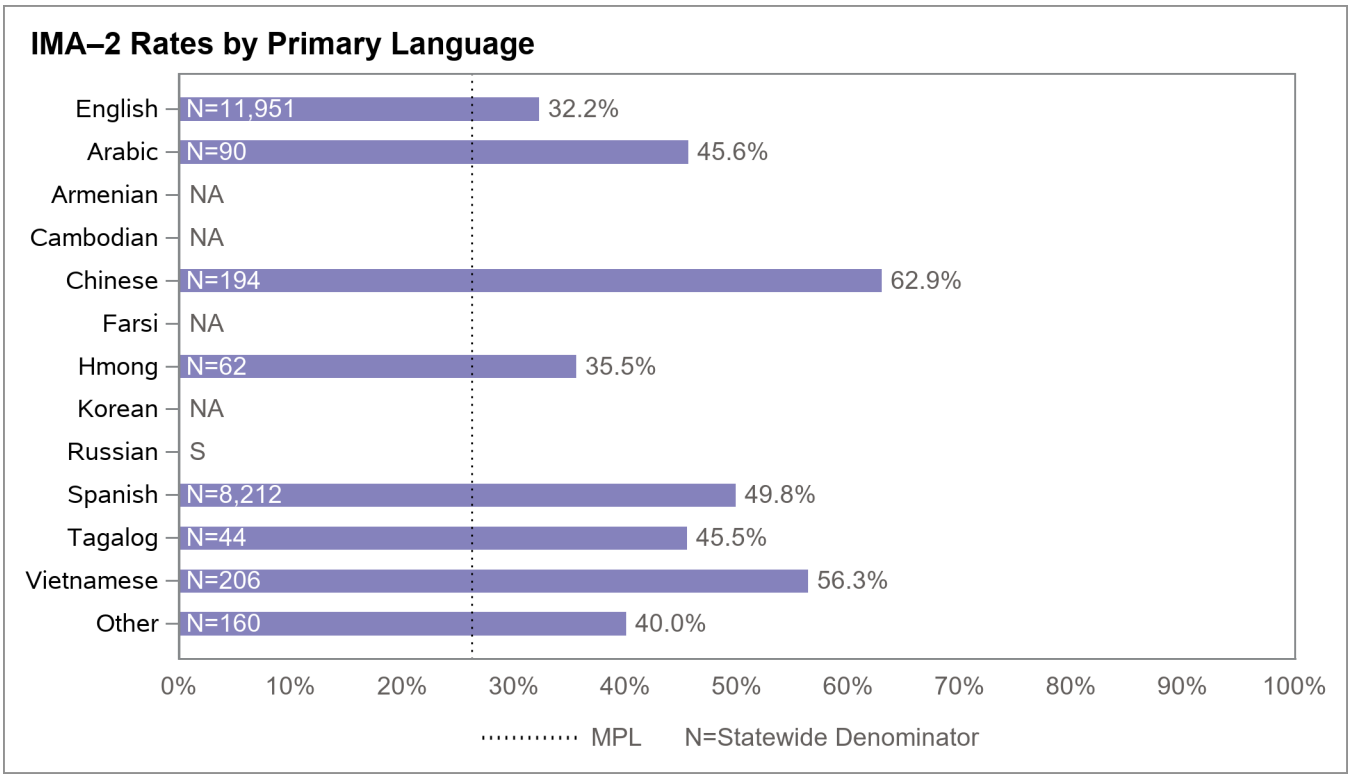


Figure A.9—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total (WCC–N) Rates by Primary Language

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

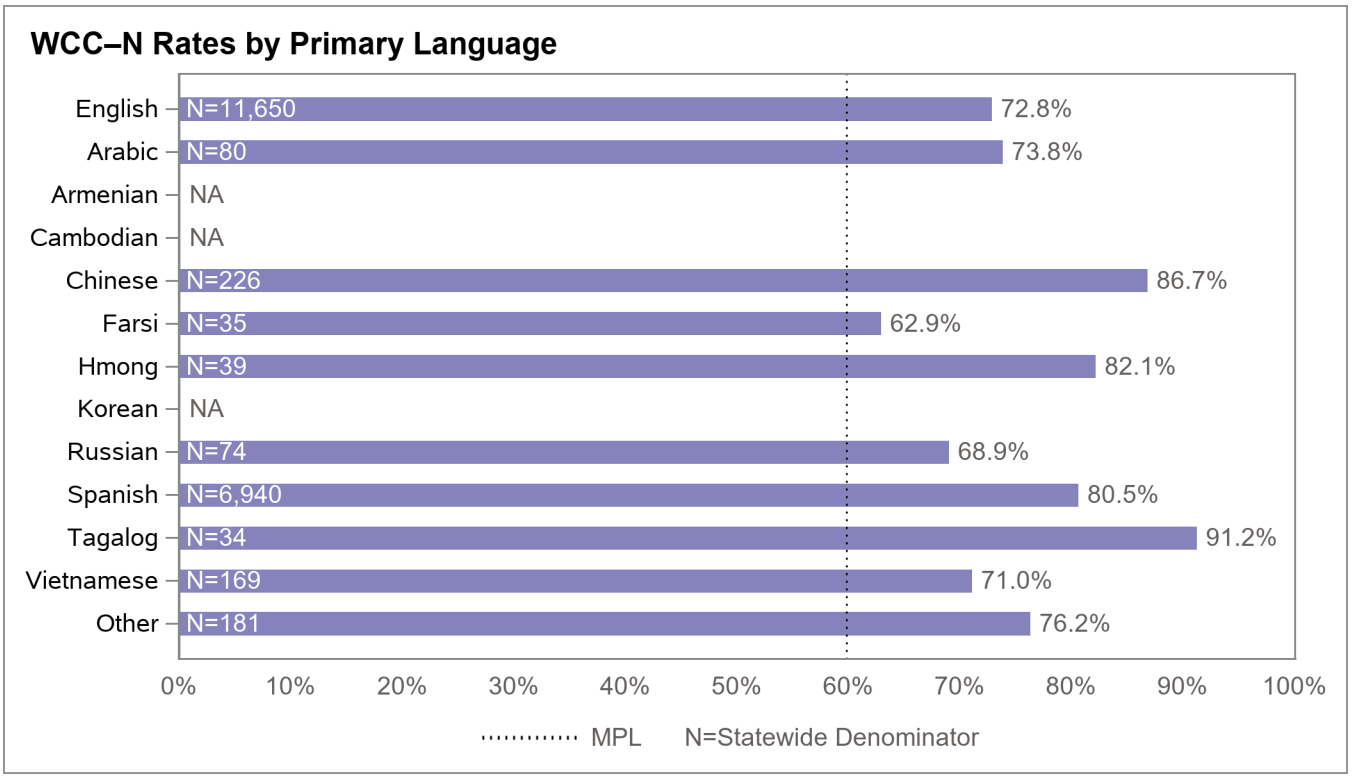


Figure A.10—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total (WCC–PA) Rates by Primary Language

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

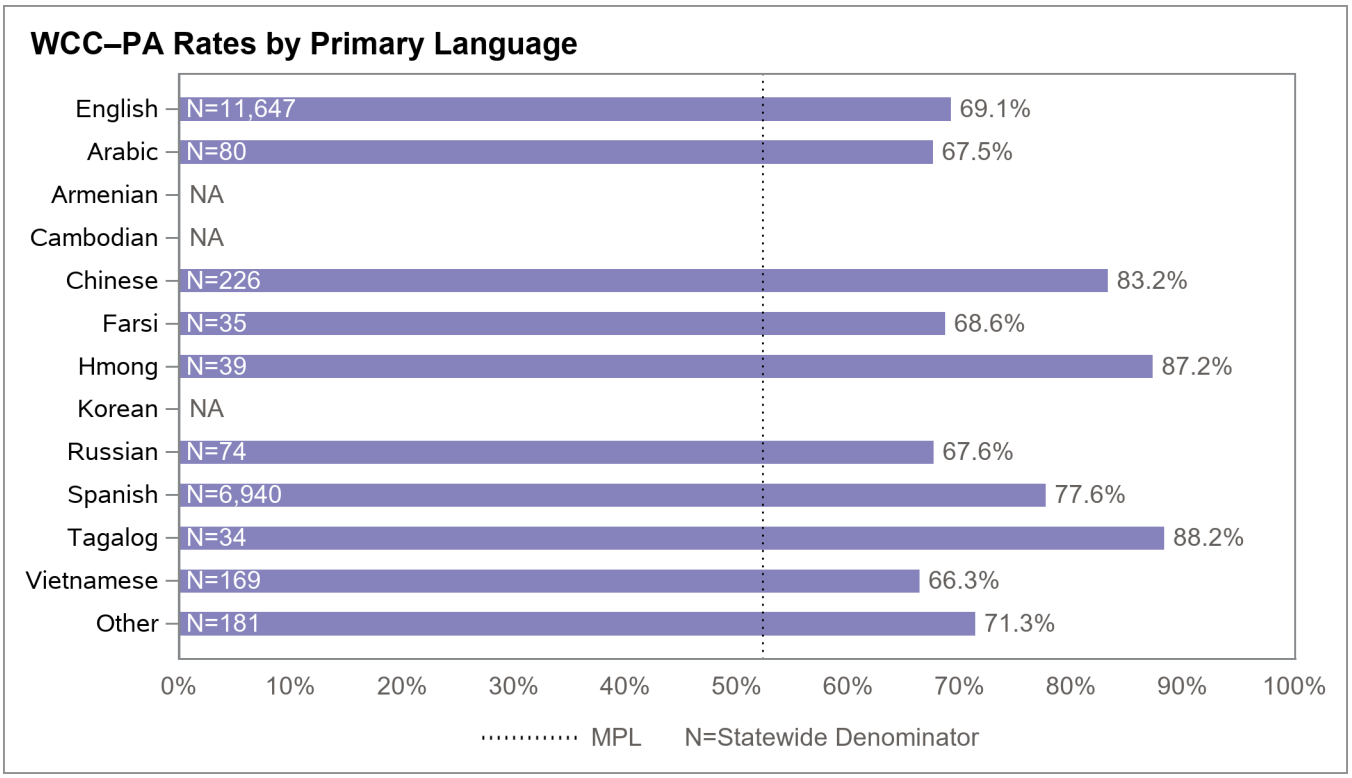
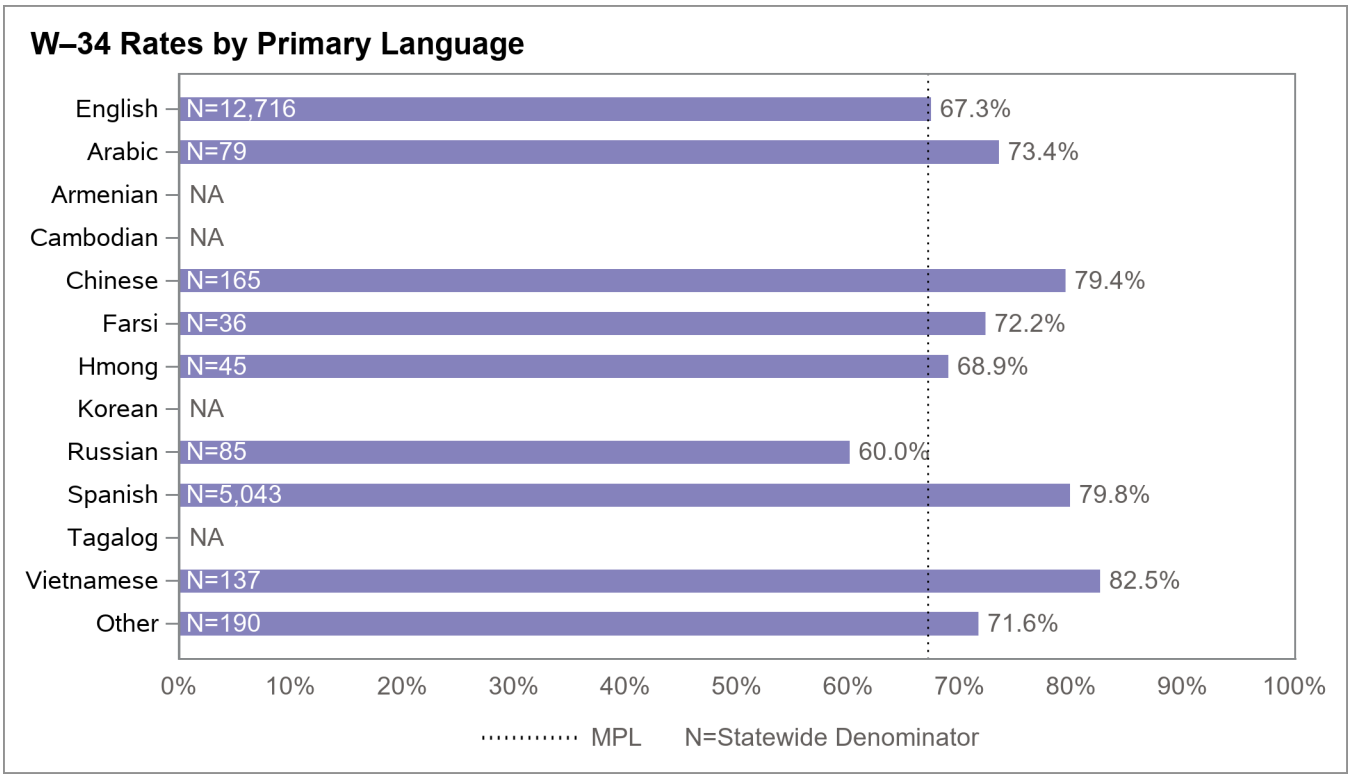


Figure A.11—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W–34) Rates by Primary Language

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



Preventive Screening and Women's Health Domain

Figure A.12 through Figure A.15 display the statewide Preventive Screening and Women's Health indicator rates and denominator for each primary language group.

Figure A.12—Breast Cancer Screening (BCS) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 45.8 percent (N=5,147).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

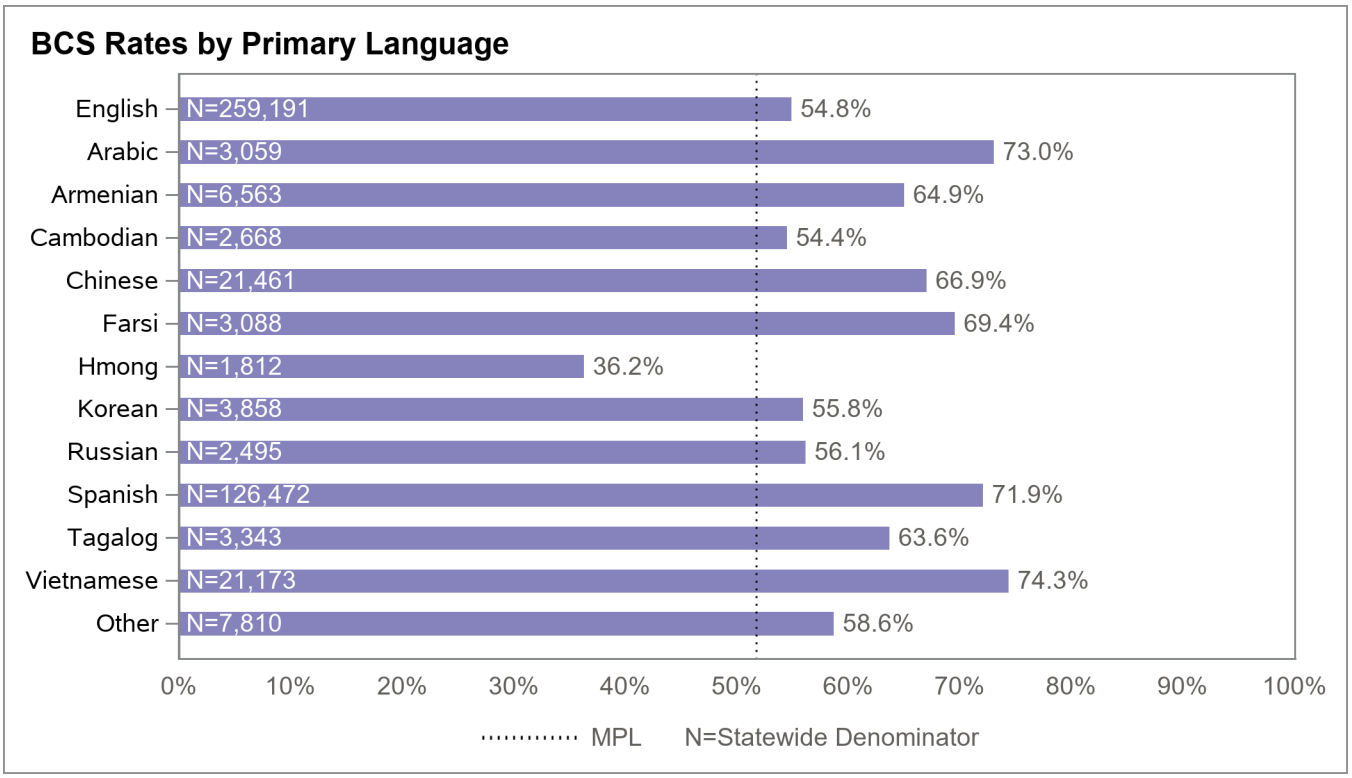


Figure A.13—Cervical Cancer Screening (CCS) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 31.9 percent (N=116).
NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

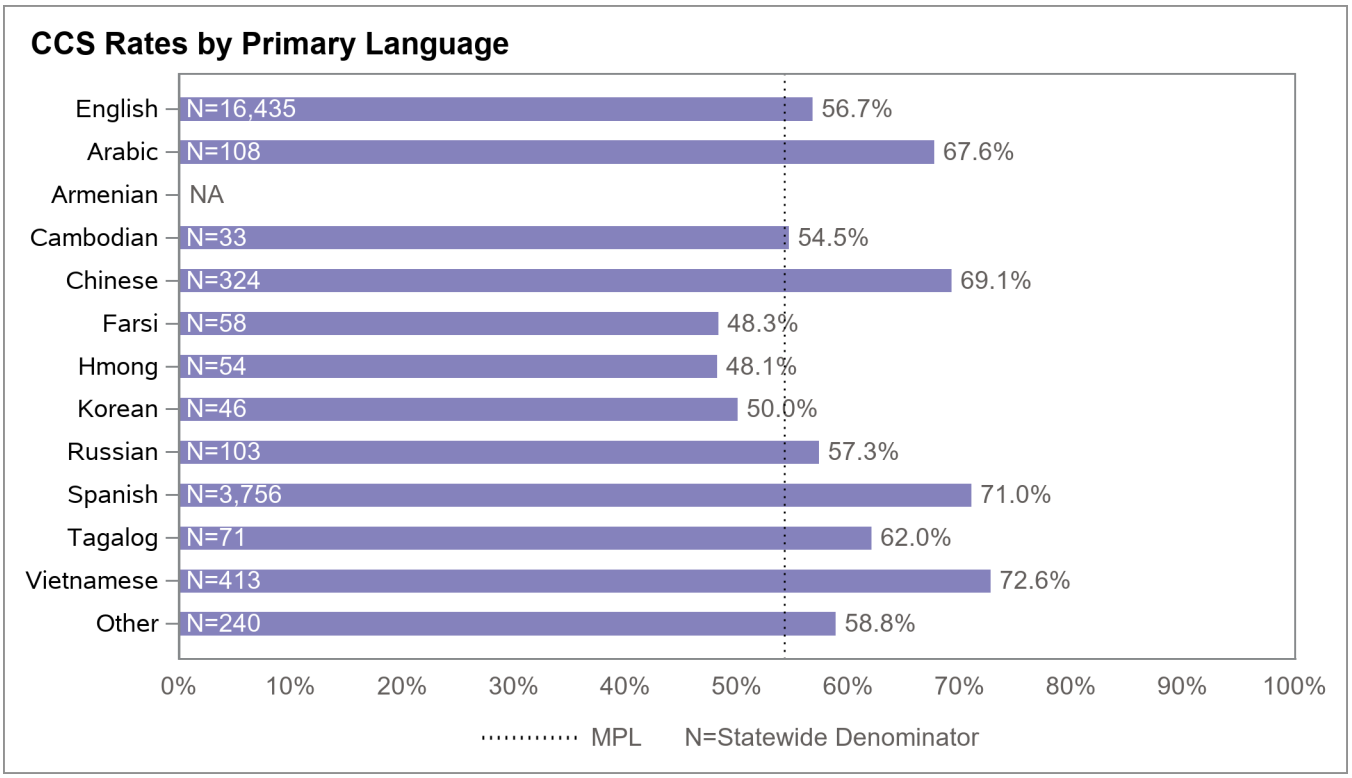


Figure A.14—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by Primary Language

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

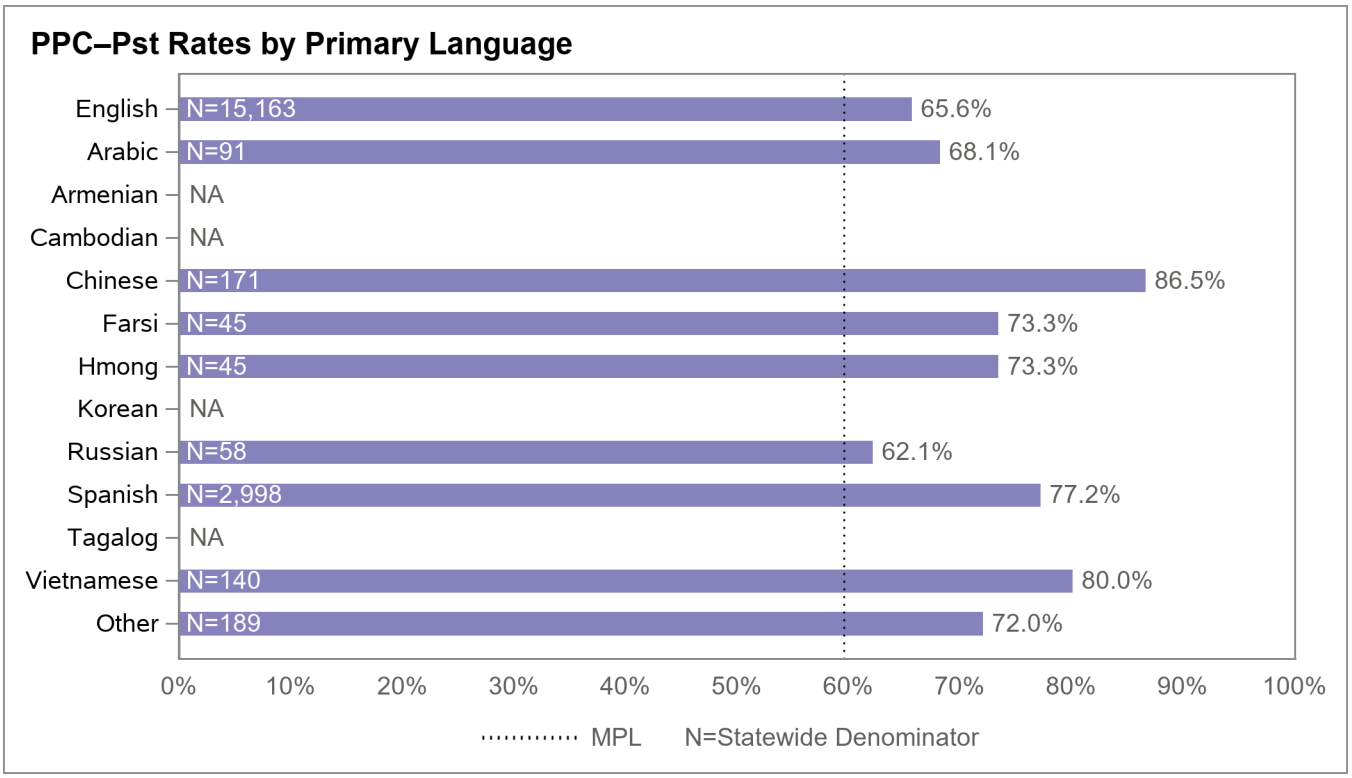
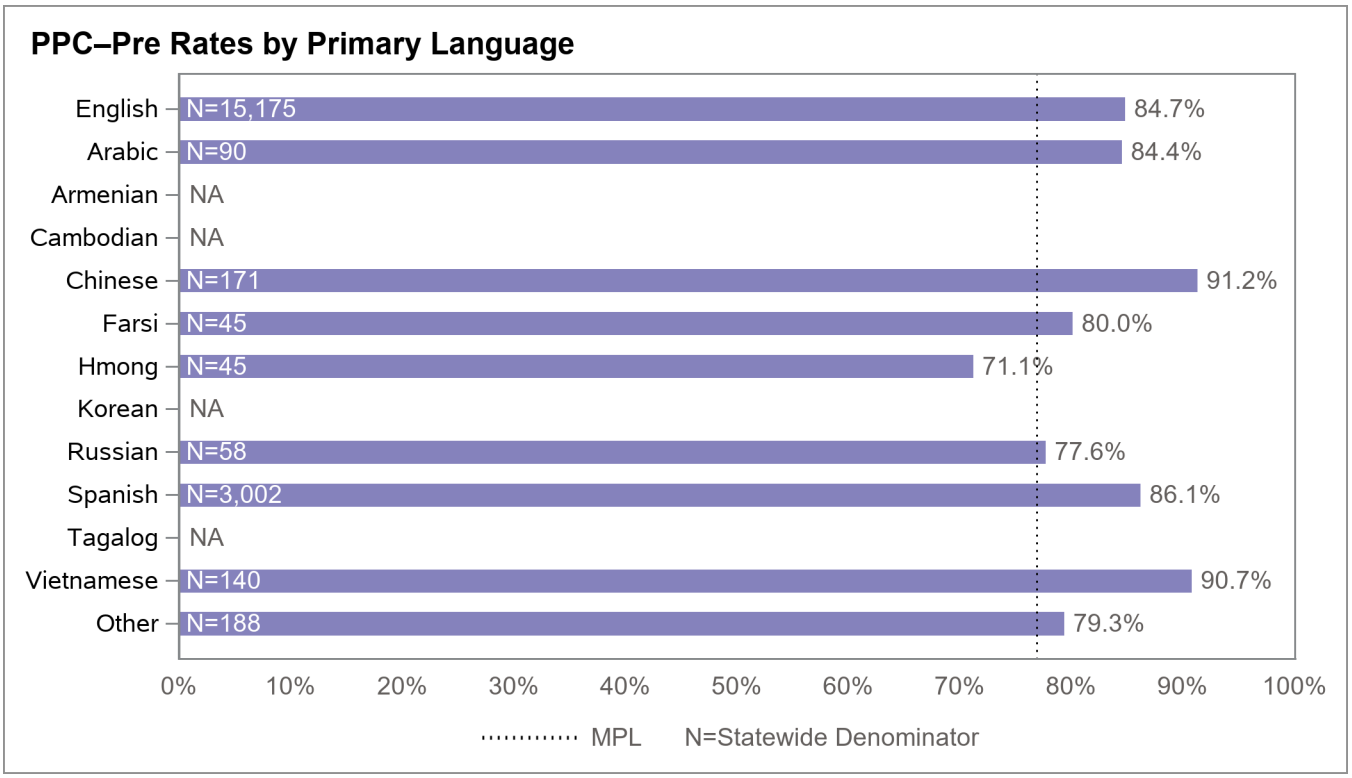


Figure A.15—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Primary Language

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



Care for Chronic Conditions Domain

Figure A.16 through Figure A.25 display the statewide Care for Chronic Conditions indicator rates and denominator for each primary language group.

