

2022 Health Disparities Report

Quality and Population Health Management
California Department of Health Care Services

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Property of the California Department of Health Care Services



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Commonly Used Abbreviations and Acronyms

The following is a list of abbreviations and acronyms used throughout this report. Italicized abbreviations are for performance measures only.

- ♦ **AAP**—*Adults’ Access to Preventive/Ambulatory Health Services*
- ♦ **ADHD**—Attention-Deficit Hyperactivity Disorder
- ♦ **ADD**—*Follow-Up Care for Children Prescribed ADHD Medication*
- ♦ **AMB**—*Ambulatory Care*
- ♦ **AMM**—*Antidepressant Medication Management*
- ♦ **AMR**—*Asthma Medication Ratio*
- ♦ **APM**—*Metabolic Monitoring for Children and Adolescents on Antipsychotics*
- ♦ **BCS**—*Breast Cancer Screening*
- ♦ **CAHPS®**—Consumer Assessment of Healthcare Providers and Systems¹
- ♦ **CBP**—*Controlling High Blood Pressure*
- ♦ **CCP**—*Contraceptive Care—Postpartum Women*
- ♦ **CCS**—*Cervical Cancer Screening*
- ♦ **CCW**—*Contraceptive Care—All Women*
- ♦ **CHIP**—Children’s Health Insurance Program
- ♦ **CHL**—*Chlamydia Screening in Women*
- ♦ **CIS**—*Childhood Immunization Status*
- ♦ **CMS**—Centers for Medicare & Medicaid Services
- ♦ **COL**—*Colorectal Cancer Screening*
- ♦ **COVID-19**—coronavirus disease 2019
- ♦ **DDG**—Data De-Identification Guidelines²
- ♦ **DEV**—*Developmental Screening in the First Three Years of Life*
- ♦ **DHCS**—California Department of Health Care Services
- ♦ **DRR**—*Depression Remission or Response for Adolescents and Adults*

¹ CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

² California Department of Health Care Services. Data De-Identification Guidelines (DDG). Version 2.2. December 6, 2022. Available at: [DHCS-DDG-V2.2.pdf \(ca.gov\)](https://www.dhcs.ca.gov/Programs/Pages/DDG-V2.2.pdf). Accessed on: Jan 31, 2024.

- ◆ **DSF**—*Depression Screening and Follow-Up for Adolescents and Adults*
- ◆ **ECDS**—Electronic Clinical Data Systems
- ◆ **EHR**—electronic health record
- ◆ **FFY**—Federal Fiscal Year
- ◆ **FUA**—*Follow-Up After Emergency Department Visit for Substance Use*
- ◆ **FUM**—*Follow-Up After Emergency Department Visit for Mental Illness*
- ◆ **HbA1c**—hemoglobin A1c
- ◆ **HBD**—*Hemoglobin A1c (HbA1c) Control for Patients With Diabetes*
- ◆ **HEDIS®**—Healthcare Effectiveness Data and Information Set³
- ◆ **HPI**—Healthy Places Index
- ◆ **HPL**—high performance level
- ◆ **HPV**—human papillomavirus
- ◆ **HSAG**—Health Services Advisory Group, Inc.
- ◆ **IMA**—*Immunizations for Adolescents*
- ◆ **LSC**—*Lead Screening in Children*
- ◆ **MCAS**—Managed Care Accountability Set
- ◆ **MCMC**—Medi-Cal managed care program
- ◆ **MCP**—managed care health plan
- ◆ **MMEC**—most or moderately effective contraception
- ◆ **MPL**—minimum performance level
- ◆ **MS**—Microsoft
- ◆ **MSP**—median state performance
- ◆ **N**—number
- ◆ **NCQA**—National Committee for Quality Assurance
- ◆ **OB/GYN**—obstetrician/gynecologist
- ◆ **PCP**—primary care physician
- ◆ **PCR**—*Plan All-Cause Readmissions*
- ◆ **PDS**—*Postpartum Depression Screening and Follow-Up*
- ◆ **PHQ-9**—Patient Health Questionnaire-9
- ◆ **PND**—*Prenatal Depression Screening and Follow-Up*
- ◆ **POD**—*Pharmacotherapy for Opioid Use Disorder*

³ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ **PPC**—*Prenatal and Postpartum Care*
- ◆ **PRS**—*Prenatal Immunization Status*
- ◆ **QMR**—*Quality Measure Reporting*
- ◆ **RUCA**—*Rural-Urban Commuting Area*
- ◆ **SPD**—*Seniors and Persons with Disabilities*
- ◆ **SSD**—*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- ◆ **Tdap**—*tetanus, diphtheria toxoids, and acellular pertussis vaccine*
- ◆ **TFL**—*Topical Fluoride for Children*
- ◆ **W30**—*Well-Child Visits in the First 30 Months of Life*
- ◆ **WCV**—*Child and Adolescent Well-Care Visits*

1. Introduction and Methodology

Introduction

Within its Comprehensive Quality Strategy, the California Department of Health Care Services (DHCS) identifies a Health Equity Framework focused on improved data collection and stratification, increased workforce diversity and cultural responsiveness, and efforts to eliminate health disparities in order to achieve more equitable health outcomes for Medi-Cal members.⁴ To address the need to understand and identify health disparities among Medi-Cal managed care health plan (MCP) members, DHCS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a health disparities study using the Managed Care Accountability Set (MCAS) measures reported by the 25 Medi-Cal MCPs for measurement year 2022 with data derived from calendar year 2022. MCAS measures reflect clinical quality, timeliness, and access to care provided by MCPs to their members, and each MCP is required to report audited MCAS results to DHCS annually. The goal of the health disparities analysis is to improve health care for Medi-Cal members by evaluating the health care disparities affecting members enrolled in Medi-Cal MCPs. This report does not include data for fee-for-service members in Medi-Cal.

To identify and understand health disparities affecting Medi-Cal members, it is important to consider the population mix of the Medi-Cal managed care program. As of March 2023, the approximate racial/ethnic distribution of the Medi-Cal managed care population consisted of the following racial/ethnic groups: Hispanic (48.2 percent), White (17.7 percent), Other or Unknown (17.0 percent), Asian (8.5 percent), Black or African American (7.3 percent), and Native Hawaiian or Other Pacific Islander (1.4 percent). In addition, the Medi-Cal managed care program's age distribution as of March 2023 was as follows: 18-year-olds and younger (35.3 percent), 19-to-64-year-olds (54.0 percent), and 65-year-olds and older (10.7 percent).⁵ Please note, these percentages may not equal 100 percent due to rounding.

⁴ State of California Department of Health Care Services. Comprehensive Quality Strategy. February 2022. Available at: <https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf>. Accessed on: Jan 31, 2024.

⁵ Managed Care Performance Monitoring Dashboard Report, October 2023. Available at: <https://data.chhs.ca.gov/dataset/managed-care-performance-monitoring-dashboard-report/resource/d2ccf65f-0cf7-41d2-916e-2aded8d86434>. Accessed on: Jan 31, 2024.

Medi-Cal Managed Care Program and Health Disparities

DHCS' vision is to preserve and improve the health of all Californians. DHCS focuses on three interconnected guiding principles to advance this vision:⁶

- ◆ Eliminating health disparities through anti-racism and community-based partnerships.
- ◆ Data-driven improvements that address the whole person.
- ◆ Transparency, accountability, and member involvement.

Based on these guiding principles, DHCS established the following goals related to preserving and improving the health of all Californians:

- ◆ Engage members as owners of their own care.
- ◆ Keep families and communities healthy via preventive care.
- ◆ Provide early interventions for rising risk and patient-centered chronic disease management.
- ◆ Provide whole person care for high-risk populations, including addressing drivers of health.

For the 2022–23 contract year, HSAG evaluated measure data collected for measurement year 2022 at the statewide level. Several measures include more than one indicator; therefore, this report will refer to indicators rather than measures (e.g., the *Depression Remission or Response for Adolescents and Adults* measure includes three indicators: *Follow-Up Patient Health Questionnaire-9 [PHQ-9]—Total*, *Depression Remission—Total*, and *Depression Response—Total*). For each indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the Healthcare Effectiveness Data and Information Set (HEDIS) specifications for the Medicaid population or by the Centers for Medicare & Medicaid Services' (CMS') Core Set of Adult Health Care Quality Measures for Medicaid and Core Set of Children's Health Care Quality Measures for Medicaid and the Children's Health Insurance Program (CHIP) (Adult and Child Core Set) specifications. HSAG aggregated results from 25 MCPs and then stratified the statewide rates for the MCAS indicators by the following demographic stratifications:

- ◆ Race/Ethnicity
- ◆ Primary Language
- ◆ Age
- ◆ Gender
- ◆ Seniors and Persons with Disabilities (SPD) and non-SPD populations

⁶ State of California Department of Health Care Services. Comprehensive Quality Strategy. February 2022. Available at: <https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf>. Accessed on: Jan 31, 2024.

- ◆ Healthy Places Index (HPI) Quartile (for select indicators)
- ◆ County
- ◆ Region

Although HSAG stratified all indicators by the demographic stratifications listed above, HSAG only identified racial/ethnic health disparities. As part of the statewide health disparity analysis for the racial/ethnic demographic stratification, HSAG compared each racial/ethnic group rate to the applicable benchmarks:

- ◆ The minimum performance levels (i.e., the 2021 and 2022 NCQA Quality Compass[®],⁷ national Medicaid 50th percentiles) for the HEDIS MCAS indicators, when available.
- ◆ The median state performance rates (i.e., the 50th percentiles) from the CMS Federal Fiscal Year (FFY) 2020 Child and Adult Health Care Quality Measures data set⁸ for non-HEDIS MCAS indicators, when available.⁹

Summary of Performance Indicators

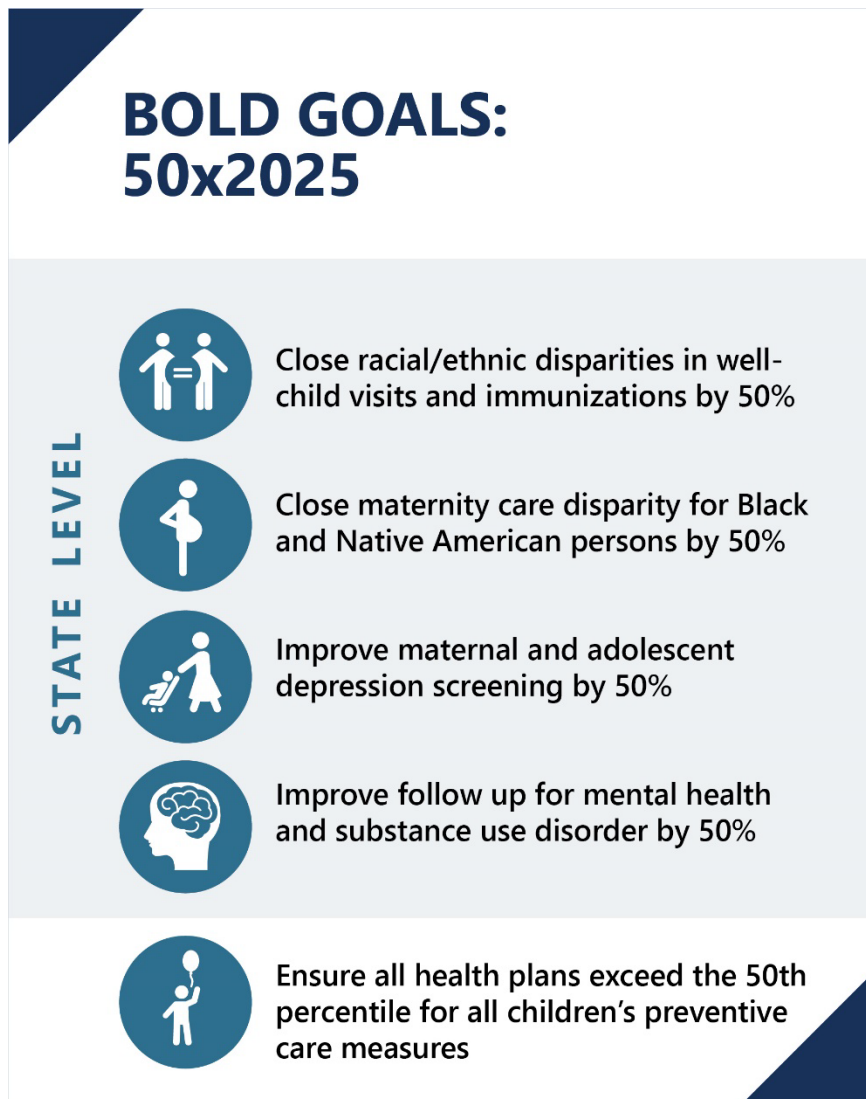
Thirty-two indicators reported by the 25 Medi-Cal MCPs were evaluated for racial/ethnic health disparities, and 49 indicators were included in the analyses for the appendices (i.e., highest performing group and demographic stratified rates). The indicators were grouped into the following domains of care: Children's Health, Reproductive Health, Cancer Prevention, Behavioral Health, and Chronic Disease Management. 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 members.

As part of DHCS' Quality Strategy, DHCS established the *Bold Goals 50x2025* initiative, which aims to improve Medi-Cal clinical and health equity outcomes by 2025. Figure 1.1 displays DHCS' Bold Goals.

⁷ Quality Compass[®] is a registered trademark of the NCQA.

⁸ CMS. 2020 Child and Adult Health Care Quality Measures. Available at: [2020 Child and Adult Health Quality Measures](#). Accessed on: Jan 31, 2024.

⁹ Given that CMS transitioned to the Quality Measure Reporting (QMR) system, state reporting for measurement year 2020 was delayed; therefore, FFY 2021 benchmarks were unavailable. As a result, HSAG compared measurement year 2021 rates for applicable non-HEDIS MCAS indicators to the FFY 2020 benchmarks.

Figure 1.1—California Department of Health Care Services—Bold Goals 50x2025

To monitor MCP progress toward the goals of the Bold Goals 50x2025 initiative, DHCS selected specific MCAS indicators associated with each Bold Goal.¹⁰ Please refer to Section 2 for which Bold Goals apply to each indicator.

Table 1.1 displays the indicators included in the analysis, the reporting methodology for each indicator, the age groups for each indicator, the available benchmarks for each indicator, and whether the indicator has a corresponding Bold Goal. Because the age parameters for each

¹⁰ State of California Department of Health Care Services. Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committee Meeting, February 17, 2022. Available at: <https://www.dhcs.ca.gov/services/Documents/021722-SAC-BH-SAC-core-presentation.pdf>. Accessed on: Jan 31, 2024.

indicator differ, HSAG collaborated with DHCS to define the age groups listed in Table 1.1 for each indicator.

Due to NCQA's recommendation for a break in trending (indicated with a *), benchmark unavailability (indicated with a ^), or limitations with the data (indicated with a +), HSAG was unable to perform analyses to identify health disparities for the following indicators:

- ◆ Measurement year 2021
 - *Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total*^{+,11}
 - *Plan All-Cause Readmissions—Observed Readmission Rate—Total*[^]
- ◆ Measurement year 2022
 - *Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total*[^]
 - *Colorectal Cancer Screening—Total*[^]
 - *Depression Remission or Response for Adolescents and Adults*[^]
 - *Depression Screening and Follow-Up for Adolescents and Adults*[^]
 - *Follow-Up After Emergency Department Visit for Substance Use*^{*}
 - *Plan All-Cause Readmissions—Observed Readmission Rate—Total*[^]
 - *Postpartum Depression Screening and Follow-Up*[^]
 - *Prenatal Depression Screening and Follow-Up*[^]

HSAG compared measurement year 2022 results to measurement year 2021 results, where applicable. For indicators where HSAG was unable to identify health disparities for only measurement year 2021, trending results are presented and disparities are identified for measurement year 2022. For indicators where HSAG was unable to identify health disparities for both measurement years 2021 and 2022, HSAG stratified these indicators by race/ethnicity, primary language, age, gender, SPD/non-SPD populations, and HPI quartile, where applicable, and presents the results in the appendices of this report.

Table 1.1—Indicators, Reporting Methodology, Age Groups, Benchmarking Sources, and Bold Goals

A = administrative methodology (claims/encounter data and supplemental administrative data sources)

H = hybrid methodology (a combination of claims/encounter data and medical record review data). For all hybrid measures, MCPs have the option to report the measure using either the hybrid or administrative reporting methodology.

¹¹ NCQA changed the *Ambulatory Care* measure from per 1,000 member months to per 1,000 member years for measurement year 2022. According to NCQA allowances, HSAG recalculated the measurement year 2021 *Ambulatory Care—Emergency Department Visits* indicator rates to be per 1,000 member years in order to trend to measurement year 2022 rates.

ECDS = Electronic Clinical Data Systems methodology (can include electronic health record [EHR] data, health information exchange data, clinical registry data, case management registry data, and administrative claims/encounter data)

N/A indicates HSAG was unable to compare rates to national benchmarks due to NCQA's recommendation for a break in trending, benchmark unavailability, or limitations with the data.

* Indicates a lower rate is better.

^ Indicates a higher or lower rate does not necessarily indicate better or worse performance.

+ Given that CMS transitioned to the QMR system, state reporting for measurement year 2020 was delayed; therefore, FFY 2021 benchmarks are unavailable. As a result, HSAG compared measurement years 2021 and 2022 rates to the FFY 2020 benchmarks.

Indicator	Reporting Methodology	Age Groups	Benchmarks	Bold Goal (Yes/No)
Children's Health				
<i>Child and Adolescent Well-Care Visits—Total</i>	A	3–11 Years; 12–17 Years; 18–21 Years	NCQA 2021 and 2022 Quality Compass	Yes
<i>Childhood Immunization Status—Combination 10</i>	H	2 Years	NCQA 2021 and 2022 Quality Compass	Yes
<i>Developmental Screening in the First Three Years of Life—Total</i> ⁺	A	1 Year; 2 Years; 3 Years	FFY 2020 CMS Child Core Set	Yes
<i>Immunizations for Adolescents—Combination 2</i>	H	13 Years	NCQA 2021 and 2022 Quality Compass	Yes
<i>Lead Screening in Children</i>	H	2 Years	NCQA 2022 Quality Compass	Yes
<i>Topical Fluoride for Children—Dental Services—Total, Oral Health Services—Total, and Dental or Oral Health Services—Total</i>	A	1–2 Years; 3–5 Years; 6–7 Years; 8–9 Years; 10–11 Years; 12–14 Years; 15–18 Years; 19–20 Years	N/A	Yes
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—</i>	A	15 Months; 30 Months	NCQA 2021 and 2022 Quality Compass	Yes

Indicator	Reporting Methodology	Age Groups	Benchmarks	Bold Goal (Yes/No)
<i>Six or More Well-Child Visits and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits</i>				
Reproductive Health				
<i>Chlamydia Screening in Women—Total</i>	A	16–20 Years; 21–24 Years	NCQA 2021 and 2022 Quality Compass	Yes
<i>Contraceptive Care—All Women—Most or Moderately Effective Contraception⁺</i>	A	15–20 Years; 21–44 Years	FFY 2020 Adult and Child Core Set	No
<i>Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days⁺</i>	A	15–20 Years; 21–44 Years	FFY 2020 Adult and Child Core Set	No
<i>Postpartum Depression Screening and Follow-Up—Depression Screening and Follow-Up on Positive Screen</i>	ECDS	<18 Years; 18–20 Years; 21–34 Years; 35–44 Years; 45+ Years	N/A	Yes
<i>Prenatal and Postpartum Care—Postpartum Care and Timeliness of Prenatal Care</i>	H	<18 Years; 18–20 Years; 21–34 Years; 35–44 Years; 45+ Years	NCQA 2021 and 2022 Quality Compass	Yes
<i>Prenatal Depression Screening and Follow-Up—Depression Screening and Follow-Up on Positive Screen</i>	ECDS	<18 Years; 18–20 Years; 21–34 Years; 35–44 Years; 45+ Years	N/A	Yes
<i>Prenatal Immunization Status—Combination (Influenza and Tdap)</i>	ECDS	<18 Years; 18–20 Years; 21–34 Years;	NCQA 2022 Quality Compass	No

Indicator	Reporting Methodology	Age Groups	Benchmarks	Bold Goal (Yes/No)
		35–44 Years; 45+ Years		
Cancer Prevention				
<i>Breast Cancer Screening—Total</i>	A	50–64 Years; 65–74 Years	NCQA 2021 and 2022 Quality Compass	No
<i>Cervical Cancer Screening</i>	H	21–64 Years	NCQA 2021 and 2022 Quality Compass	No
<i>Colorectal Cancer Screening—Total</i>	A	46–49 Years; 50–75 Years	N/A	No
Behavioral Health				
<i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total and Effective Continuation Phase Treatment—Total</i>	A	18+ Years	NCQA 2021 and 2022 Quality Compass	No
<i>Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total, Depression Remission—Total, and Depression Response—Total</i>	ECDS	12–17 Years; 18–44 Years; 45–64 Years; 65+ Years	N/A	No
<i>Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total and Follow-Up on Positive Screen—Total</i>	ECDS	12–17 Years; 18–64 Years; 65+ Years	N/A	Yes

Indicator	Reporting Methodology	Age Groups	Benchmarks	Bold Goal (Yes/No)
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i>	A	18–64 Years	NCQA 2021 and 2022 Quality Compass	No
<i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up and 30-Day Follow-Up</i>	A	13–17 Years; 18+ Years	N/A	Yes
<i>Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up</i>	A	6–17 Years; 18–64 Years; 65+ Years	NCQA 2021 and 2022 Quality Compass	No
<i>Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication—Initiation Phase and Continuation and Maintenance Phase</i>	A	6–12 Years	NCQA 2021 and 2022 Quality Compass	No
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total, and Blood Glucose and Cholesterol Testing—Total</i>	A	1–11 Years; 12–17 Years	NCQA 2021 and 2022 Quality Compass	No
<i>Pharmacotherapy for Opioid Use Disorder</i>	A	16–64 Years; 65+ Years	NCQA 2022 Quality Compass	No

Indicator	Reporting Methodology	Age Groups	Benchmarks	Bold Goal (Yes/No)
Chronic Disease Management				
<i>Ambulatory Care— Emergency Department Visits per 1,000 Member Years—Total</i> [^]	A	<1 Years; 1–9 Years; 10–19 Years; 20–44 Years; 45–64 Years; 65–74 Years; 75–84 Years; 85+ Years	N/A	No
<i>Asthma Medication Ratio—Total</i>	A	5–11 Years; 12–18 Years; 19–50 Years; 51–64 Years	NCQA 2021 and 2022 Quality Compass	No
<i>Controlling High Blood Pressure—Total</i>	H	18–20 Years; 21–44 Years; 45–64 Years; 65+ Years	NCQA 2021 and 2022 Quality Compass	No
<i>Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)*</i>	H	18–20 Years; 21–44 Years; 45–64 Years; 65+ Years	NCQA 2021 and 2022 Quality Compass	No
<i>Plan All-Cause Readmissions— Observed Readmission Rate—Total*</i>	A	18–44 Years; 45–54 Years; 55–64 Years	N/A	No

Methodology Overview

The information below provides a high-level overview of the health disparities analyses conducted on the measurement year 2022 data for DHCS. For the detailed methodology, please see Appendix D. Methodology.