Figure A.16—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs (MPM–ACE) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 90.0 percent (N=4,500).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

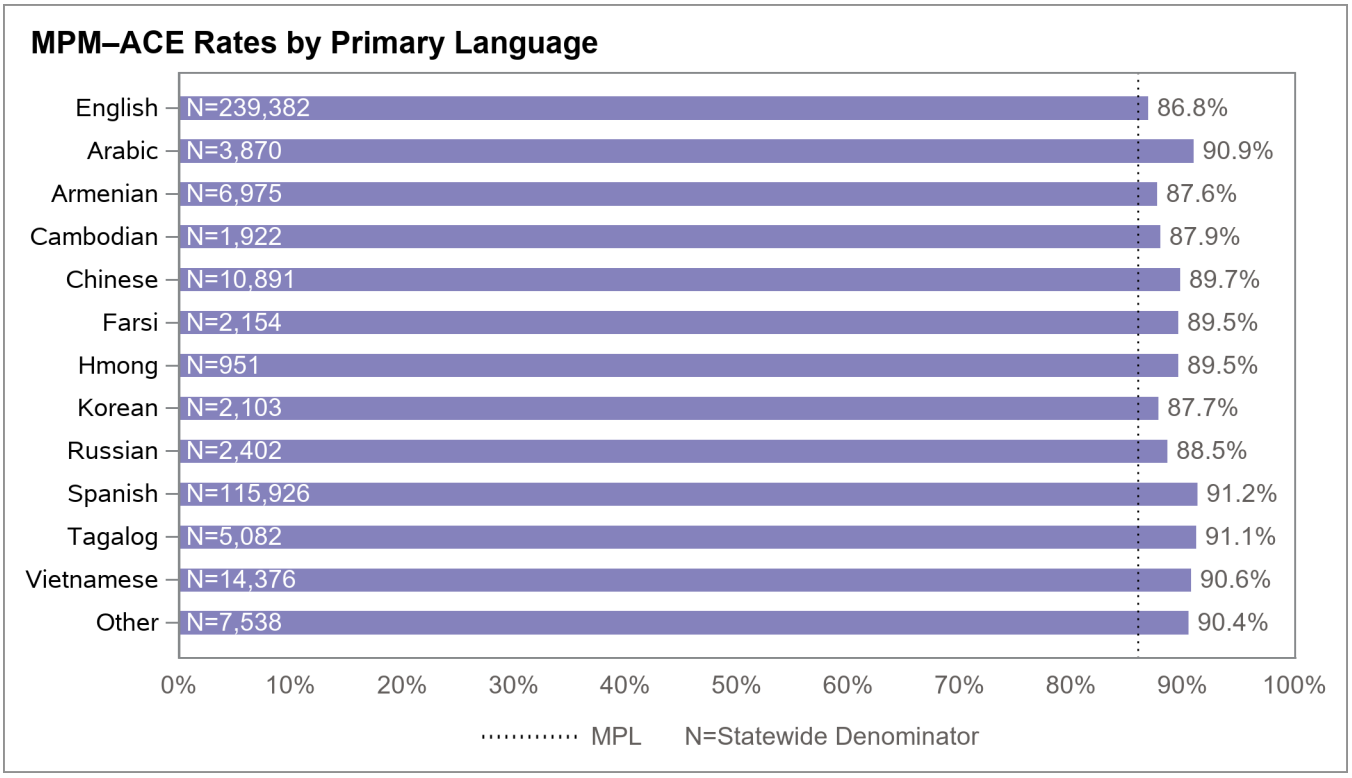


Figure A.17—Annual Monitoring for Patients on Persistent Medications—Diuretics (MPM–Diu) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 89.9 percent (N=2,424).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

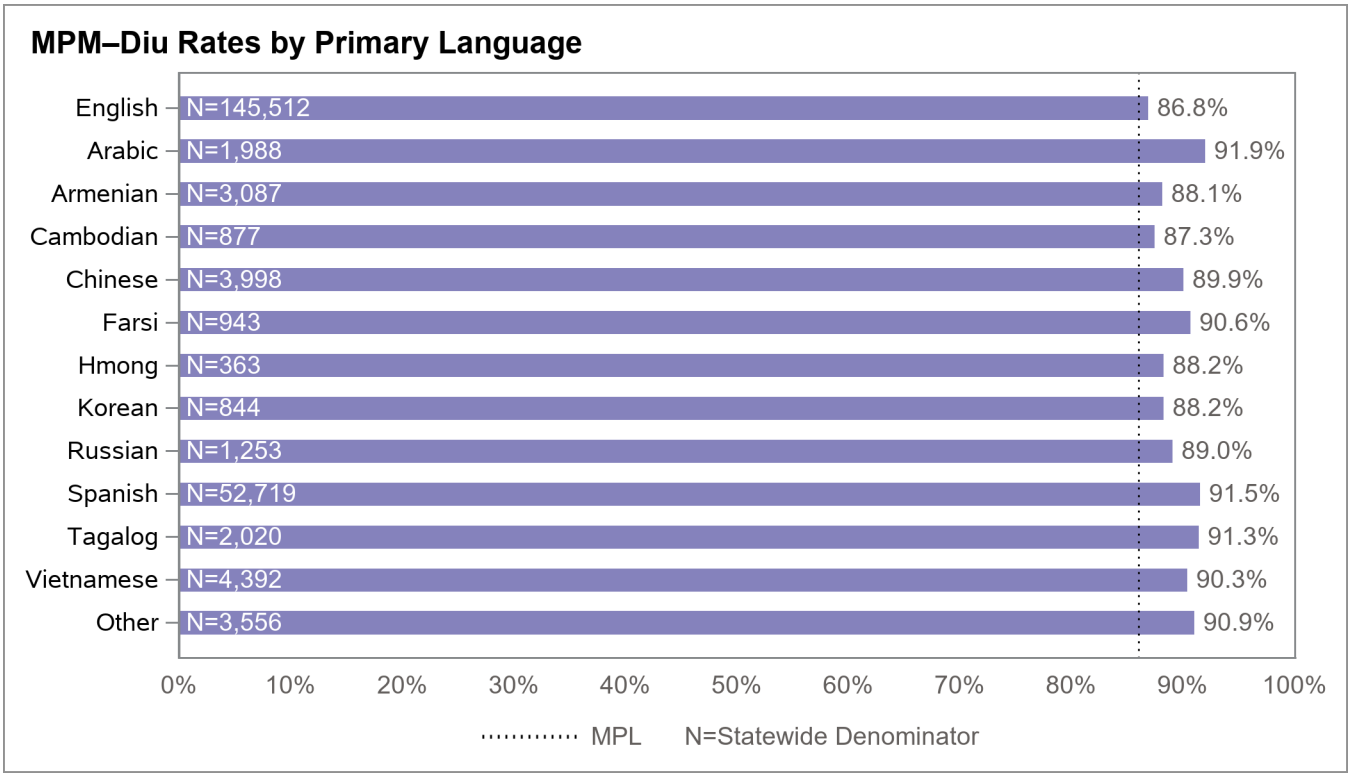


Figure A.18—Asthma Medication Ratio (AMR) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 62.8 percent (N=468).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

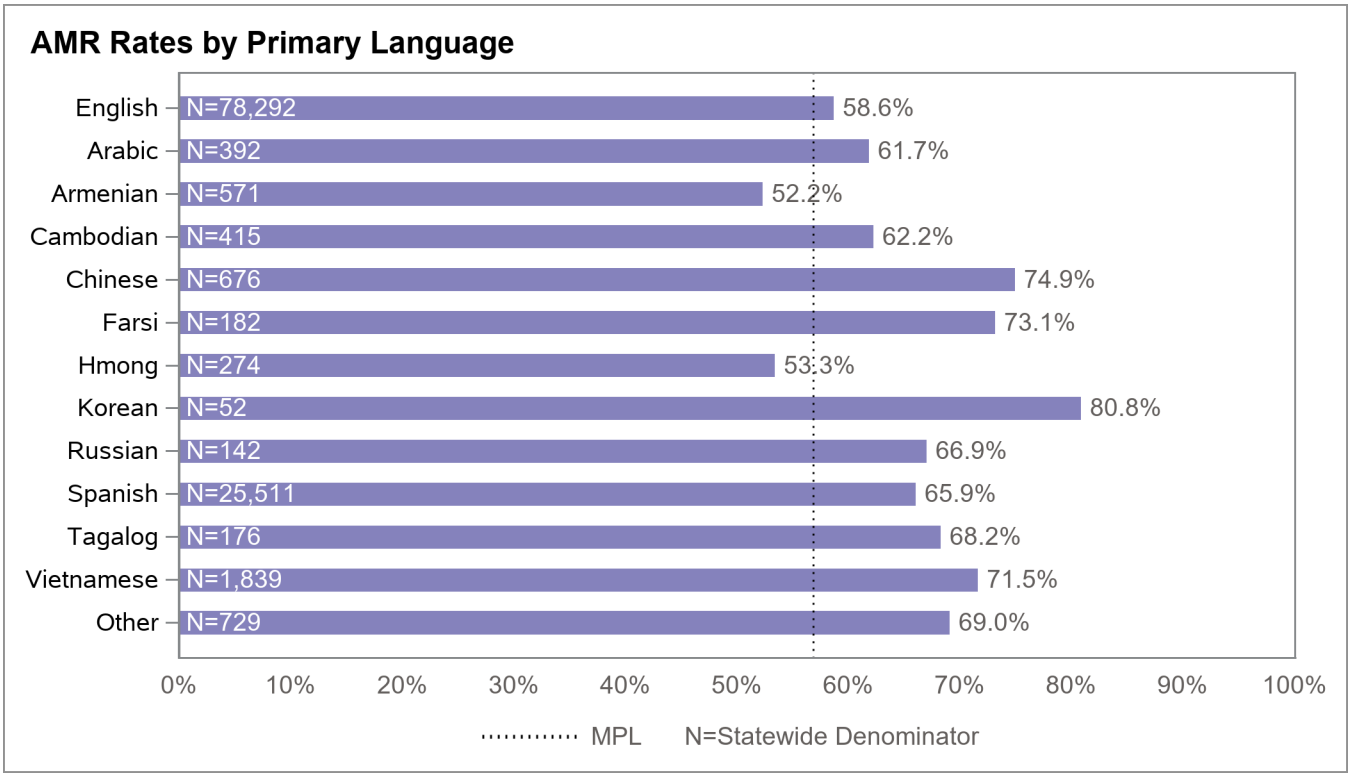


Figure A.19—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) (CDC–BP) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 64.4 percent (N=194).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

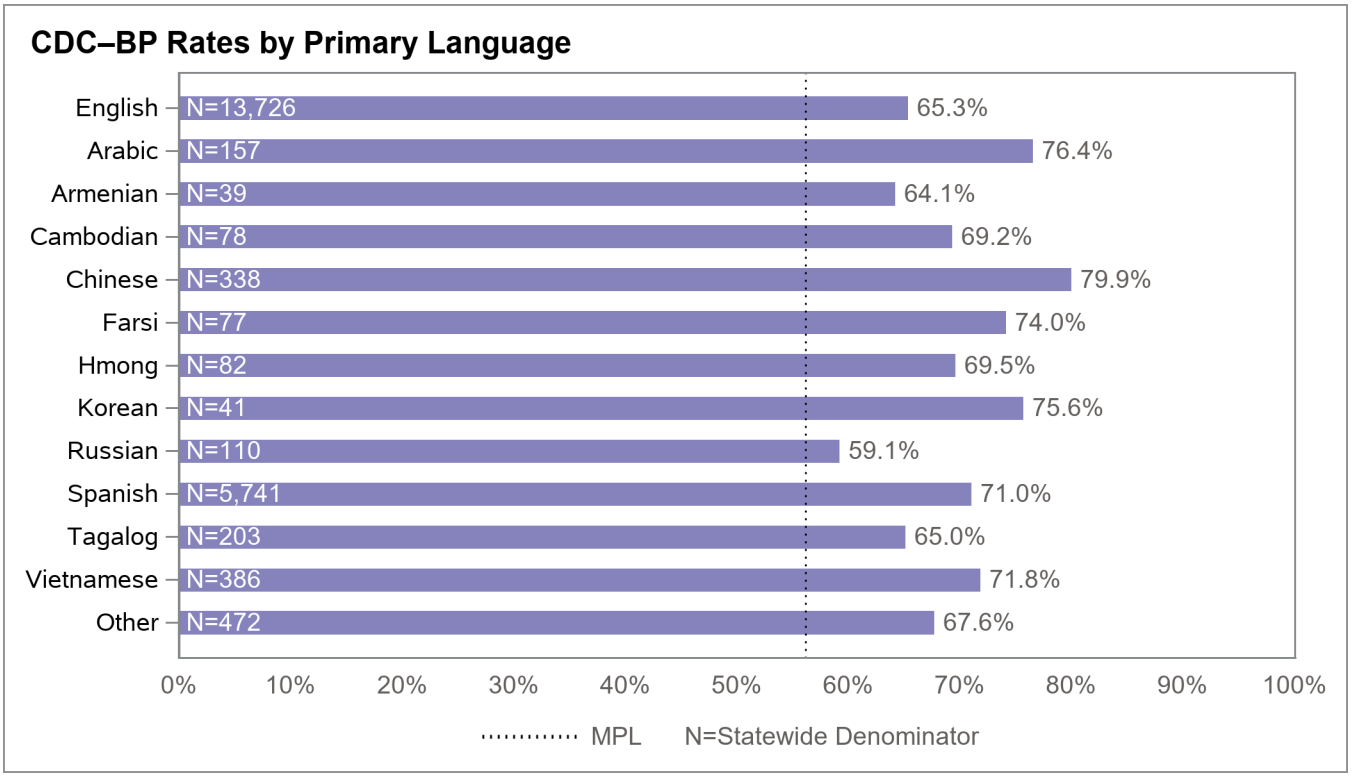


Figure A.20—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 50.5 percent (N=194).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

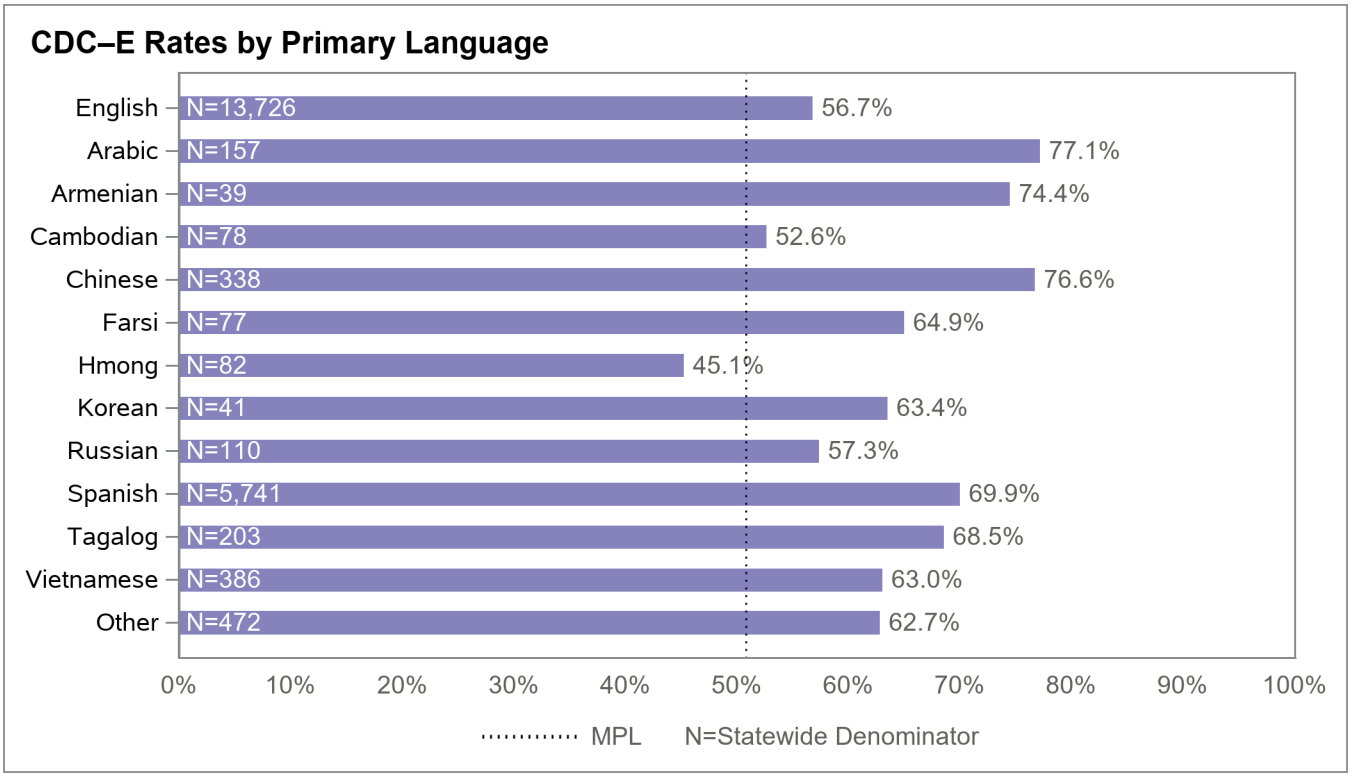


Figure A.21—Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) (CDC–H8) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 58.8 percent (N=194).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

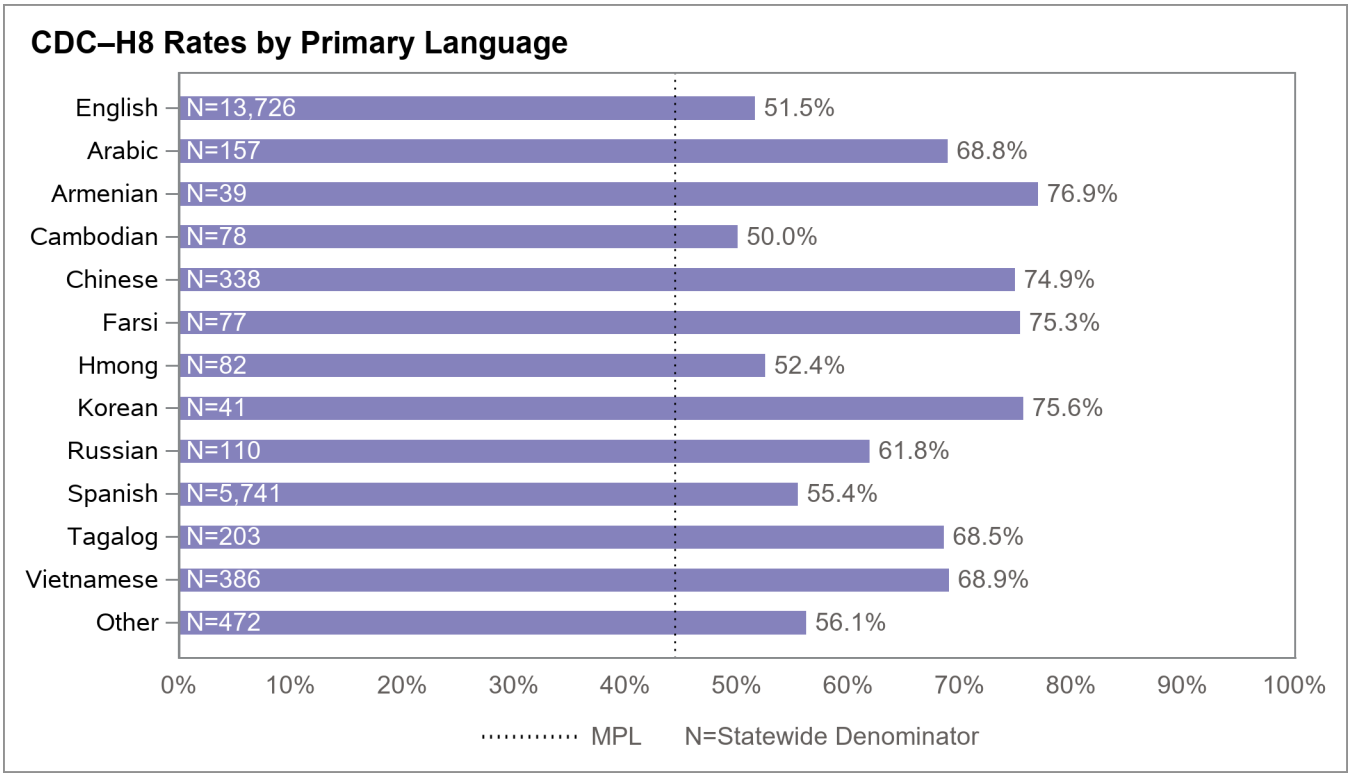


Figure A.22—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 33.5 percent (N=194).

S indicates fewer than 11 cases exist in the numerator for the primary language group; therefore, HSAG suppresses displaying the rate in this report to satisfy the HIPAA Privacy Rule's de-identification standard.

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

A lower rate indicates more favorable performance for this indicator.

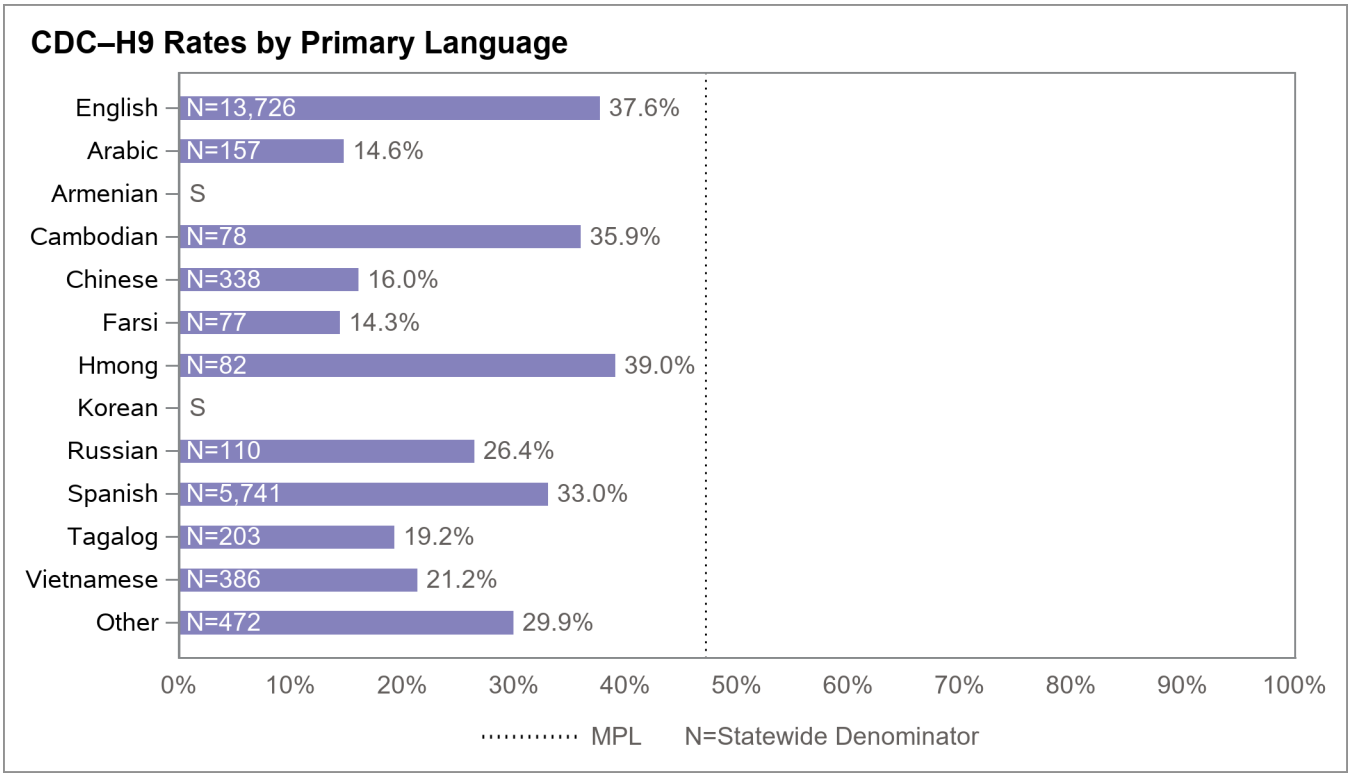


Figure A.23—Comprehensive Diabetes Care—HbA1c Testing (CDC–HT) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 84.5 percent (N=194).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

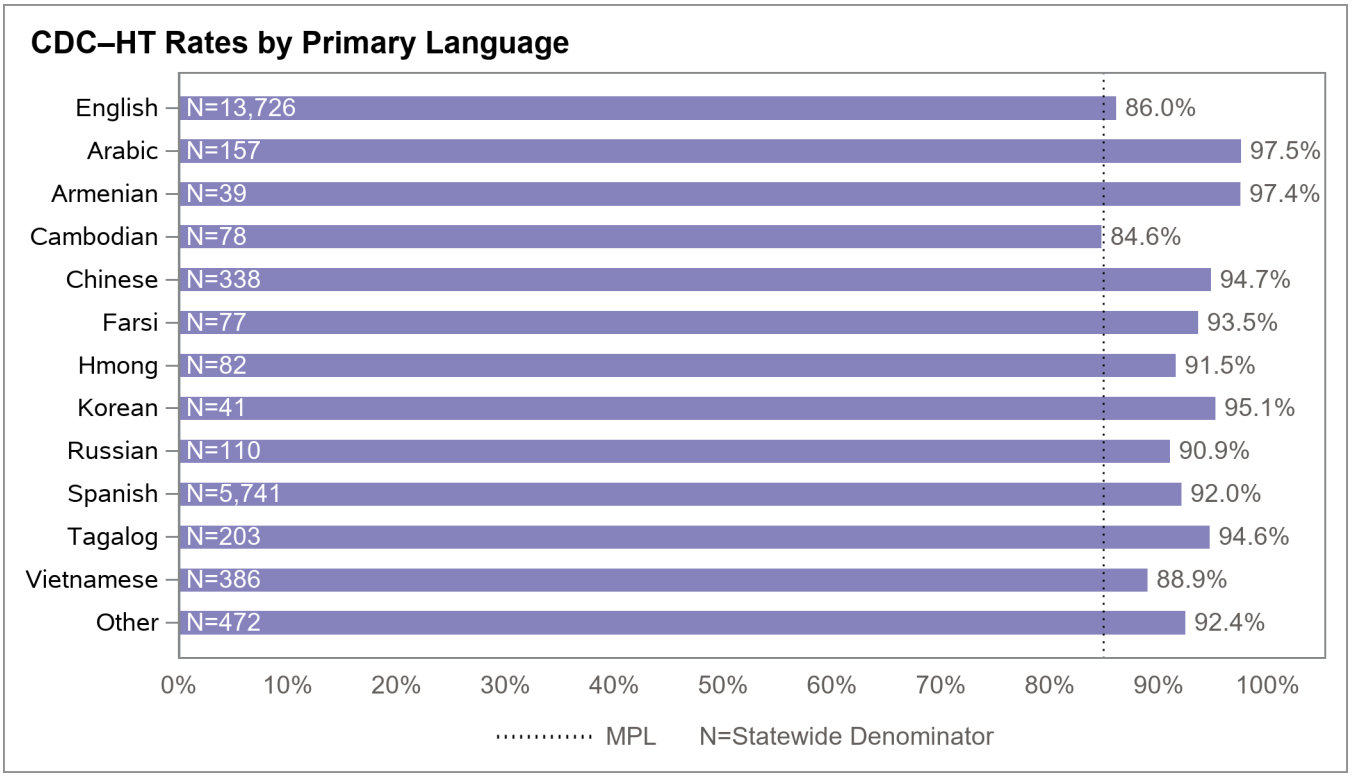


Figure A.24—Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 85.1 percent (N=194).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

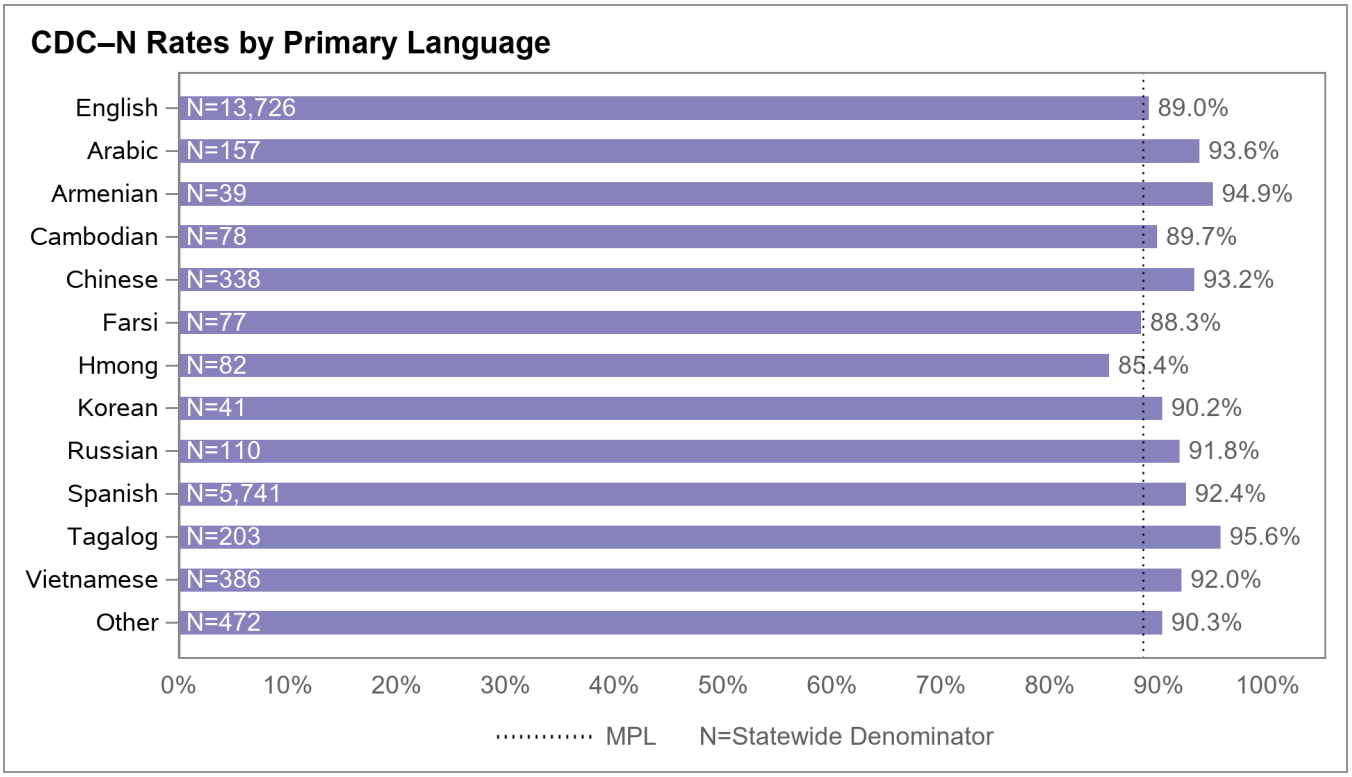
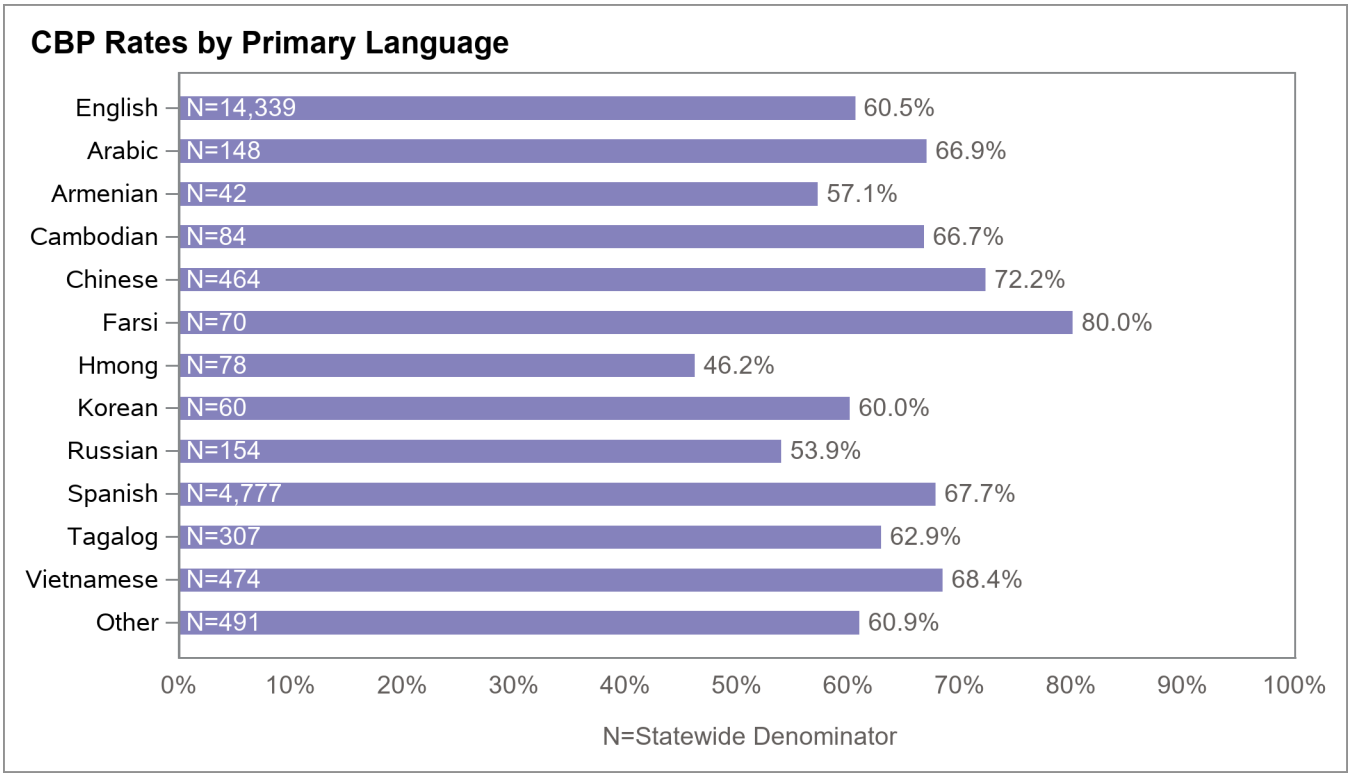


Figure A.25—Controlling High Blood Pressure (CBP) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 64.5 percent (N=220).
Due to changes in the technical specifications for the *Controlling High Blood Pressure* indicator, NCQA recommended a break in trending between reporting year 2019 and prior years; therefore, the minimum performance level is not displayed.



Appropriate Treatment and Utilization Domain

Figure A.26 through Figure A.30 display the statewide Appropriate Treatment and Utilization indicator rates and denominator for each primary language group.

Figure A.26—Plan All-Cause Readmissions (PCR) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 19.6 percent (N=2,207).
The *Plan All-Cause Readmissions* indicator does not have an established minimum performance level.

A lower rate indicates more favorable performance for this indicator.

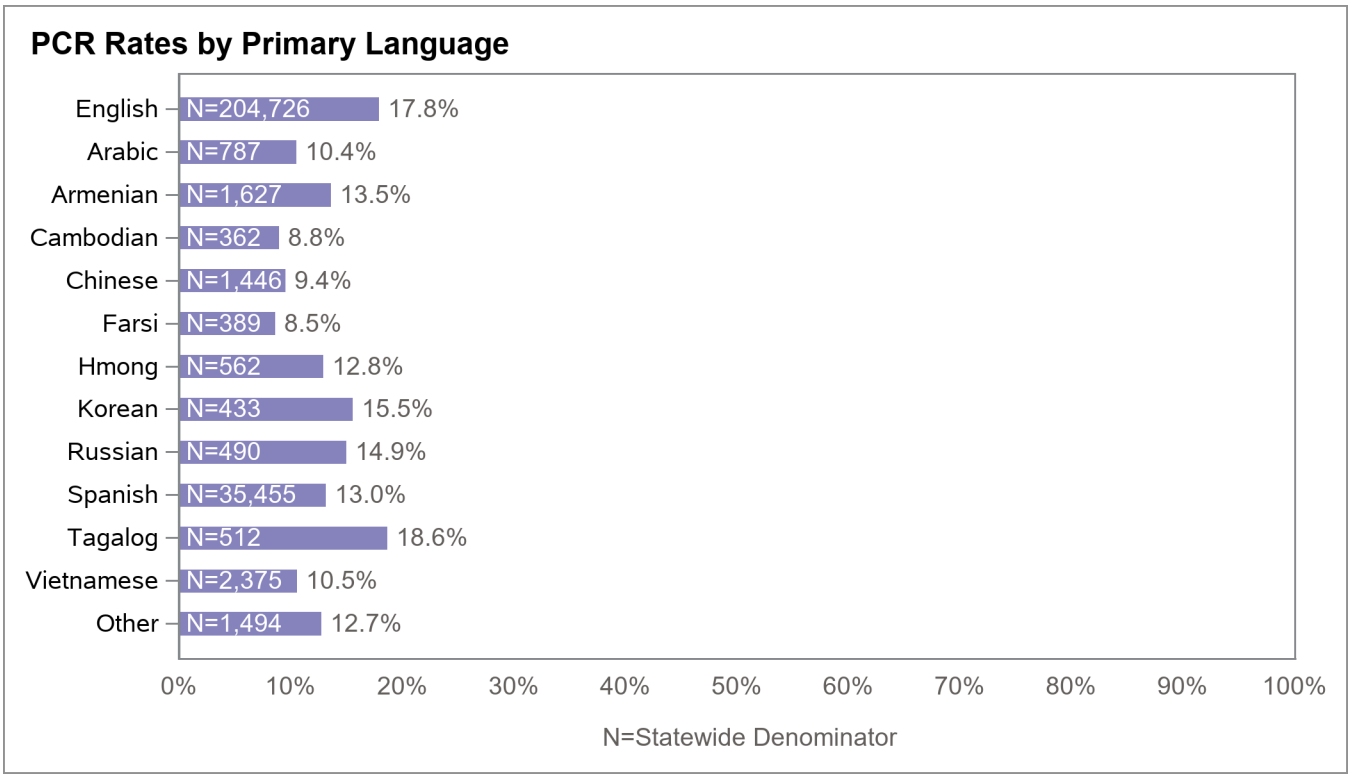


Figure A.27—Ambulatory Care—Emergency Department Visits (AMB–ED) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 37.6 emergency department visits per 1,000 member months (N=447,142).
The *Ambulatory Care—Emergency Department Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

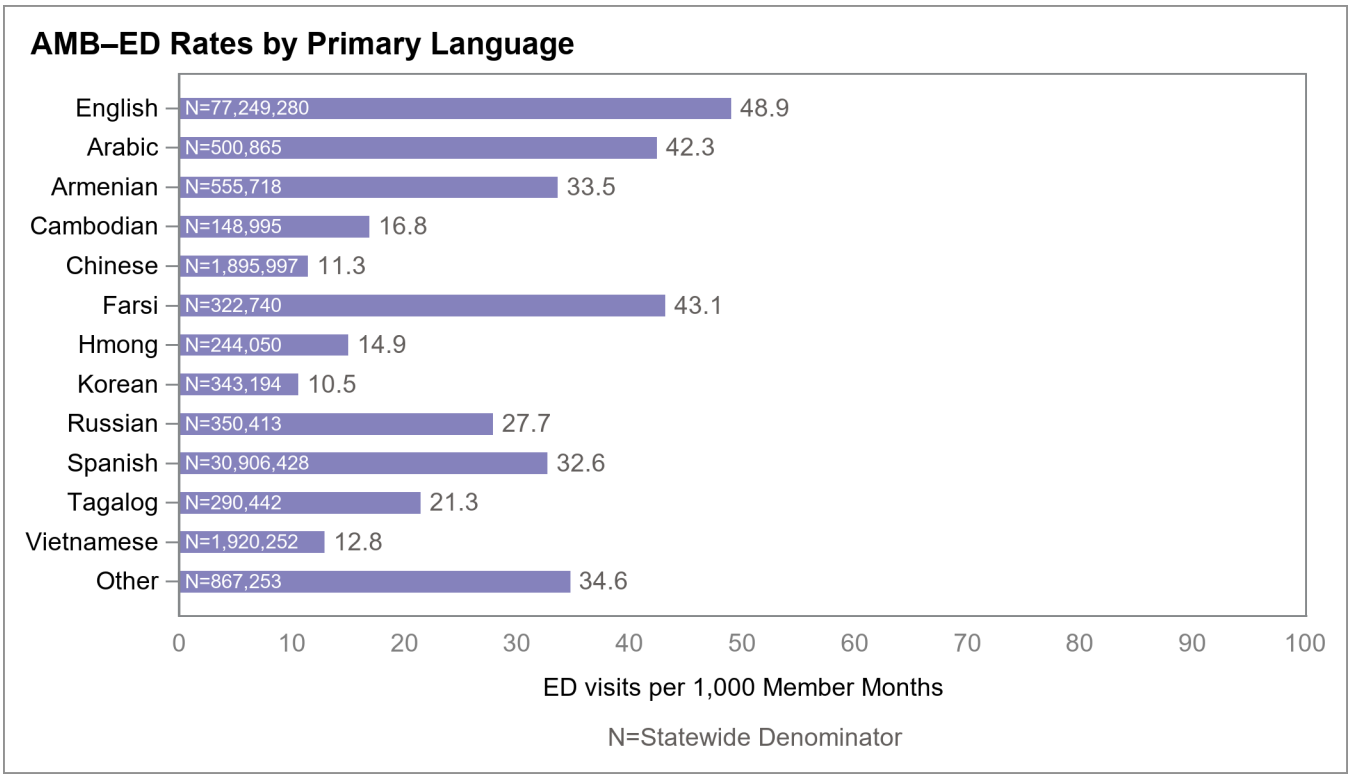


Figure A.28—Ambulatory Care—Outpatient Visits (AMB–OP) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 351.8 outpatient visits per 1,000 member months (N=447,142).

The *Ambulatory Care—Outpatient Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

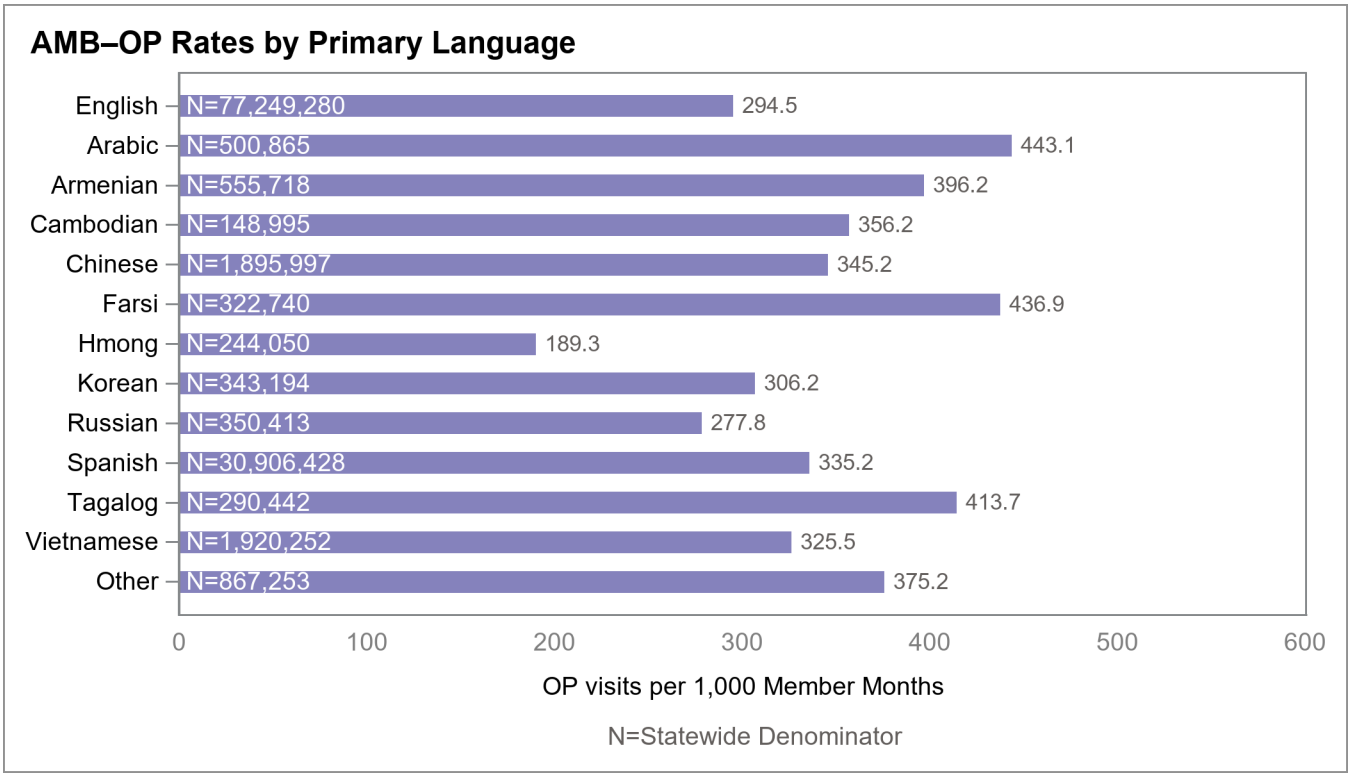


Figure A.29—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 33.9 percent (N=304).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

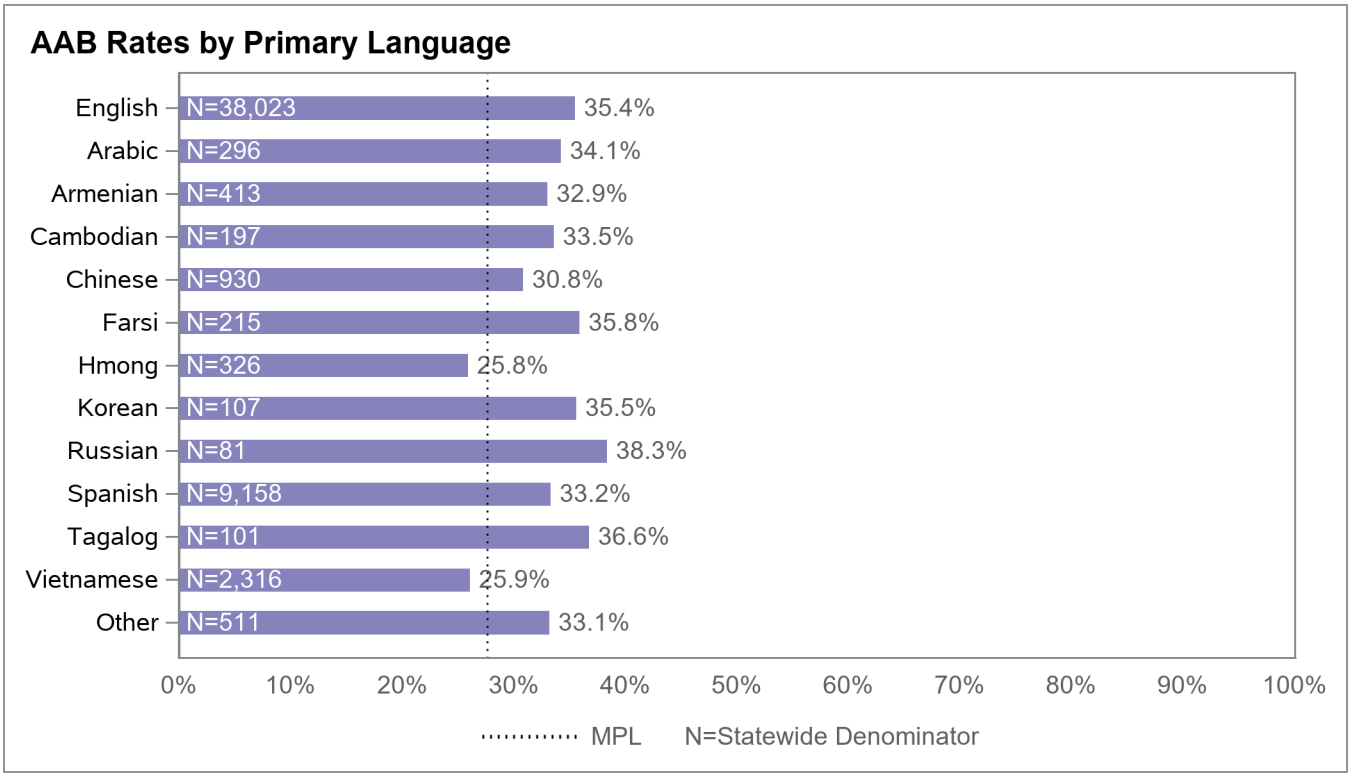
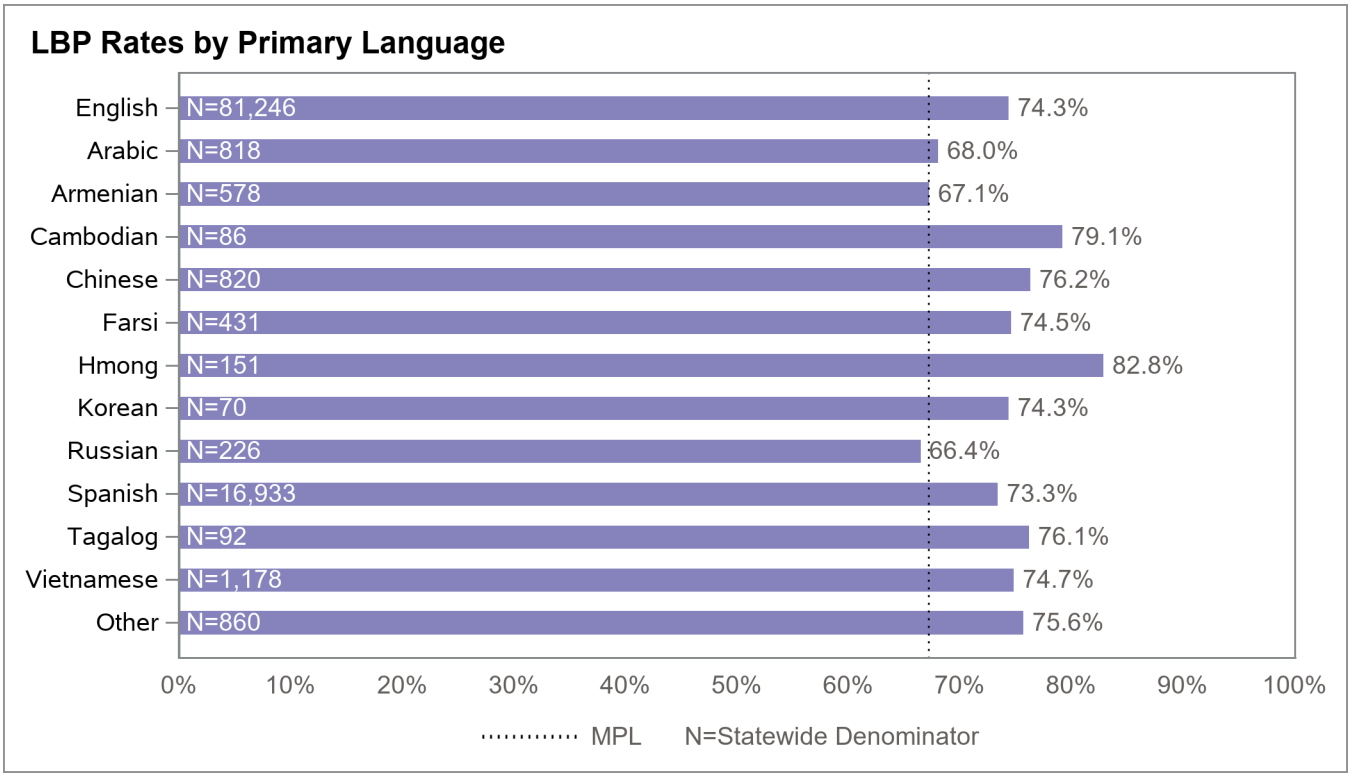


Figure A.30—Use of Imaging Studies for Low Back Pain (LBP) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 73.3 percent (N=187).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.



Age

Figure A.31 through Figure A.51 display the statewide rates by age group for each indicator. HSAG collaborated with DHCS to define the age groups for each indicator. Please note, HSAG did not present age stratifications for indicators with only one age group (e.g., *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*).

Preventive Screening and Children's Health Domain

Figure A.31 and Figure A.32 display the statewide Preventive Screening and Children's Health indicator rates and denominator for each age group.

Figure A.31—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total (WCC–N) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

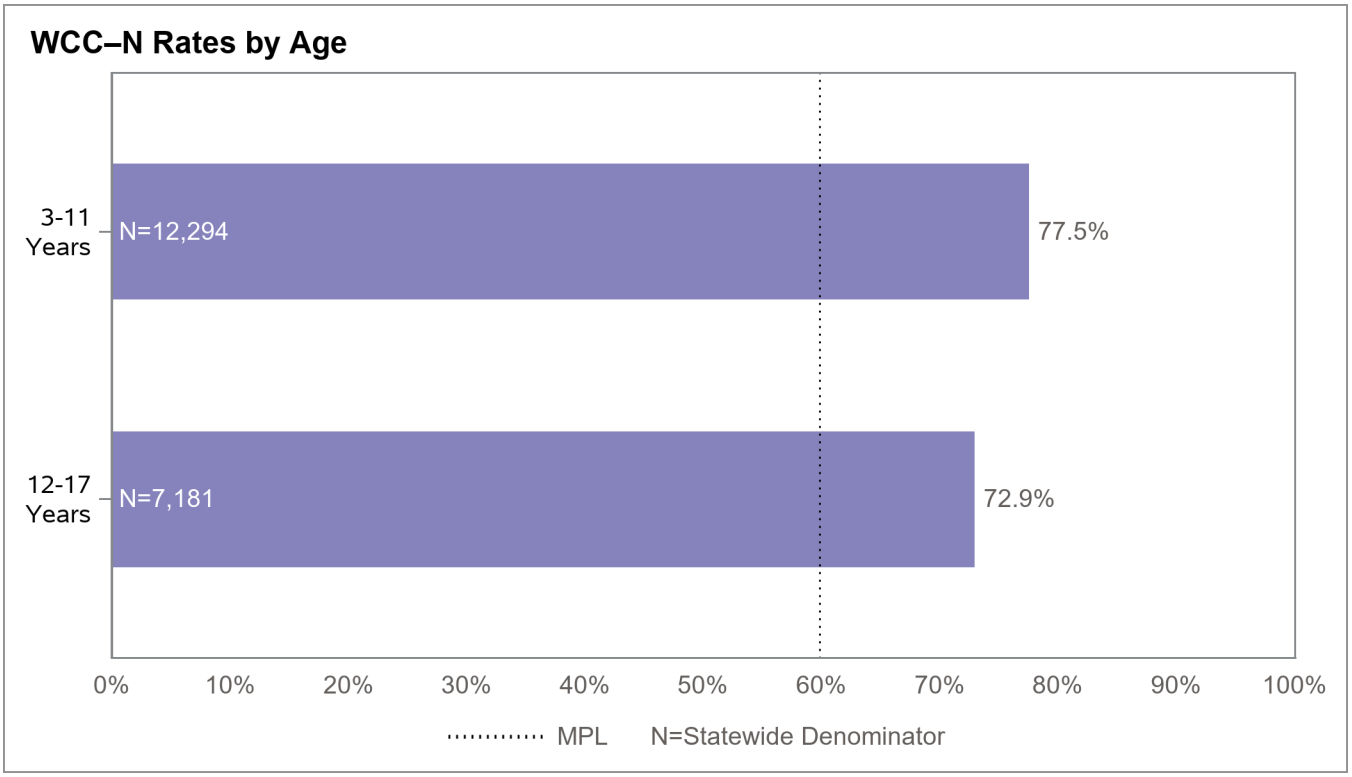
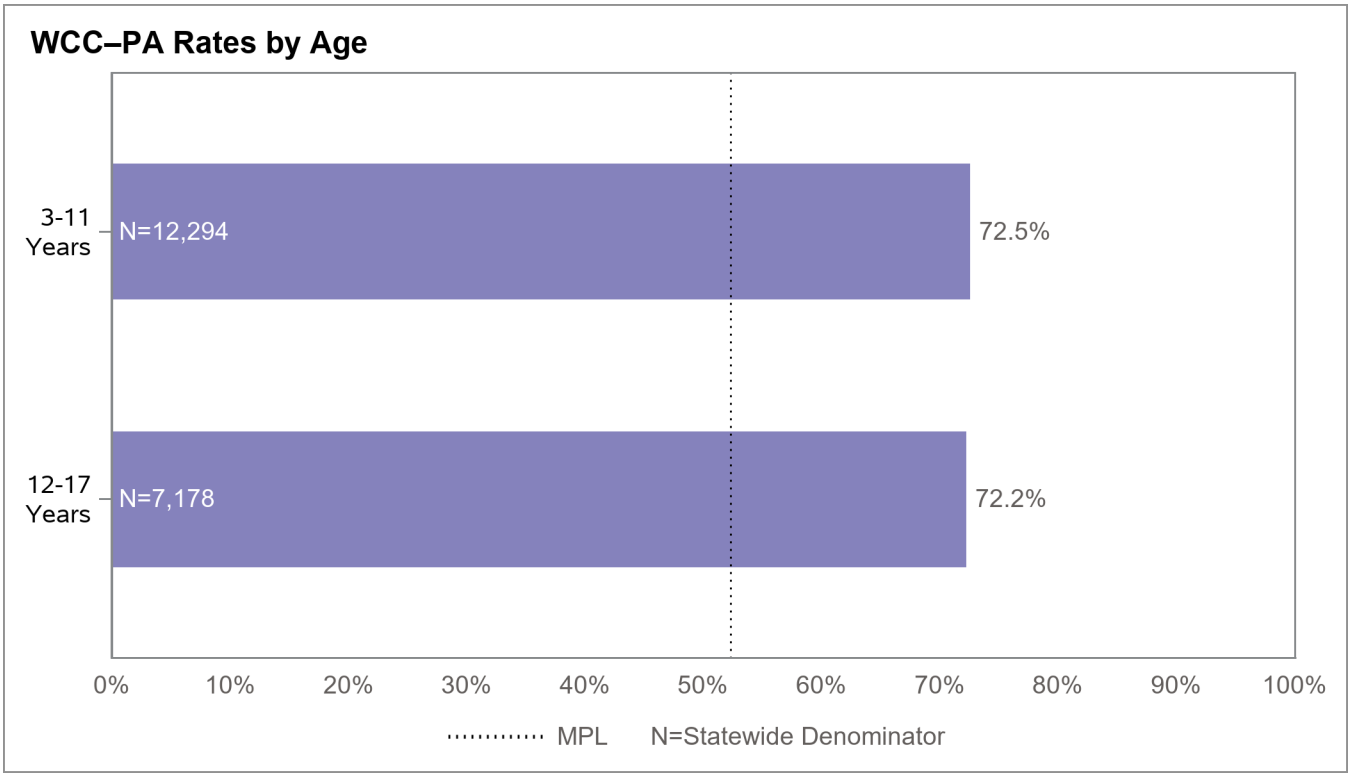


Figure A.32—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total (WCC–PA) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.



Preventive Screening and Women's Health Domain

Figure A.33 through Figure A.36 display the statewide Preventive Screening and Women's Health indicator rates and denominator for each age group.

Figure A.33—Breast Cancer Screening (BCS) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

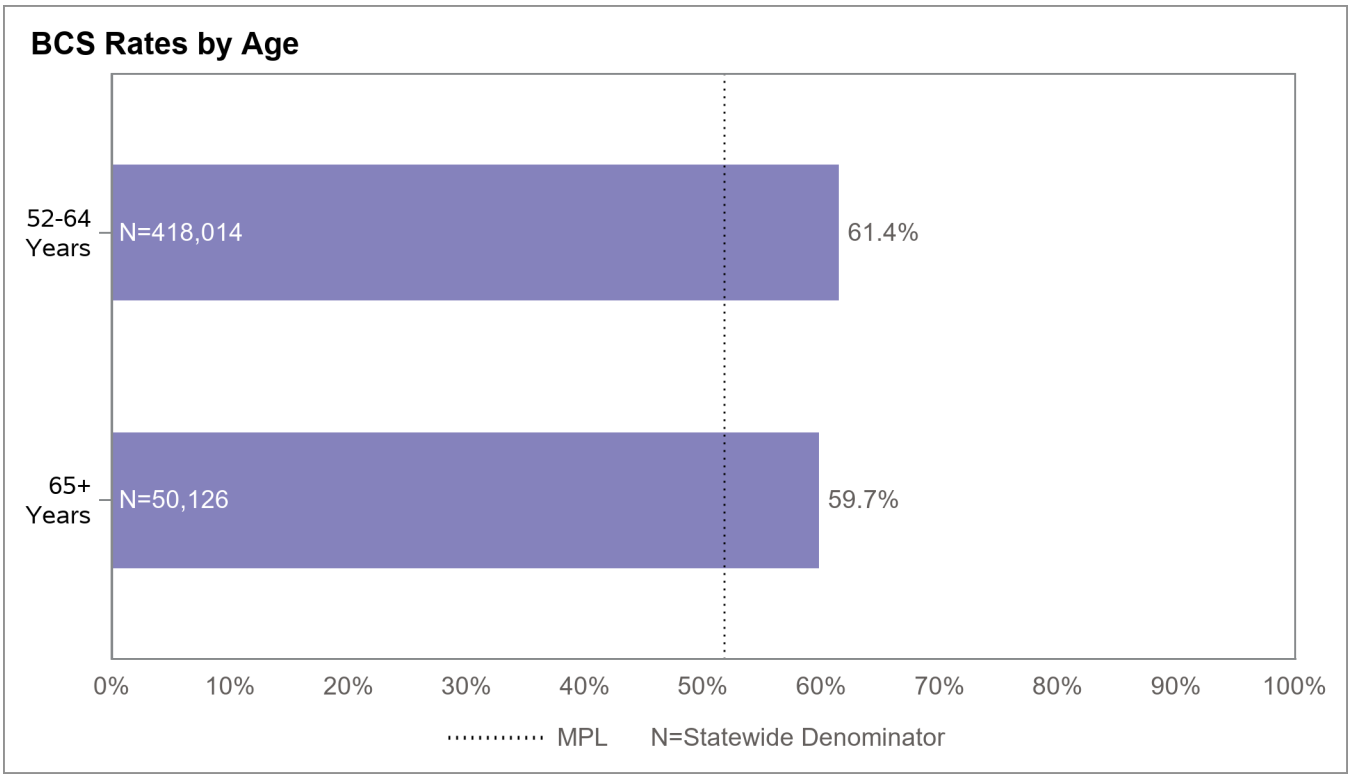


Figure A.34—Cervical Cancer Screening (CCS) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

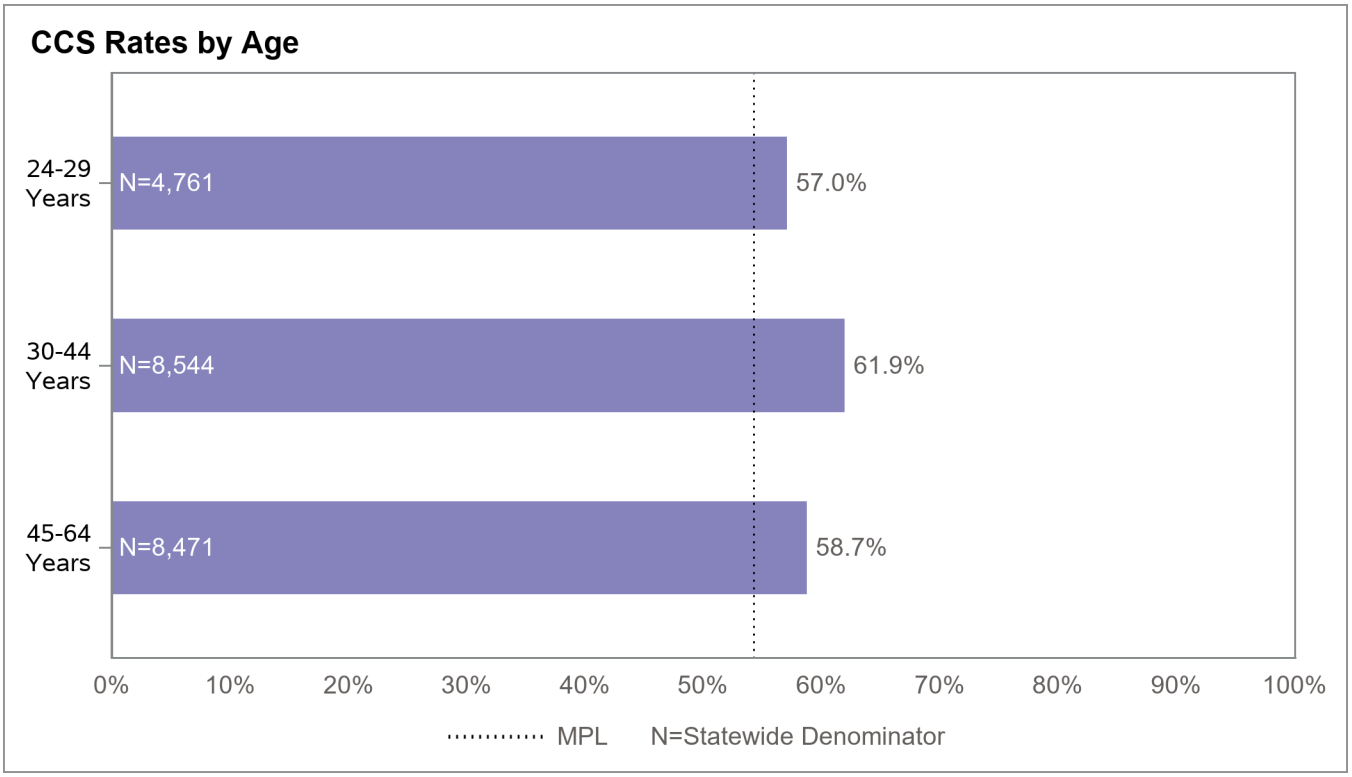


Figure A.35—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

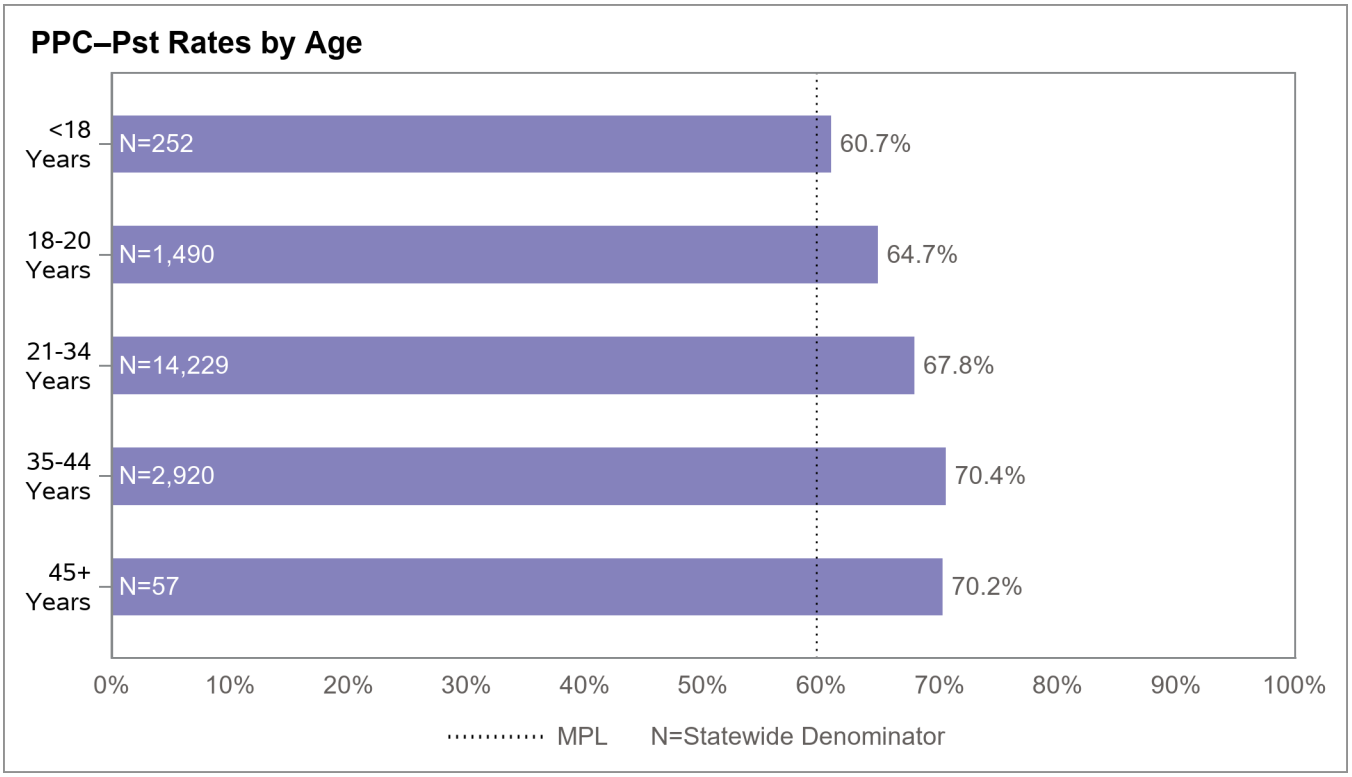
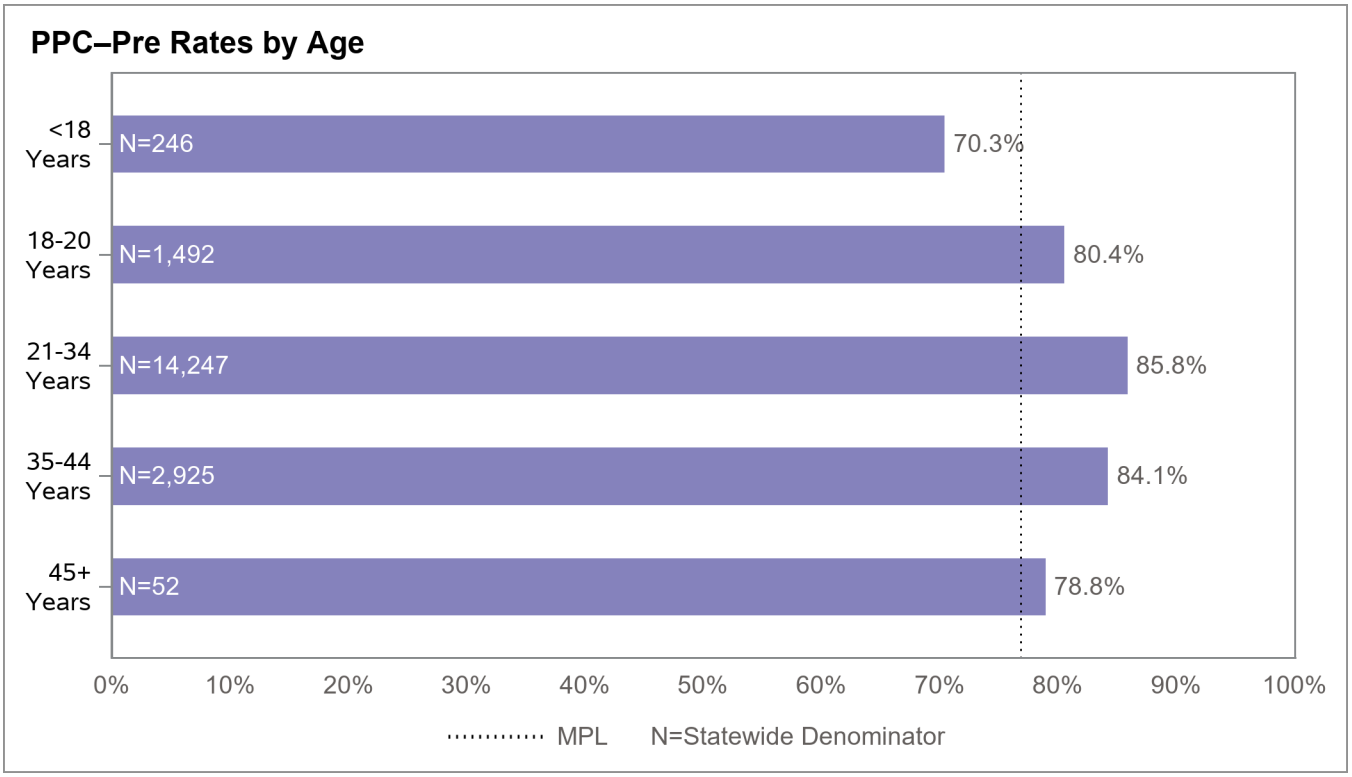


Figure A.36—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.