Data Sources

HSAG received a California-required patient-level detail file from each MCP for each HEDIS reporting unit. The measurement year 2022 patient-level detail files followed HSAG's patient-level detail file instructions and included the Medi-Cal client identification number and date of birth for members included in the audited MCP-calculated indicator rates. Additionally, the patient-level detail files indicated whether a member was included in the numerator and/or denominator for each applicable MCP-calculated 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 and non-HEDIS Microsoft (MS) Excel reporting files. Please note, it is possible that non-certified eligible members were included by some or all MCPs in the measurement year 2022 rates. HSAG used these patient-level detail files, along with supplemental files (e.g., demographic data provided by DHCS), to perform the evaluation. HSAG obtained the following data elements from the demographic file from DHCS' Management Information System/Decision Support System data system:

- ◆ Member's Medi-Cal Client Identification Number
- ◆ Date of Birth
- ◆ ZIP Code
- ◆ Gender
- ◆ Race/Ethnicity
- ◆ Primary Language
- ◆ County

To present trending results, HSAG used the combined patient-level detail file (i.e., patient-level detail files combined with supplemental demographic data provided by DHCS) created for the 2021 Health Disparity Study. For more detailed information regarding data sources and combining data for measurement year 2021, please refer to the methodology presented in the *2021 Health Disparities Report*.¹²

HSAG also downloaded the HPI 3.0 Master File from the Public Health Alliance of Southern California website which contains data regarding the demographic composition of various communities, stratified by ZIP Code (e.g., average household income, education level, supermarket availability).¹³

¹² State of California Department of Health Care Services. 2021 Health Disparities Report. May 2023. Available at: <https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2021-22-Health-Disparities-Report-F3.pdf>. Accessed on: Jan 31, 2024.

¹³ Public Health Alliance of Southern California. The California Healthy Places Index. Available at: <https://www.healthyplacesindex.org/>. Accessed on: Jan 31, 2024.

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 applicable benchmarks:

- ◆ The minimum performance levels (i.e., the 2021 and 2022 NCQA Quality Compass national Medicaid 50th percentiles) for the HEDIS MCAS indicators, when available.
- ◆ The median state performance rates (i.e., the 50th percentiles) from the CMS' FFY 2020 Child and Adult Health Care Quality Measures data set for non-HEDIS MCAS indicators, when available.

For each indicator, HSAG calculated a 95 percent confidence interval around each racial/ethnic group's rate following NCQA's methodology:

$$\text{lower interval} = \text{rate} - 1.96 \sqrt{\frac{\text{rate}(1 - \text{rate})}{\text{denominator}}} - \frac{1}{2 \times \text{denominator}}$$

$$\text{upper interval} = \text{rate} + 1.96 \sqrt{\frac{\text{rate}(1 - \text{rate})}{\text{denominator}}} + \frac{1}{2 \times \text{denominator}}$$

For this report, a health disparity was defined as a rate for a racial/ethnic group that was worse than the reference rate (i.e., the minimum performance level or median state performance rate) and the upper interval of the 95 percent confidence interval was below the minimum performance level/median state performance rate. If the upper interval of the 95 percent confidence interval was at or above the minimum performance level/median state performance rate, then no disparity was identified.

Determining Key Findings Analysis

In alignment with the Comprehensive Quality Strategy report and the state's clinical focus areas, HSAG only presented key findings and/or Bold Goals measures in the body of the report. HSAG only considered a result a key finding if at least one of the following criteria was met:

- ◆ **Persistent Disparity:** Racial/ethnic disparities that persisted between measurement years (i.e., a racial/ethnic disparity that existed in both measurement years 2021 and 2022).
 - **Persistent Disparity—Improved:** Persistent racial/ethnic disparities for which the distance between the rate for the racial/ethnic group and the minimum performance level/median state performance rate decreased from measurement year 2021 to measurement year 2022.

- **Persistent Disparity—Worsened:** Persistent racial/ethnic disparities for which the distance between the rate for the racial/ethnic group and the minimum performance level/median state performance rate increased from measurement year 2021 to measurement year 2022.
- ◆ **New Disparity:** Racial/ethnic disparities that did not exist in measurement year 2021 but exist in measurement year 2022.
- ◆ **Eliminated Disparity:** Racial/ethnic disparities that existed in measurement year 2021 but did not exist in measurement year 2022.
- ◆ **Widespread Disparity:** Racial/ethnic disparities that were widespread (i.e., disparities that existed across a large number of racial/ethnic groups or a certain racial/ethnic group had disparities across multiple indicators/domains).
- ◆ **Large Disparity:** Racial/ethnic disparities that were large (e.g., racial/ethnic rates that were below the minimum performance level/median state performance rate by at least a 10 percent relative difference).
- ◆ **Emerging Disparity:** Racial/ethnic group indicator rates that were not a disparity in measurement year 2021 or 2022, but would be at risk of becoming a disparity in measurement year 2023 if the indicator rate continued to decline at a similar rate relative to the minimum performance level/median state performance rate.

Caveats

Hybrid Indicators

For hybrid measures/indicators, NCQA recommends the submission of a sample of 411 members 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 were based on fewer than 411 members, 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 Members

To match the age parameters for each indicator, HSAG limited the analysis to members whose age was in one of the valid age groups for each indicator, as defined in Table 1.1. For the indicators in the Reproductive Health domain, as well as the *Breast Cancer Screening* and *Cervical Cancer Screening* measures, HSAG only kept members who were identified as female in the demographic file. Of note, one MCP (Molina Healthcare of California) had a large proportion of members with Medi-Cal client identification numbers included in its patient level

detail files that were not included in DHCS' demographic data; therefore, HSAG was unable to verify gender within DHCS' demographic data. As a result, members for whom HSAG was unable to verify gender were excluded from rate calculations. Additionally, HSAG included the rates for "Unknown/Missing" race/ethnicity, primary language, and gender groups in the formal report as a footnote above the figures.

Health Disparities Results

While HSAG identified health disparities in this analysis, data were not available and analyses were not performed related to the cause of the health disparities. Therefore, conclusions cannot be drawn about the cause of any health disparities identified. Additionally, the use of national benchmarks as the reference for identifying disparities results in disparities being captured based on low performance relative to national standards rather than differences in rates between racial/ethnic groups.

EHR Data

Due to unreliable reporting of EHR data by MCPs, caution should be exercised when interpreting the *Depression Remission or Response for Adolescents and Adults*, *Depression Screening and Follow-Up for Adolescents and Adults*, *Postpartum Depression Screening and Follow-Up*, *Prenatal Depression Screening and Follow-Up*, and *Prenatal Immunization Status* indicator rates in the health disparities analysis.

Adult and Child Core Set Median State Performance Rates

HSAG used the NCQA 2021 and 2022 Quality Compass benchmarks to identify disparities for the HEDIS MCAS indicators, HSAG compared non-HEDIS MCAS indicators to the FFY 2020 Adult and Child Core Set median state performance rates, where possible. Adult and Child Core Set median state performance rates are established using statewide measure rates. This differs from the NCQA 2021 and 2022 Quality Compass benchmark methodology, which is established using individual health plan information.

2. Findings

The Findings section presents the racial/ethnic disparities results for measurement years 2021 and 2022, where applicable, organized by domain (Children's Health, Reproductive Health, Cancer Prevention, Behavioral Health, and Chronic Disease Management) for those indicators determined to be key findings. The Findings section includes the following:

- ◆ Domain-level results that include a summary of all racial/ethnic disparities identified within each domain regardless of whether the disparity is considered a key finding.
- ◆ Indicator-level results for those indicators determined to be a key finding or a Bold Goal. Indicator rates for each racial/ethnic group for measurement years 2021 and 2022, where applicable, are presented. For all indicators, including those that are not considered to be key findings, indicator-level racial/ethnic disparity results are presented in Appendix C. Demographic Stratification Results.
- ◆ Regional-level results for all indicator-racial/ethnic group combinations that were determined to be key findings. Maps are presented for those indicator-racial/ethnic group combinations with disparities identified. Please note, if a racial/ethnic group had a disparity identified at the statewide level but the denominator was too small for sufficient reporting of county-level results, the map is not presented. Additionally, maps are not presented for eliminated disparities.

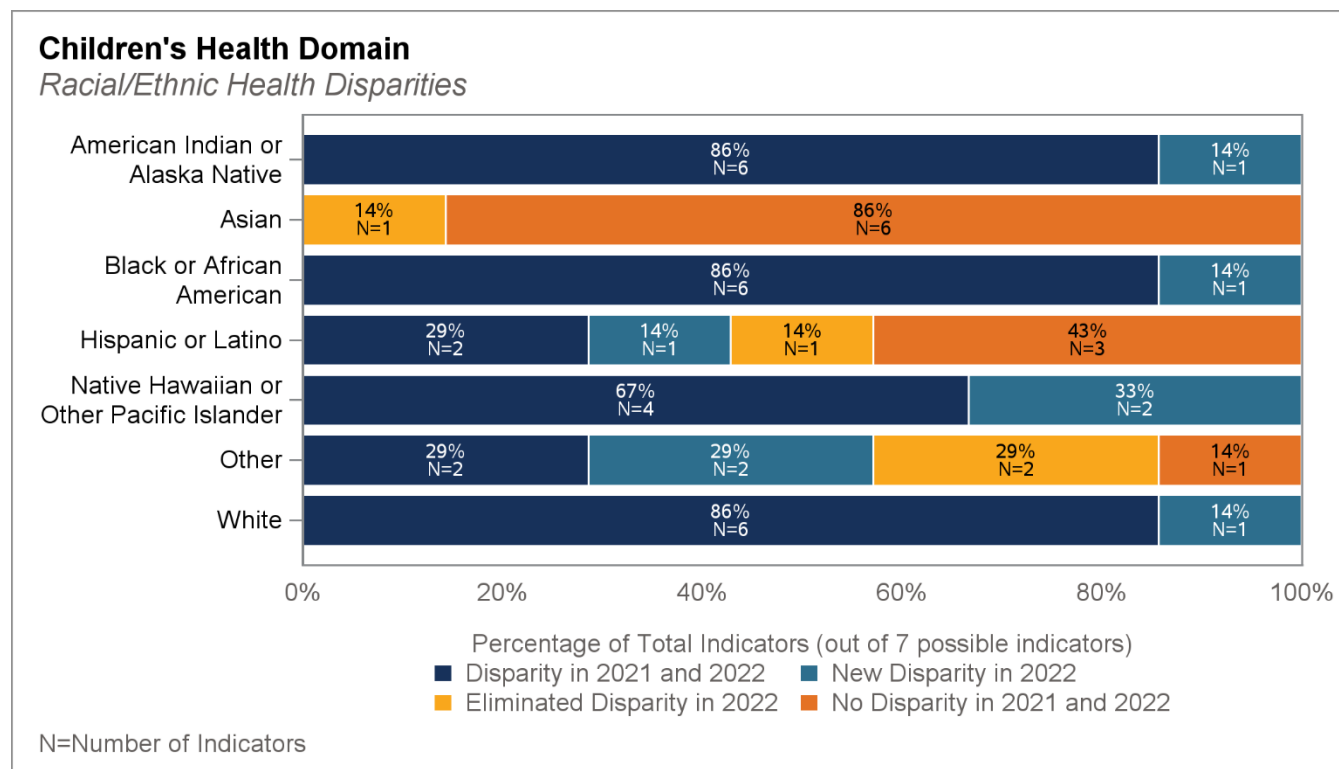
Racial/Ethnic Health Disparities: Children's Health Domain

Health disparities were identified when indicator rates for racial/ethnic groups were below the minimum performance level/median state performance rate (i.e., the upper bound of the 95 percent confidence interval for the rate was below the national reference rate). If a racial/ethnic group's indicator rate was equal to or higher than the minimum performance level/median state performance rate, then no health disparity was identified.

Figure 2.1 displays the percentage and number of Children's Health domain indicators (out of seven possible indicators) for which disparities were identified or were not identified for each racial/ethnic group in addition to newly identified and eliminated disparities within the Children's Health domain.

Figure 2.1—Racial/Ethnic Health Disparities Summary: Children’s Health Domain

Note: Due to small numerators or denominators, the Native Hawaiian or Other Pacific Islander (N=6) group was not evaluated for health disparities for all seven possible indicators.



The following key findings were identified for the Children’s Health Domain:

- ◆ The following persistent disparities improved from measurement year 2021 to measurement year 2022:
 - *Developmental Screening in the First Three Years of Life—Total* indicator rates for four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, and White) had a persistent, improving disparity identified.
 - *Immunizations for Adolescents—Combination 2* indicator rates for two of seven (28.6 percent) racial/ethnic groups (Black or African American and White) had a persistent, improving disparity identified.
 - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rates for five of seven (71.4 percent) racial/ethnic groups (Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had a persistent, improving disparity identified.
 - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* indicator rates for five of seven (71.4 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African

American, Native Hawaiian or Other Pacific Islander, Other, and White) had a persistent, improving disparity identified.

- ◆ The following persistent disparities worsened from measurement year 2021 to measurement year 2022:
 - *Child and Adolescent Well-Care Visits—Total* indicator rates for four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had a persistent, worsening disparity identified.
 - *Childhood Immunization Status—Combination 10* indicator rates for three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and White) had a persistent, worsening disparity identified.
 - *Developmental Screening in the First Three Years of Life—Total* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Native Hawaiian or Other Pacific Islander) had a persistent, worsening disparity identified.
 - *Immunizations for Adolescents—Combination 2* indicator rates for one of seven (14.3 percent) racial/ethnic groups (American Indian or Alaska Native) had a persistent, worsening disparity identified.
 - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rates for one of seven (14.3 percent) racial/ethnic groups (American Indian or Alaska Native) had a persistent, worsening disparity identified.
- ◆ New disparities were identified for two indicators within the Children’s Health domain.
 - *Child and Adolescent Well-Care Visits—Total* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Other) had a new disparity identified.
 - *Immunizations for Adolescents—Combination 2* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Native Hawaiian or Other Pacific Islander) had a new disparity identified.
- ◆ Eliminated disparities were identified for four indicators within the Children’s Health domain.
 - *Developmental Screening in the First Three Years of Life—Total* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Other) had an eliminated disparity identified.
 - *Immunizations for Adolescents—Combination 2* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Other) had an eliminated disparity identified.
 - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Asian) had an eliminated disparity identified.
 - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Hispanic or Latino) had an eliminated disparity identified.
- ◆ Widespread disparities were identified for all measures in the Children’s Health domain, except the *Childhood Immunization Status—Combination 10* indicator, and all racial/ethnic groups except the Asian and Hispanic or Latino groups.

- For measurement year 2022, *Lead Screening in Children* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rates for six of seven (85.7 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had disparities identified.
- For measurement year 2022, *Child and Adolescent Well-Care Visits—Total* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* indicator rates for five of seven (71.4 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and White) had disparities identified.
- For measurement year 2022, *Developmental Screening in the First Three Years of Life—Total* indicator rates for five of seven (71.4 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White) had disparities identified.
- For measurement year 2022, *Immunizations for Adolescents—Combination 2* indicator rates for four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had disparities identified.
- For measurement year 2022, the rates for the American Indian or Alaska Native, Black or African American, and White racial/ethnic groups had disparities identified for all seven indicators within the Children’s Health domain.
- For measurement year 2022, the rates for the Native Hawaiian or Other Pacific Islander racial/ethnic group had disparities identified for six of seven (85.7 percent) indicators within the Children’s Health domain.
- For measurement year 2022, the rates for the Other racial/ethnic group had disparities identified for four of seven (57.1 percent) indicators within the Children’s Health domain.
- ◆ Large disparities were identified for all seven indicators in the Children’s Health domain. The following are the most notable large disparities:
 - The *Child and Adolescent Well-Care Visits—Total*, *Developmental Screening in the First Three Years of Life—Total*, and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rates for four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had large disparities identified across both measurement years 2021 and 2022.
 - The *Childhood Immunization Status—Combination 10* indicator rates for three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and White) had large disparities identified for both measurement years 2021 and 2022.
 - *Lead Screening in Children* indicator rates for five of seven (71.4 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and White) had large disparities identified for measurement year 2022.

- The *Immunizations for Adolescents—Combination 2* indicator rates for three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and White) had large disparities identified across both measurement years 2021 and 2022. A large disparity was identified for one additional racial/ethnic group (Native Hawaiian or Other Pacific Islander) for measurement year 2022.
- ◆ An emerging disparity was identified for the *Child and Adolescent Well-Care Visits—Total—Hispanic or Latino* indicator-racial/ethnic group combination.

Racial/Ethnic Health Disparities: Children's Health Domain Key Findings

For the indicators in the Children's Health domain, the following Bold Goals apply:

- ◆ Close racial/ethnic disparities in well-child visits and immunizations by 50 percent*
- ◆ Ensure all health plans exceed the 50th percentile for all children's preventative care measures^

Based on evaluating the results of the key findings above, the following indicators were determined to be key findings and/or a Bold Goal measure for the Children's Health domain. Additionally, HSAG used symbols to identify the indicators associated with a Bold Goal (e.g., an asterisk [*] corresponds to the first Bold Goal listed above):

- ◆ *Child and Adolescent Well-Care Visits—Total**^
- ◆ *Childhood Immunization Status—Combination 10**^
- ◆ *Developmental Screening in the First Three Years of Life—Total*^
- ◆ *Immunizations for Adolescents—Combination 2**^
- ◆ *Lead Screening in Children*^
- ◆ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits**^
- ◆ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits**^

Please note, the results for the *Topical Fluoride for Children* indicators were not considered to be key findings given that benchmarks were unavailable, and disparities could not be identified. Please refer to Appendix C. Demographic Stratification Results for the racial/ethnic rates for these indicators.

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

Figure 2.2 through Figure 2.36 display the racial/ethnic health disparities and applicable regional results for indicators with results determined to be key findings and/or Bold Goal indicators in the Children's Health domain. For each figure, the denominator, rate, and confidence interval for each racial/ethnic group are displayed. A downward arrow is displayed when a disparity is identified. Additionally, the measurement year 2022 statewide average, high performance level, where applicable, and minimum performance level/median state performance rate, where applicable, are displayed as rates on top of the figure and as dotted lines in the figure.

Child and Adolescent Well-Care Visits—Total (WCV)

The *Child and Adolescent Well-Care Visits—Total (WCV)* indicator measures the percentage of children ages 3 to 21 years who had at least one comprehensive well-care visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner. Figure 2.2 through Figure 2.10 display the statewide racial/ethnic and applicable regional-level results for the *Child and Adolescent Well-Care Visits—Total (WCV)* indicator in addition to identified health disparities.

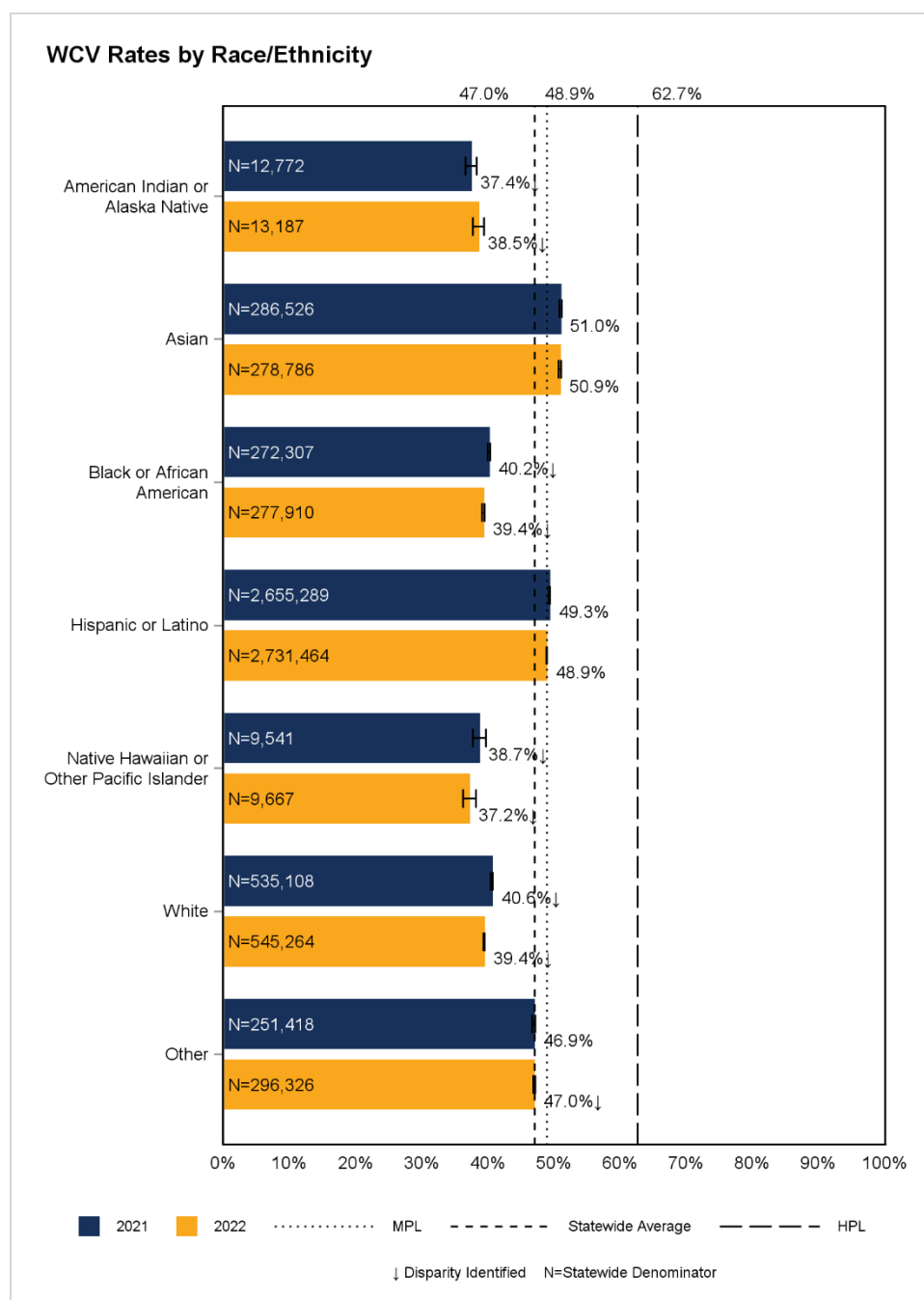
Figure 2.2—Child and Adolescent Well-Care Visits—Total (WCV) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 49.1 percent (N=182,090) and 48.7 percent (N=211,890), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 45.3 percent and 62.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 47.5 percent.



The following key findings were identified for the *Child and Adolescent Well-Care Visits—Total* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had a persistent, worsening disparity identified, and no persistent disparities improved.

- ◆ One of seven (14.3 percent) racial/ethnic group rates (Other) had a new disparity identified in measurement year 2022.
- ◆ Widespread disparities were identified, with five of seven (71.4 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and White) having disparities identified for measurement year 2022.
- ◆ Four of seven (57.1 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had large disparities identified for measurement years 2021 and 2022.
- ◆ While two of seven (28.6 percent) racial/ethnic group rates (Asian and Hispanic or Latino) did not have a disparity identified in either measurement year, the Hispanic or Latino racial/ethnic group is at risk of having a disparity emerge in measurement year 2023.
- ◆ No eliminated disparities were identified for the *Child and Adolescent Well-Care Visits—Total* indicator.