Care for Chronic Conditions Domain

Figure A.37 through Figure A.46 display the statewide Care for Chronic Conditions indicator rates and denominator for each age group.

Figure A.37—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs (MPM–ACE) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

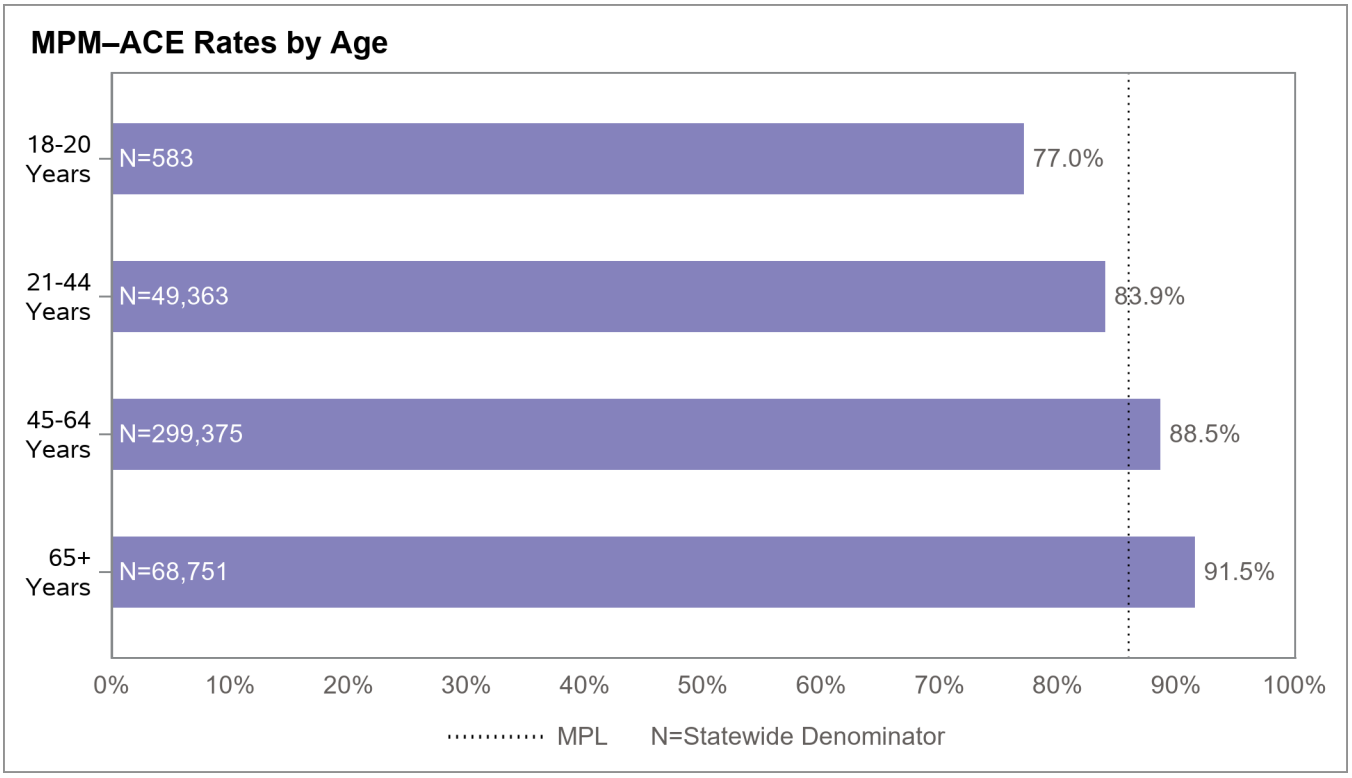


Figure A.38—Annual Monitoring for Patients on Persistent Medications—Diuretics (MPM–Diu) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

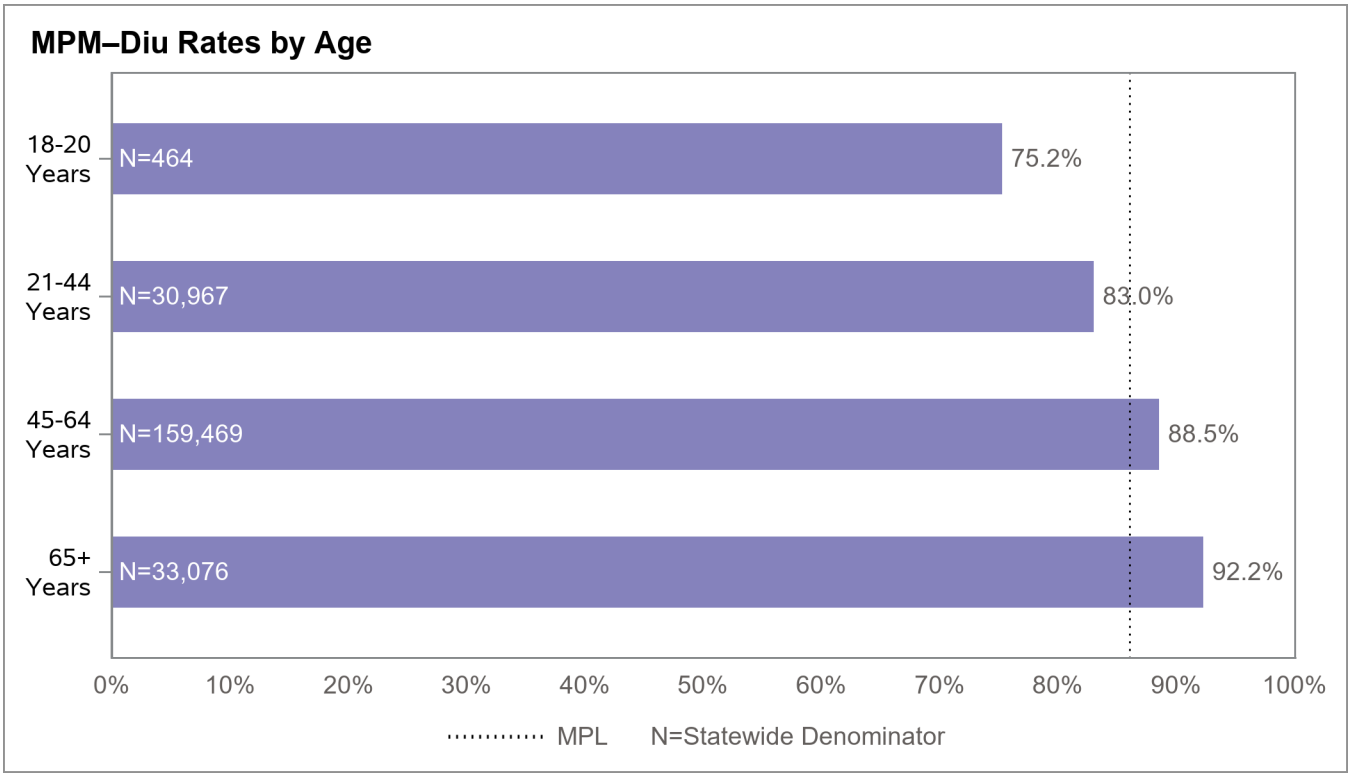


Figure A.39—Asthma Medication Ratio (AMR) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

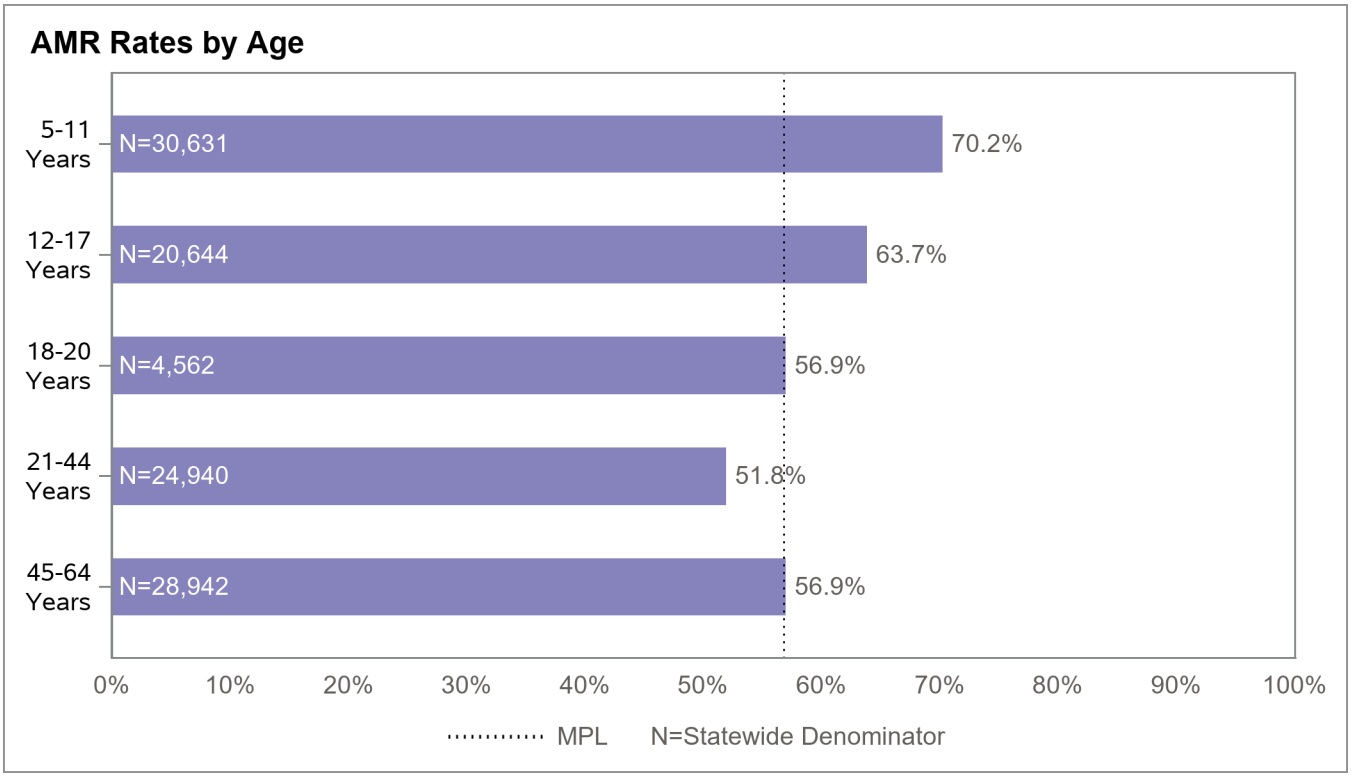


Figure A.40—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) (CDC–BP) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

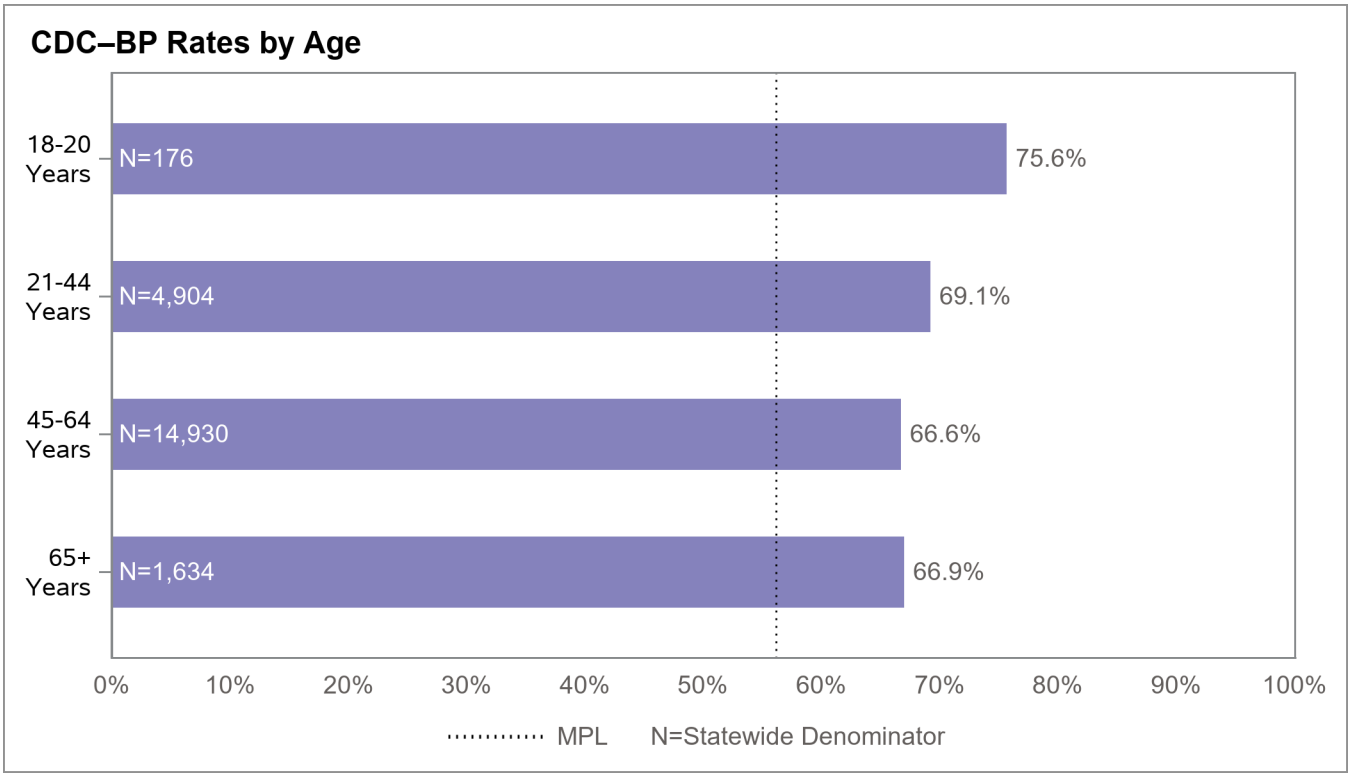


Figure A.41—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

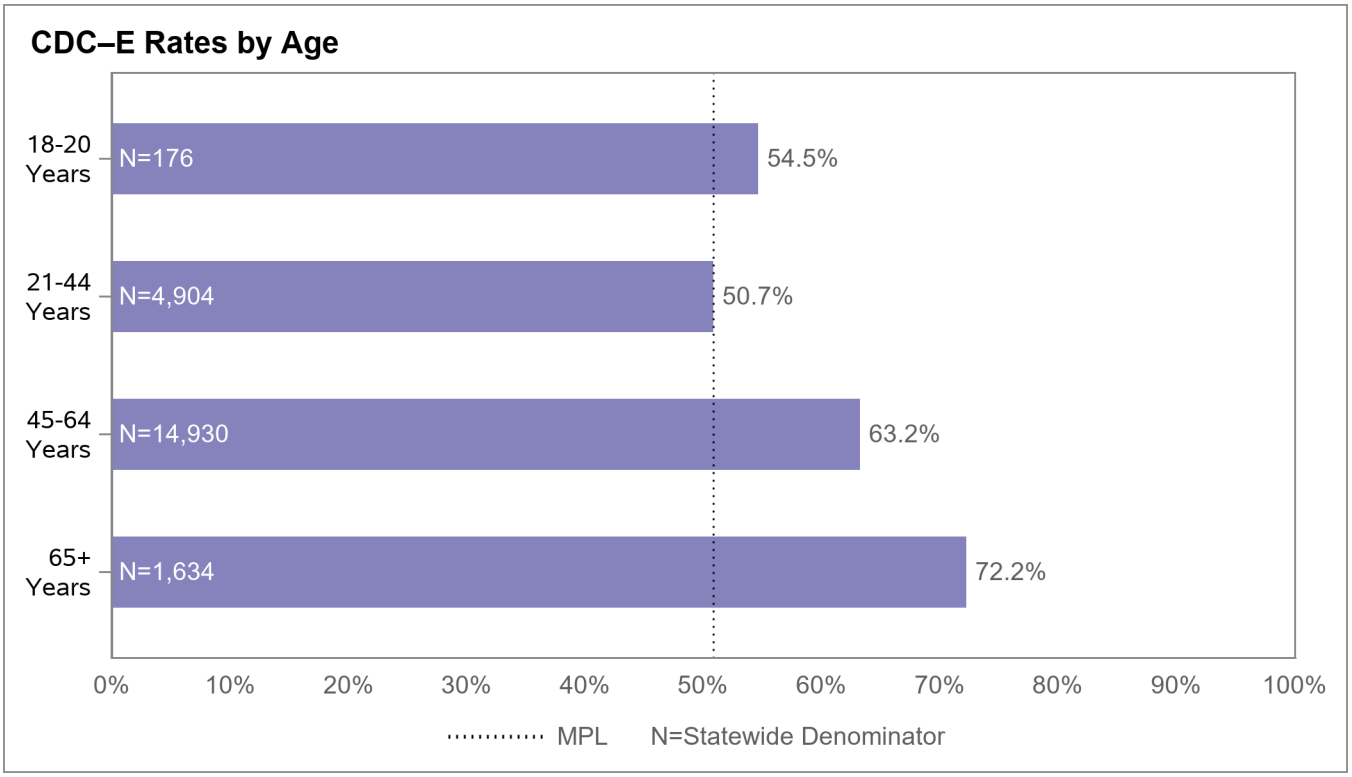


Figure A.42—Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) (CDC–H8) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

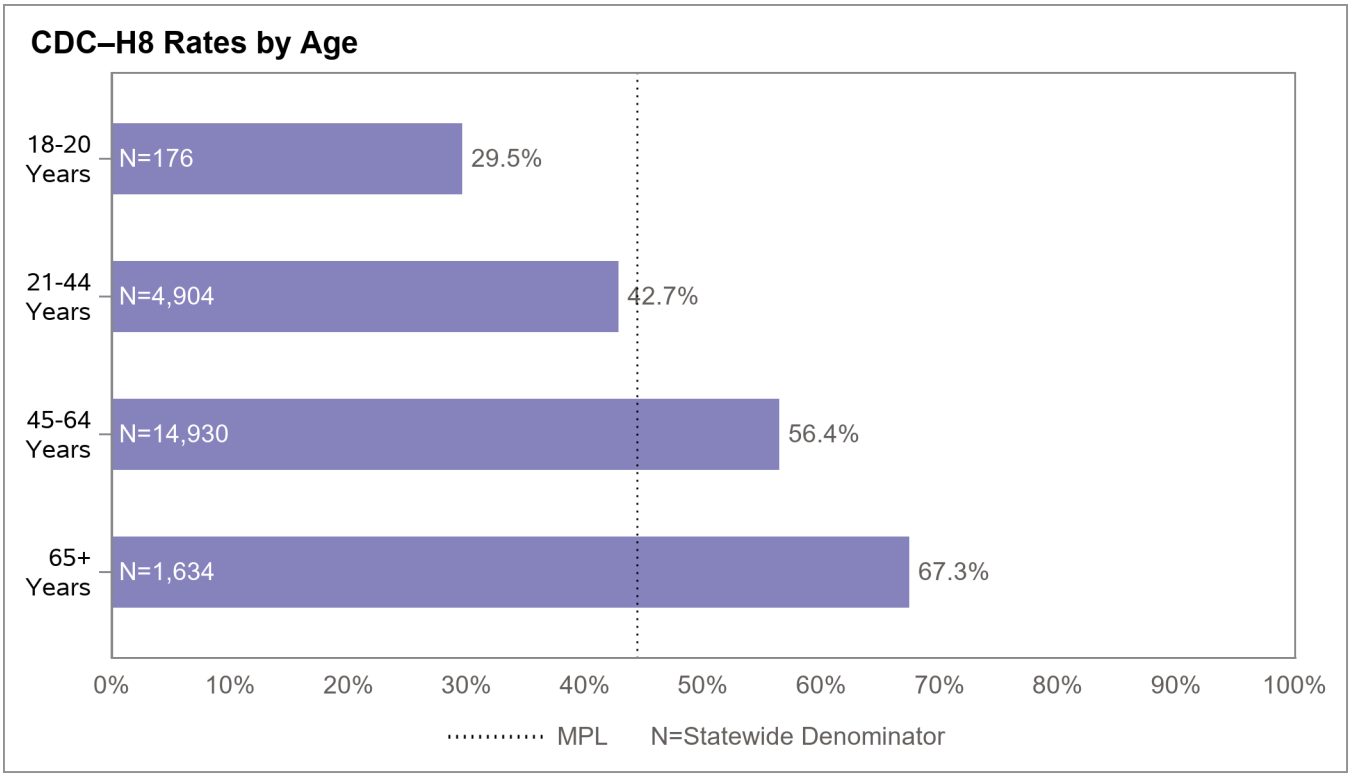


Figure A.43—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.
A lower rate indicates more favorable performance for this indicator.

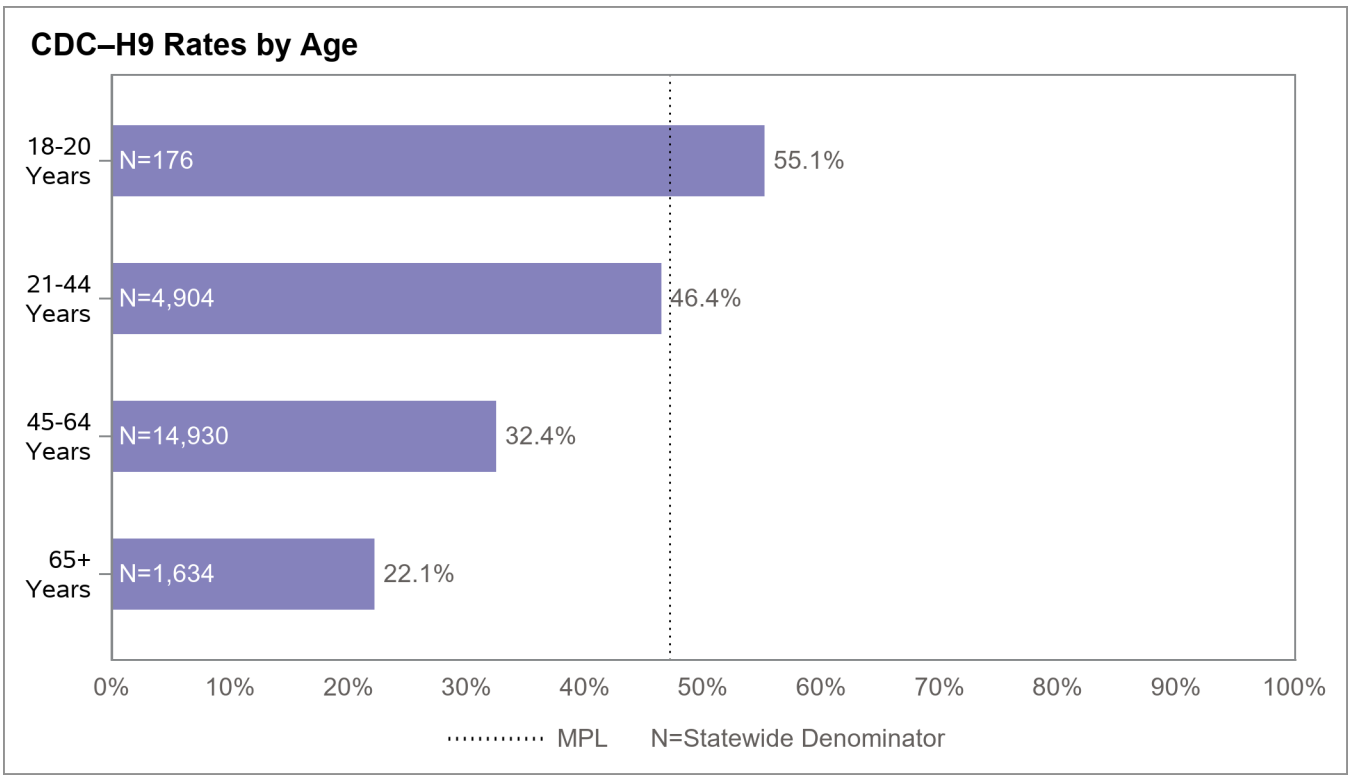


Figure A.44—Comprehensive Diabetes Care—HbA1c Testing (CDC–HT) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