Figure 2.3—Child and Adolescent Well-Care Visits—Total (WCV)—American Indian or Alaska Native—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for WCV—American Indian or Alaska Native

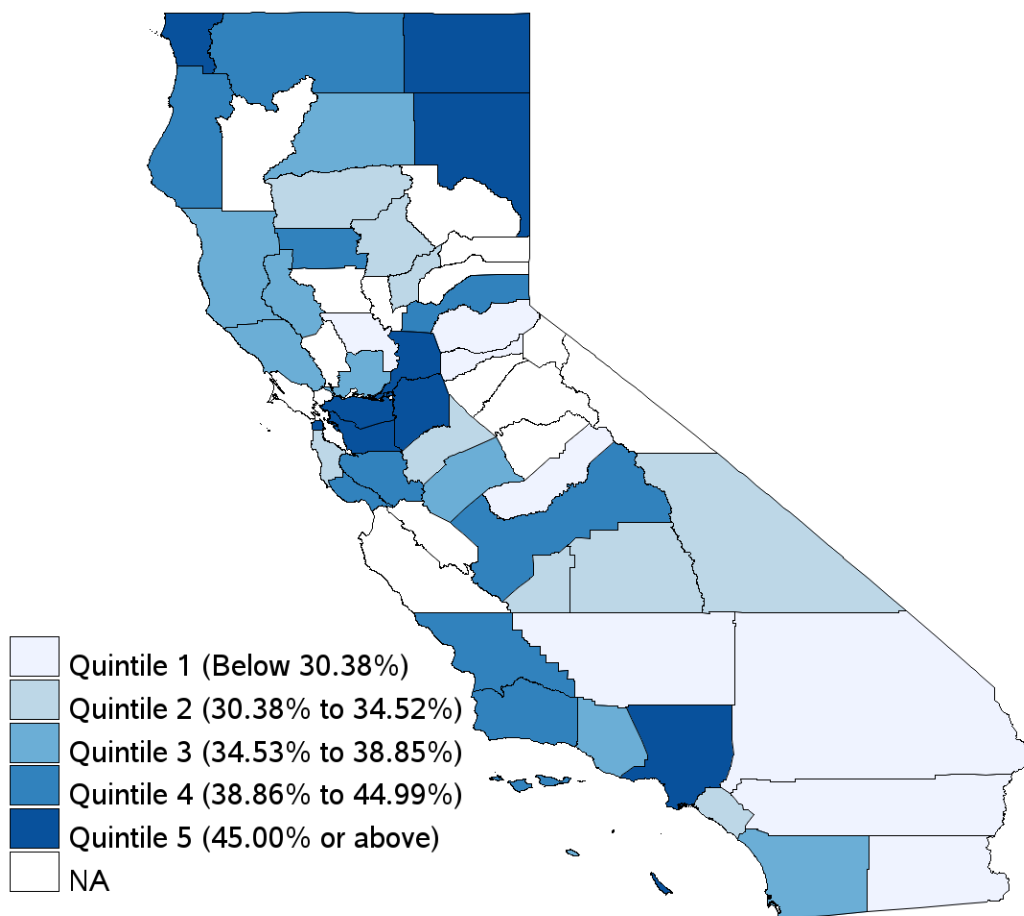
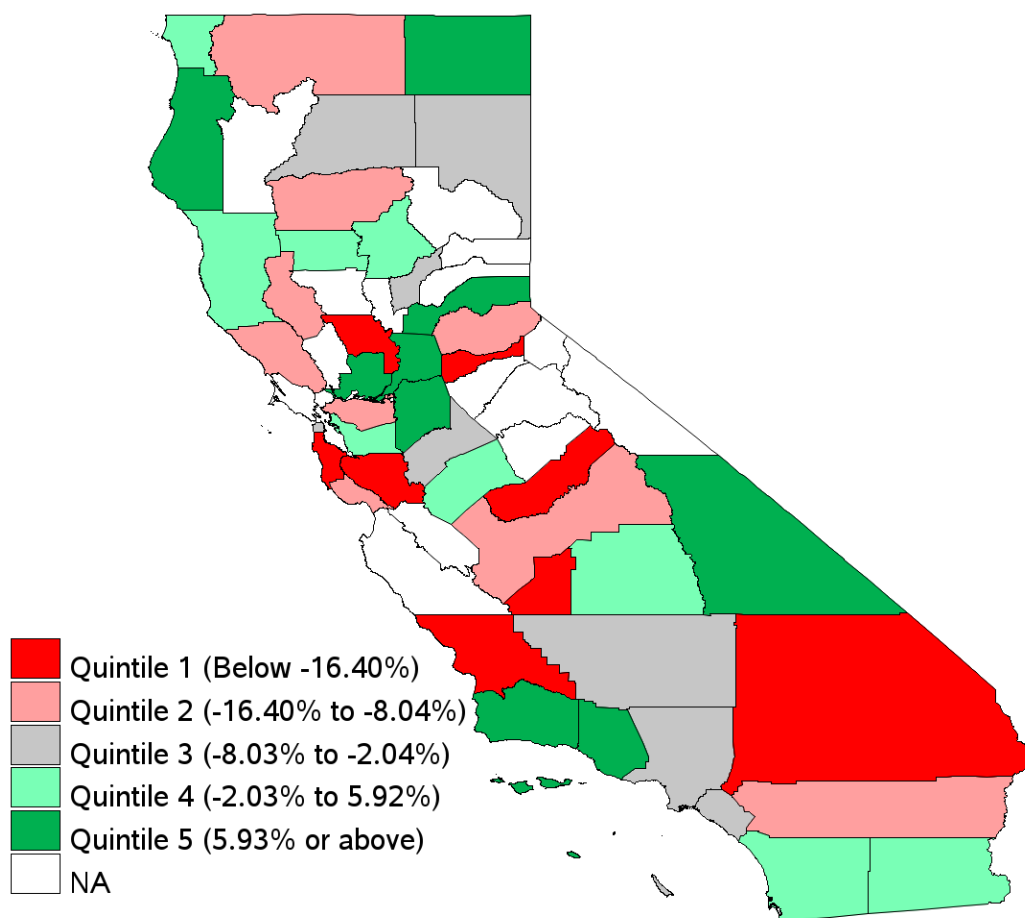


Figure 2.4—Child and Adolescent Well-Care Visits—Total (WCV)—American Indian or Alaska Native—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for WCV—American Indian or Alaska Native



The following are the key findings for the *Child and Adolescent Well-Care Visits—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southeastern regions had low performance for the *Child and Adolescent Well-Care Visits—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.
 - Rates for five of seven (71.4 percent) counties (Kern, Kings, Madera, Stanislaus, and Tulare) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Additionally, the rates for these counties were below the minimum performance level by more than a 30 percent relative difference.

- ◆ Rates for all three counties (Imperial, Riverside, and San Bernardino) in the Southeastern region were in Quintile 1 for current year performance. Additionally, the rates for two counties (Riverside and San Bernardino) were in the bottom two quintiles for trending. Counties in the Central Coast and San Francisco Bay/Sacramento regions had high performance for the *Child and Adolescent Well-Care Visits—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.
 - Rates for three of four (75.0 percent) counties with reportable rates (San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in Quintile 4 for current year performance. However, none of the rates for these counties met the minimum performance level.
 - Rates for five of eight (62.5 percent) counties with reportable rates (Alameda, Contra Costa, Sacramento, San Francisco, and Santa Clara) in the San Francisco Bay/Sacramento region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance.
- ◆ Contra Costa and Del Norte counties were the only two counties with rates that met the minimum performance level for the *Child and Adolescent Well-Care Visits—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.

Figure 2.5—Child and Adolescent Well-Care Visits—Total (WCV)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for WCV—Black or African American

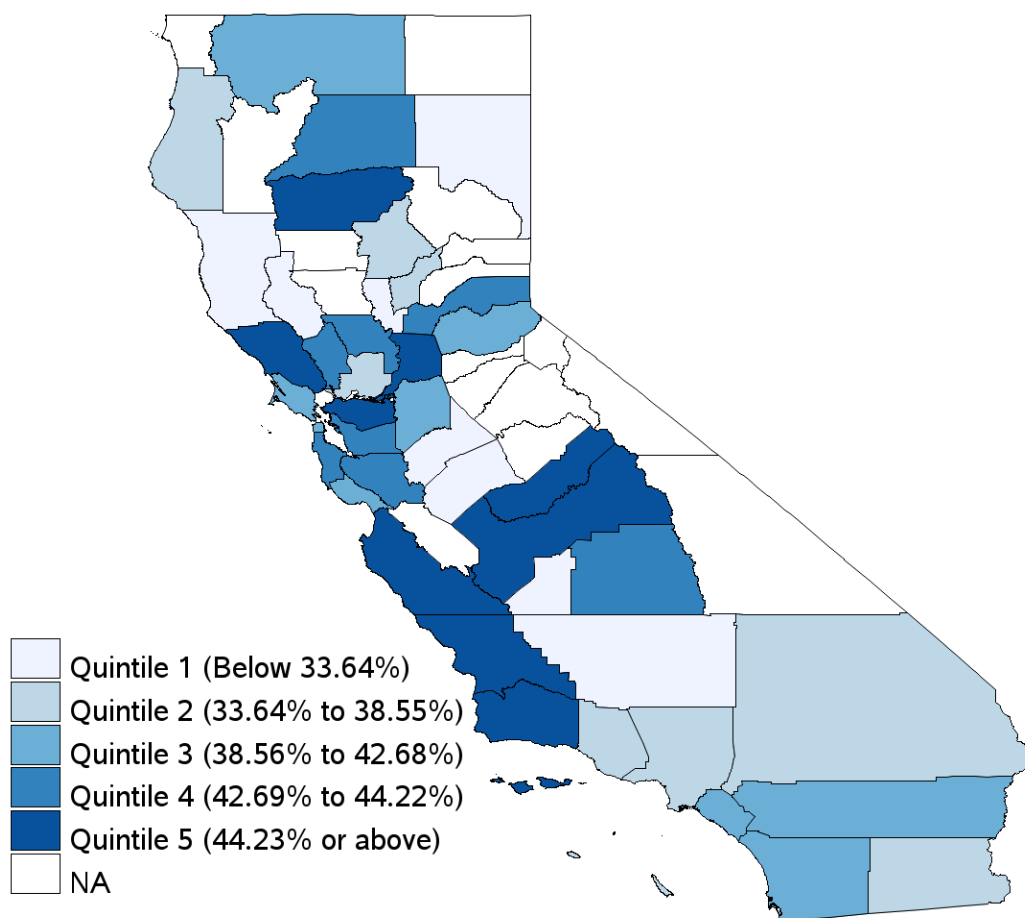
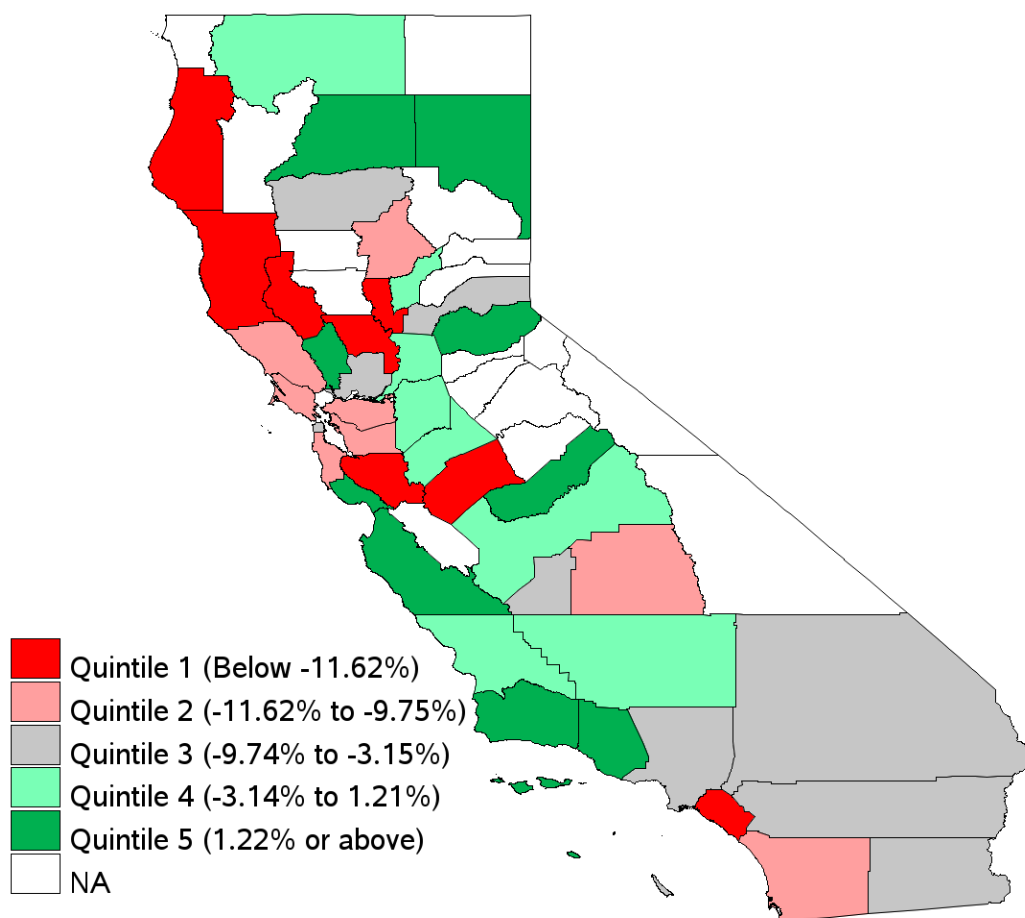


Figure 2.6—Child and Adolescent Well-Care Visits—Total (WCV)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for WCV—Black or African American



The following are the key findings for the *Child and Adolescent Well-Care Visits—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain, San Joaquin Valley, and Southeastern regions had low performance for the *Child and Adolescent Well-Care Visits—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:
 - Rates for seven of 13 (53.8 percent) counties with reportable rates (Butte, Humboldt, Lake, Lassen, Mendocino, Sutter, and Yuba) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Additionally, the rates for five of the seven (71.4 percent) counties (Butte, Humboldt, Lake, Mendocino, and Sutter) were in the bottom two quintiles for trending results. The rates

for all seven of these counties were below the minimum performance level by at least a 20 percent relative difference. Of note, Tehama County in the North/Mountain region was the only county to meet the minimum performance level.

- Rates for four of eight (50.0 percent) counties (Kern, Kings, Merced, and Stanislaus) in the San Joaquin Valley region were in Quintile 1 for current year performance. Rates for all four of these counties were below the minimum performance level by more than a 30 percent relative difference.
- Rates for two of three (66.7 percent) counties (Imperial and San Bernardino) in the Southeastern region were in Quintile 2 for current year performance.
- ◆ Counties in the Central Coast and San Francisco Bay/Sacramento regions had high performance for the *Child and Adolescent Well-Care Visits—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:
 - Rates for three of five (60.0 percent) counties with reportable rates (Monterey, San Luis Obispo, and Santa Barbara) in the Central Coast region were in Quintile 5 for current year performance. Despite the rates for these three counties being in the top two quintiles (i.e., Quintiles 4 and 5) for trending results, none of the rates for these counties met the minimum performance level.
 - Rates for seven of 10 (70.0 percent) counties (Alameda, Contra Costa, Napa, Sacramento, San Mateo, Santa Clara, and Sonoma) in the San Francisco Bay/Sacramento region were in top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Additionally, rates for five of the seven (71.4 percent) counties (Alameda, Contra Costa, San Mateo, Santa Clara, and Sonoma) were in the bottom two quintiles for trending results.

Figure 2.7—Child and Adolescent Well-Care Visits—Total (WCV)—Native Hawaiian or Other Pacific Islander—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for WCV—Native Hawaiian or Other Pacific Islander

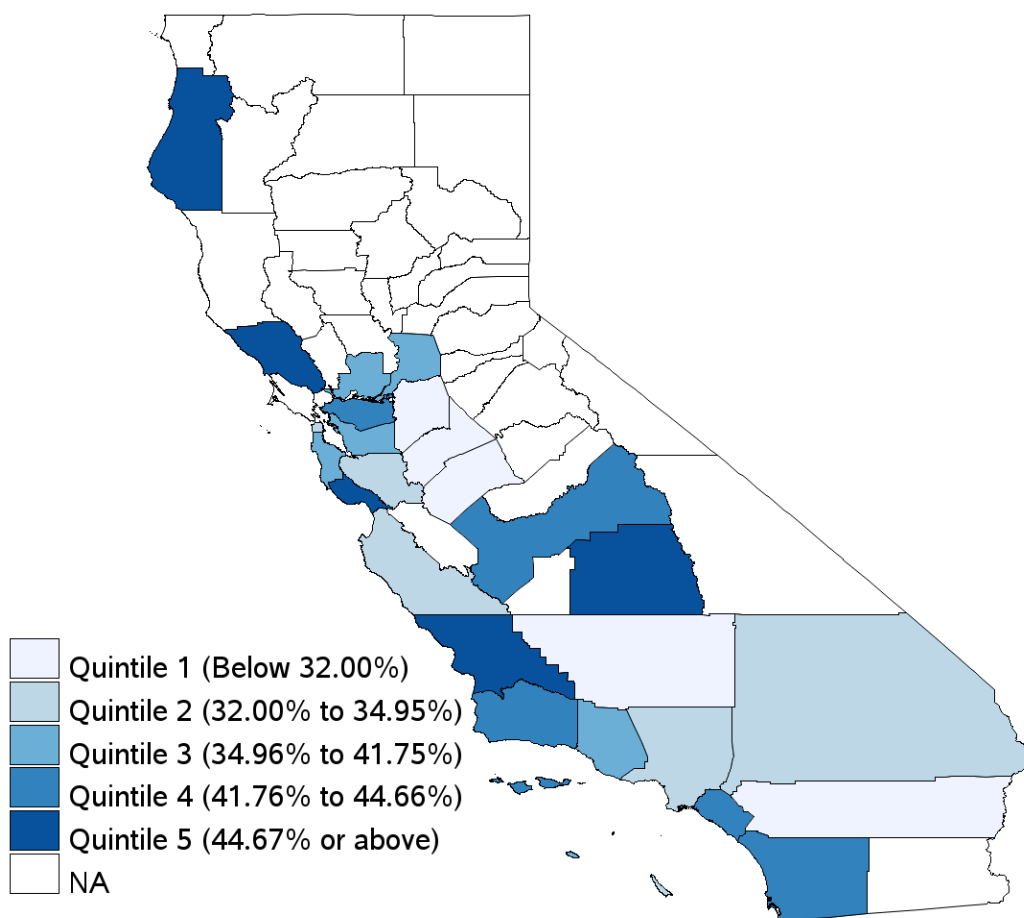
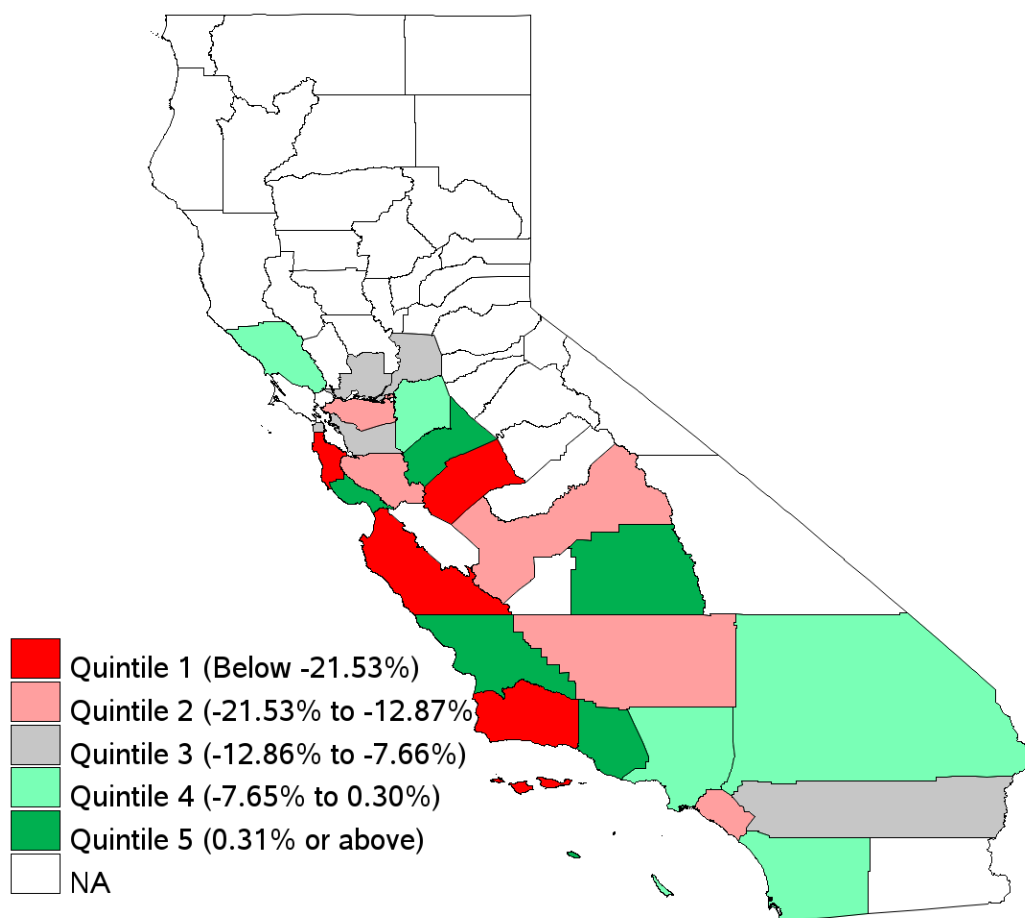


Figure 2.8—Child and Adolescent Well-Care Visits—Total (WCV)—Native Hawaiian or Other Pacific Islander—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for WCV—Native Hawaiian or Other Pacific Islander



The following are the key findings for the *Child and Adolescent Well-Care Visits—Total—Native Hawaiian or Other Pacific Islander* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley region had low performance for the *Child and Adolescent Well-Care Visits—Total—Native Hawaiian or Other Pacific Islander* indicator-racial/ethnic group combination.
 - Rates for four of six (66.7 percent) counties with reportable rates (Kern, Merced, San Joaquin, and Stanislaus) were in Quintile 1 for current year performance. Rates for two of these four (50.0 percent) counties (San Joaquin and Stanislaus) improved from

measurement year 2021 to measurement year 2022 and were in the top two quintiles (i.e., Quintiles 4 and 5) for trending results.

- ◆ Counties in the Central Coast and Southern Coast regions had high performance for the *Child and Adolescent Well-Care Visits—Total*—Native Hawaiian or Other Pacific Islander indicator-racial/ethnic group combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in the top two quintiles for current year performance. Additionally, the rates for two of the three (66.7 percent) counties (San Luis Obispo and Santa Cruz) were in the top two quintiles for trending results. Of note, the rates for San Luis Obispo and Santa Cruz counties were the only two rates to meet the minimum performance level.
 - Rates for two of three (66.7 percent) counties (Orange and San Diego) in the Southern Coast region were in Quintile 4 for current year performance. However, the rates for these two counties were below the minimum performance level by at least a 10 percent relative difference.