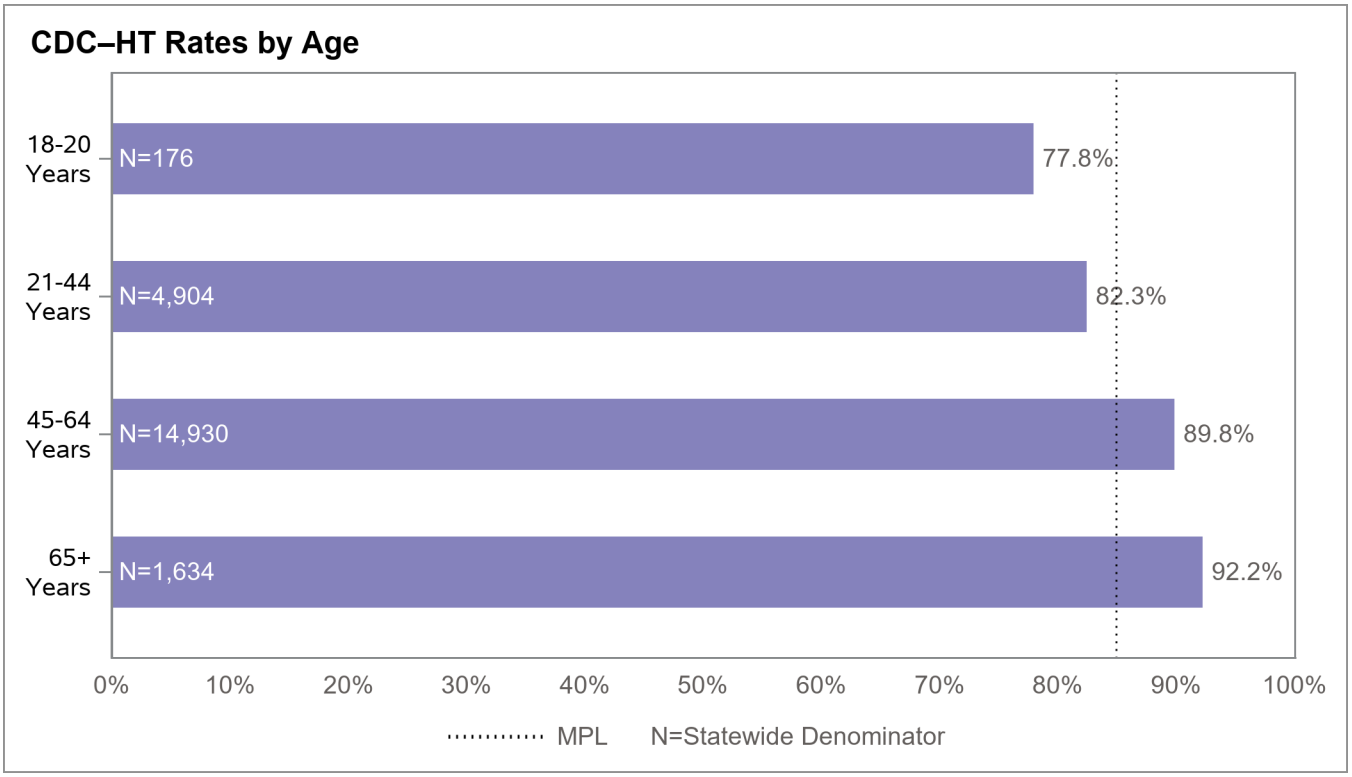


Figure A.45—Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

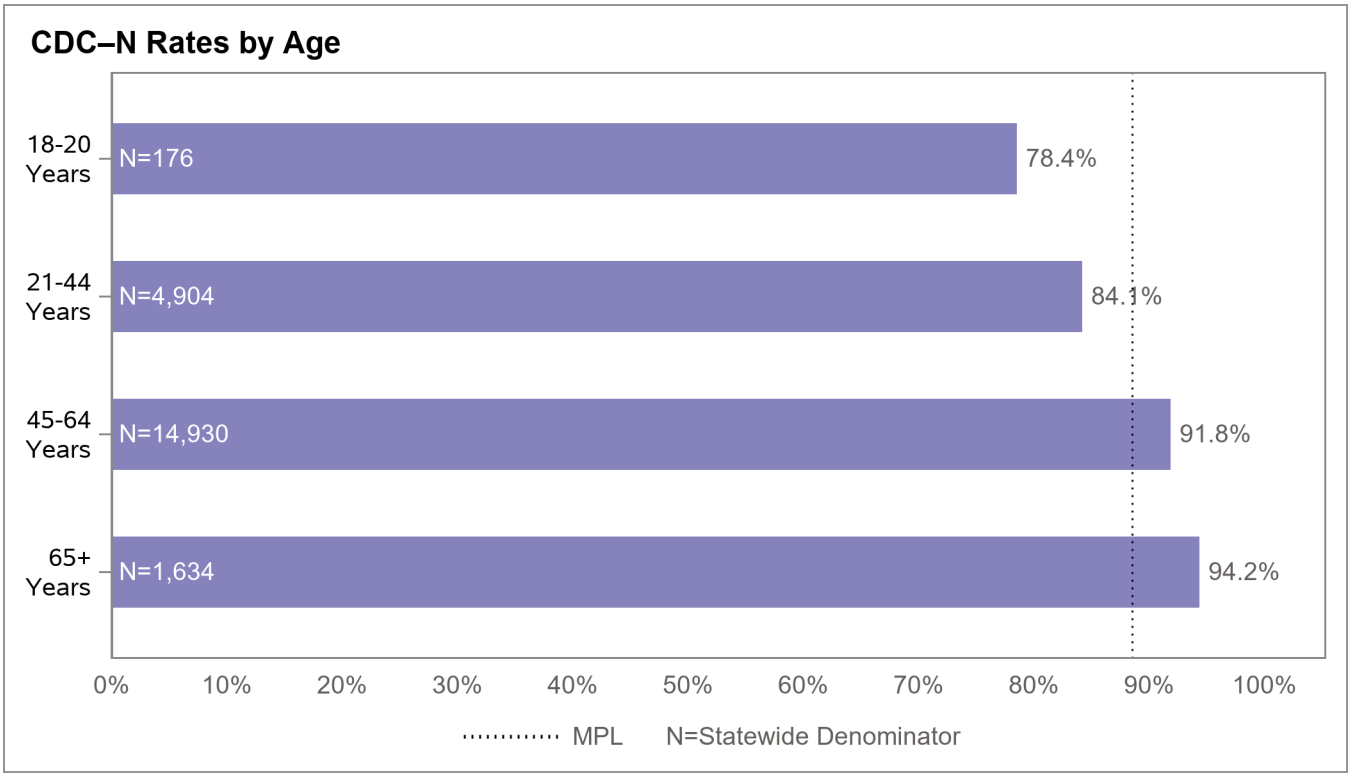
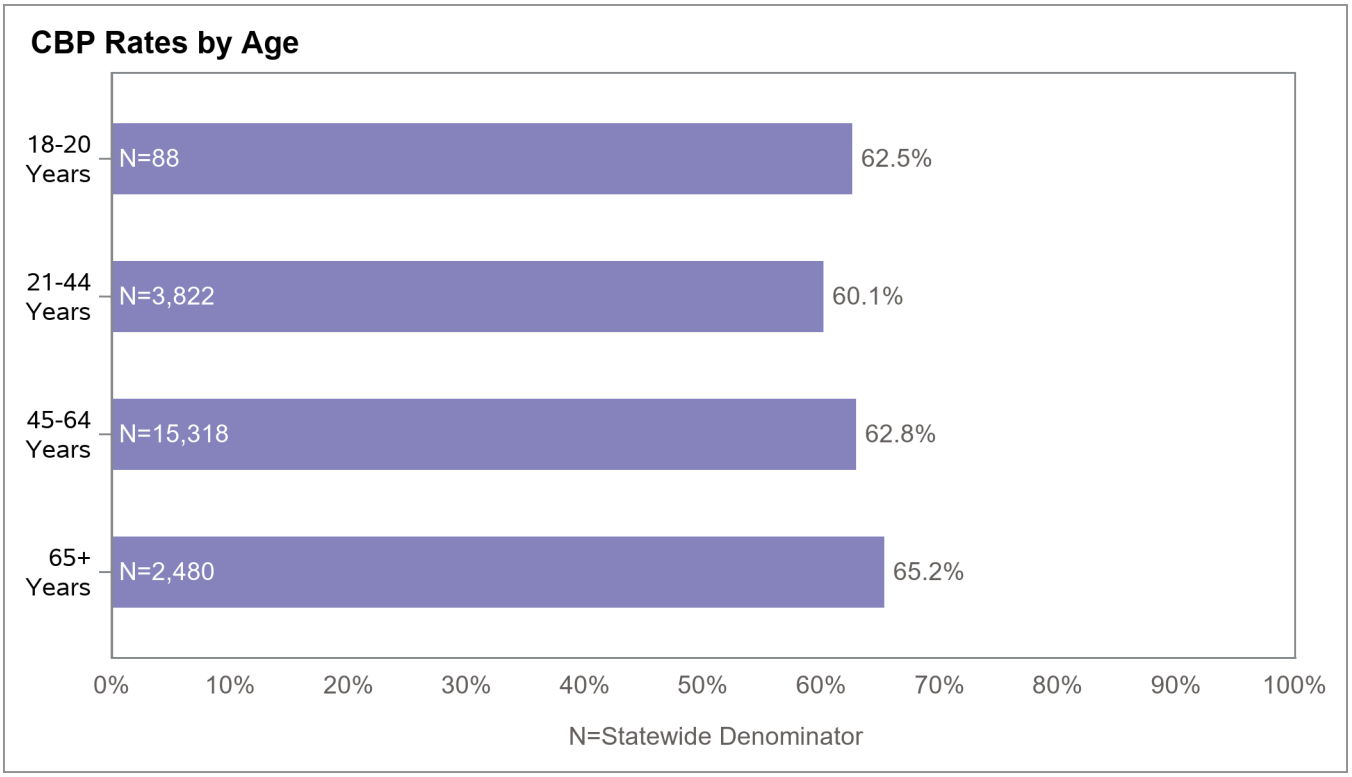


Figure A.46—Controlling High Blood Pressure (CBP) Rates by Age

Due to changes in the technical specifications for the *Controlling High Blood Pressure* indicator, NCQA recommended a break in trending between reporting year 2019 and prior years; therefore, the minimum performance level is not displayed.



Appropriate Treatment and Utilization Domain

Figure A.47 through Figure A.51 display the statewide Appropriate Treatment and Utilization indicator rates and denominator for each age group.

Figure A.47—Plan All-Cause Readmissions (PCR) Rates by Age

The *Plan All-Cause Readmissions* indicator does not have an established minimum performance level.

A lower rate indicates more favorable performance for this indicator.

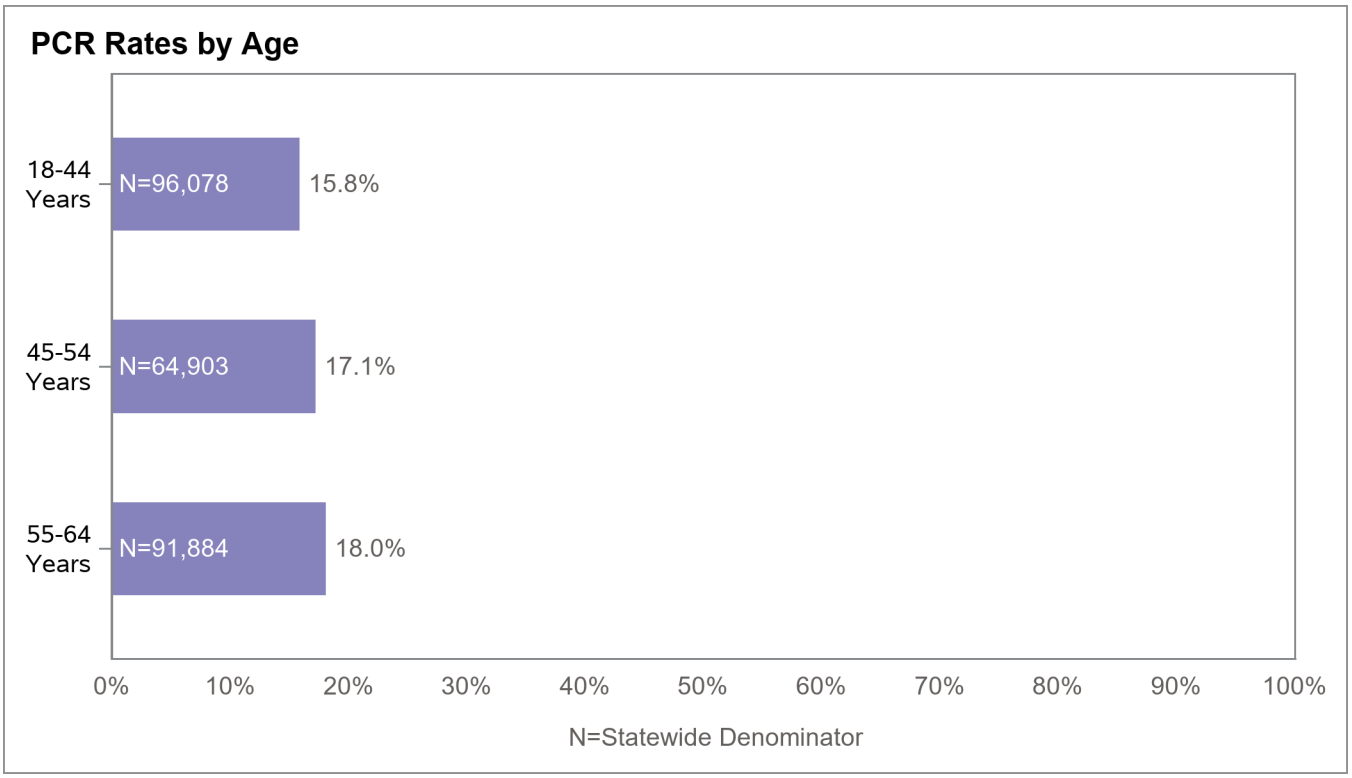


Figure A.48—Ambulatory Care—Emergency Department Visits (AMB–ED) Rates by Age

The *Ambulatory Care—Emergency Department Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

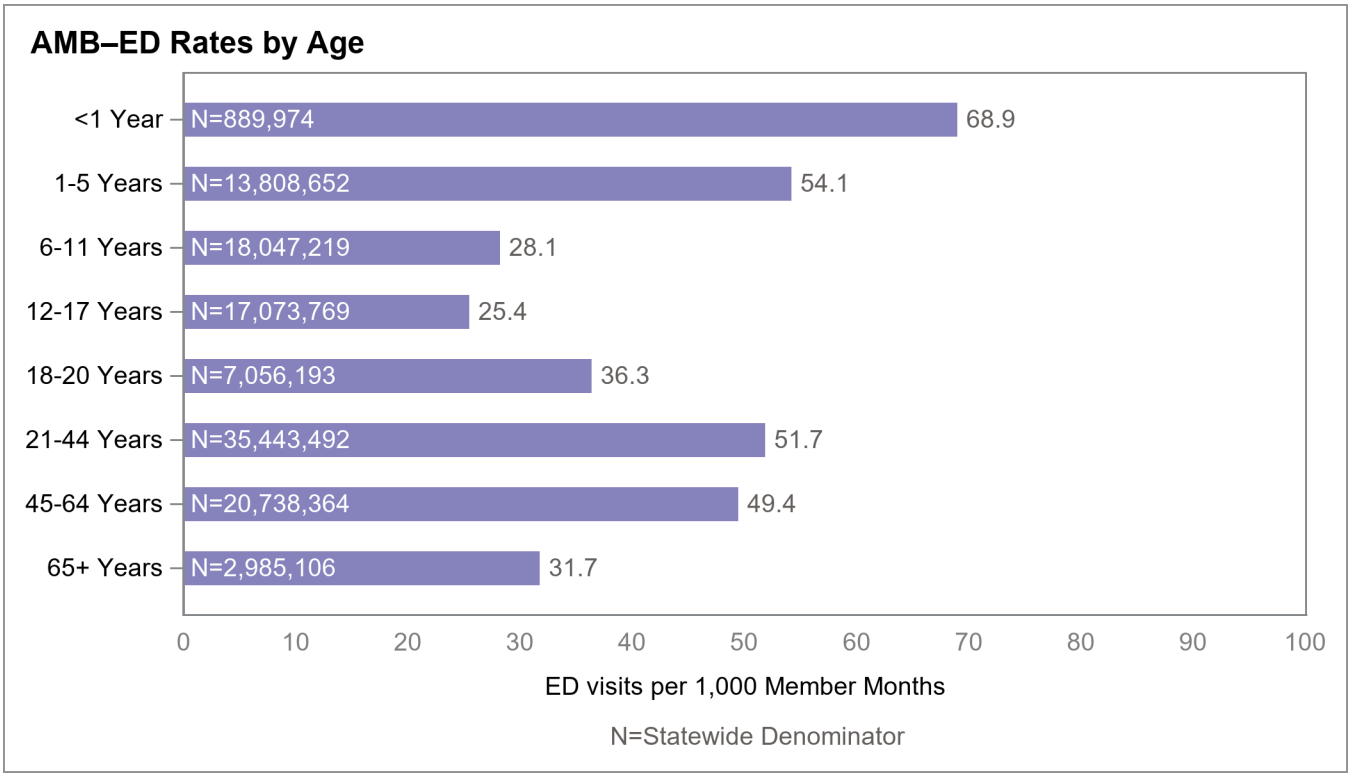


Figure A.49—Ambulatory Care—Outpatient Visits (AMB–OP) Rates by Age

The *Ambulatory Care—Outpatient Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

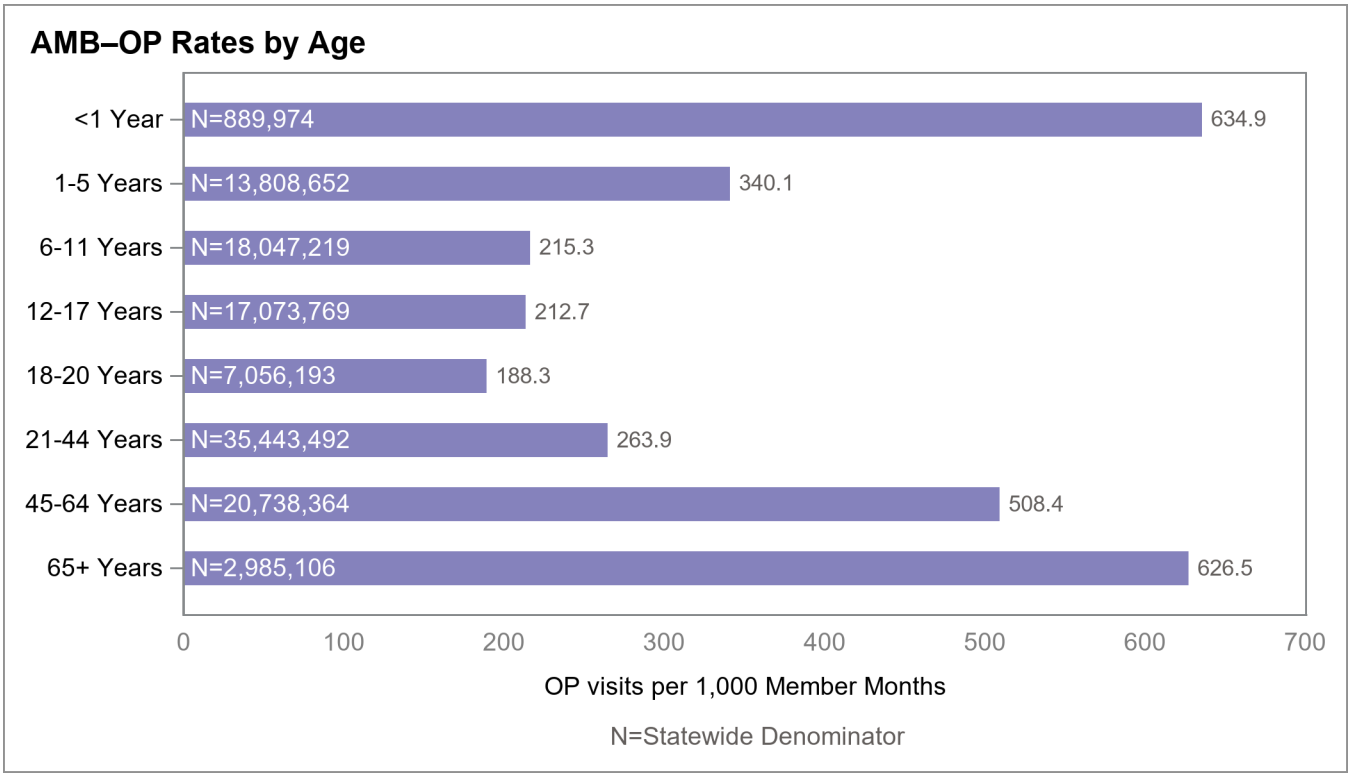


Figure A.50—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

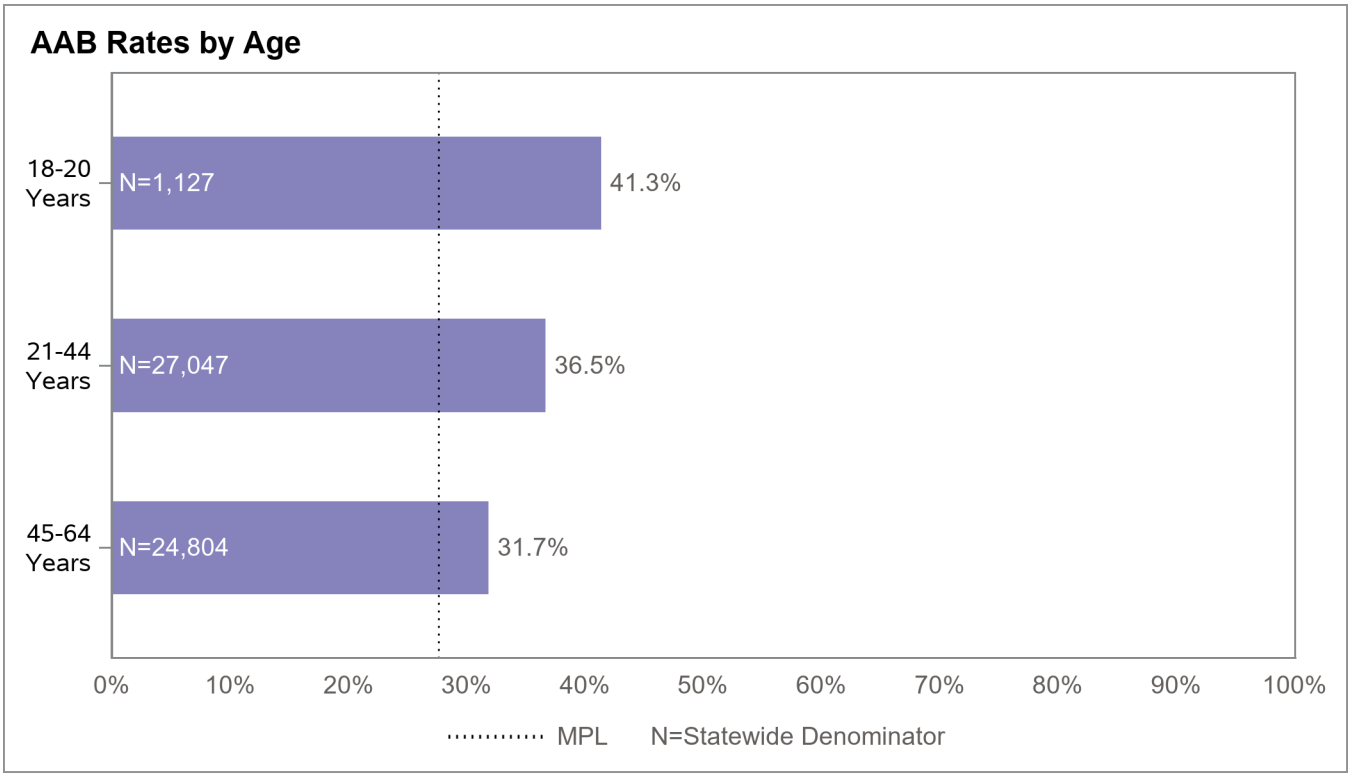
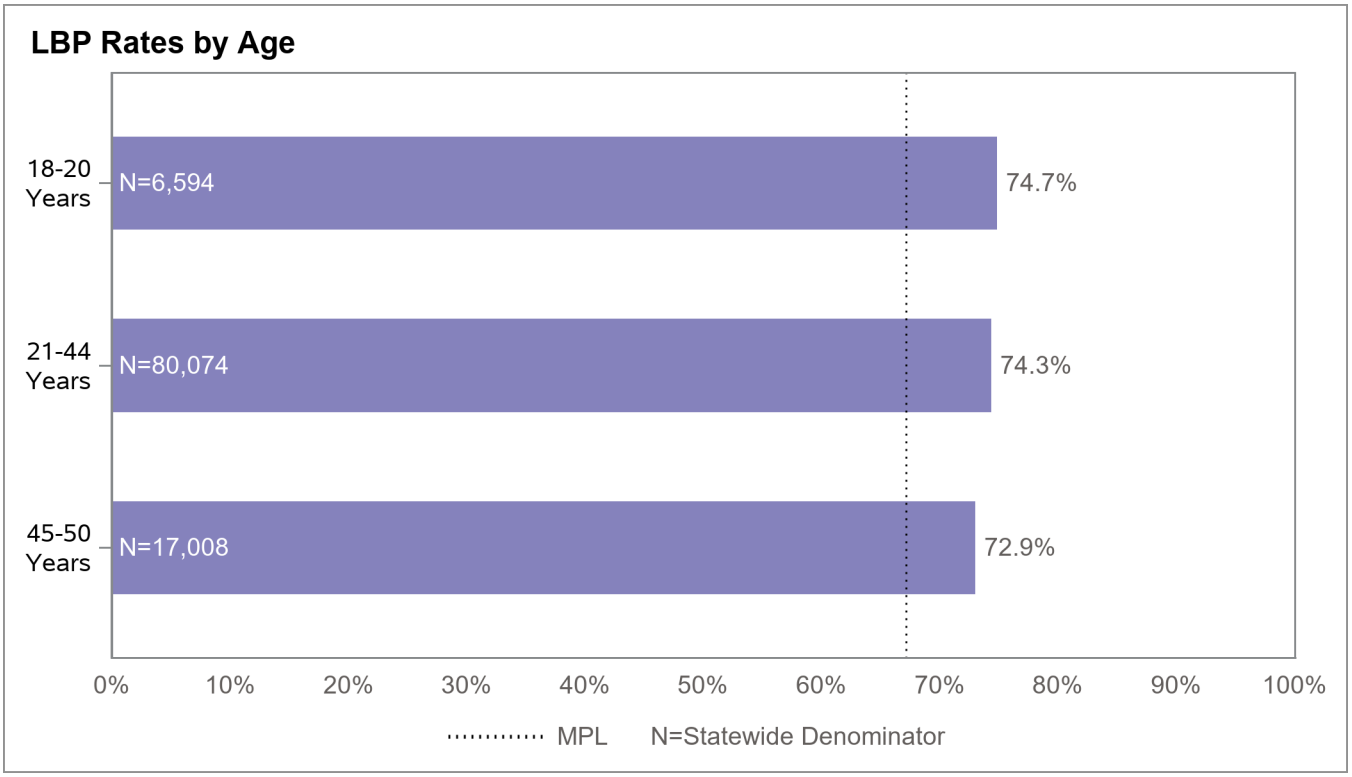


Figure A.51—Use of Imaging Studies for Low Back Pain (LBP) Rates by Age

The minimum performance level represents the national Medicaid 25th percentile for this indicator.



Gender

Figure A.52 through Figure A.75 display the statewide rates by gender for each indicator. Please note that gender stratifications were not reported for the following indicators: *Cervical Cancer Screening, Breast Cancer Screening*, and *Prenatal and Postpartum Care*.

Preventive Screening and Children's Health Domain

Figure A.52 through Figure A.60 display the statewide Preventive Screening and Children's Health indicator rates and denominator by gender.

Figure A.52—Childhood Immunization Status—Combination 3 (CIS–3) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

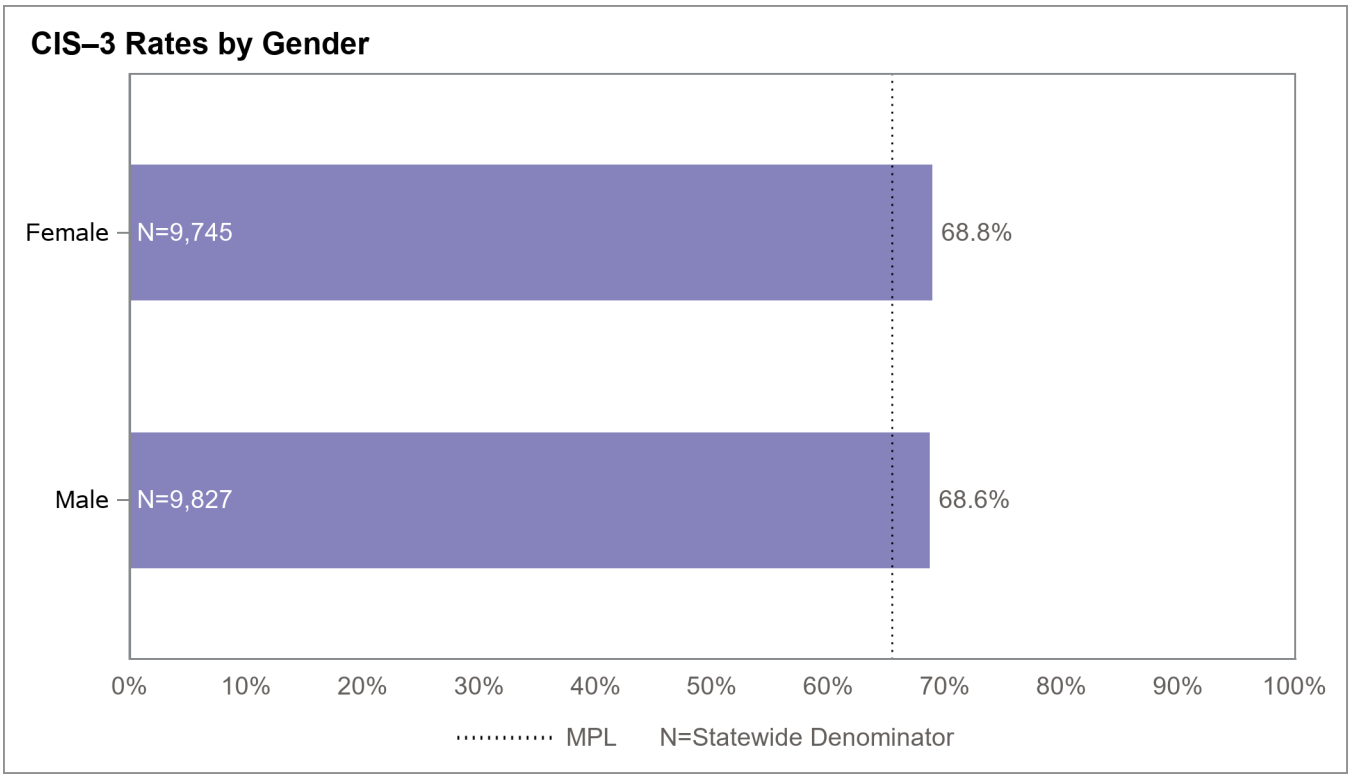


Figure A.53—Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months (CAP–1224) Rates by Gender

Note: The rate for the Unknown/Missing group was 65.8 percent (N=117).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

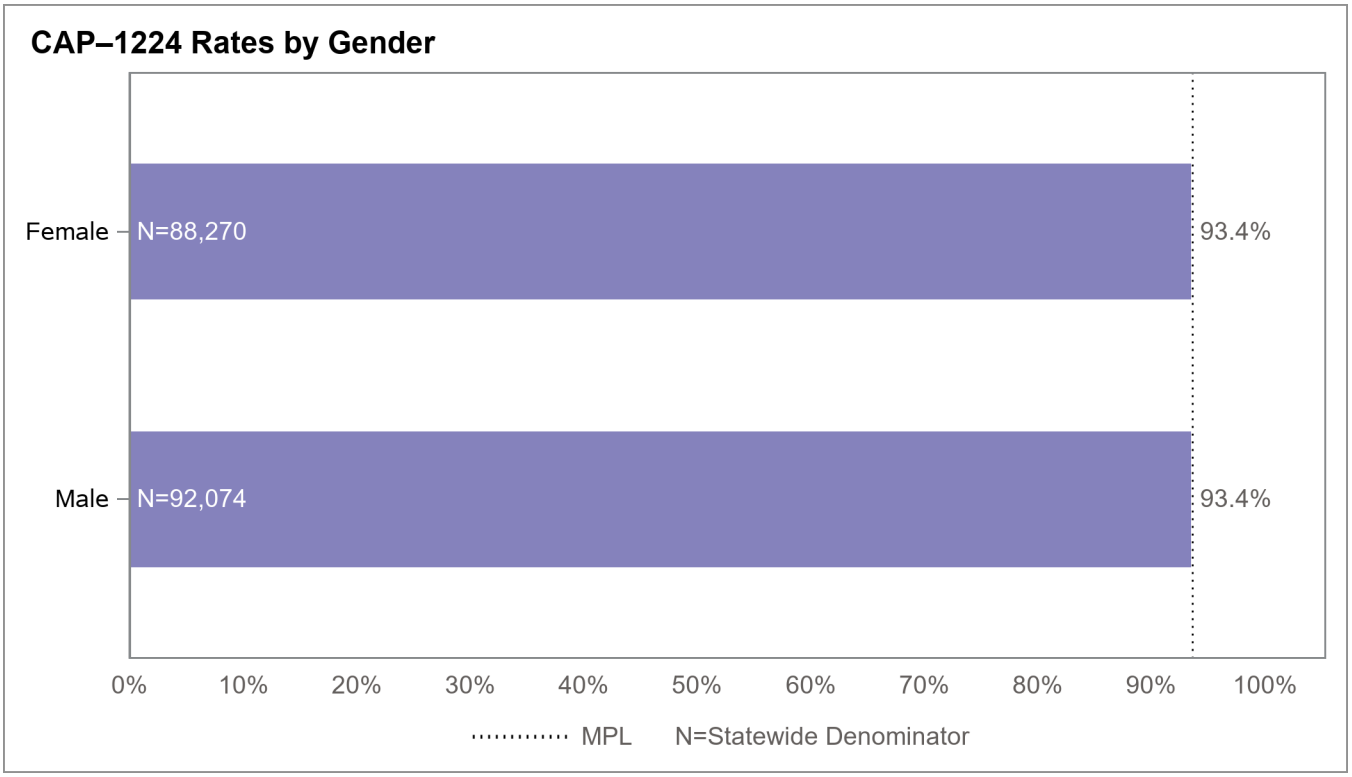


Figure A.54—Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years (CAP–256) Rates by Gender

Note: The rate for the Unknown/Missing group was 81.9 percent (N=421).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