Figure 2.9—Child and Adolescent Well-Care Visits—Total (WCV)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for WCV—White

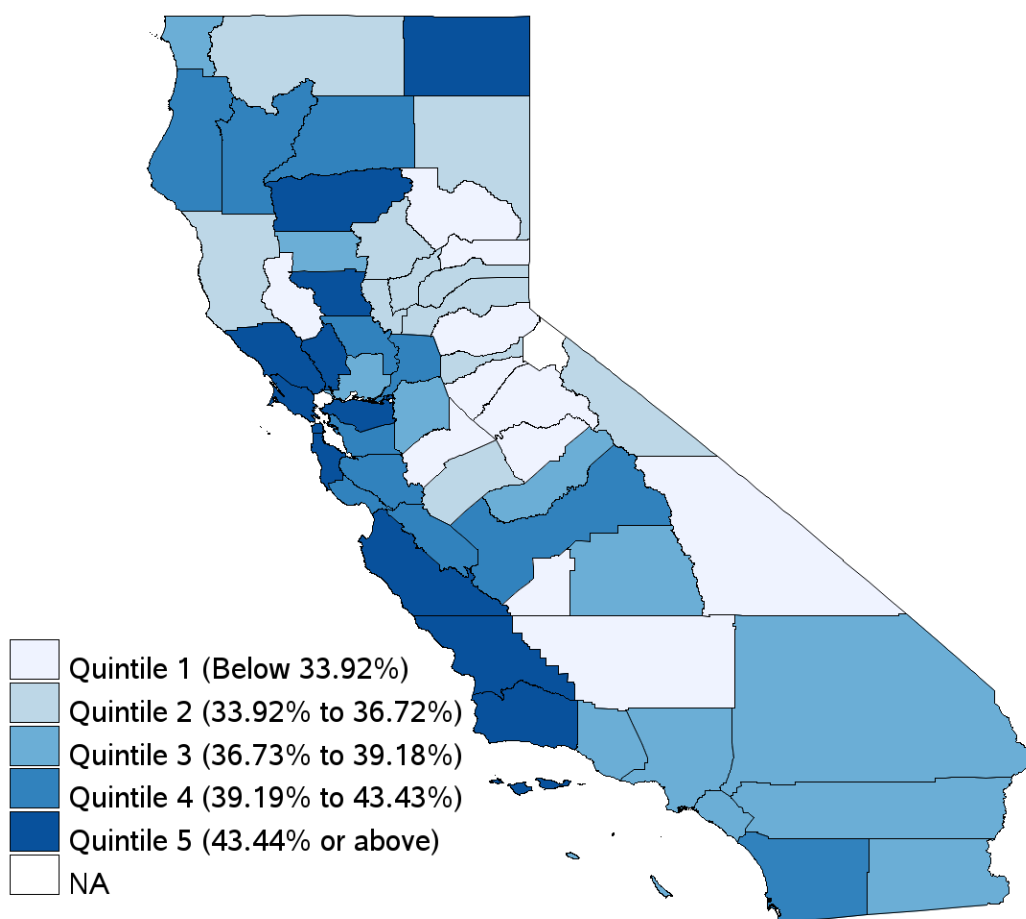
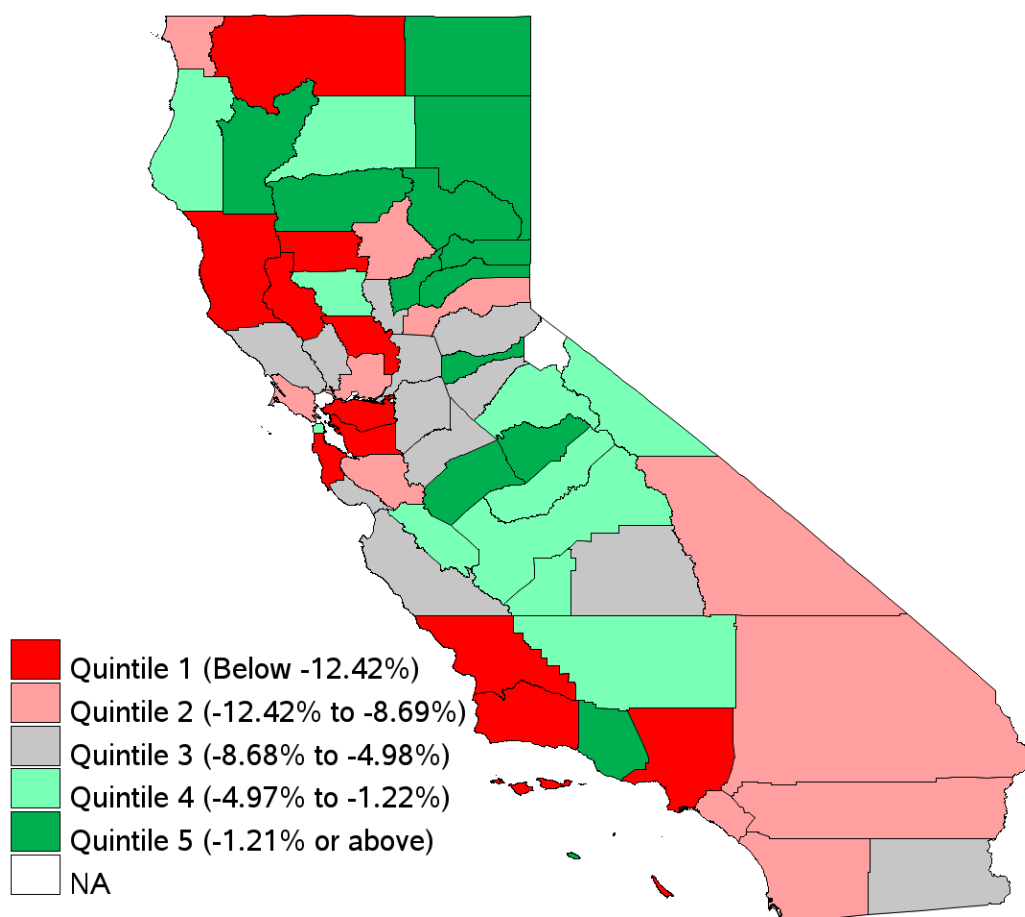


Figure 2.10—Child and Adolescent Well-Care Visits—Total (WCV)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for WCV—White



The following are the key findings for the *Child and Adolescent Well-Care Visits—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain and San Joaquin Valley regions had low performance for the *Child and Adolescent Well-Care Visits—Total—White* indicator-racial/ethnic group combination.
 - Rates for 18 of 27 (66.7 percent) counties with reportable rates (Amador, Butte, Calaveras, El Dorado, Inyo, Lake, Lassen, Mariposa, Mendocino, Mono, Nevada, Placer, Plumas, Sierra, Siskiyou, Sutter, Tuolumne, and Yuba) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Rates for nine of the 18 (50.0 percent) counties (Amador, Lassen, Mariposa, Mono, Nevada, Plumas, Sierra, Tuolumne, and Yuba) were in the top two

quintiles (i.e., Quintiles 4 and 5) for trending results. Of note, the rates for all 18 of these counties were below the minimum performance level by at least a 25 percent relative difference.

- Rates for four of eight (50.0 percent) counties (Kern, Kings, Merced, and Stanislaus) in the San Joaquin Valley region were in the bottom two quintiles for current year performance. Rates for three of these four (75.0 percent) counties (Kern, Kings, and Merced) improved from measurement year 2021 to measurement year 2022 and were in the top two quintiles for trending results.
- ◆ Counties in the Central Coast and San Francisco Bay/Sacramento regions had high performance for the *Child and Adolescent Well-Care Visits—Total—White indicator-racial/ethnic group combination*.
 - Rates for five of six (83.3 percent) counties (Monterey, San Benito, San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in the top two quintiles for current year performance. However, rates for San Luis Obispo and Santa Barbara counties were in the bottom quintile for trending. Of note, Santa Barbara County was the only county to meet the minimum performance level in measurement year 2022.
 - Rates for nine of 10 (90.0 percent) counties (Alameda, Contra Costa, Marin, Napa, Sacramento, San Francisco, San Mateo, Santa Clara, and Sonoma) in the San Francisco Bay/Sacramento region were in the top two quintiles for current year performance. Rates for five of those nine (55.6 percent) counties (Alameda, Contra Costa, Marin, San Mateo, and Santa Clara) were in the bottom two quintiles for trending results.

Childhood Immunization Status—Combination 10 (CIS-10)

The *Childhood Immunization Status—Combination 10 (CIS-10)* indicator measures the percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis; three polio; one measles, mumps, and rubella; three haemophilus influenza type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday. Figure 2.11 displays the statewide racial/ethnic and applicable regional-level results for the *Childhood Immunization Status—Combination 10 (CIS-10)* indicator in addition to identified health disparities.

Figure 2.11—Childhood Immunization Status—Combination 10 (CIS-10) Rates by Race/Ethnicity

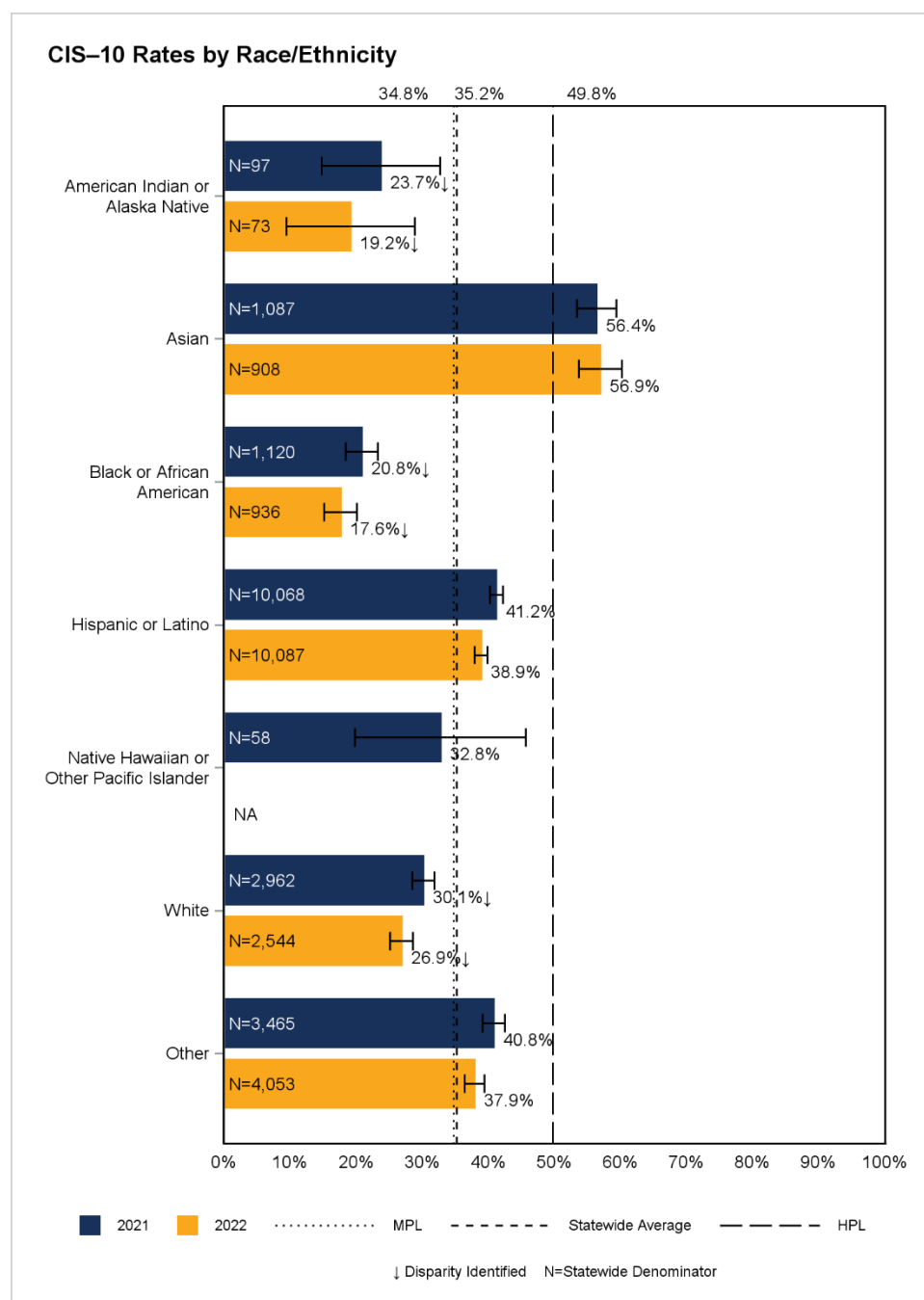
Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 31.1 percent (N=3,236) and 27.2 percent (N=3,539), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.2 percent and 53.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 37.8 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).



The following key findings were identified for the *Childhood Immunization Status—Combination 10* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American,

and White) had a persistent, worsening disparity identified, and no persistent disparities improved.

- ◆ Three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and White) had large disparities identified for both measurement years 2021 and 2022.
- ◆ No new, eliminated, widespread, or emerging disparities were identified for the *Childhood Immunization Status—Combination 10* indicator.

Developmental Screening in the First Three Years of Life—Total (DEV)

The *Developmental Screening in the First Three Years of Life—Total (DEV)* indicator measures the percentage of children who were screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on the child's first, second, or third birthday. Due to inconsistent reporting of EHR data by MCPs, differences in rates may be impacted by data completeness. Figure 2.12 through Figure 2.18 display the statewide racial/ethnic and applicable regional-level results for the *Developmental Screening in the First Three Years of Life—Total (DEV)* indicator in addition to identified health disparities.

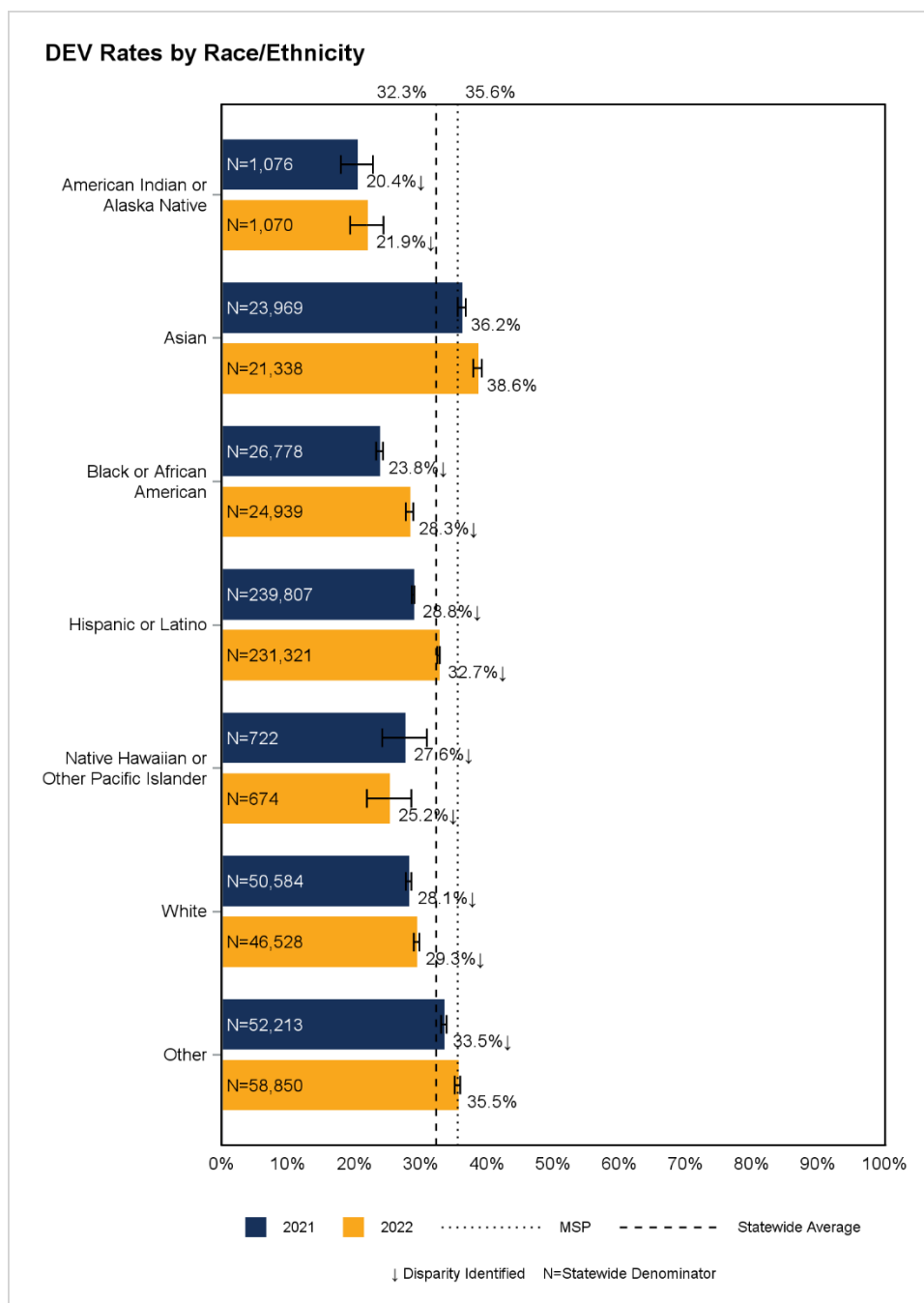
Figure 2.12—Developmental Screening in the First Three Years of Life—Total (DEV) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 24.9 percent (N=60,590) and 29.9 percent (N=65,084), respectively.

The median state performance rate represents the 50th percentile.

The median state performance rate for measurement year 2021 was 35.6 percent.

The statewide aggregate for measurement year 2021 was 28.8 percent.



The following key findings were identified for the *Developmental Screening in the First Three Years of Life—Total* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, and White) had a persistent, improving disparity identified, and one of seven (14.3 percent) racial/ethnic groups (Native Hawaiian or Other Pacific Islander) had a persistent, worsening disparity identified.

- ◆ Widespread disparities were identified, with five of seven (71.4 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White) having disparities identified for measurement year 2022.
- ◆ Four of seven (57.1 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had large disparities identified for measurement years 2021 and 2022.
- ◆ While the Other racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.
- ◆ No new or emerging disparities were identified for the *Developmental Screening in the First Three Years of Life—Total* indicator.

Figure 2.13—Developmental Screening in the First Three Years of Life—Total (DEV)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for DEV—Black or African American

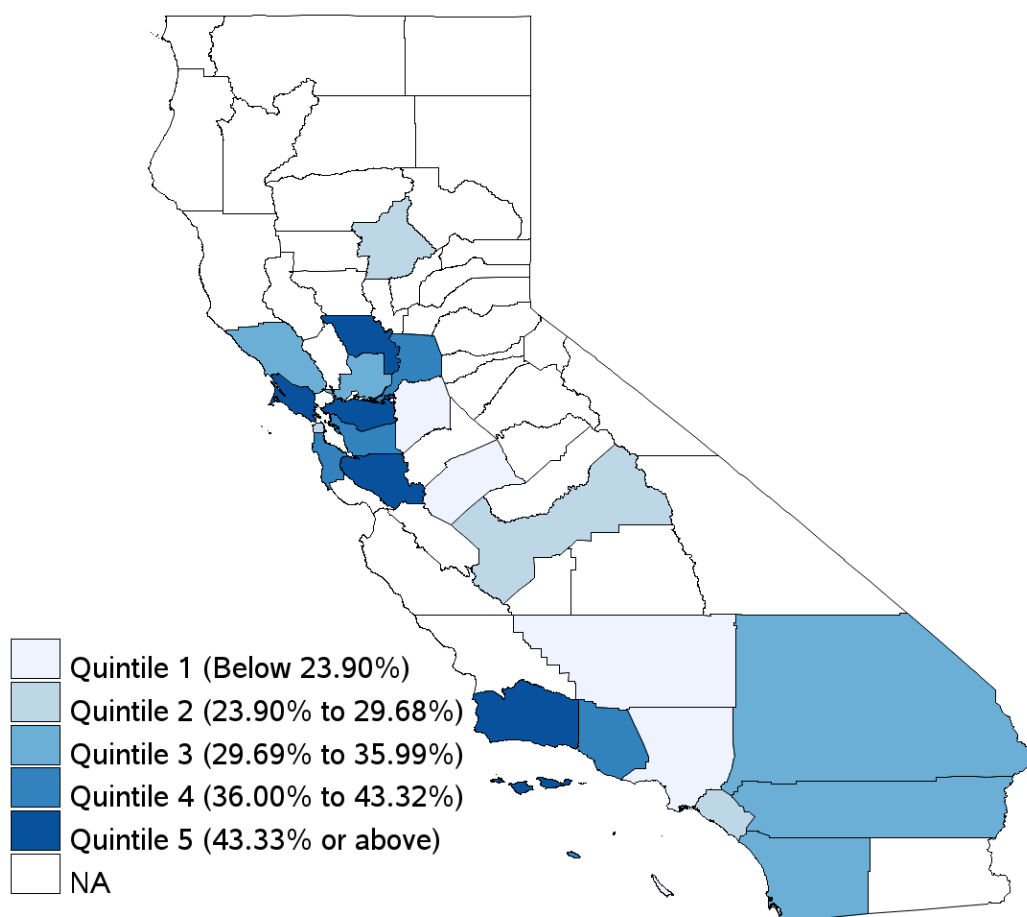
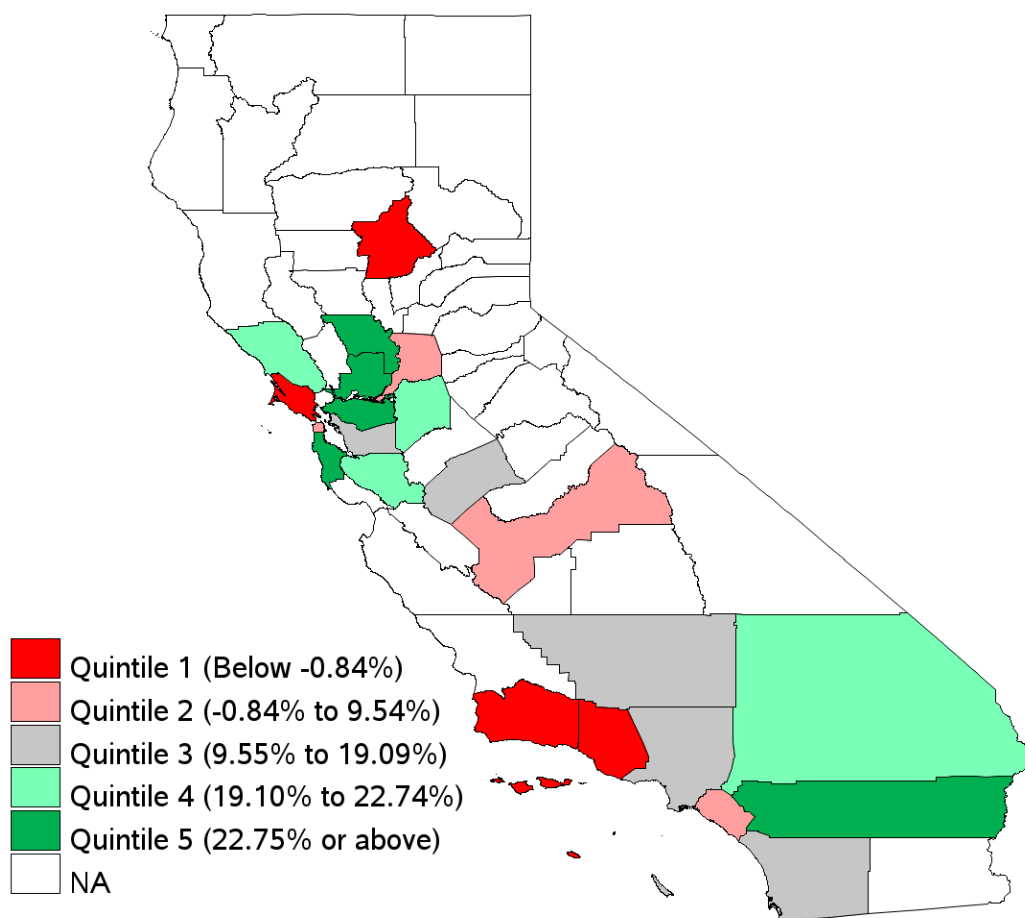


Figure 2.14—Developmental Screening in the First Three Years of Life—Total (DEV)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for DEV—Black or African American



The following are the key findings for the *Developmental Screening in the First Three Years of Life—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southern Coast regions had low performance for the *Developmental Screening in the First Three Years of Life—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for all four counties with reportable rates (Fresno, Kern, Merced, and San Joaquin) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level for measurement year 2022 by more than a 20 percent relative difference. Of note, the rate for Kern

County was below the minimum performance level by more than a 70 percent relative difference.

- Rates for two of three (66.7 percent) counties (Los Angeles and Orange) in the Southern Coast region were in the bottom two quintiles and were below the minimum performance level by more than a 30 percent relative difference.
- ◆ Counties in the Central Coast and San Francisco Bay/Sacramento regions had high performance for the *Developmental Screening in the First Three Years of Life—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for both counties with reportable rates (Santa Barbara and Ventura) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Rates for both counties declined from measurement year 2021 to measurement year 2022 and were in Quintile 1 for trending results.
 - Rates for six of nine (66.7 percent) counties with reportable rates (Alameda, Contra Costa, Marin, Sacramento, San Mateo, and Santa Clara) in the San Francisco Bay/Sacramento region were in the top two quintiles for current year performance. Of note, the rate for Santa Clara County was above the minimum performance level by more than a 60 percent relative difference.