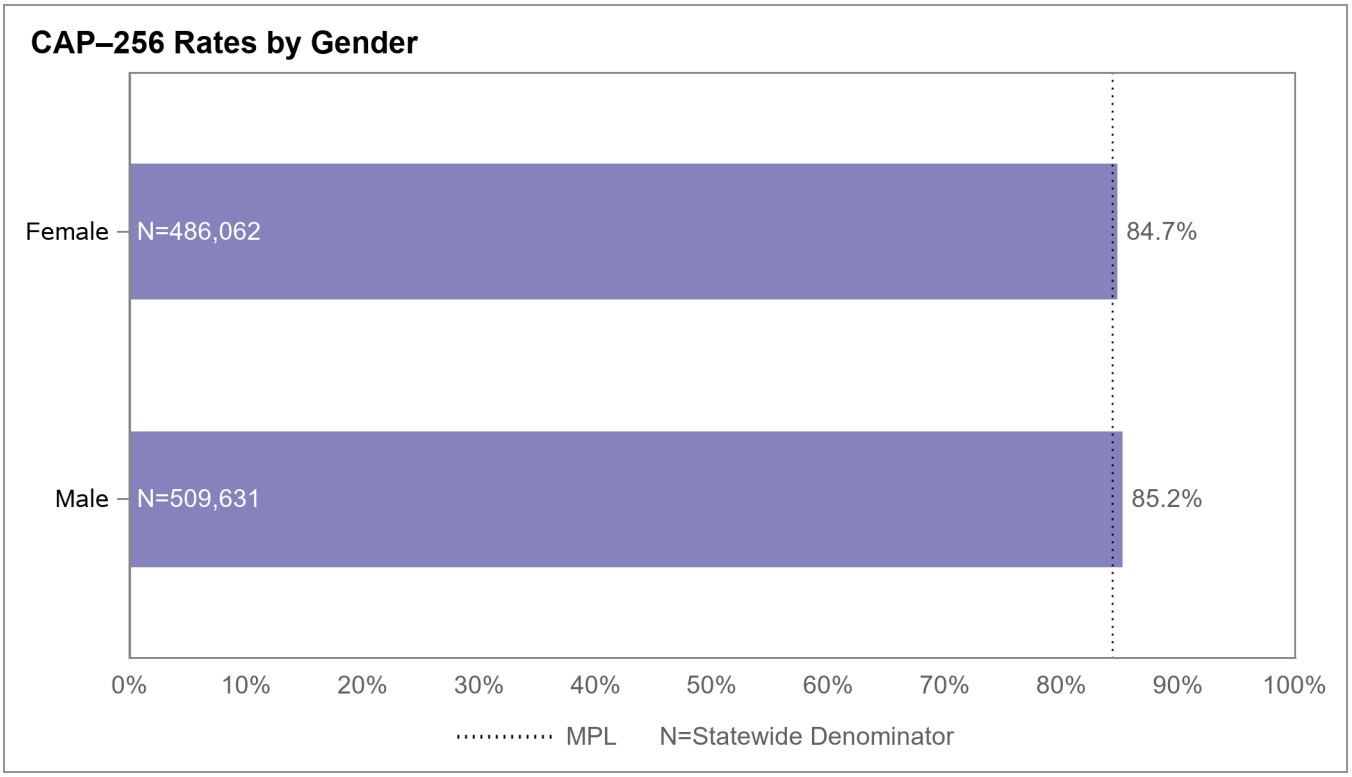


Figure A.55—Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years (CAP–711) Rates by Gender

Note: The rate for the Unknown/Missing group was 86.3 percent (N=205).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

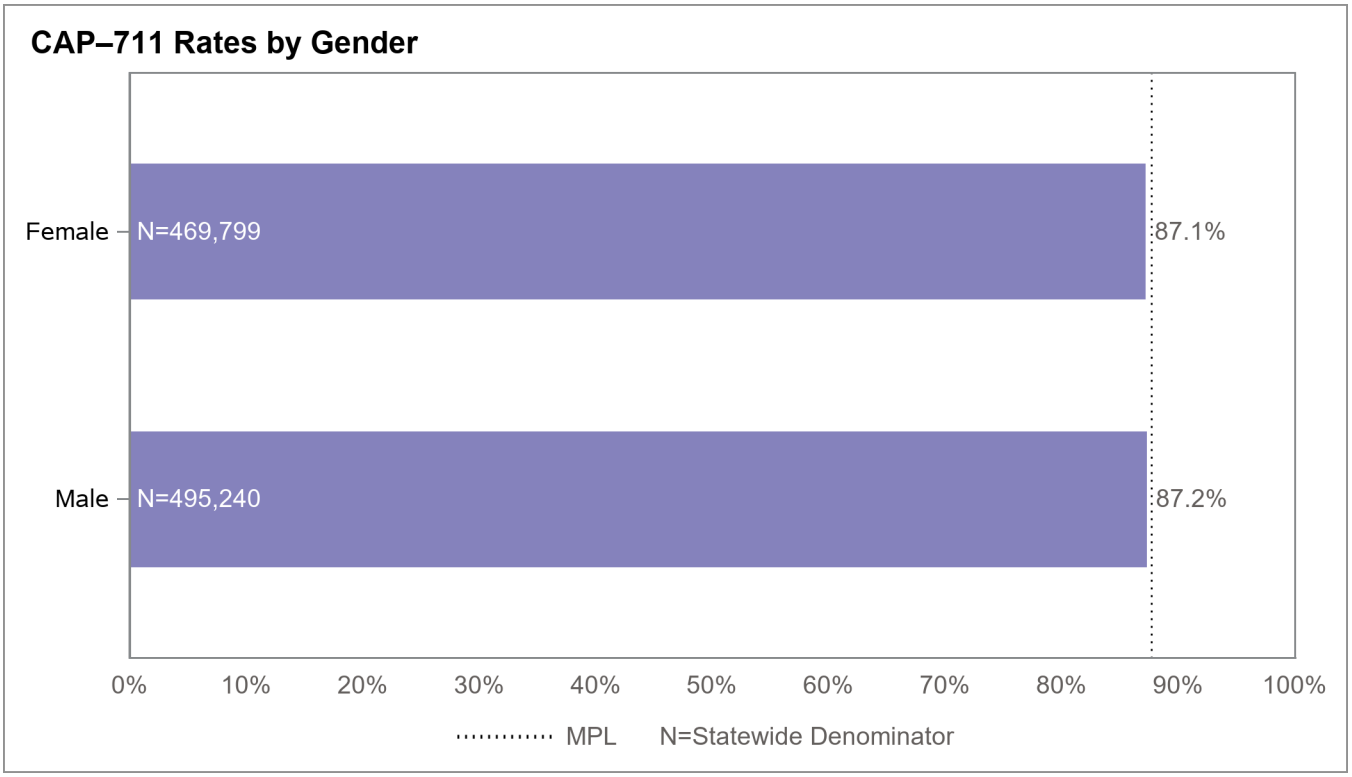


Figure A.56—Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years (CAP–1219) Rates by Gender

Note: The rate for the Unknown/Missing group was 85.3 percent (N=293).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

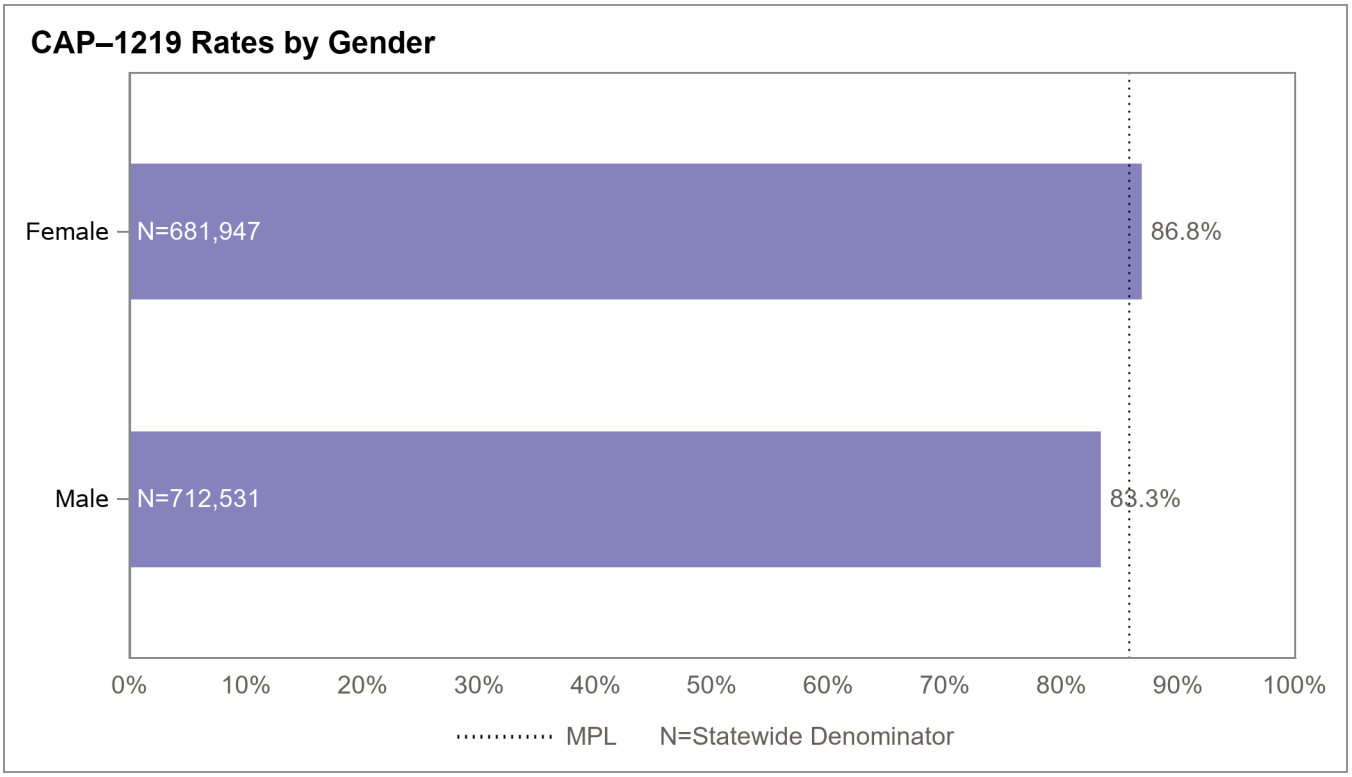


Figure A.57—Immunizations for Adolescents—Combination 2 (IMA–2) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

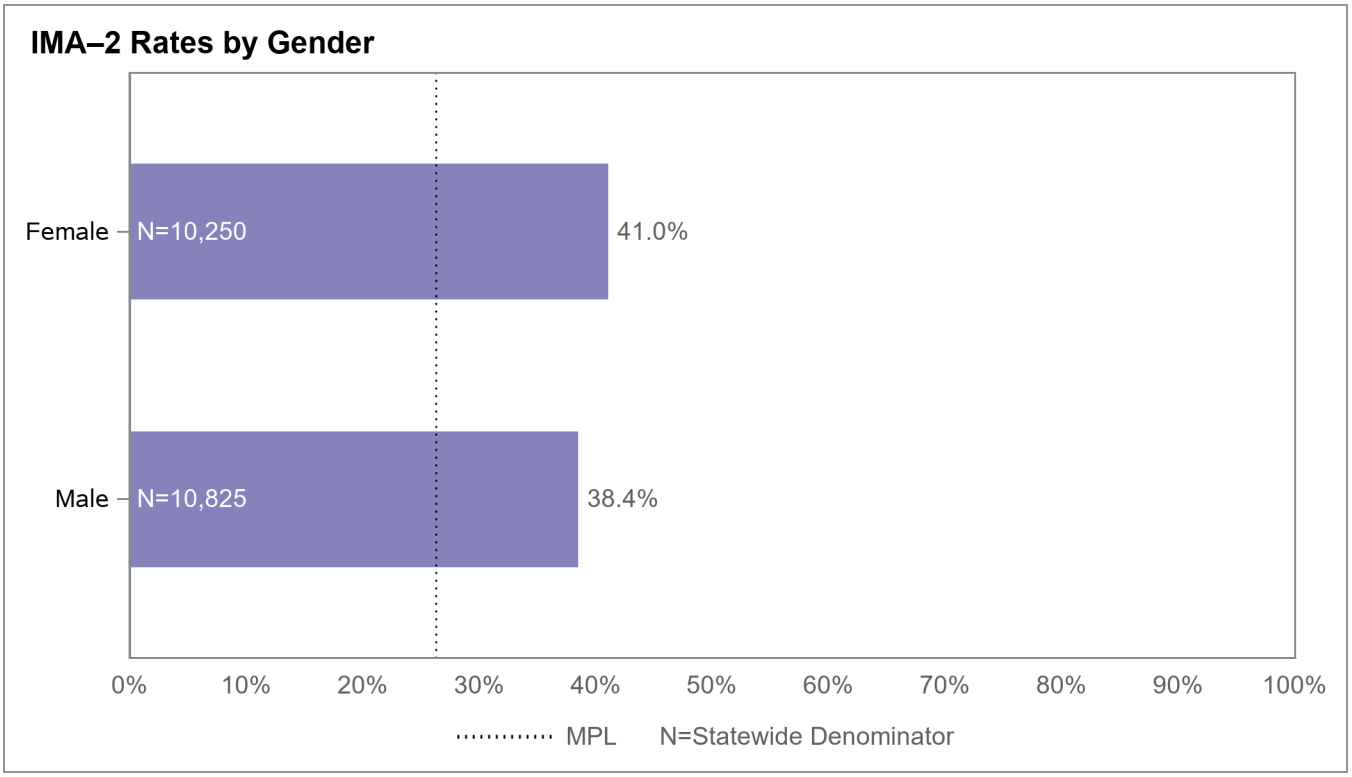


Figure A.58—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total (WCC–N) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

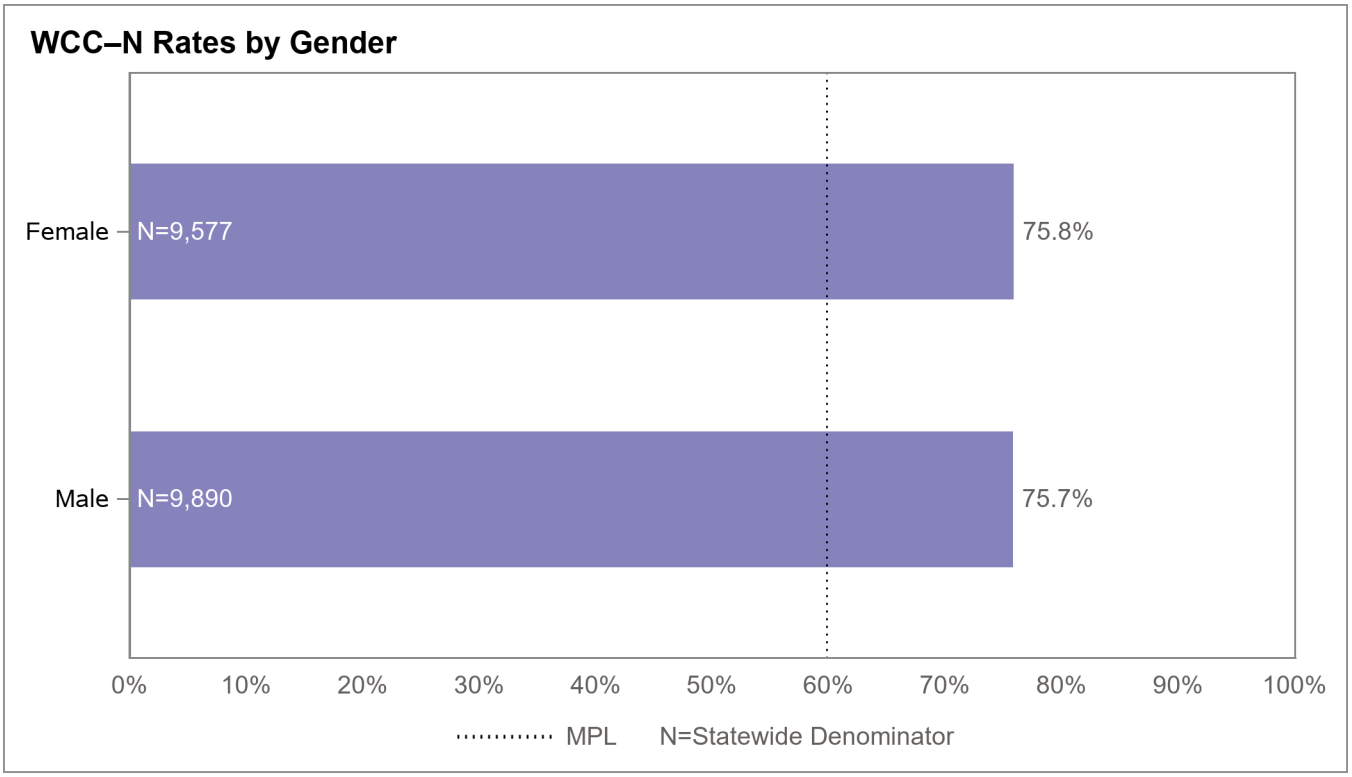


Figure A.59—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total (WCC–PA) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

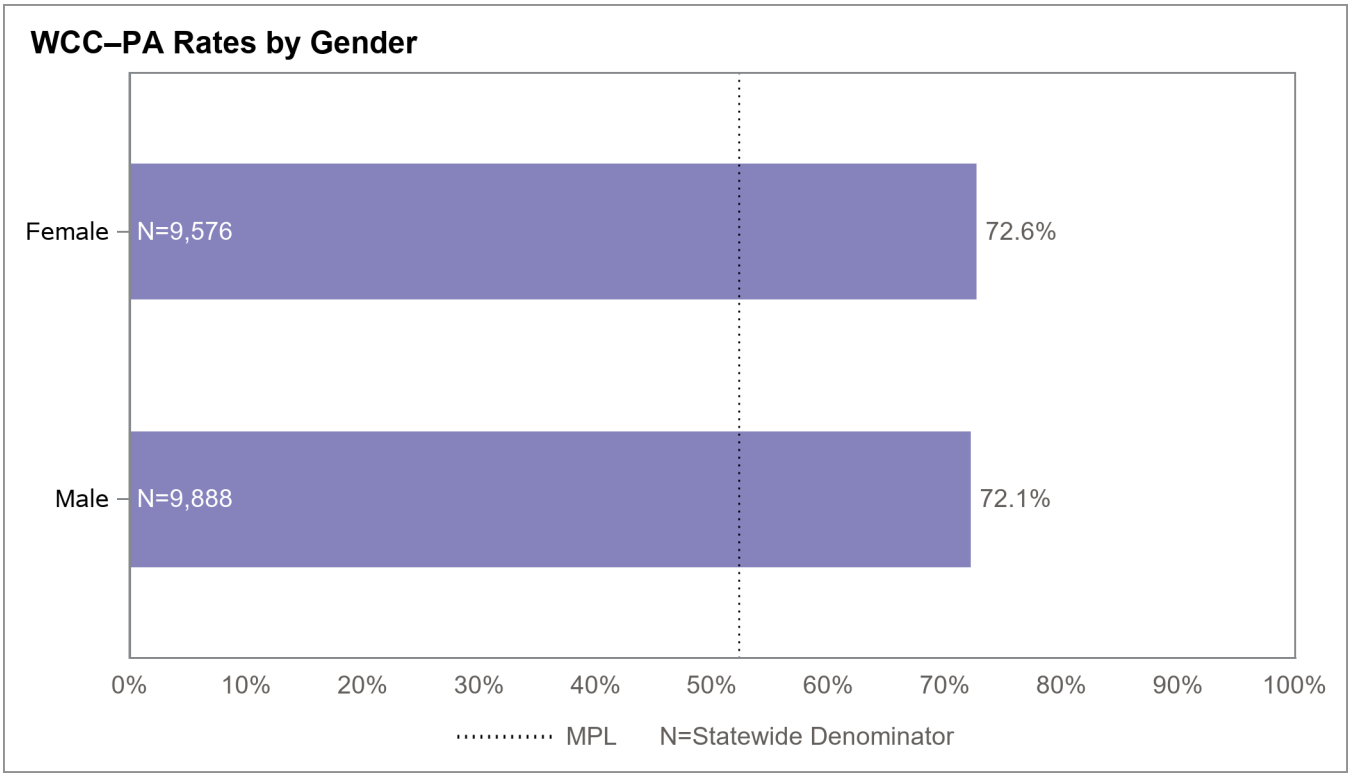
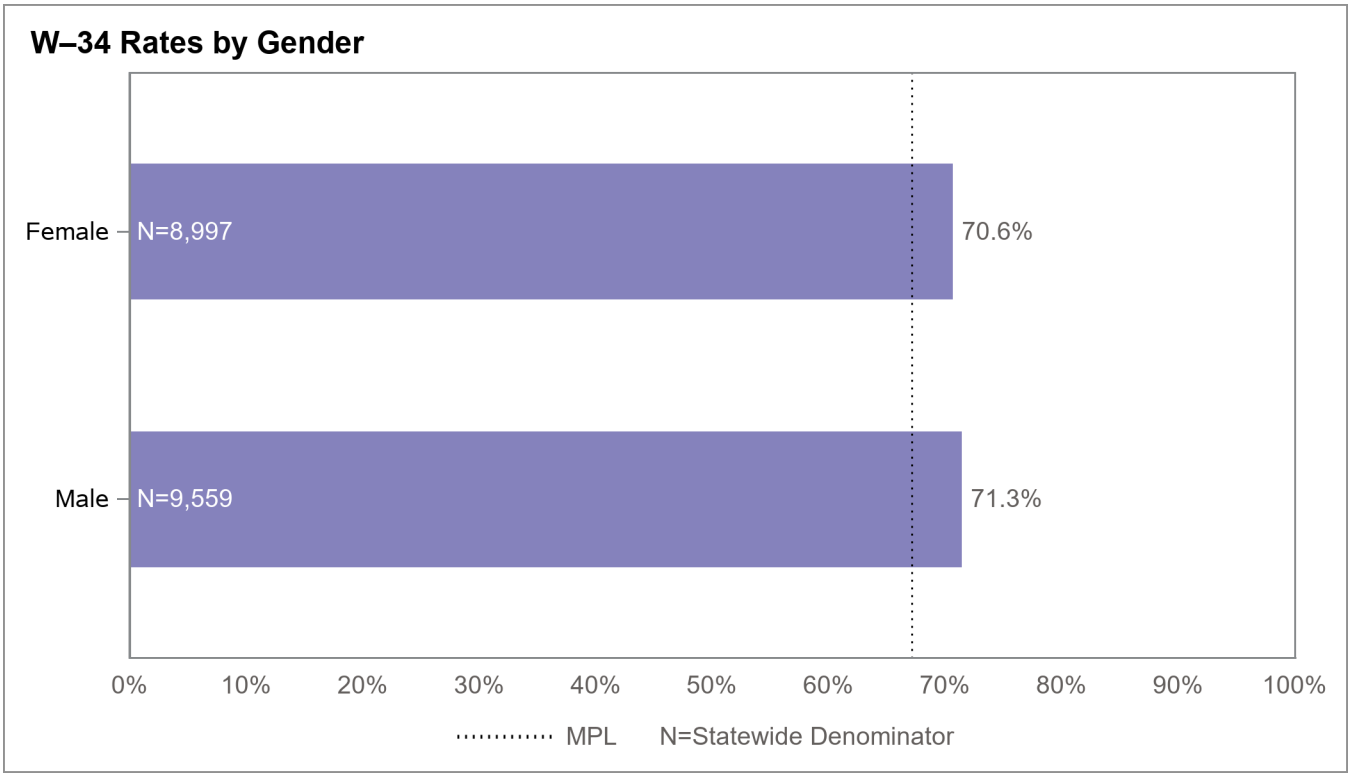


Figure A.60—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W–34) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.



Care for Chronic Conditions Domain

Figure A.61 through Figure A.70 display the statewide Care for Chronic Conditions indicator rates and denominator by gender.

Figure A.61—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs (MPM–ACE) Rates by Gender

Note: The rate for the Unknown/Missing group was 95.8 percent (N=144).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

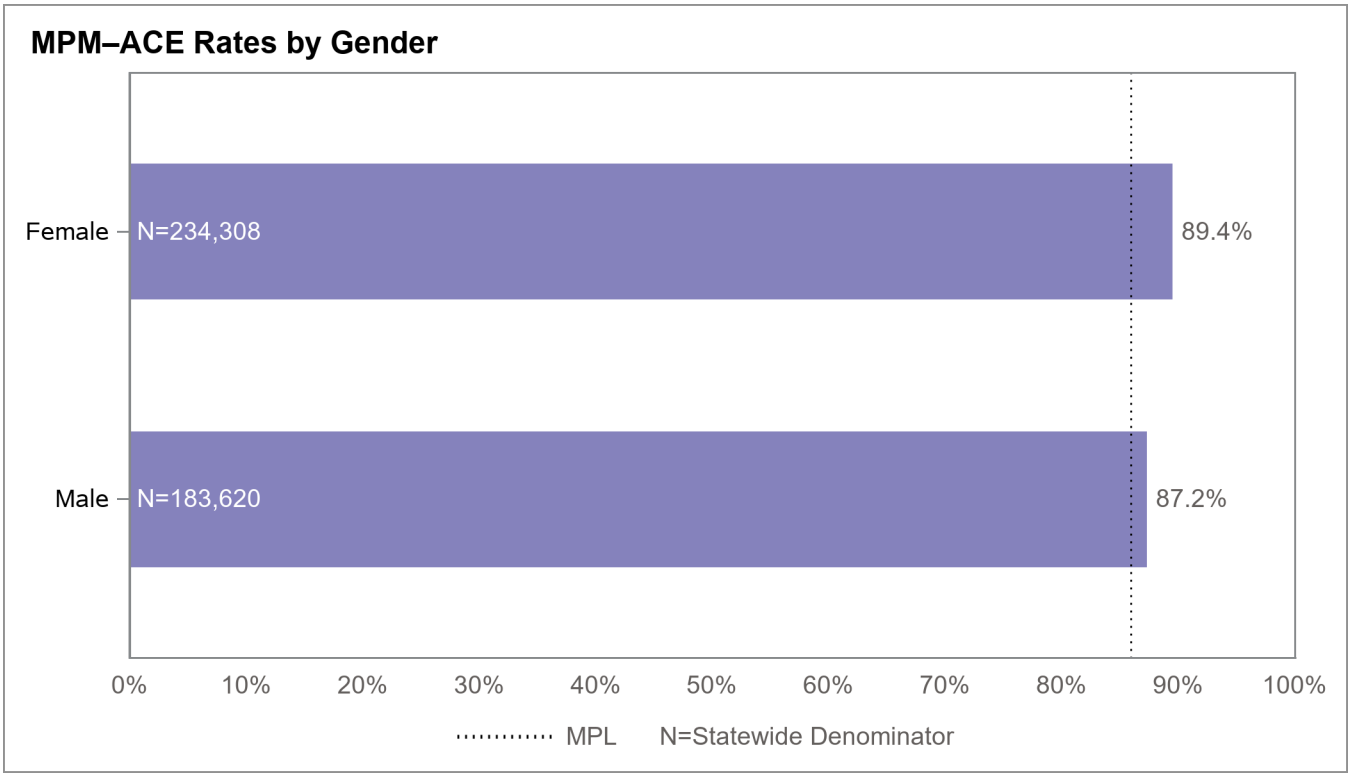


Figure A.62—Annual Monitoring for Patients on Persistent Medications—Diuretics (MPM–Diu) Rates by Gender

Note: The rate for the Unknown/Missing group was 95.0 percent (N=80).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

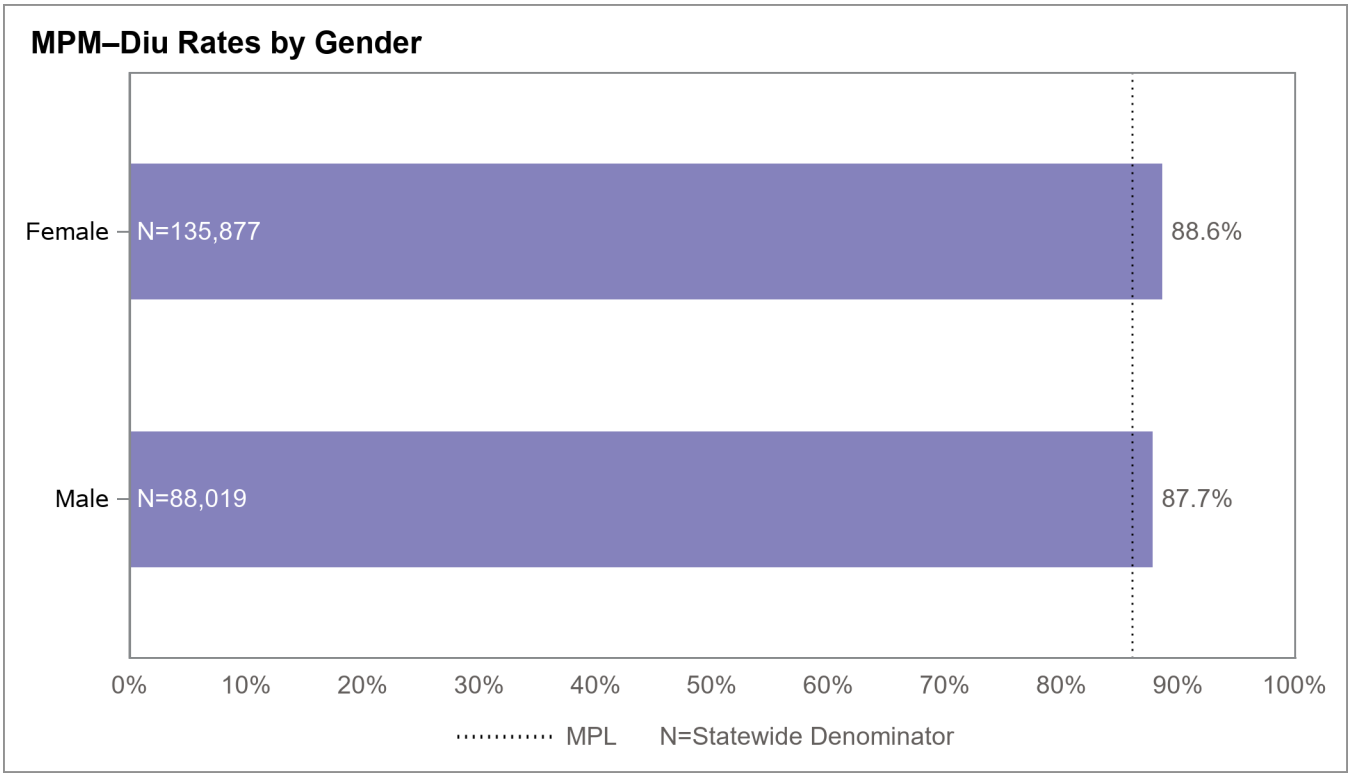


Figure A.63—Asthma Medication Ratio (AMR) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

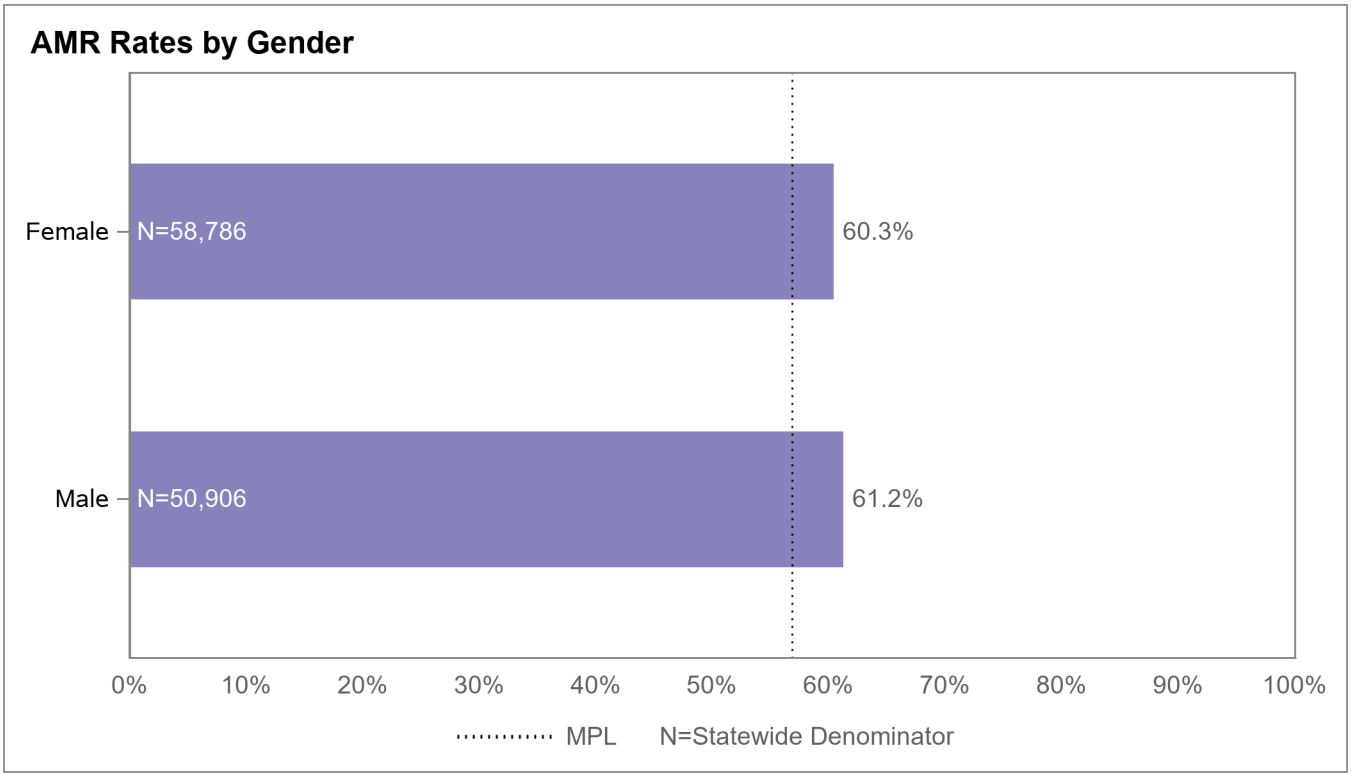


Figure A.64—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) (CDC–BP) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

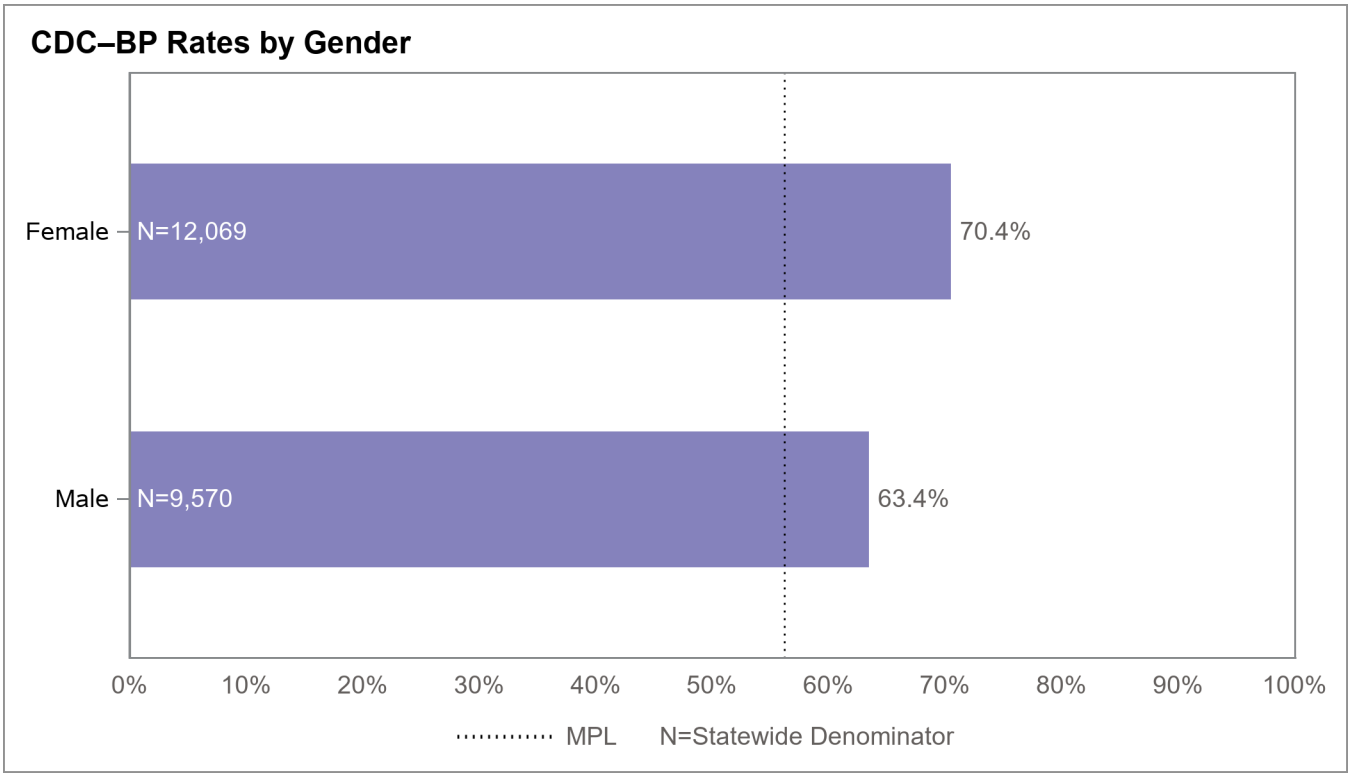


Figure A.65—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

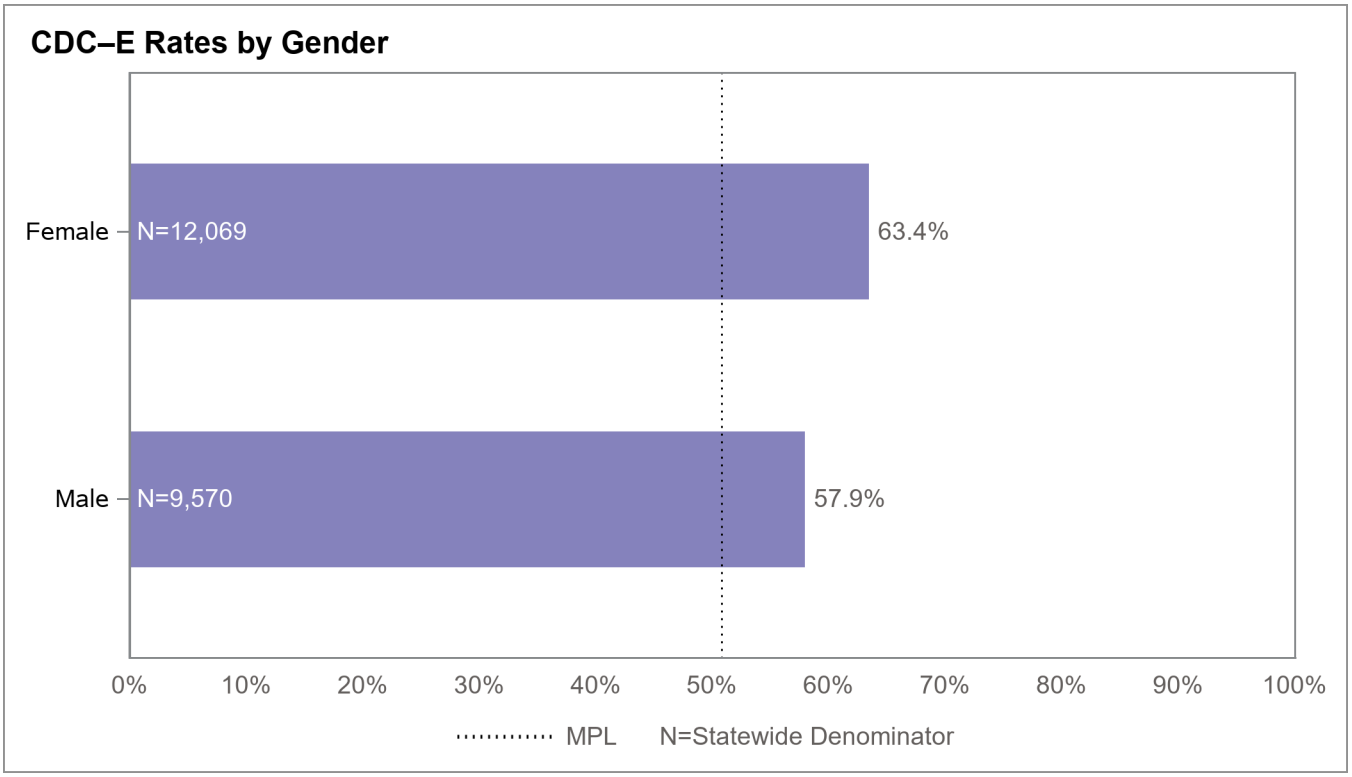


Figure A.66—Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) (CDC–H8) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

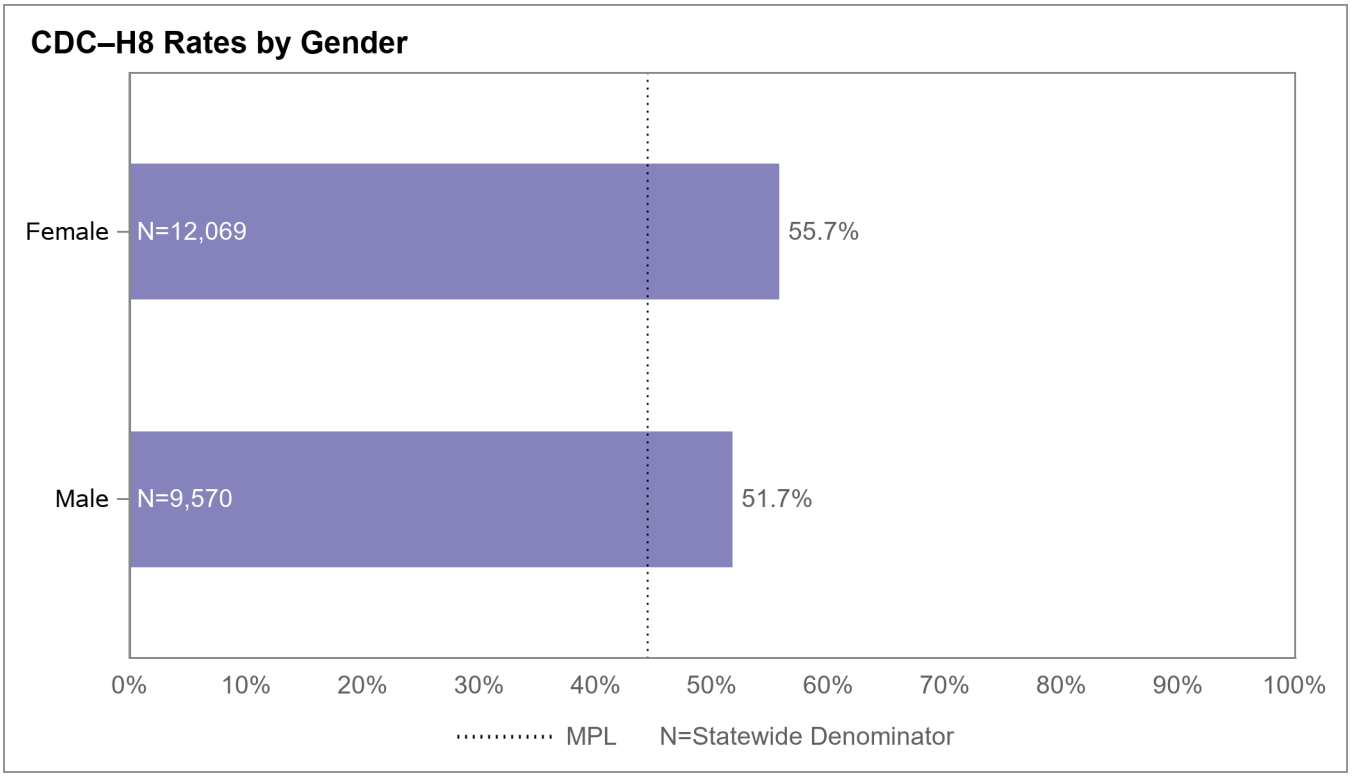


Figure A.67—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent) (CDC–H9) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.
A lower rate indicates more favorable performance for this indicator.

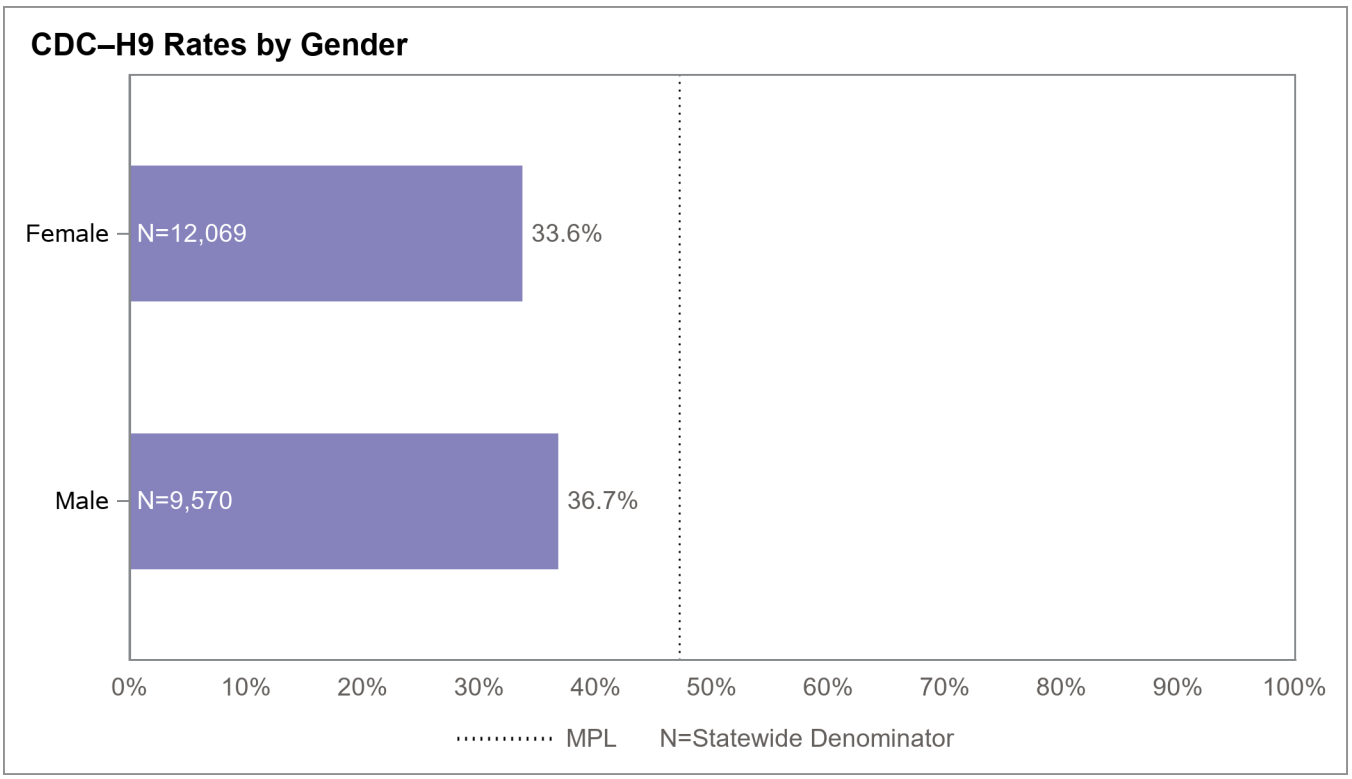


Figure A.68—Comprehensive Diabetes Care—HbA1c Testing (CDC–HT) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

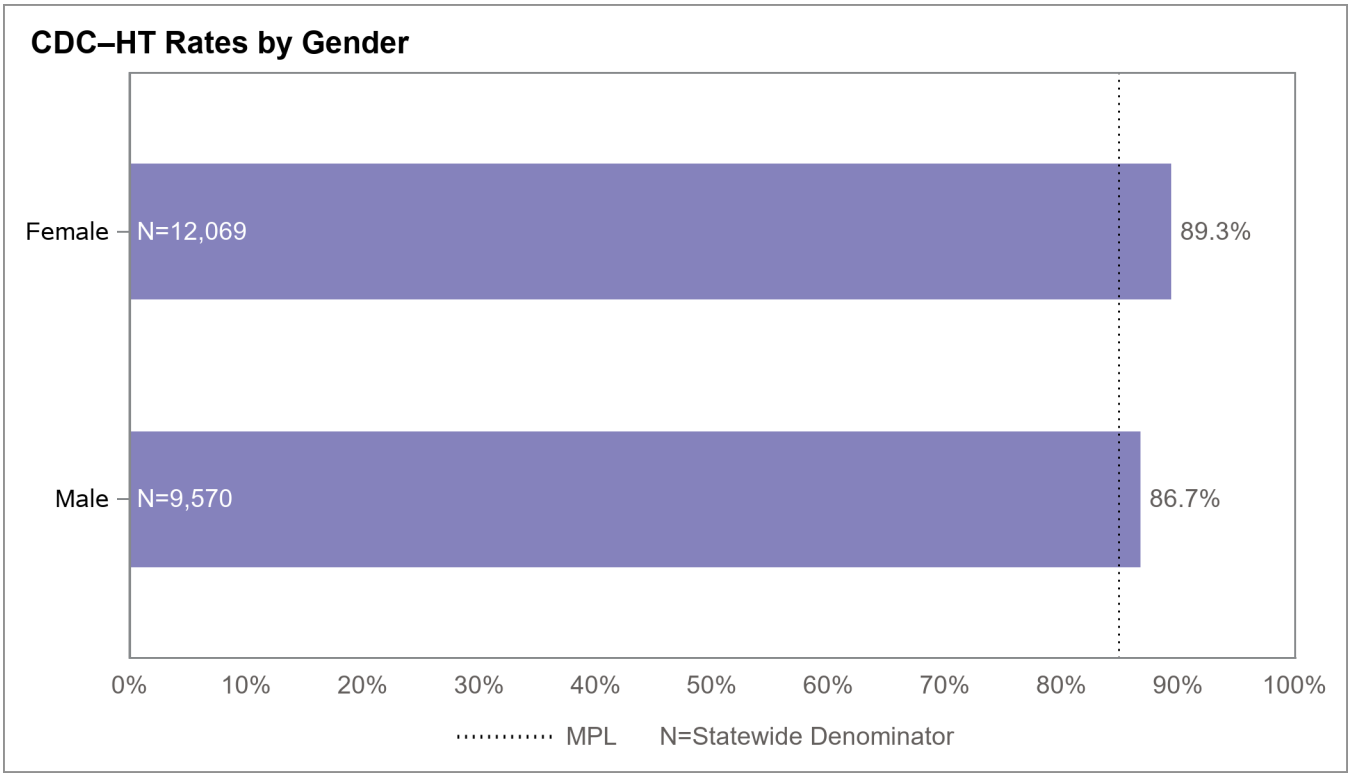


Figure A.69—Comprehensive Diabetes Care—Medical Attention for Nephropathy (CDC–N) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

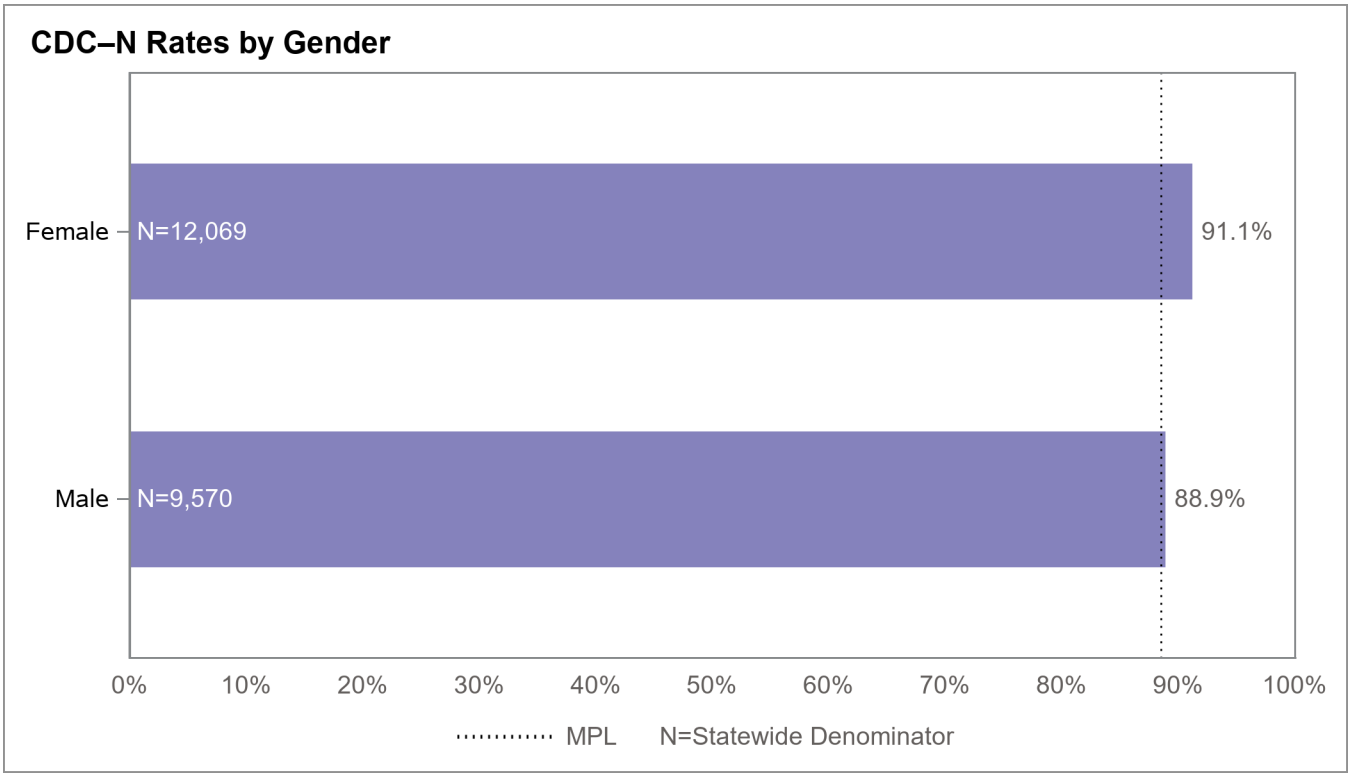
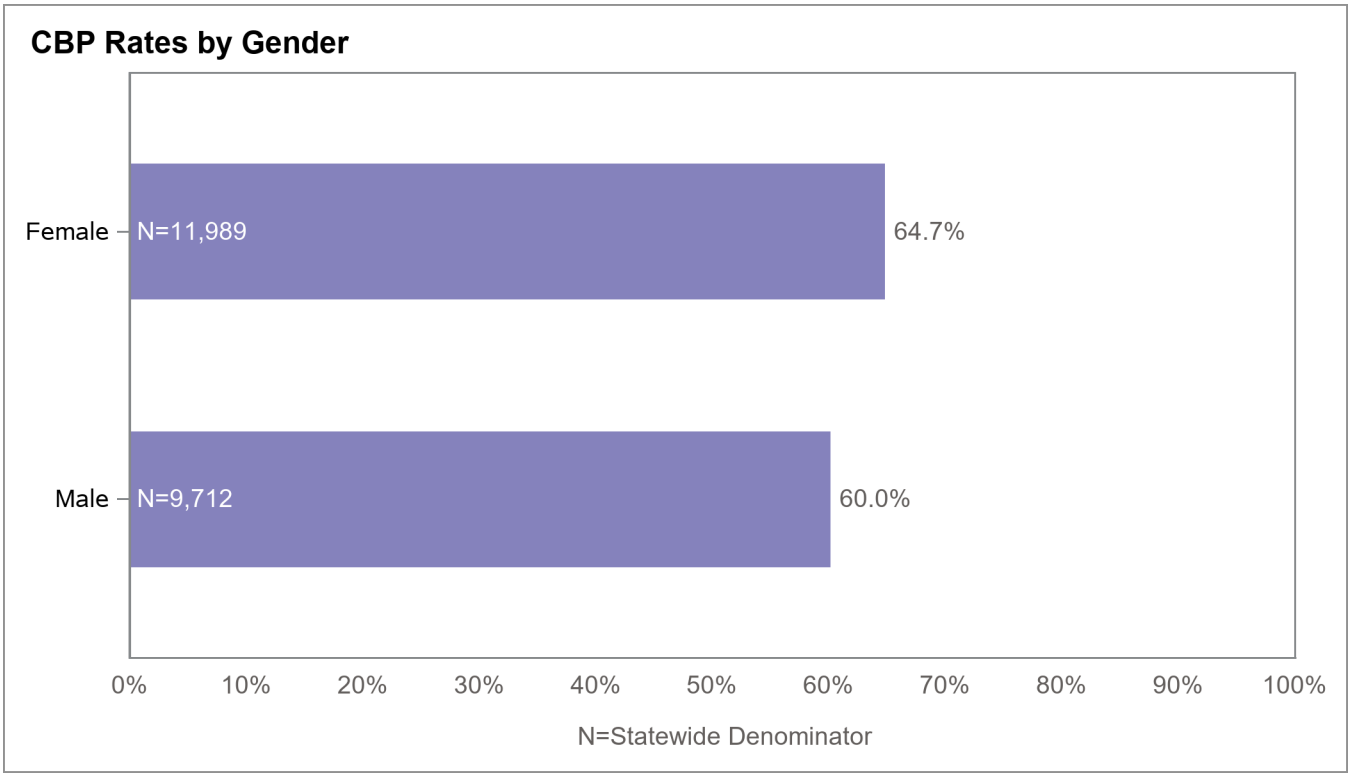


Figure A.70—Controlling High Blood Pressure (CBP) Rates by Gender

Due to changes in the technical specifications for the *Controlling High Blood Pressure* indicator, NCQA recommended a break in trending between reporting year 2019 and prior years; therefore, the minimum performance level is not displayed.



Appropriate Treatment and Utilization Domain

Figure A.71 through Figure A.75 display the statewide Appropriate Treatment and Utilization indicator rates and denominator by gender.

Figure A.71—Plan All-Cause Readmissions (PCR) Rates by Gender

The *Plan All-Cause Readmissions* indicator does not have an established minimum performance level.

A lower rate indicates more favorable performance for this indicator.

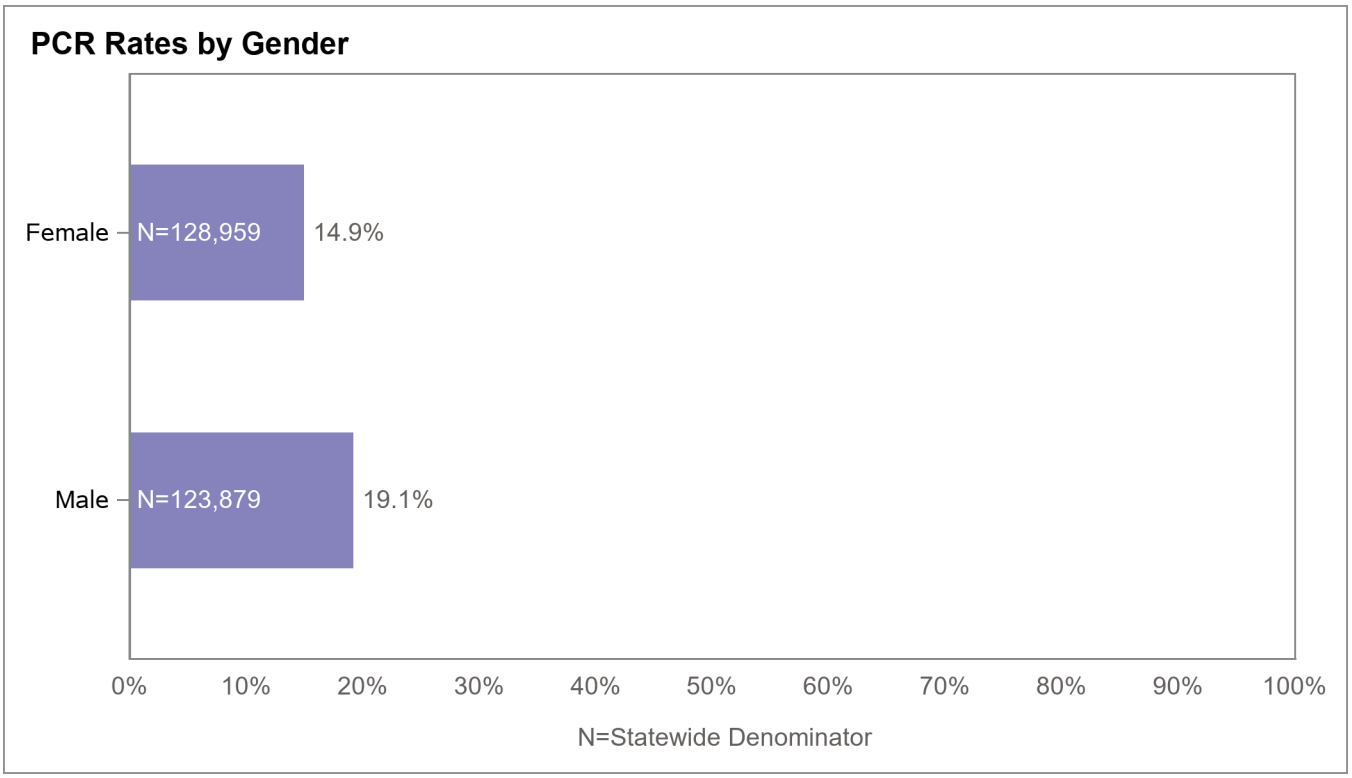


Figure A.72—Ambulatory Care—Emergency Department Visits (AMB–ED) Rates by Gender

Note: The rate for the Unknown/Missing group was 39.6 emergency department visits per 1,000 member months (N= 59,091).
The *Ambulatory Care—Emergency Department Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