Figure 2.15—Developmental Screening in the First Three Years of Life—Total (DEV)—Hispanic or Latino—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for DEV—Hispanic or Latino

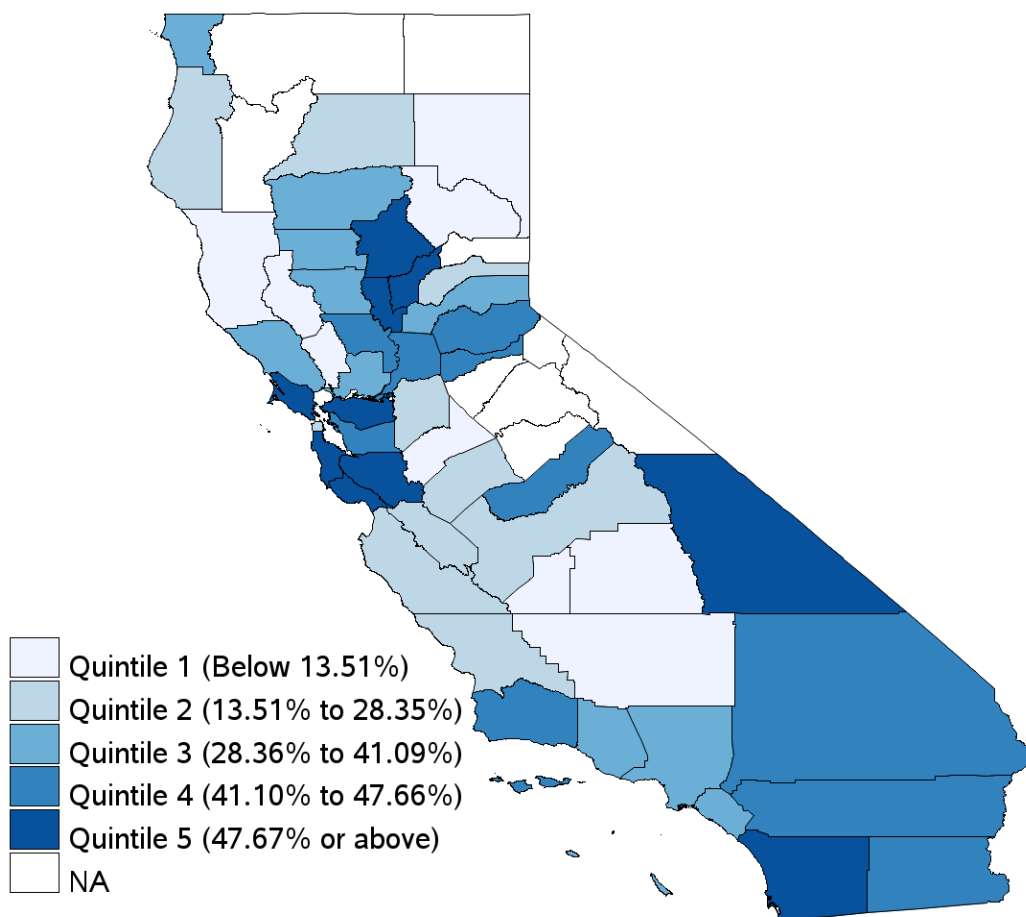
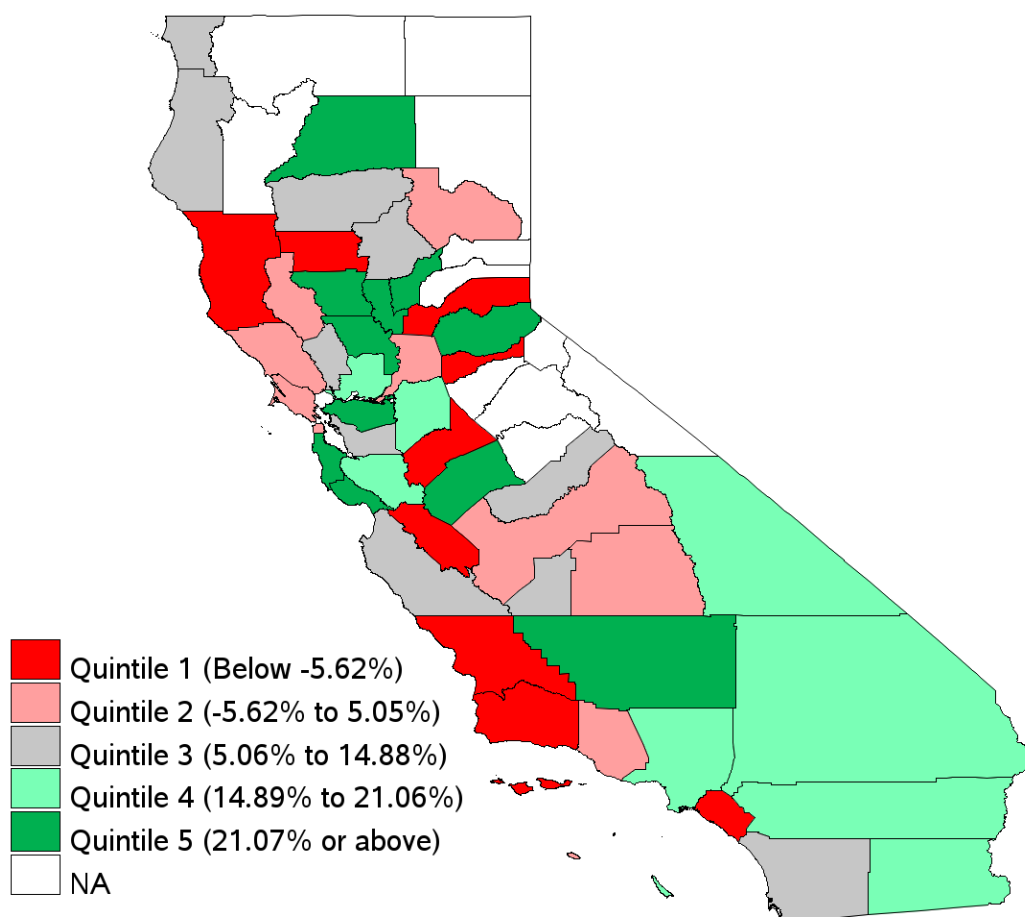


Figure 2.16—Developmental Screening in the First Three Years of Life—Total (DEV)—Hispanic or Latino—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for DEV—Hispanic or Latino



The following are the key findings for the *Developmental Screening in the First Three Years of Life—Total—Hispanic or Latino* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Central Coast and San Joaquin Valley regions had low performance for the *Developmental Screening in the First Three Years of Life—Total—Hispanic or Latino* indicator-racial/ethnic group combination.
 - Rates for three of six (50.0 percent) counties (Monterey, San Benito, and San Luis Obispo) in the Central Coast region were in Quintile 2. Rates for two of the three (66.7 percent) counties (San Benito and San Luis Obispo) were in Quintile 1 for trending results.
 - Rates for seven of eight (87.5 percent) counties (Fresno, Kern, Kings, Merced, San Joaquin, Stanislaus, and Tulare) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Of note, despite

improving from measurement year 2021 to measurement year 2022, the rate for Kings County was below the minimum performance level by more than a 90 percent relative difference.

- ◆ Counties in the San Francisco Bay/Sacramento and Southeastern regions had high performance for the *Developmental Screening in the First Three Years of Life—Total—Hispanic or Latino indicator-racial/ethnic group combination*.
 - Rates for six of 10 (60.0 percent) counties (Alameda, Contra Costa, Marin, Sacramento, San Mateo, and Santa Clara) in the San Francisco Bay/Sacramento region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Rates for three of these six (50.0 percent) counties (Contra Costa, San Mateo, and Santa Clara) were in the top two quintiles for trending results. Of note, despite declining from measurement year 2021 to measurement year 2022, the rate for Marin County was above the minimum performance level by more than a 70 percent relative difference.
 - The rates for all three counties (Imperial, Riverside, and San Bernardino) in the Southeastern region were in Quintile 4 for current year performance and trending results.

Figure 2.17—Developmental Screening in the First Three Years of Life—Total (DEV)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for DEV—White

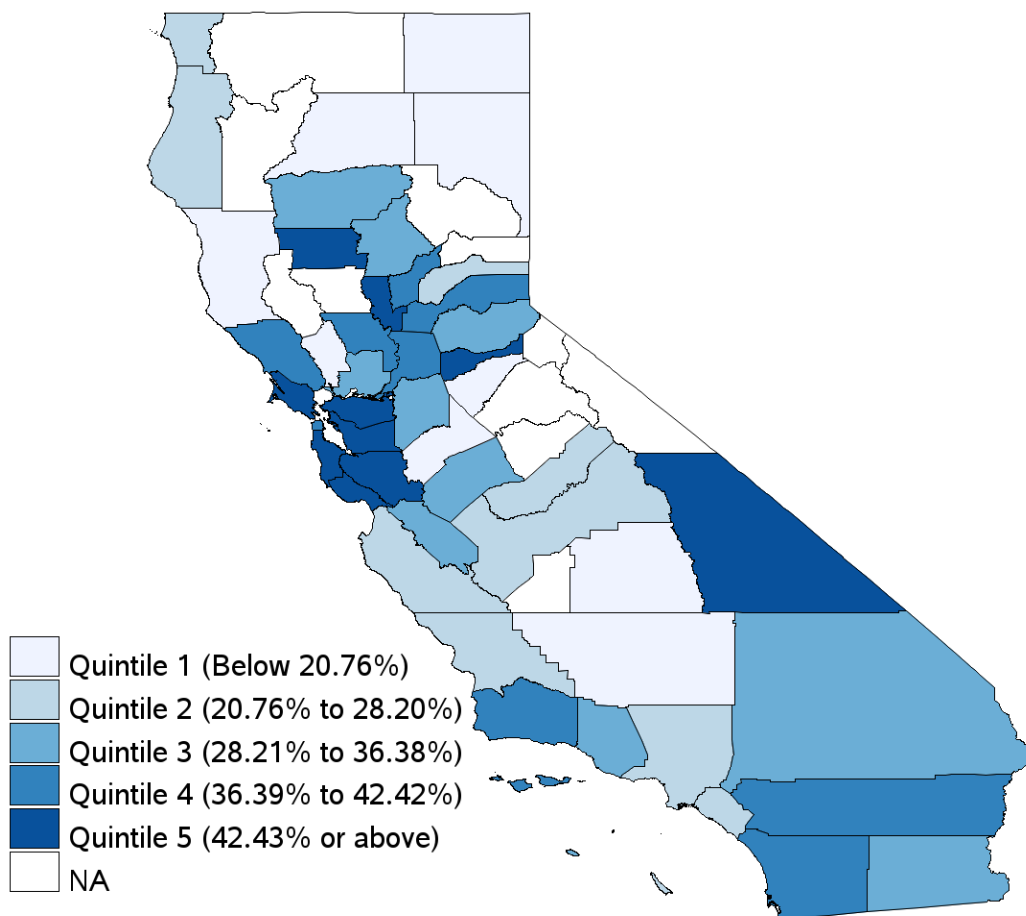
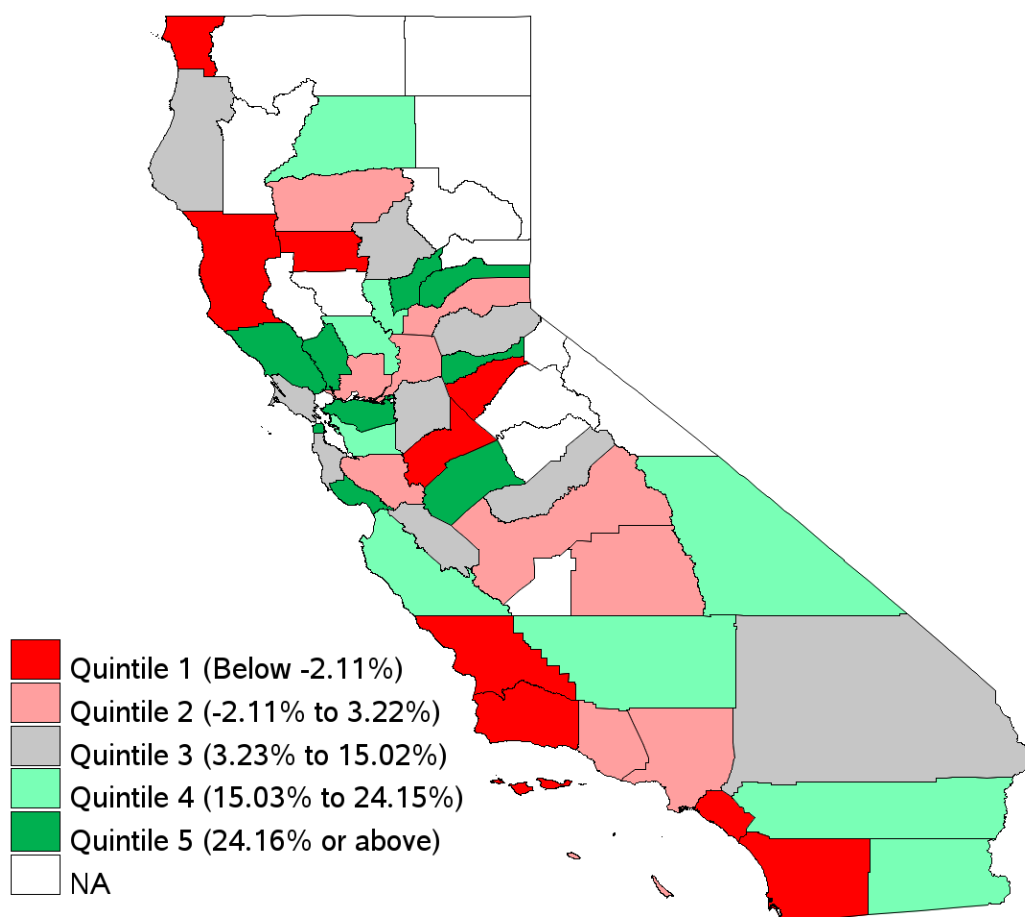


Figure 2.18—Developmental Screening in the First Three Years of Life—Total (DEV)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for DEV—White



The following are the key findings for the *Developmental Screening in the First Three Years of Life—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southern Coast regions had low performance for the *Developmental Screening in the First Three Years of Life—Total—White* indicator-racial/ethnic group combination.
 - Rates for five of seven (71.4 percent) counties with reportable rates (Fresno, Kern, Madera, Stanislaus, and Tulare) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and below the minimum performance level by more than a 20 percent relative difference for current year performance. Of note, the rate for Tulare County was below the minimum performance level by more than an 80 percent relative difference.

- Rates for two of three (66.7 percent) counties (Los Angeles and Orange) in the Southern Coast region were in Quintile 2 for current year performance. Rates for both counties were below the minimum performance level by at least a 35 percent relative difference. Additionally, all three counties (Los Angeles, Orange, and San Diego) in the Southern Coast region were in the bottom two quintiles for trending results.
- ◆ Counties in the San Francisco Bay/Sacramento region had high performance for the *Developmental Screening in the First Three Years of Life—Total—White* indicator-racial/ethnic group combination.
 - Rates for eight of 10 (80.0 percent) counties (Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Mateo, Santa Clara, and Sonoma) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Additionally, rates for four of these eight (50.0 percent) counties (Alameda, Contra Costa, San Francisco, and Sonoma) were in the top two quintiles for trending results. Of note, the rates for Marin and Santa Clara counties were above the minimum performance level by more than a 45 percent relative difference.

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 vaccine (Tdap); and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. Figure 2.19 through Figure 2.21 display the statewide racial/ethnic and applicable regional-level results for the *Immunizations for Adolescents—Combination 2 (IMA–2)* indicator in addition to identified health disparities.

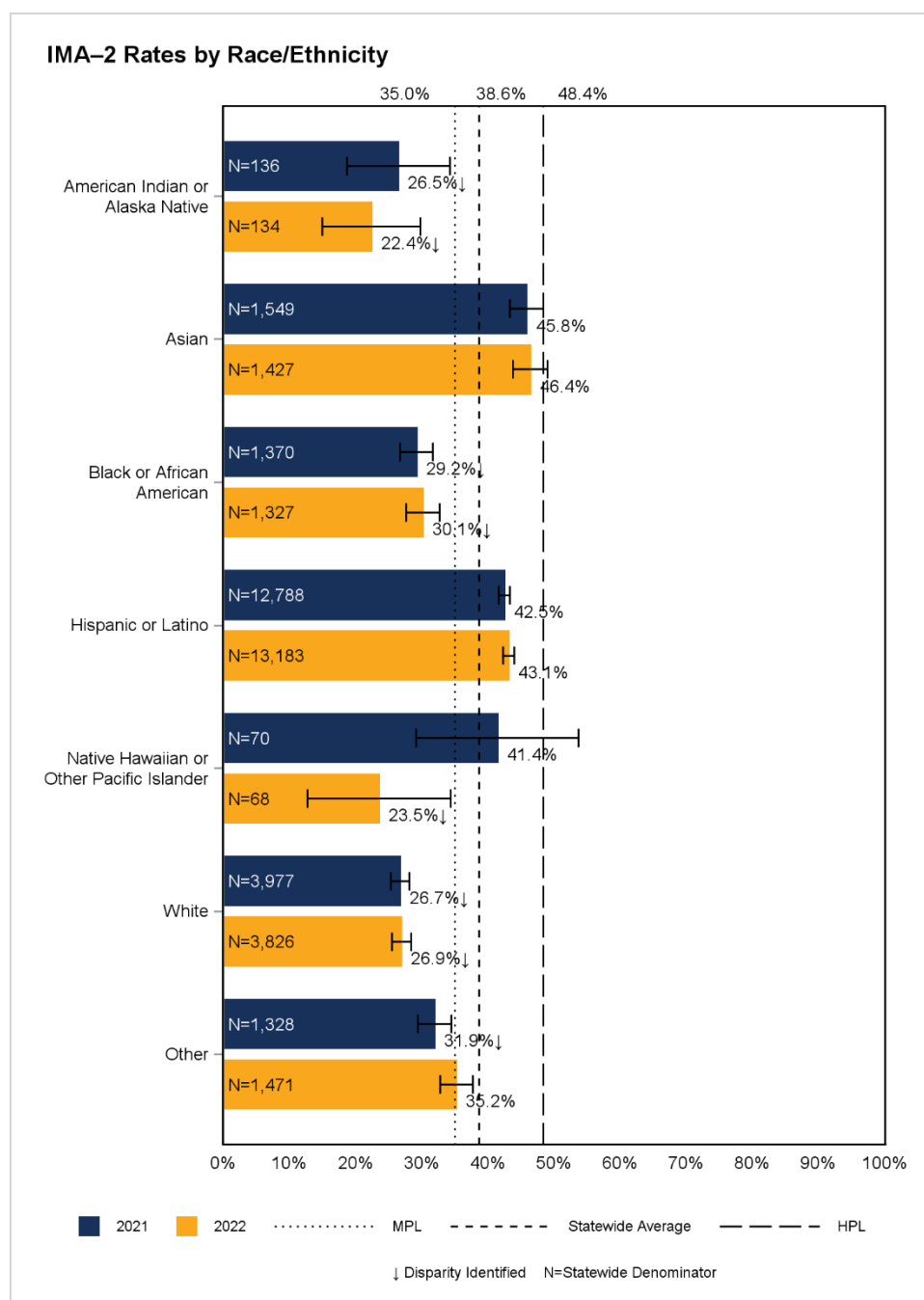
Figure 2.19—Immunizations for Adolescents—Combination 2 (IMA–2) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 29.3 percent (N=485) and 27.8 percent (N=586), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 36.7 percent and 50.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.0 percent.



The following key findings were identified for the *Immunizations for Adolescents—Combination 2* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for two of seven (28.6 percent) racial/ethnic groups (Black or African American and White) had a persistent, improving disparity identified, and one of seven (14.3 percent) racial/ethnic groups (American Indian or Alaska Native) had a persistent, worsening disparity identified.

- ◆ One of seven (14.3 percent) racial/ethnic groups (Native Hawaiian or Other Pacific Islander) had a new disparity identified in measurement year 2022.
- ◆ Widespread disparities were identified, with four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) having disparities identified for measurement year 2022.
- ◆ Three of seven (42.9 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, and White) had a large disparity identified for measurement year 2021; however, for measurement year 2022, a large disparity was identified for one additional racial/ethnic group rate (Native Hawaiian or Other Pacific Islander).
- ◆ While the Other racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.
- ◆ No emerging disparities were identified for the *Immunizations for Adolescents—Combination 2* indicator.

Figure 2.20—Immunizations for Adolescents—Combination 2 (IMA-2)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for IMA-2—White

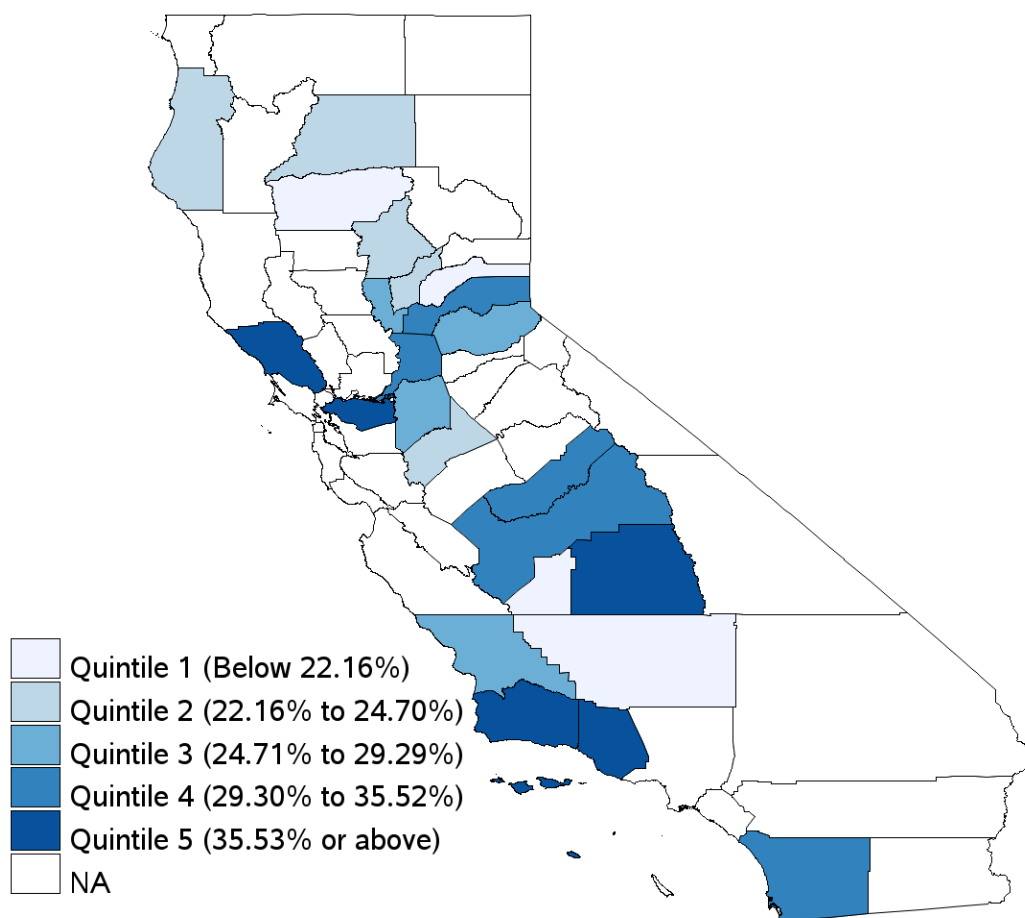
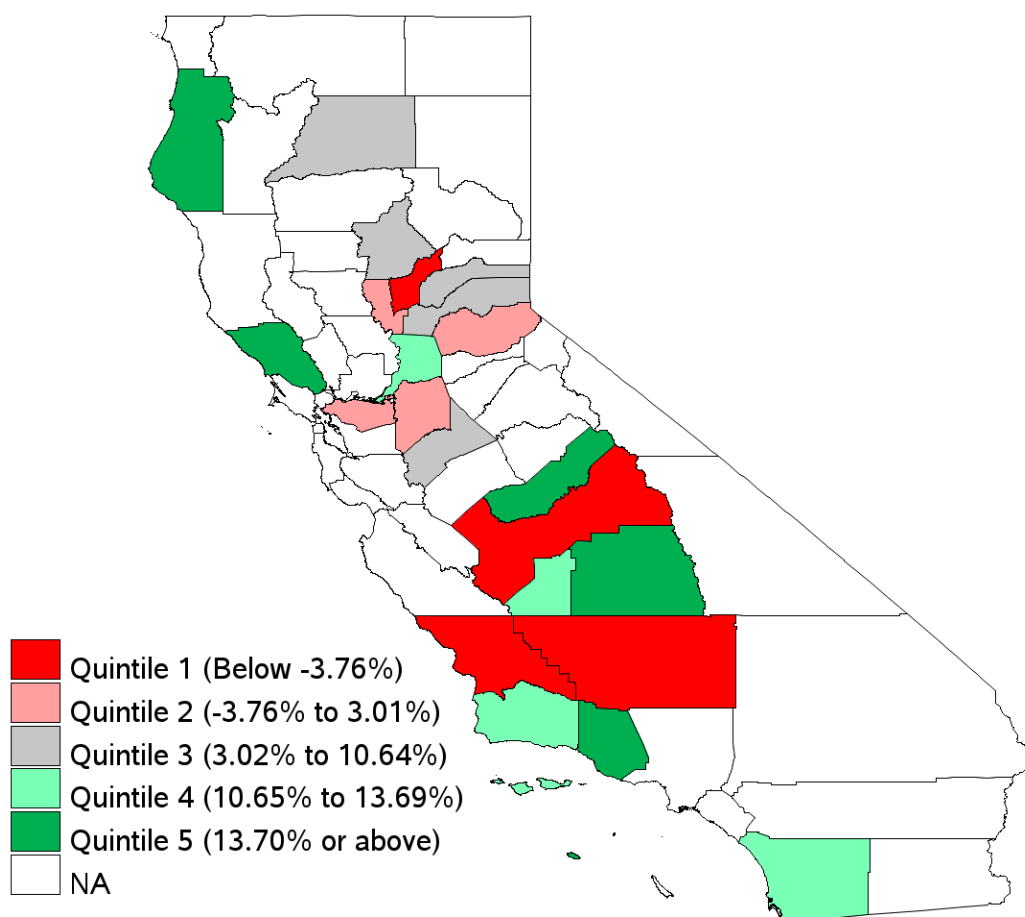


Figure 2.21—Immunizations for Adolescents—Combination 2 (IMA-2)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for IMA-2—White



The following are the key findings for the *Immunizations for Adolescents—Combination 2—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain region had low performance for the *Immunizations for Adolescents—Combination 2—White* indicator-racial/ethnic group combination.
 - Rates for six of nine (66.7 percent) counties with reportable rates (Butte, Humboldt, Nevada, Shasta, Tehama, and Yuba) were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. The rates for all six of these counties were below the minimum performance level by more than a 30 percent relative difference.