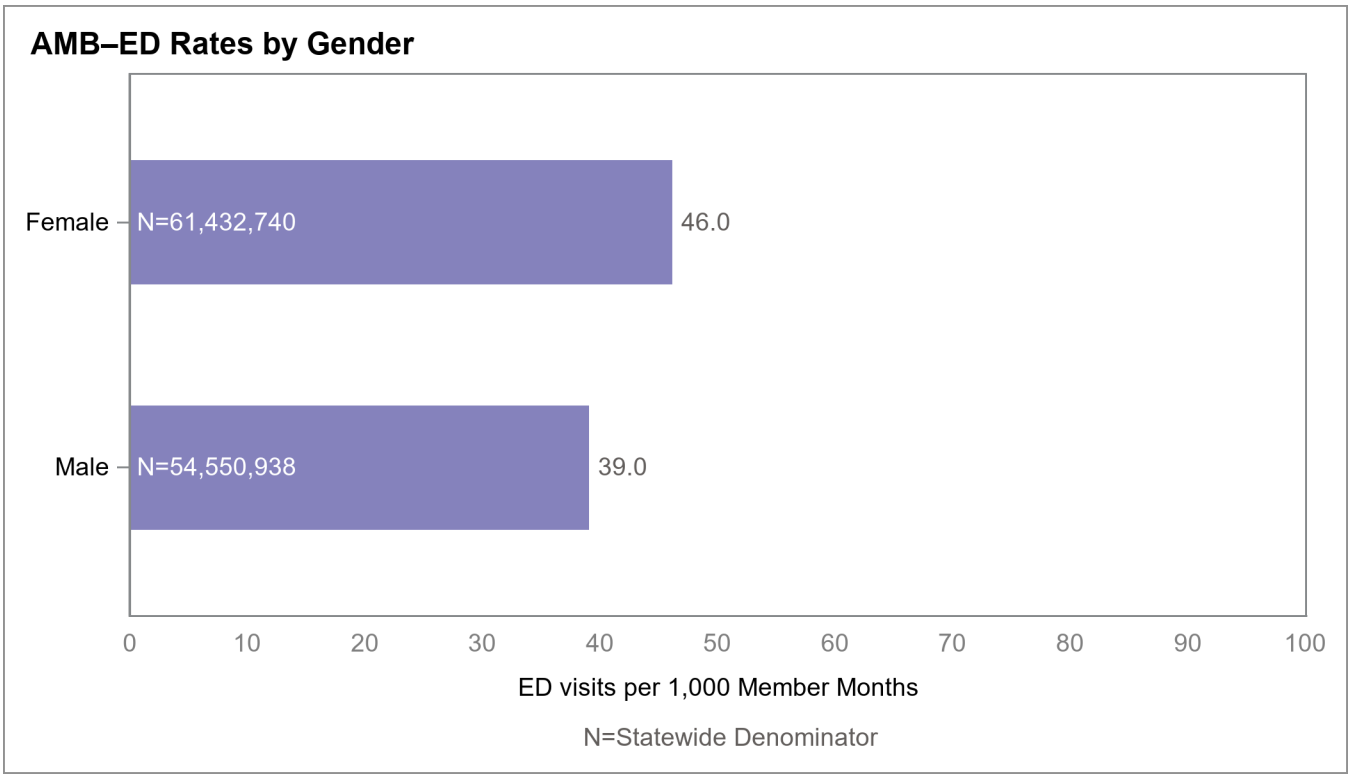


Figure A.73—Ambulatory Care—Outpatient Visits (AMB–OP) Rates by Gender

Note: The rate for the Unknown/Missing group was 303.1 outpatient visits per 1,000 member months (N= 59,091).
The *Ambulatory Care—Outpatient Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

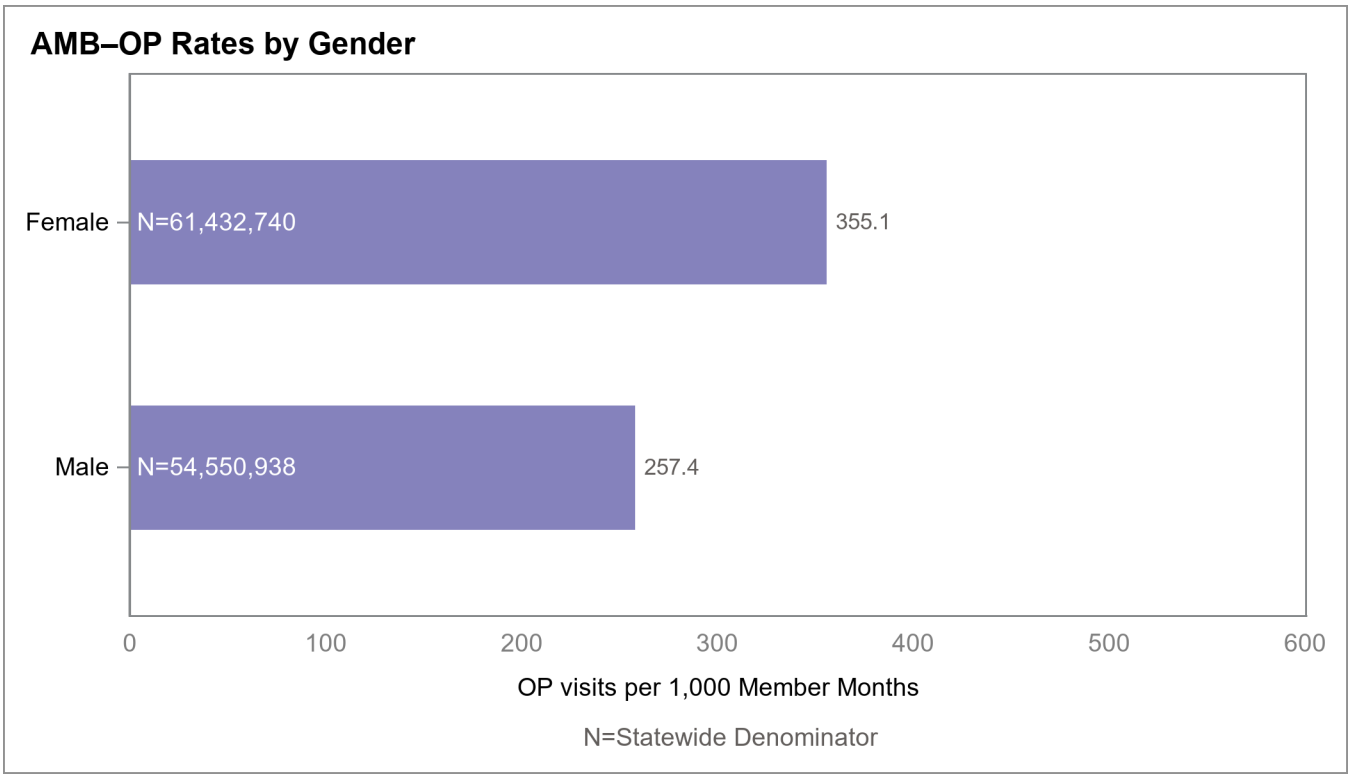


Figure A.74—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

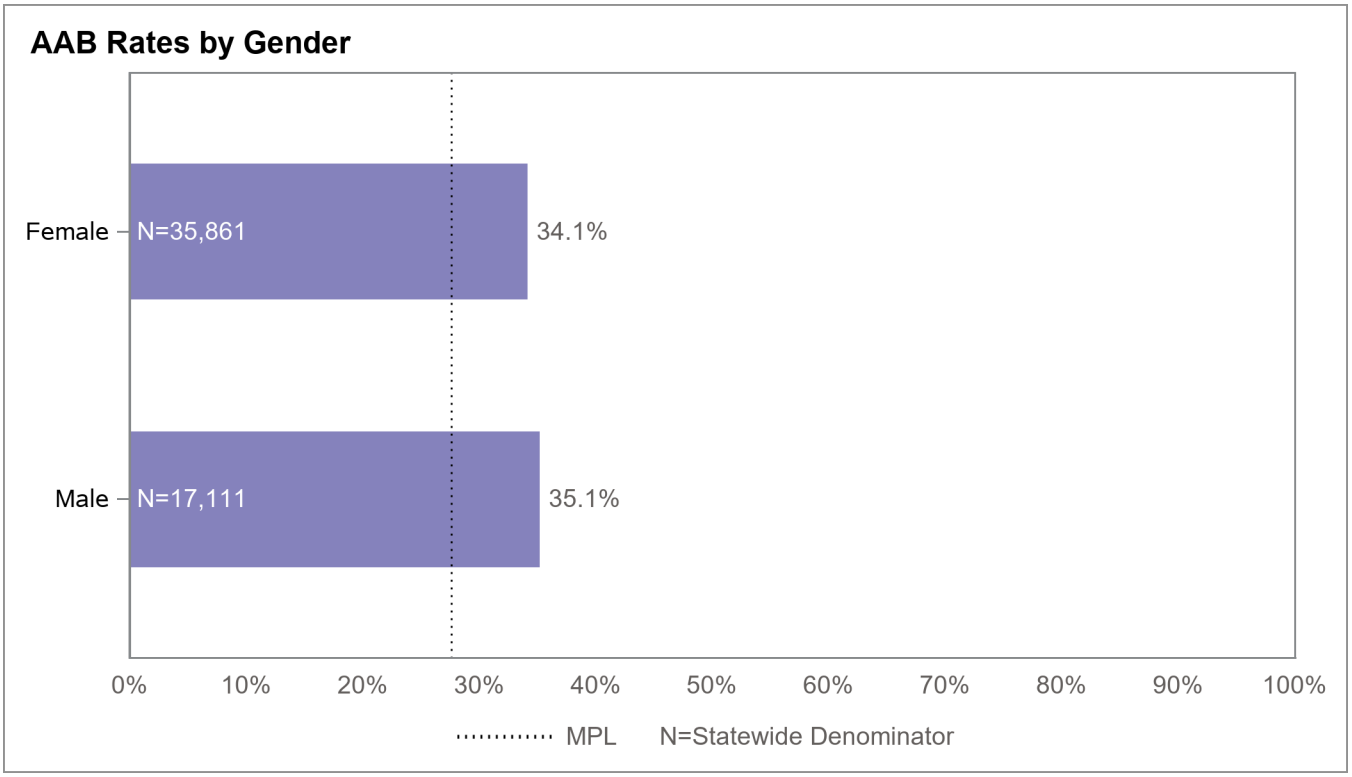
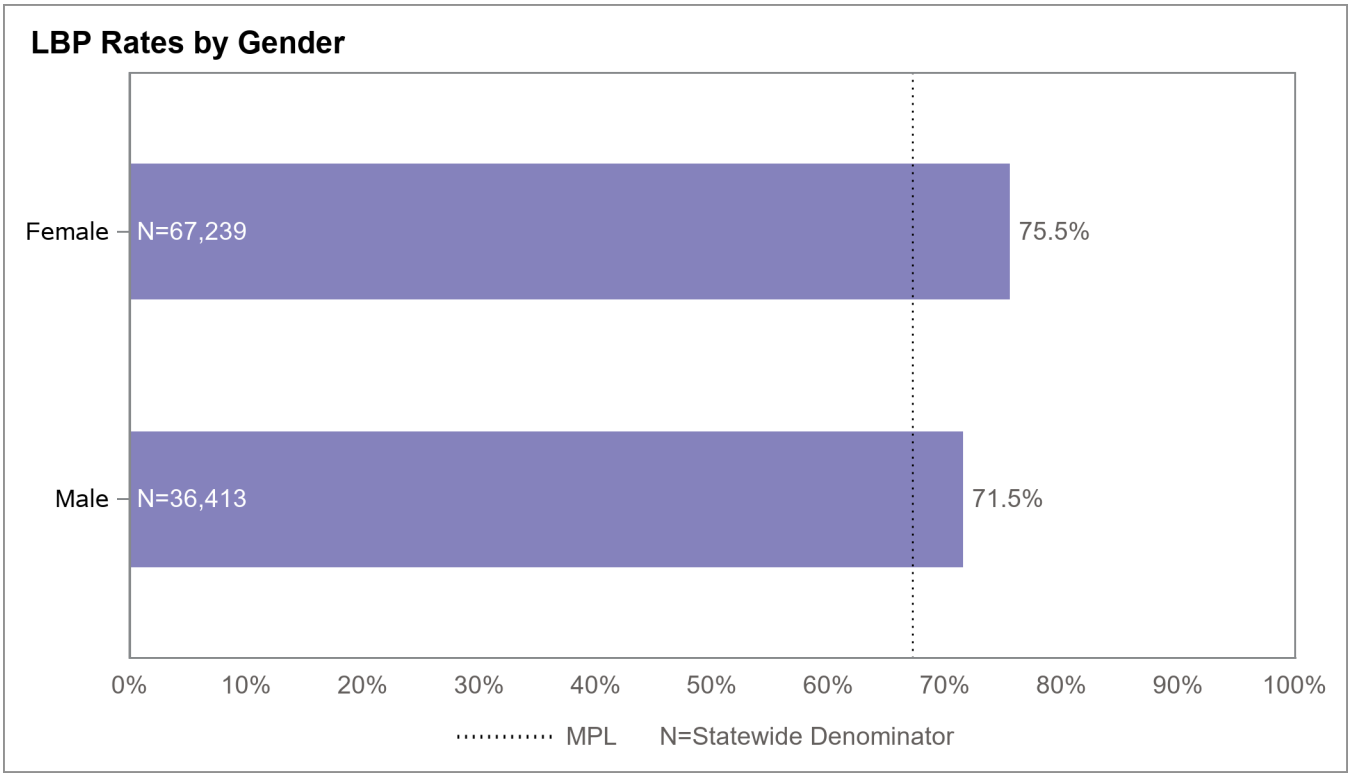


Figure A.75—Use of Imaging Studies for Low Back Pain (LBP) Rates by Gender

The minimum performance level represents the national Medicaid 25th percentile for this indicator.



Appendix B. Methodology

Overview

A health disparity is the difference in health outcomes between groups within a population.[13] To assess and improve health disparities, the California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a health disparities study using the external accountability set (EAS) measures reported by the 25 full-scope Medi-Cal managed care plans (MCPs) for reporting year 2019 with data that is derived from calendar year 2018. EAS measures reflect clinical quality, timeliness, and access to care provided by MCPs to their beneficiaries, and each MCP is required to report audited EAS results to DHCS annually. This report also includes a trending section with results for reporting years 2017–2019. Please note that Aetna Better Health of California and United Healthcare Community Plan were new MCPs for reporting year 2019 and were not able to report all reporting year 2019 measures and were not included in the aggregate rates for reporting year 2017 or 2018. The goal of the Health Disparities Report is to improve health care for Medi-Cal beneficiaries by evaluating the health care disparities affecting beneficiaries enrolled in Medi-Cal MCPs. This report does not include data for fee-for-service beneficiaries in Medi-Cal.

For the 2018–19 contract year, HSAG evaluated measure data collected for reporting year 2019 at the statewide level, which consists of data collected during calendar year 2018 also known as Healthcare Effectiveness Data and Information Set (HEDIS®)[14] measurement year 2018. Several measures include more than one indicator; therefore, this report will refer to indicators rather than measures. The indicator set for this analysis included a total of 28 EAS indicators. Please note, HSAG did not include the *Depression Screening and Follow-Up for Adolescents and Adults* indicator in the health disparities analysis due to unreliable data and inconsistent reporting by MCPs. For each indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined by the HEDIS specification for the Medicaid population. HSAG aggregated results from 25 full-scope MCPs and then stratified the statewide rates for the 28 EAS indicators by the following demographic stratifications:

- Race/ethnicity
- Primary language
- Age
- Gender

Although HSAG stratified all indicators by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic

[13] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

[14] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

stratification. To ensure the methodology aligned with national standards, HSAG used the Centers for Medicare & Medicaid Services' *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.

Data Sources

HSAG received a CA-required patient-level detail file from each MCP for each HEDIS reporting unit. The reporting year 2019 patient-level detail files followed HSAG's patient-level detail file instructions and included the member ID, date of birth, and member months for beneficiaries included in the audited HEDIS rates. Additionally, the patient-level detail files indicated whether a beneficiary was included in the numerator and/or denominator for each applicable HEDIS indicator. HSAG validated the patient-level detail files to ensure the numerator and denominator counts matched what was reported by MCPs in the audited HEDIS Interactive Data Submission System files. Please note, it is possible that non-certified eligible beneficiaries were included by some or all MCPs in the reporting year 2019 HEDIS rates. HSAG used these patient-level detail files, along with supplemental files (e.g., demographic data provided by DHCS), to perform the evaluation. The following demographic file was obtained from DHCS' Management Information System/Decision Support System data system:

- CA-required demographic file
  - Beneficiary's Medi-Cal ID
  - Date of birth
  - ZIP code
  - Gender
  - Race/Ethnicity
  - Primary language
  - County

Combining Data

To calculate indicator rates for the demographic stratifications, HSAG first had to combine the indicator files provided by MCPs with the demographic file provided by DHCS. The following outlines HSAG's process for matching beneficiaries in the indicator files:

Step 1: Records that were missing demographic information for every field were deleted from the demographic file.

Step 2: For records missing demographic values (e.g., race/ethnicity, language, gender, or county), HSAG obtained the demographic values from another record in the demographic file using the following logic:

- HSAG prioritized records from the same reporting unit. If there were no records within the same reporting unit, then HSAG used records from other reporting units to retrieve missing information.
- HSAG prioritized the most recent non-missing observation within the measurement year using the following logic:
  - HSAG first tried to recover the missing demographic values from the most recent non-missing observation within calendar year 2018.
  - If HSAG could not recover the missing demographic values from a record within calendar year 2018, then the most recent non-missing observation from calendar year 2017 was used.
  - If HSAG could not recover the missing demographic values from a calendar year 2018 or calendar year 2017 record, then the earliest non-missing observation from calendar year 2019 was used.
- If HSAG could not obtain data for the missing demographic values, then they were assigned a value of "Unknown/Missing."

Step 3: HSAG combined the demographic file with the indicator file by Medi-Cal client identification number and prioritized matches within the same reporting unit first, using records from other reporting units when necessary and using the same logic as in Step 2. If a client identification number had multiple records in the demographic file with a date of birth within 10 years of each other, the most recent non-missing demographic information was used. Additionally, to avoid combining a parent record with a child record that contains the same client identification number, HSAG only considered a client identification number to match if the date of birth in the demographic file was within 10 years of the date of birth recorded in the indicator file. If HSAG could not obtain county data from the demographic file, then HSAG did the following:

- If the county code was missing or was "Unknown," then HSAG imputed the county based on the ZIP code from the demographic file. If the ZIP code and the county were missing, then a county of "Unknown/Missing" was assigned.

Indicators and Stratifications

Table B.1 displays the demographic stratification groups for race/ethnicity, primary language, age, and gender.

Table B.1—Demographic Stratification Groups

Gender stratifications are not reported for the following indicators: *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care.*

Stratification	Groups
Race/ethnicity	Hispanic or Latino, White, Black or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, Other, and Unknown/Missing (see Table B.2 for more detail)
Primary language	English, Spanish, Arabic, Armenian, Cambodian, Chinese (Mandarin or Cantonese), Farsi, Hmong, Korean, Russian, Tagalog, Vietnamese, Other, and Unknown/Missing
Age	Vary depending on indicator specifications (see Table B.3 for more detail)
Gender	Male and Female

Table B.2 displays the individual racial/ethnic groups that comprise the racial/ethnic demographic stratifications. Please note that for the analyses, the stratifications were collapsed into more meaningful comparison groups, as displayed in Table B.1. Racial/ethnic stratifications were based on data collection guidance from the federal Office of Management and Budget as well as the U.S. Department of Health and Human Services. Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of June 2017.

Table B.2—Racial/Ethnic Stratification Groups

*Some “Other Pacific Islanders” were erroneously included in the Asian group due to limitations of existing data fields.

Stratification	Groups
Hispanic or Latino	Hispanic or Latinx
White	White
Black or African American	Black or African American

Stratification	Groups
Asian	Filipino, Amerasian, Chinese, Cambodian, Japanese, Korean, Laotian, Vietnamese, and Other Asian or Pacific Islander*
American Indian or Alaska Native	American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander	Hawaiian, Guamanian, and Samoan
Other	Other
Unknown/Missing	Unknown/Missing

Because the age parameters for each indicator differ, HSAG collaborated with DHCS to define the following age groups for each indicator. Of note, each indicator includes an "Unknown/Missing" age group. Table B.3 displays the indicators included in the analysis, the reporting methodology for each indicator ("H" indicates hybrid and "A" indicates administrative), and the age groups for each indicator.

Table B.3—Indicators, Methodology, and Age Groups

Indicators	Methodology	Age Groups
Preventive Screening and Children's Health		
Childhood Immunization Status—Combination 3	H	2 Years
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	12 to 24 Months
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	25 Months to 6 Years
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	7 to 11 Years
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	12 to 19 Years
Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	H	13 Years
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total; *Counseling for Physical Activity—Total*	H	3 to 11 Years 12 to 17 Years
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	H	3 to 6 Years

Indicators	Methodology	Age Groups
Preventive Screening and Women's Health		
Breast Cancer Screening	A	52 to 64 Years 65+ Years
Cervical Cancer Screening	H	24 to 29 Years 30 to 44 Years 45 to 64 Years
Prenatal and Postpartum Care—Postpartum Care; *Timeliness of Prenatal Care*	H	<18 Years 18 to 20 Years 21 to 34 Years 35 to 44 Years 45+ Years
Care for Chronic Conditions		
Asthma Medication Ratio	A	5 to 11 Years 12 to 17 Years 18 to 20 Years 21 to 44 Years 45 to 64 Years
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg); *Eye Exam (Retinal) Performed*; *Hemoglobin A1c (HbA1c) Control (<8.0 Percent)*; *HbA1c Poor Control (>9.0 Percent)*; *HbA1c Testing*; *Medical Attention for Nephropathy*	H	18 to 20 Years 21 to 44 Years 45 to 64 Years 65+ Years
Controlling High Blood Pressure	H	18 to 20 Years 21 to 44 Years 45 to 64 Years 65+ Years
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs; *Diuretics*	A	18 to 20 Years 21 to 44 Years 45 to 64 Years 65+ Years

Indicators	Methodology	Age Groups
Appropriate Treatment and Utilization		
Ambulatory Care—Emergency Department Visits; *Outpatient Visits*	A	<1 Year 1 to 5 Years 6 to 11 Years 12 to 17 Years 18 to 20 Years 21 to 44 Years 45 to 64 Years 65+ Years
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	A	18 to 20 Years 21 to 44 Years 45 to 64 Years
Plan All-Cause Readmissions	A	18 to 44 Years 45 to 54 Years 55 to 64 Years
Use of Imaging Studies for Low Back Pain	A	18 to 20 Years 21 to 44 Years 45 to 50 Years

Rate Spreadsheets

After performing the analyses, HSAG compiled and produced indicator rate spreadsheets in a Microsoft Excel format that provided all indicator data for all stratifications (race/ethnicity, primary language, age, and gender). HSAG produced a statewide and 25 MCP-specific rate spreadsheets that contain applicable numerator, denominator, eligible population, demographic, and rate data for each reporting unit. HSAG did not suppress any data in the rate spreadsheets and did not weight rates.

Statistical Analysis

Using the beneficiary-level files created from matching the demographic records with the indicator files, HSAG performed a statewide-level disparity analysis of the racial/ethnic demographic stratification using logistic regression. To facilitate this, HSAG performed the procedures described below.

Pre-Analysis

Based on the methodology for combining data described above, HSAG created separate beneficiary-level files for each indicator containing the numerator, denominator, and matched demographic information for each beneficiary. HSAG limited the beneficiary-level files to beneficiaries with a non-zero denominator.

Some of the indicators were event-based rather than beneficiary-based, which allowed for denominators greater than one. To satisfy the requirements for performing a logistic regression, HSAG altered the indicator files to convert all observations to have dichotomous values for the numerator and denominator (e.g., if an observation had a denominator value of four and a numerator value of three, HSAG created four separate observations that each had a denominator value of one—three of which had a numerator value of one and one of which had a numerator value of zero). HSAG applied this logic to the following indicators:

- *Plan All-Cause Readmissions*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

The rate spreadsheets contain data for all beneficiaries included in MCPs' indicator reporting; however, for this report, HSAG pulled a random sample of 411 beneficiaries for each Kaiser reporting unit for hybrid indicators since Kaiser reported all indicators that allowed for the hybrid option using administrative data only. This was done to limit the overrepresentation of Kaiser beneficiaries toward the statewide average for hybrid indicators.

Statewide-Level Health Disparity Analysis

HSAG performed a statewide-level health disparity analysis for the racial/ethnic demographic stratification. Specifically, HSAG compared each racial/ethnic group to the White group (i.e., the reference group) for each indicator. The White racial/ethnic group was chosen as the reference group because it is used in a majority of national health disparities reports and has historically been used as a reference point for reporting health care and non-health care disparities. Since the *Ambulatory Care* indicator does not meet the assumptions for logistic regression (i.e., the numerator and denominator are not dichotomous), HSAG did not perform logistic regression for this indicator.

HSAG performed the logistic regression using the beneficiary-level file created from matching the demographic file to the indicator file, and used the categorical variable of race/ethnicity as

the independent variable and the dichotomous numerator variable as the dependent variable. Race/ethnicity was assigned to each beneficiary based on the race/ethnicity values provided by DHCS in the demographic file. The White racial/ethnic group was used as the reference group (i.e., all other racial/ethnic groups were compared to the White group). HSAG performed the logistic regression using SAS software. The *p*-value of the coefficient from the logistic regression was used to identify statistically significant differences when comparing the racial/ethnic groups to the reference group.

For each indicator, HSAG calculated an absolute difference by taking the absolute value of the difference between the rate for a racial/ethnic group and the rate for the reference group. For this report, a "health disparity" was defined as a rate for a racial/ethnic group with an absolute difference greater than or equal to 3 percentage points ***and*** a *p*-value of the coefficient of the logistic regression that is less than 0.05. When analyzing the rate for a racial/ethnic group, HSAG classified the rate in one of the following three categories based on the preceding analyses:

- Better Rate = The absolute difference from the reference group was greater than or equal to 3 percentage points, the *p*-value of the coefficient of the logistic regression was less than 0.05, and the rate for the racial/ethnic group was higher or more favorable than the rate for the reference group. In other words, the reference group showed a health disparity compared to the racial/ethnic group being evaluated.
- Worse Rate = The absolute difference from the reference group was greater than or equal to 3 percentage points, the *p*-value of the coefficient of the logistic regression was less than 0.05, and the rate for the racial/ethnic group was lower or less favorable than the rate for the reference group. In other words, the racial/ethnic group being evaluated showed a health disparity compared to the reference group.
- Similar Rate = The absolute difference from the reference group was less than 3 percentage points; or, the *p*-value of the coefficient of the logistic regression was greater than or equal to 0.05. This means no health disparities were identified when the racial/ethnic group was compared to the reference group.

For more information on how HSAG displayed the results from the statistical analysis, please refer to the "Reporting" section below.

Reporting

HSAG produced a formal report focusing on racial/ethnic disparities at the statewide level. Since the report is public-facing, HSAG suppressed results with small denominators (less than 30) or small numerators (less than 11). In the Health Disparities Report, rates shown in bar graphs or text for indicators represent the total denominator divided by the total numerator as a percentage, unless otherwise indicated.

HSAG produced horizontal bar graphs for each indicator to display the rates for each racial/ethnic group. To highlight identified health disparities, HSAG displayed arrows next to the rate on the bar graph to indicate whether the rate for the racial/ethnic group being

evaluated was a better rate (indicated by an upward arrow) or worse rate (indicated by a downward arrow) than the rate for the reference group. No arrow represents similar rates compared to the reference group, which means no health disparities were identified. "N" represents the total statewide denominator for an indicator for a particular group.

In addition, HSAG produced a horizontal stacked bar graph for each domain (Preventive Screening and Children's Health, Preventive Screening and Women's Health, Care for Chronic Conditions, and Appropriate Treatment and Utilization) that displays for each racial/ethnic group the percentage of indicators within that domain that had a better rate, worse rate, or similar rate when compared to the reference group. A similar horizontal stacked bar graph was created to display overall racial/ethnic health disparities for all indicators analyzed in this study. "N" represents the number of indicators.

To present trending disparities results, HSAG produced a stacked column graph for each racial/ethnic group that displays the number of indicators for each reporting year that had a better rate, worse rate, or similar rate when compared to the rate for the reference group. Additionally, HSAG produced three-year rate trending figures (i.e., reporting years 2017–2019) by race/ethnicity and primary language for the following indicators:

- *Childhood Immunization Status—Combination 3*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Breast Cancer Screening*
- *Prenatal and Postpartum Care—Postpartum Care and Timeliness of Prenatal Care*
- *Asthma Medication Ratio*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Controlling High Blood Pressure*

DHCS selected the indicators listed above for the three-year rate trending because they satisfy all of the following criteria: (1) they represent a wide range of health care needs including preventive care for children, women's health, and chronic disease management; (2) they represent areas of interest given the variation in rates among the different racial/ethnic and primary language groups; and (3) there is an expectation of the continuity of measurement (i.e., trends for these indicators can be evaluated in the future). Within the Health Disparities Report, HSAG organized the trending graphics for the indicators listed above by domain (Preventive Screening and Children's Health, Preventive Screening and Women's Health, and Care for Chronic Conditions). For each indicator, HSAG created a gridded figure (i.e., a figure that displays separate graphs for each racial/ethnic and primary language group compared to the applicable reference group [i.e., White group or English group] within one figure) that shows the three-year trend line for each racial/ethnic and primary language group. Any racial/ethnic group or primary language group that had an insufficient numerator or denominator (i.e., less than 11 for the numerator or less than 30 for the denominator) for any reporting year was excluded from the trending graph.

Within the appendix of the Health Disparities Report, HSAG also calculated indicator rates for the primary language, age, and gender demographic stratifications; however, statistical

analysis was not performed on these demographic stratifications to identify health disparities. For each indicator, HSAG created horizontal bar graphs for all demographic stratifications that display the rates for each demographic group and indicate the minimum performance level for the corresponding indicator as established by DHCS, if applicable. The minimum performance levels for each indicator are based on NCQA's Quality Compass national Medicaid Health Maintenance Organization 25th percentile. The minimum performance level is displayed not as a statistical benchmark for health disparities but to provide more information about overall performance for a specific indicator. "N" represents the total statewide denominator for an indicator for a particular group.

Geographic Variability by County for Select Indicators

After review of the analyses with DHCS, HSAG developed California-wide choropleth maps to show geographic variability at the county level. DHCS determined that choropleth maps would be produced for the following select EAS indicators:

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Breast Cancer Screening*
- *Asthma Medication Ratio*
- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

To highlight regional performance differences, HSAG first assigned a county to each beneficiary based on the county code provided in the DHCS demographic file. If the county code was missing for a beneficiary in the demographic data file, HSAG used the ZIP code to determine the appropriate county. HSAG then calculated county-level rates for each indicator listed previously by summing the numerators and denominators for all beneficiaries within a county. For each indicator, HSAG and DHCS determined cut points (e.g., 60.00 percent, 65.00 percent, 70.00 percent, 80.00 percent) based on the distribution of county-level rates to display the variation of county performance. HSAG then created performance levels (Lowest Performance [darkest blue], Low Performance, Middle/Average Performance, High Performance, and Highest Performance [lightest blue]) based on the cut points for each indicator. Once the performance levels were set for each indicator, each county was shaded the corresponding color of the performance level. Table B.4, on the following page, displays the performance levels and corresponding colors for each indicator.

Table B.4—Performance Level and Corresponding Colors

For county rates with a small denominator (i.e., less than 30) or small numerator (i.e., less than 11), HSAG shaded the county white.

Indicator	Performance Level and Corresponding Colors
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	Below 80.00%
	80.00% to 83.99%
	84.00% to 85.99%
	86.00% to 88.99%
	89.00%+
Breast Cancer Screening	Below 45.00%
	45.00% to 49.99%
	50.00% to 54.99%
	55.00% to 59.99%
	60.00%+
Asthma Medication Ratio	Below 53.00%
	53.00% to 57.99%
	58.00% to 62.99%
	63.00% to 66.99%
	67.00%+
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Below 26.00%
	26.00% to 31.99%
	32.00% to 38.99%
	39.00% to 45.99%
	46.00%+

Caveats

Hybrid Indicators

For hybrid measures/indicators, NCQA recommends the submission of a sample of 411 beneficiaries per reporting unit to limit bias and to allow for results from the sample to be generalizable to the entire eligible population. As the rates for individual strata will be based on fewer than 411 beneficiaries, it should be noted that the stratified rates may not be generalizable to the total eligible population. Due to this caveat, the stratified rates produced for hybrid indicators should be interpreted with caution. Additionally, HSAG did not weight the statewide rates for hybrid indicators by the total eligible population, so all MCPs, regardless of size, count equally toward the statewide rates. As such, performance may not be representative of actual statewide performance.

Limiting Beneficiaries

To match the age parameters for each indicator, HSAG limited the analysis to beneficiaries whose age was in one of the valid age groups for each indicator, as defined in Table B.3. For indicators in the Preventive Screening and Women's Health domain, HSAG only kept beneficiaries who were identified as female in the demographic file. Additionally, HSAG included the "Unknown/Missing" group for race/ethnicity, primary language, and gender in the formal report as a note above the figures.