- ◆ Counties in the Central Coast and San Francisco Bay/Sacramento regions had high performance for the *Immunizations for Adolescents—Combination 2—White indicator-racial/ethnic group combination*.
 - Rates for two of three (66.7 percent) counties with reportable rates (Santa Barbara and Ventura) in the Central Coast region were in Quintile 5 for current year performance and in the top two quintiles (i.e., Quintiles 4 and 5) for trending results. Of note, the rate for Santa Barbara County was above the minimum performance level by more than a 50 percent relative difference.
 - Rates for all three counties with reportable rates (Contra Costa, Sacramento, and Sonoma) in the San Francisco Bay/Sacramento region were in the top two quintiles for current year performance. Additionally, rates for two of these three (66.7 percent) counties (Sacramento and Sonoma) were in the top two quintiles for trending results.

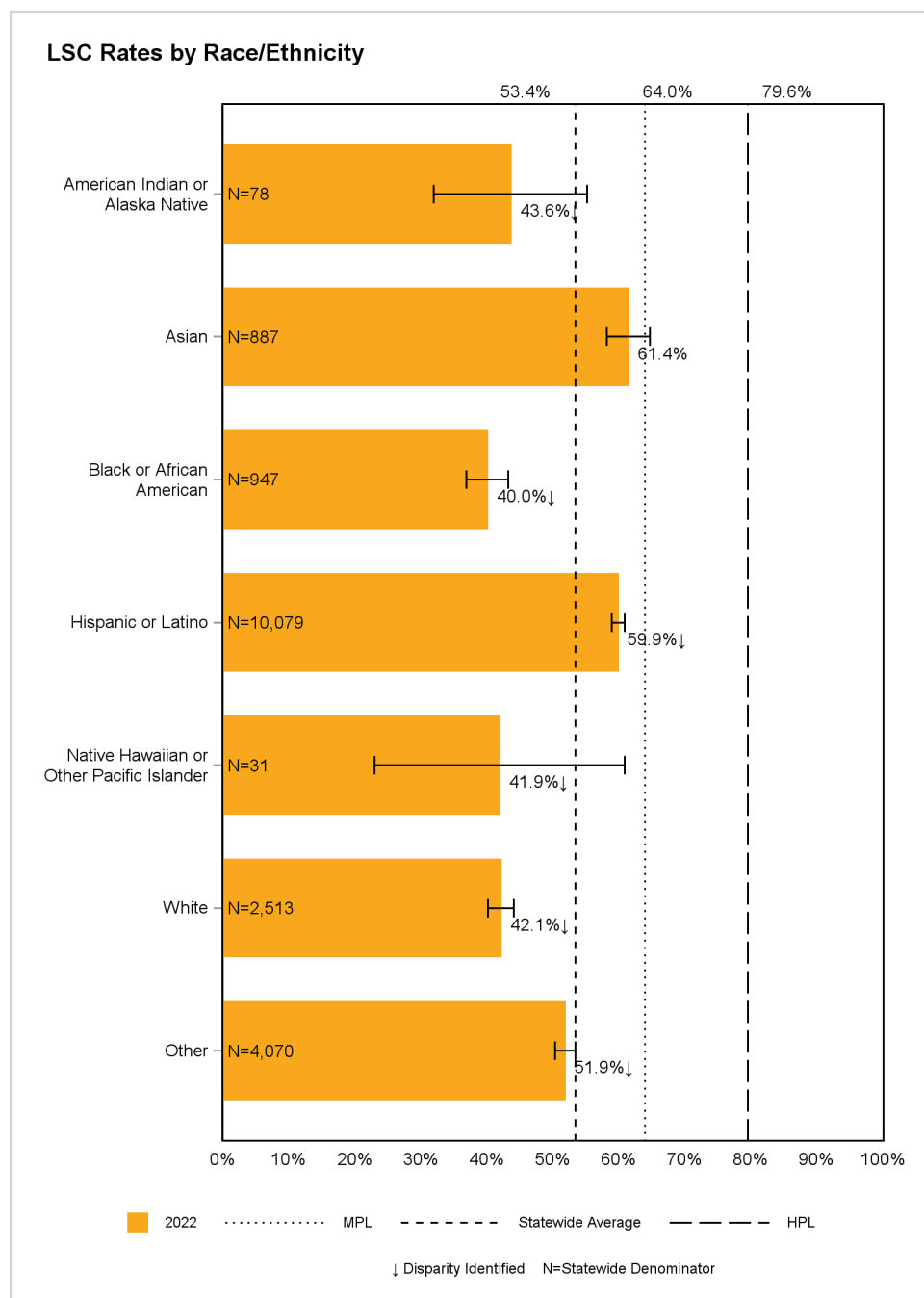
Lead Screening in Children (LSC)

The *Lead Screening in Children (LSC)* indicator measures the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. Figure 2.22 through Figure 2.24 display the statewide racial/ethnic and applicable regional-level results for the *Lead Screening in Children (LSC)* indicator in addition to identified health disparities.

Figure 2.22—Lead Screening in Children (LSC) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 46.7 percent (N=3,561).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.



The following key findings were identified for the *Lead Screening in Children* indicator:

- ◆ As this indicator was not tested for disparities in measurement year 2021, all disparities identified were new. Given this, six of seven (85.7 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had a new disparity identified in measurement year 2022.

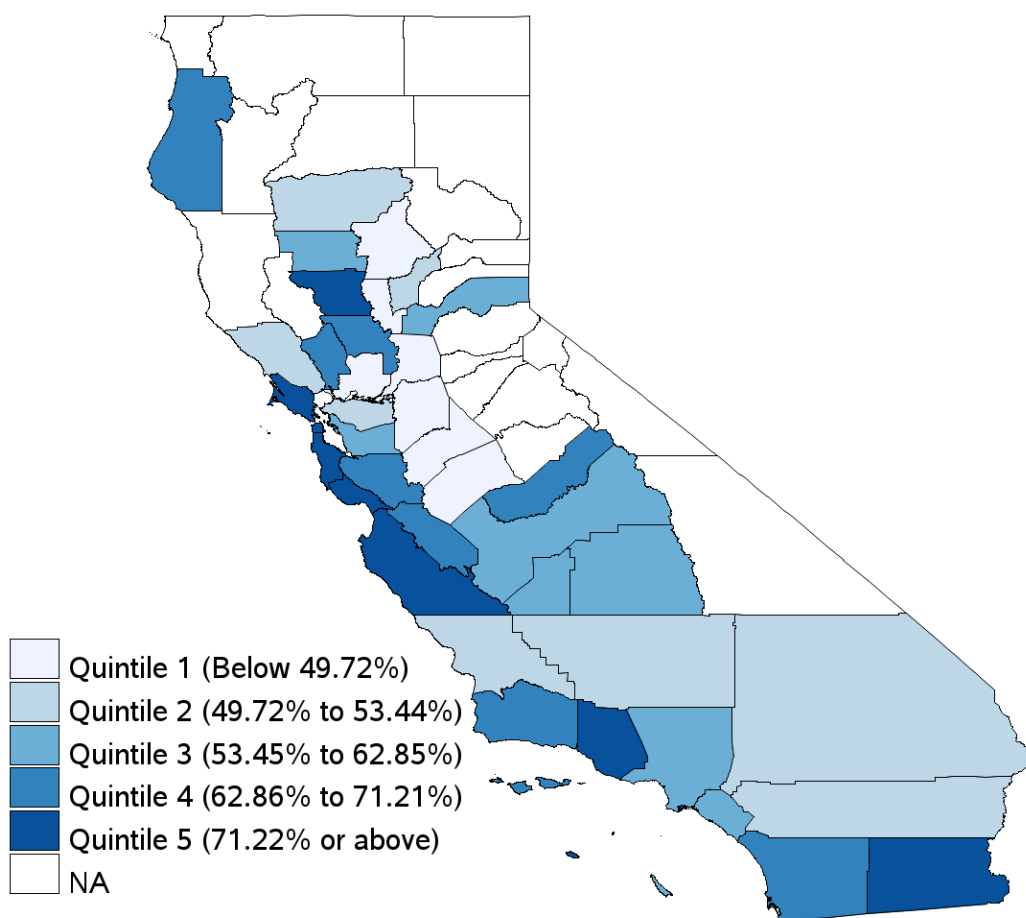
- ◆ Widespread disparities were identified, with all racial/ethnic groups except Asian having disparities identified for measurement year 2022.
- ◆ Five of seven (71.4 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and White) had a large disparity identified for measurement year 2022.

Figure 2.23—Lead Screening in Children (LSC)—Hispanic or Latino—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for LSC—Hispanic or Latino



The following are the key findings for the *Lead Screening in Children—Hispanic or Latino* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southeastern regions had low performance for the *Lead Screening in Children—Hispanic or Latino* indicator-racial/ethnic group combination.
 - Rates for four of eight (50.0 percent) counties (Kern, Merced, San Joaquin, and Stanislaus) in the San Joaquin Valley region were in the bottom two quintiles (i.e.,

Quintiles 1 and 2). Of note, the rate for Stanislaus County was below the minimum performance level by more than a 35 percent relative difference.

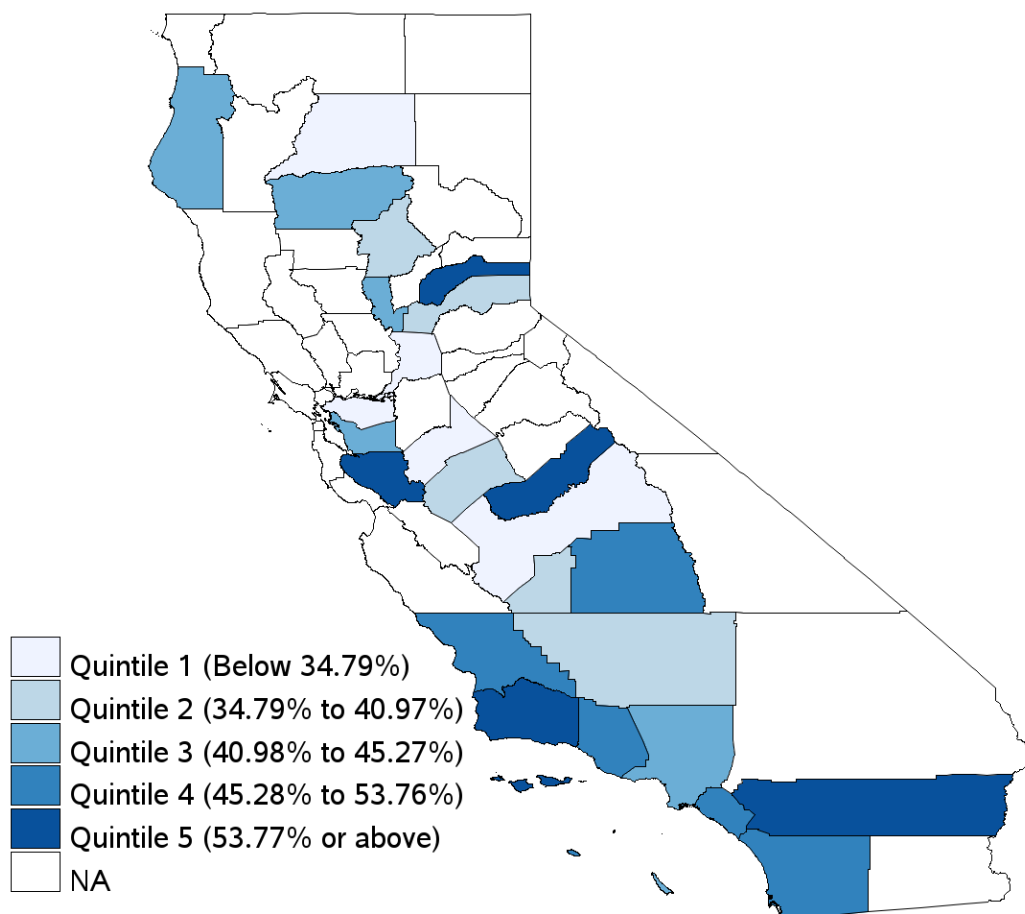
- Rates for two of three (66.7 percent) counties (Riverside and San Bernardino) in the Southeastern region were in Quintile 2. Rates for both of these counties were below the minimum performance level by more than a 20 percent relative difference.
- ◆ Counties in the Central Coast and San Francisco Bay/Sacramento regions had high performance for the *Lead Screening in Children*—Hispanic or Latino indicator-racial/ethnic group combination.
 - Rates for five of six (83.3 percent) counties (Monterey, San Benito, Santa Barbara, Santa Cruz, and Ventura) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5).
 - Rates for five of 10 (50.0 percent) counties (Marin, Napa, San Francisco, San Mateo, and Santa Clara) in the San Francisco Bay/Sacramento region were in the top two quintiles. Of note, the rate for Marin County was above the minimum performance level by nearly a 40 percent relative difference.

Figure 2.24—Lead Screening in Children (LSC)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for LSC—White



The following are the key findings for the *Lead Screening in Children—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Francisco Bay/Sacramento and San Joaquin Valley regions had low performance for the *Lead Screening in Children—White* indicator-racial/ethnic group combination.
 - Rates for two of four (50.0 percent) counties with reportable rates (Contra Costa and Sacramento) in the San Francisco Bay/Sacramento region were in Quintile 1. Of note, rates for these two counties were below the minimum performance level by more than a 45 percent relative difference.
 - Rates for five of seven (71.4 percent) counties with reportable rates (Fresno, Kern, Kings, Merced, and Stanislaus) in the San Joaquin Valley region were in the bottom two

quintiles (i.e., Quintiles 1 and 2). Of note, rates for Fresno and Stanislaus counties were below the minimum performance level by more than a 50 percent relative difference.

- ◆ Counties in the Central Coast and Southern Coast regions had high performance for the *Lead Screening in Children*—White indicator-racial/ethnic group combination.
 - All three counties with reportable rates (San Luis Obispo, Santa Barbara, and Ventura) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5).
 - Rates for two of three (66.7 percent) counties (Orange and San Diego) in the Southern Coast region were in Quintile 4.
- ◆ None of the counties with reportable rates met the minimum performance level for the *Lead Screening in Children*—White indicator-racial/ethnic group combination.

Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)* indicator measures the percentage of children who turned 15 months old during the measurement year who received six or more well-child visits with a PCP. Figure 2.25 through Figure 2.31 display the statewide racial/ethnic and applicable regional-level results for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)* indicator in addition to identified health disparities.

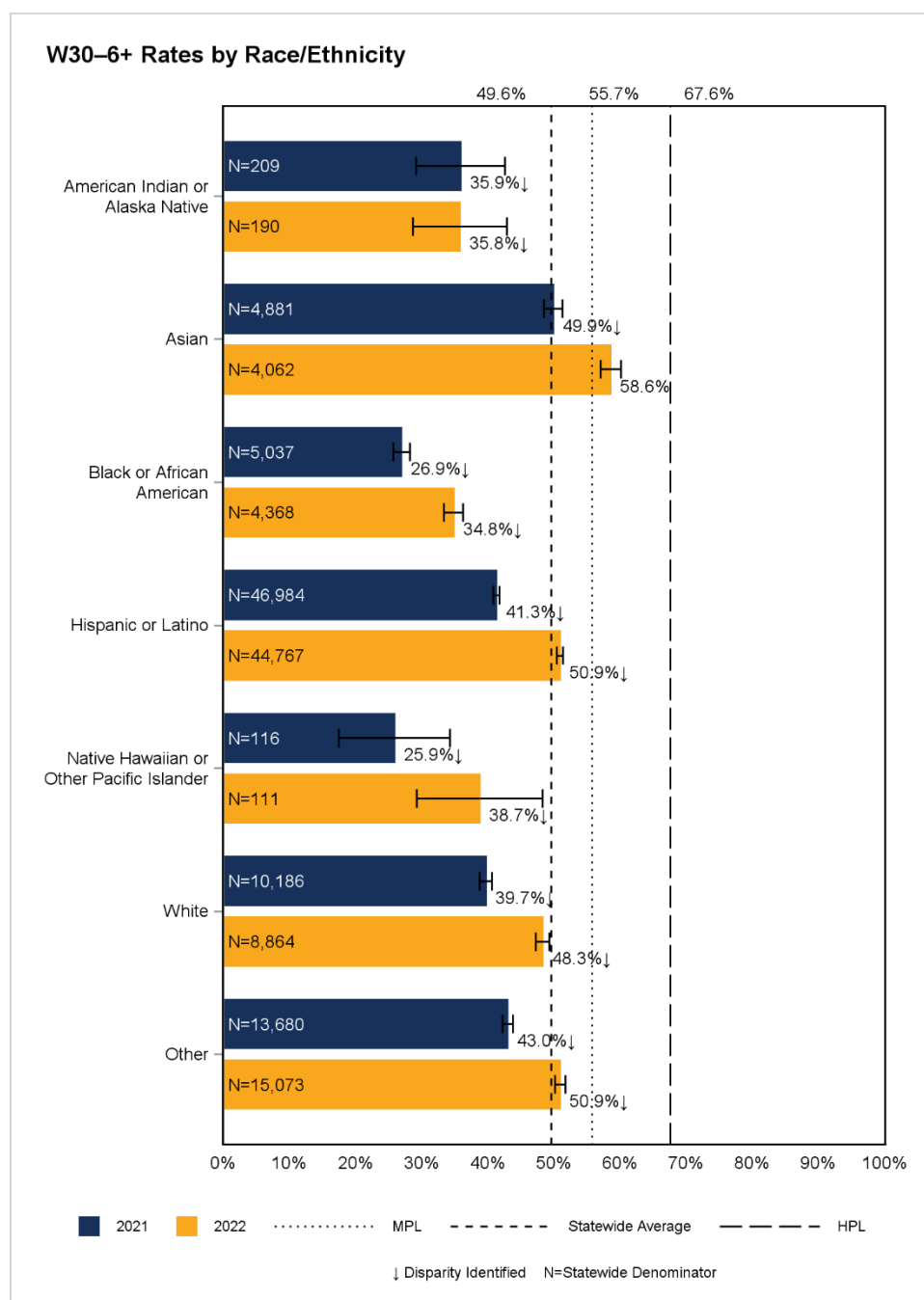
Figure 2.25—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 36.6 percent (N=15,652) and 47.5 percent (N=16,328), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 68.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 40.2 percent.



The following key findings were identified for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator:

- ◆ From measurement year 2021 to measurement year 2022, five of seven (71.4 percent) racial/ethnic groups (Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had a persistent, improving disparity identified, and one of seven (14.3 percent) racial/ethnic groups (American Indian or Alaska Native) had a persistent, worsening disparity identified.

- ◆ Widespread disparities were identified, with six of seven (85.7 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) having disparities identified for measurement year 2022.
- ◆ Four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had large disparities identified for measurement years 2021 and 2022.
- ◆ While the Asian racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.
- ◆ No new or emerging disparities were identified for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator.

Figure 2.26—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for W30–6+—Black or African American

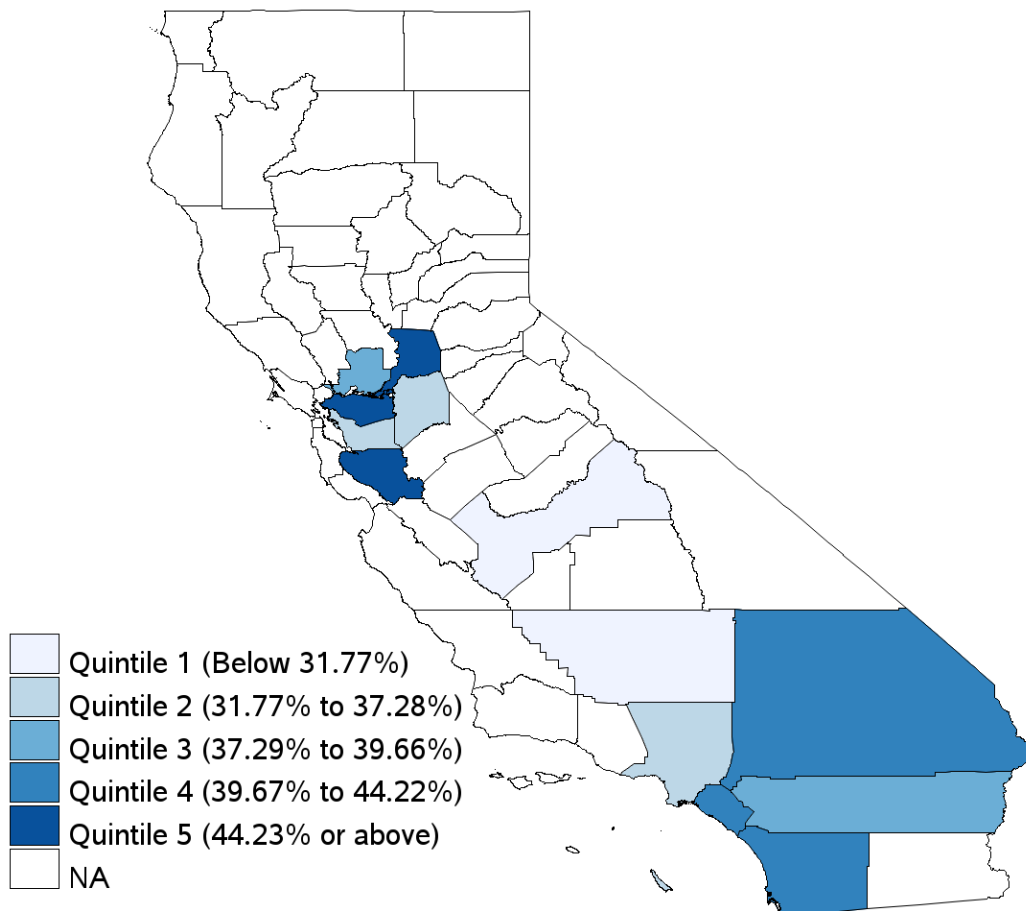
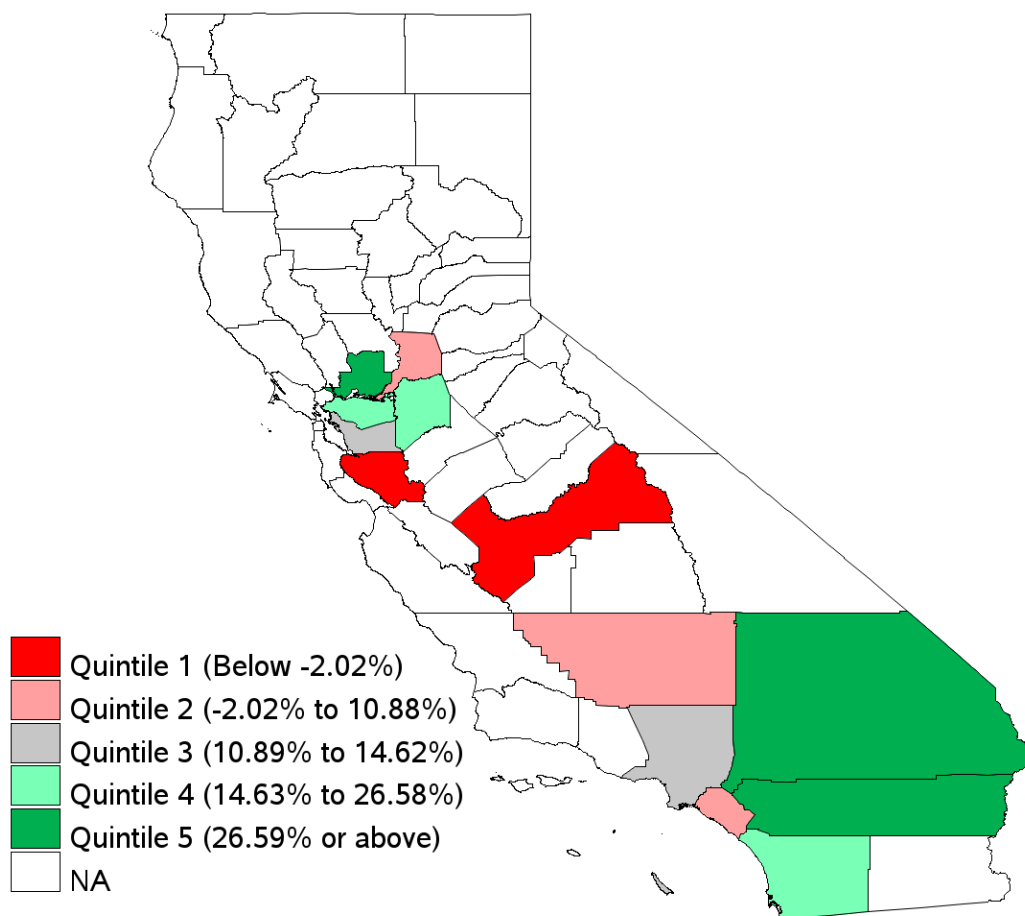


Figure 2.27—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for W30–6+—Black or African American



The following are the key findings for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley region had low performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Black or African American* indicator-racial/ethnic group combination.
 - All three counties with reportable rates (Fresno, Kern, and San Joaquin) were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level for measurement year 2022 by at least a 35 percent relative difference.

Additionally, rates for two of these three (66.7 percent) counties (Fresno and Kern) were in the bottom two quintiles for trending results.

- ◆ Counties in the San Francisco Bay/Sacramento and Southern Coast regions had high performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Black or African American indicator-racial/ethnic group combination*.
 - Rates for three of five (60.0 percent) counties with reportable rates (Contra Costa, Sacramento, and Santa Clara) in the San Francisco Bay/Sacramento region were in Quintile 5 for current year performance. However, rates for these three counties fell below the minimum performance level by more than a 15 percent relative difference. Additionally, rates for two of these three (66.7 percent) counties (Sacramento and Santa Clara) were in the bottom two quintiles for trending results.
 - Rates for two of three (66.7 percent) counties (Orange and San Diego) in the Southern Coast region were in Quintile 4 for current year performance. Despite this, the rates for all three counties were below the minimum performance level by more than a 20 percent relative difference.
- ◆ None of the counties with reportable rates met the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Black or African American indicator-racial/ethnic group combination*.

Figure 2.28—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6+)—Hispanic or Latino—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for W30-6+—Hispanic or Latino

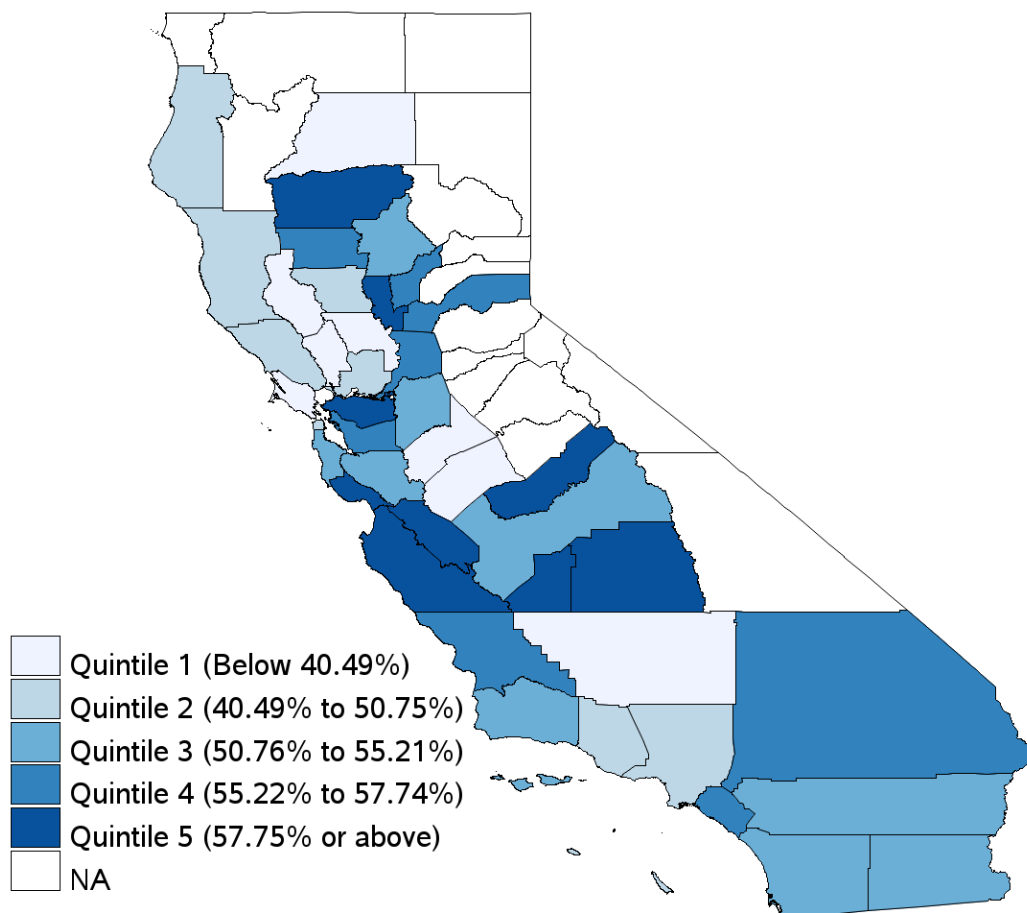
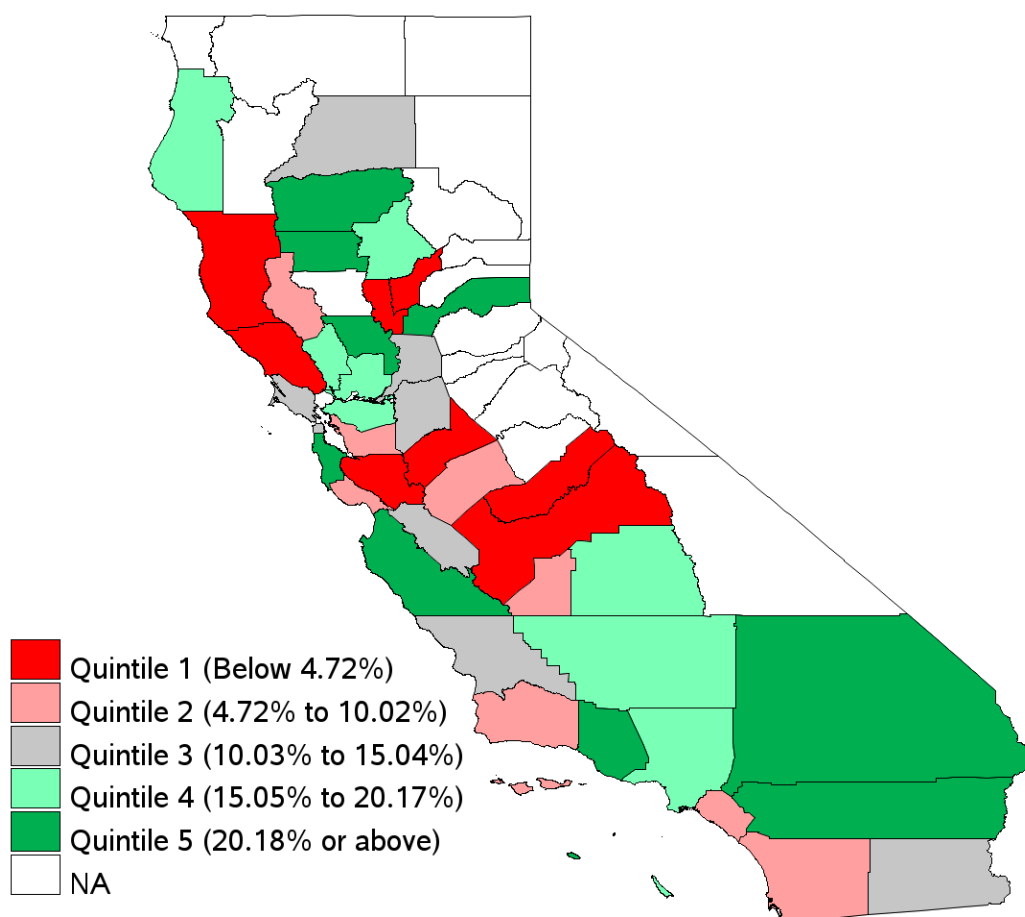


Figure 2.29—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)—Hispanic or Latino—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for W30–6+—Hispanic or Latino



The following are the key findings for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Hispanic or Latino* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain and San Francisco Bay/Sacramento regions had low performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—Hispanic or Latino* indicator-racial/ethnic group combination.
 - Rates for six of 12 (50.0 percent) counties with reportable rates (Colusa, Humboldt, Lake, Mendocino, Shasta, and Yolo) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level for measurement year 2022 by more than a 15 percent relative difference.

- Rates for five of 10 (50.0 percent) counties with reportable rates (Marin, Napa, San Francisco, Solano, and Sonoma) in the San Francisco Bay/Sacramento region were in the bottom two quintiles and were below the minimum performance level for measurement year 2022 by more than a 20 percent relative difference. Of note, the rate for Napa County was below the minimum performance level by more than a 45 percent relative difference.
- ◆ Counties in the Central Coast region had high performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*—Hispanic or Latino indicator-racial/ethnic group combination.
 - Rates for four of six (66.7 percent) counties with reportable rates (Monterey, San Benito, San Luis Obispo, and Santa Cruz) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Of note, rates for all four of these counties improved from measurement year 2021 to measurement year 2022 and now all exceed the minimum performance level.

Figure 2.30—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for W30–6+—White

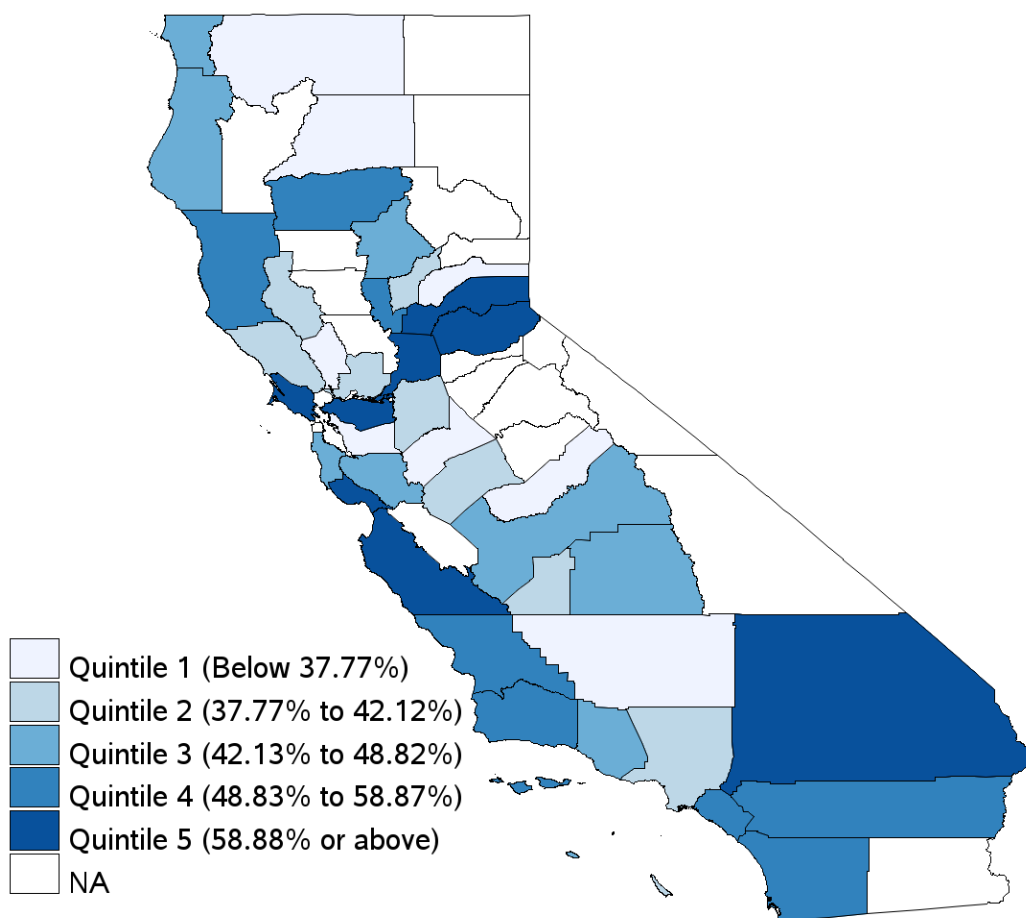
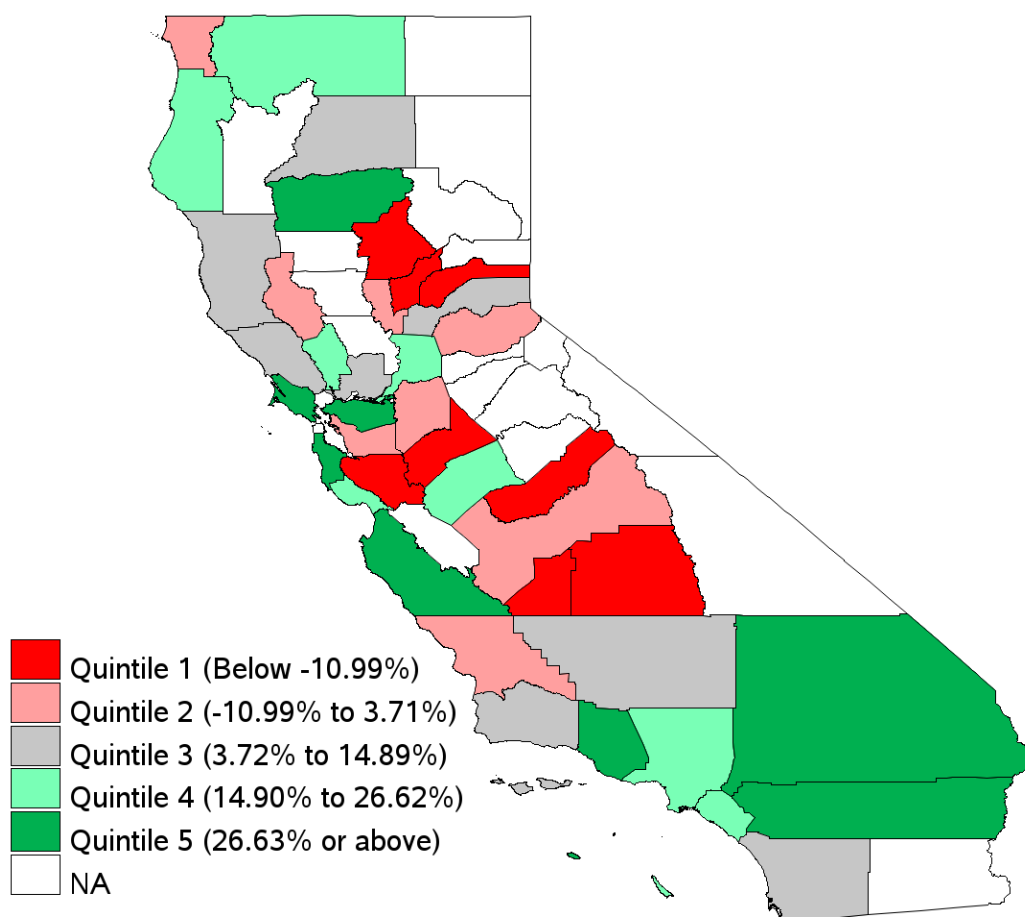


Figure 2.31—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for W30–6+—White



The following are the key findings for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley region had low performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—White* indicator-racial/ethnic group combination.
 - Rates for six of eight (75.0 percent) counties (Kern, Kings, Madera, Merced, San Joaquin, and Stanislaus) were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Four of these six (66.7 percent) counties (Kings, Madera, San Joaquin, and Stanislaus) were also in the bottom two quintiles for trending results.

Of note, rates for all six counties were below the minimum performance level by at least a 20 percent relative difference.

- ◆ Counties in the Central Coast and Southern Coast regions had high performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits—White* indicator-racial/ethnic group combination.
 - Rates for four of five (80.0 percent) counties with reportable rates (Monterey, San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5). Of note, the rate for Monterey County improved by more than a 40 percent relative difference from measurement year 2021 to measurement year 2022, and now exceeds the minimum performance level.
 - Rates for two of three (66.7 percent) counties (Orange and San Diego) in the Southern Coast region were in Quintile 4. Despite the high performance of these two counties, the rates are below the minimum performance level by more than a 10 percent relative difference.

Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)* indicator measures the percentage of children who turned 30 months old during the measurement year who received two or more well-child visits with a PCP. Figure 2.32 through Figure 2.36 display the statewide racial/ethnic and applicable regional-level results for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2)* indicator in addition to identified health disparities.

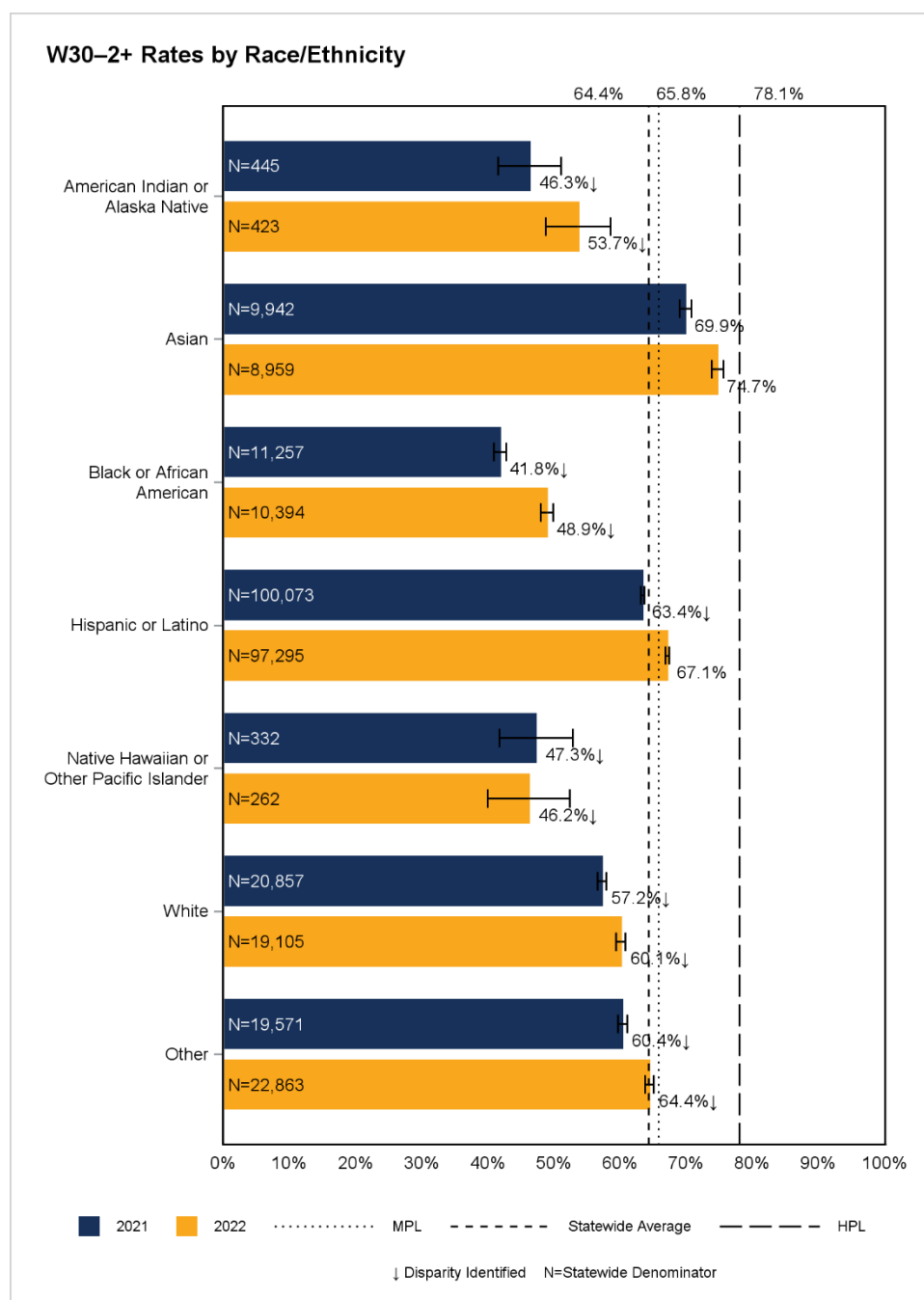
Figure 2.32—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 55.0 percent (N=24,062) and 60.0 percent (N=25,447), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 70.7 percent and 82.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 60.3 percent.



The following key findings were identified for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* indicator:

- ◆ From measurement year 2021 to measurement year 2022, five of seven (71.4 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and White) had a persistent, improving disparity identified, and no persistent disparities worsened.

- ◆ Widespread disparities were identified, with five of seven (71.4 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, Other, and White) having disparities identified for measurement year 2022.
- ◆ Three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and Native Hawaiian or Other Pacific Islander) had large disparities identified for measurement years 2021 and 2022.
- ◆ While the Hispanic or Latino racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.
- ◆ No new or emerging disparities were identified for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* indicator.

Figure 2.33—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for W30–2+—Black or African American

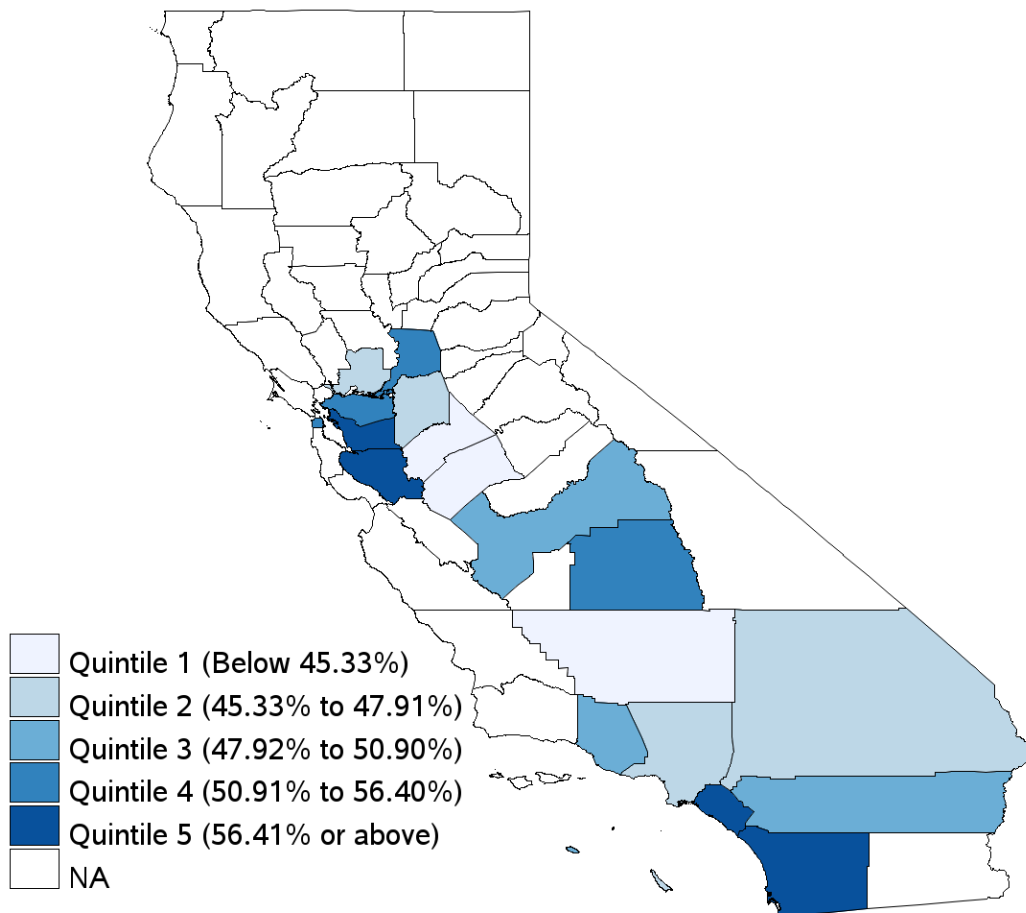
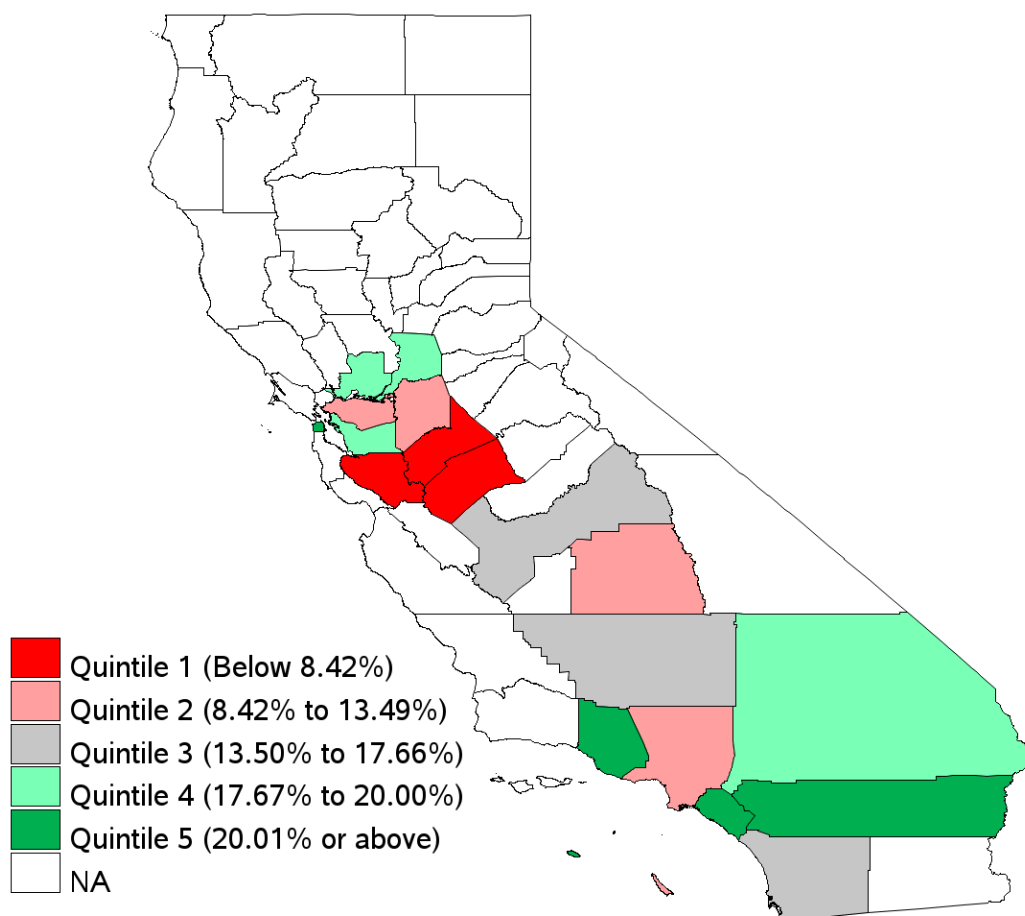


Figure 2.34—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30-2+)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for W30-2+—Black or African American



The following are the key findings for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley region had low performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Black or African American* indicator-racial/ethnic group combination.
 - Rates for four of six (66.7 percent) counties with reportable rates (Kern, Merced, San Joaquin, and Stanislaus) were in the bottom two quintiles (i.e., Quintiles 1 and 2) for

current year performance. Three of these four (75.0 percent) counties (Merced, San Joaquin, and Stanislaus) were also in the bottom two quintiles for trending results.

- ◆ Counties in the San Francisco Bay/Sacramento and Southern Coast regions had high performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Black or African American* indicator-racial/ethnic group combination.
 - Rates for five of six (83.3 percent) counties with reportable rates (Alameda, Contra Costa, Sacramento, San Francisco, and Santa Clara) in the San Francisco Bay/Sacramento region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Despite this, the rates for all five of these counties were below the minimum performance level by at least a 10 percent relative difference.
 - Rates for two of three (66.7 percent) counties (Orange and San Diego) in the Southern Coast region were in Quintile 5 for current year performance.
- ◆ None of the counties with reportable rates met the minimum performance level for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—Black or African American* indicator-racial/ethnic group combination.

Figure 2.35—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30-2+)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for W30-2+—White

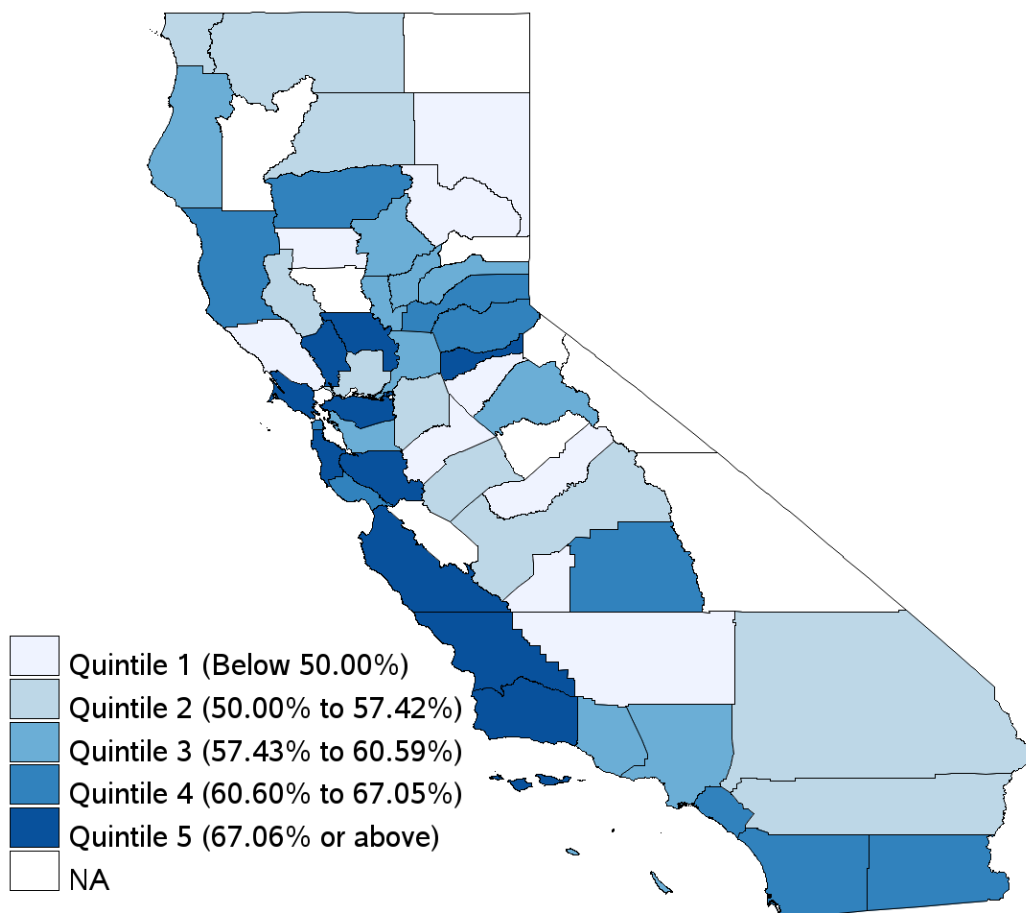
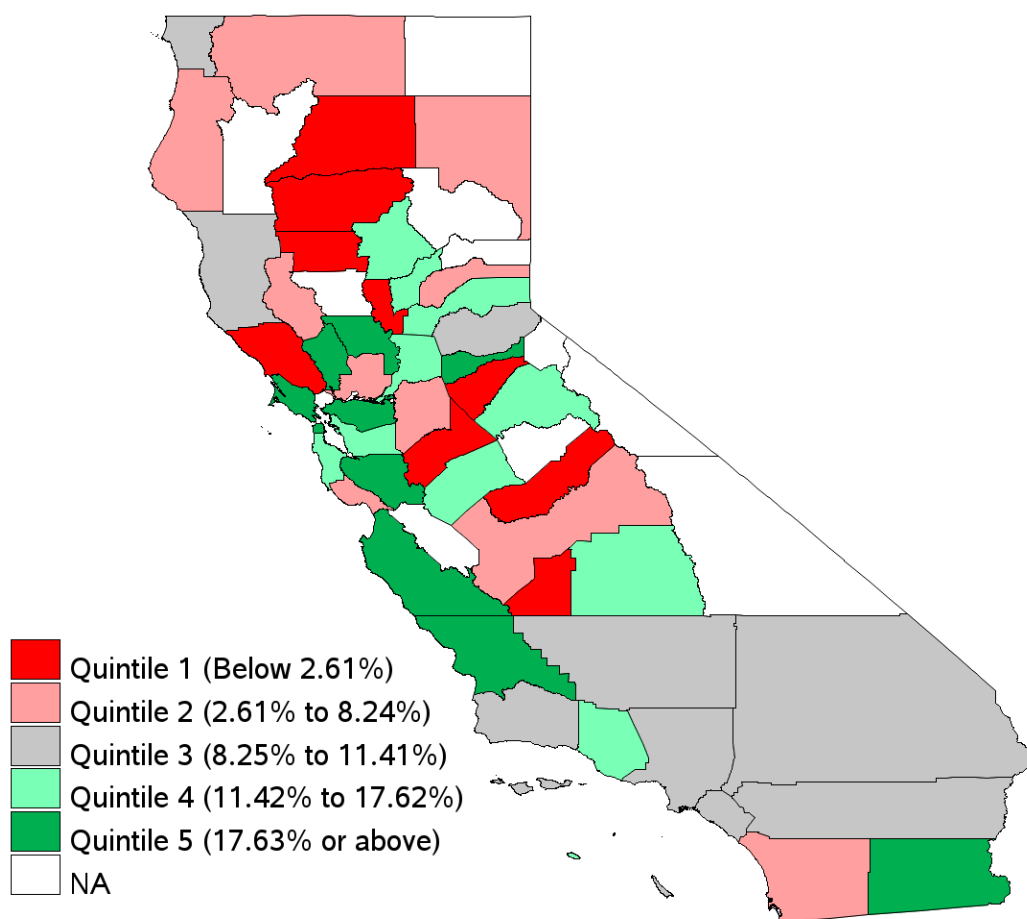


Figure 2.36—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for W30–2+—White



The following are the key findings for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southeastern regions had low performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—White* indicator-racial/ethnic group combination.
 - Rates for seven of eight (87.5 percent) counties (Fresno, Kern, Kings, Madera, Merced, San Joaquin, and Stanislaus) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and below the minimum performance level by more than a 15 percent relative difference for current year performance. Five of these seven

(71.4 percent) counties (Fresno, Kings, Madera, San Joaquin, and Stanislaus) were also in the bottom two quintiles for trending results.

- Rates for two of three (66.7 percent) counties (Riverside and San Bernardino) in the Southeastern region were in Quintile 2 and were below the minimum performance level by at least a 10 percent relative difference for current year performance.
- ◆ Counties in the Central Coast, San Francisco Bay/Sacramento, and Southern Coast regions had high performance for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits—White* indicator-racial/ethnic group combination.
 - Rates for four of five (80.0 percent) counties with reportable rates (Monterey, San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Of note, the rates for Santa Barbara and San Luis Obispo counties exceeded the minimum performance level by more than a 15 percent relative difference.
 - Rates for six of 10 (60.0 percent) counties (Contra Costa, Marin, Napa, San Francisco, San Mateo, and Santa Clara) in the San Francisco Bay/Sacramento region were in the top two quintiles for current year performance and trending results. Additionally, all six counties exceeded the minimum performance level in measurement year 2022.
 - Rates for two of three (66.7 percent) counties (Orange and San Diego) in the Southern Coast region were in Quintile 4 for current year performance. Despite this, the rates for these two counties did not meet the minimum performance level.

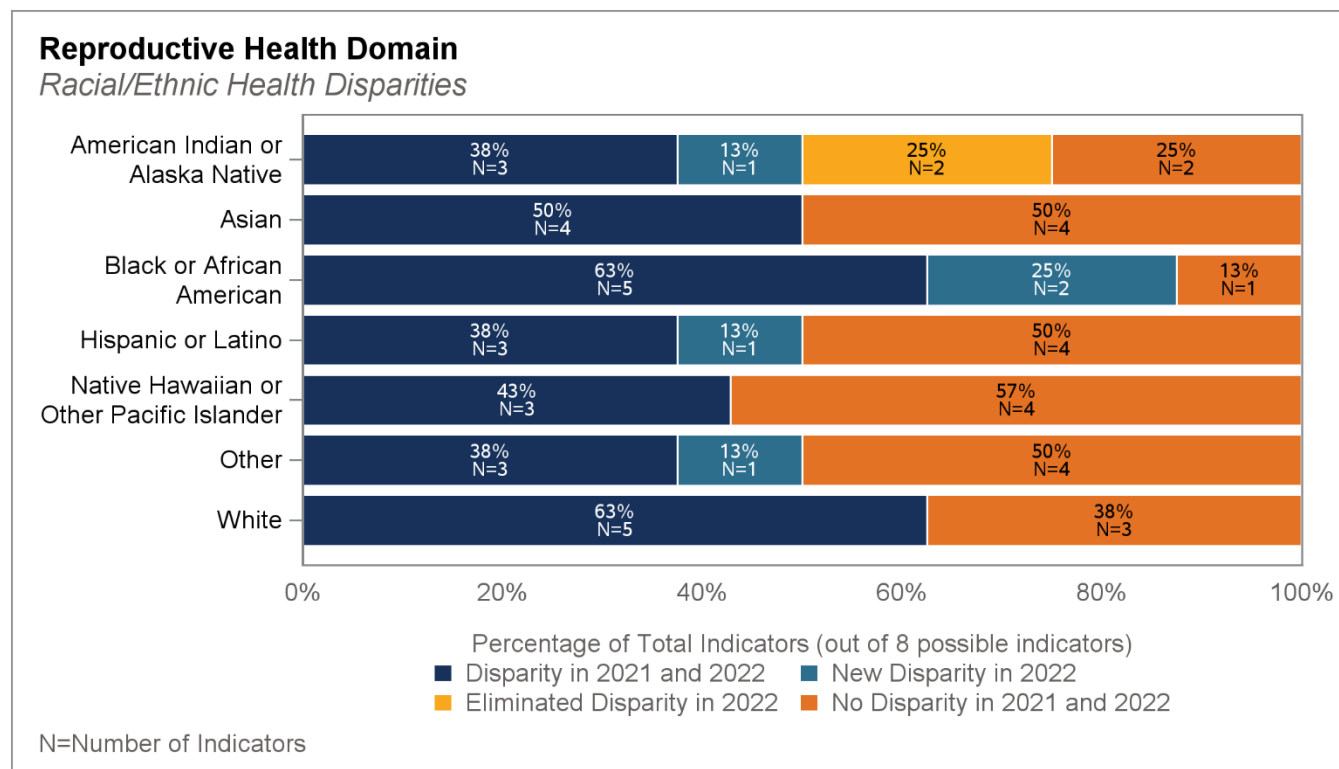
Racial/Ethnic Health Disparities: Reproductive Health Domain

Health disparities were identified when indicator rates for racial/ethnic groups were below the minimum performance level/median state performance rate (i.e., the upper bound of the 95 percent confidence interval for the rate was below the national reference rate). If a racial/ethnic group's indicator rate was equal to or higher than the minimum performance level/median state performance rate, then no health disparity was identified.

Figure 2.37 displays the percentage and number of Reproductive Health domain indicators (out of eight possible indicators) for which disparities were identified or were not identified for each racial/ethnic group in addition to newly identified and eliminated disparities within the Reproductive Health domain.

Figure 2.37—Racial/Ethnic Health Disparities Summary: Reproductive Health Domain

Note: Due to small numerators or denominators, the Native Hawaiian or Other Pacific Islander (N=7) group was not evaluated for health disparities for all eight possible indicators.



The following key findings were identified for the Reproductive Health domain:

- ◆ The following persistent disparities worsened from measurement year 2021 to measurement year 2022:
 - *Chlamydia Screening in Women—Total* indicator rates for one of seven (14.3 percent) racial/ethnic groups (White) had a persistent, worsening disparity identified.
 - *Prenatal and Postpartum Care—Postpartum Care* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Black or African American) had a persistent, worsening disparity identified.
- ◆ No persistent disparities improved from measurement year 2021 to measurement year 2022 in the Reproductive Health domain.
- ◆ A new disparity was identified for one indicator within the Reproductive Health domain:
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Black or African American) had a new disparity identified in measurement year 2022.

- ◆ Eliminated disparities were identified for two indicators within the Reproductive Health domain:
 - *Prenatal and Postpartum Care—Postpartum Care* indicator rates for one of seven (14.3 percent) racial/ethnic groups (American Indian or Alaska Native) had an eliminated disparity identified.
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator rates for one of seven (14.3 percent) racial/ethnic groups (American Indian or Alaska Native) had an eliminated disparity identified.
- ◆ Widespread disparities were identified for the *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years*, *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years*, *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*, and *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years* indicators, and for all racial/ethnic groups except Native Hawaiian or Other Pacific Islander.
 - For measurement year 2022, *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years* indicator rates for six of seven (85.7 percent) racial/ethnic groups (American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Other, and White) had disparities identified.
 - For measurement year 2022, *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years*, *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*, and *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44* indicator rates for all seven racial/ethnic groups had disparities identified.
 - For measurement year 2022, the rates for the American Indian or Alaska Native, Asian, Hispanic or Latino, and Other racial/ethnic groups had disparities identified for four of eight (50.0 percent) indicators within the Reproductive Health domain. Rates for the Black or African American racial/ethnic group had disparities identified for seven of eight (87.5 percent) indicators in the Reproductive Health domain. Rates for the White racial/ethnic group had disparities identified for five of eight (62.5 percent) indicators in the Reproductive Health domain.
- ◆ A large disparity was identified for one indicator in the Reproductive Health domain:
 - The *Prenatal Immunization Status—Combination* indicator rate for one of seven (14.3 percent) racial/ethnic groups (Black or African American) had a large disparity identified for measurement year 2022.
- ◆ An emerging disparity was identified for the *Prenatal and Postpartum Care—Postpartum Care—White* indicator-racial/ethnic group combination.

Racial/Ethnic Health Disparities: Reproductive Health Domain Key Findings

For the indicators in the Reproductive Health domain, the following Bold Goals apply:

- ◆ Ensure all health plans exceed the 50th percentile for all children's preventative care measures*
- ◆ Close maternity care disparity for Black and Native American Persons by 50 percent^

Based on evaluating the results of the key findings above, the following indicators were determined to be key findings and/or a Bold Goal measure for the Reproductive Health domain. Additionally, HSAG used symbols to identify the indicators associated with a Bold Goal (e.g., an asterisk [*] corresponds to the first Bold Goal listed above):

- ◆ *Chlamydia Screening in Women—Total**
- ◆ *Prenatal and Postpartum Care—Postpartum Care*^
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal*^
- ◆ *Prenatal Immunization Status—Combination*

Please note, the results for the *Contraceptive Care—All Women* and the *Contraceptive Care—Postpartum Women* indicators were not considered to be key findings given that the choice to use contraceptive medications is heavily impacted by member preference; therefore, low rates may not be indicative of poor performance. Additionally, the results for the *Postpartum Depression Screening and Follow-Up* and *Prenatal Depression Screening and Follow-Up* indicators were not considered to be key findings given that benchmarks were unavailable and disparities could not be identified. Please refer to Appendix C. Demographic Stratification Results for the racial/ethnic rates for these indicators.

Racial/Ethnic Health Disparities: Reproductive Health Domain Indicator Results

Figure 2.38 through Figure 2.50 display the racial/ethnic health disparities and applicable regional results for indicators with results determined to be key findings in the Reproductive Health domain. For each figure, the denominator, rate, and confidence interval for each racial/ethnic group are displayed. A downward arrow is displayed when a disparity is identified. Additionally, the measurement year 2022 statewide average, high performance level, where applicable, and minimum performance level/median state performance rate, where applicable, are displayed as rates on top of the figure and as dotted lines in the figure.

Chlamydia Screening in Women—Total (CHL)

The *Chlamydia Screening in Women—Total (CHL)* indicator measures the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. Figure 2.38 through Figure 2.40 display the statewide racial/ethnic and applicable regional-level results for the *Chlamydia Screening in Women—Total (CHL)* indicator in addition to identified health disparities.

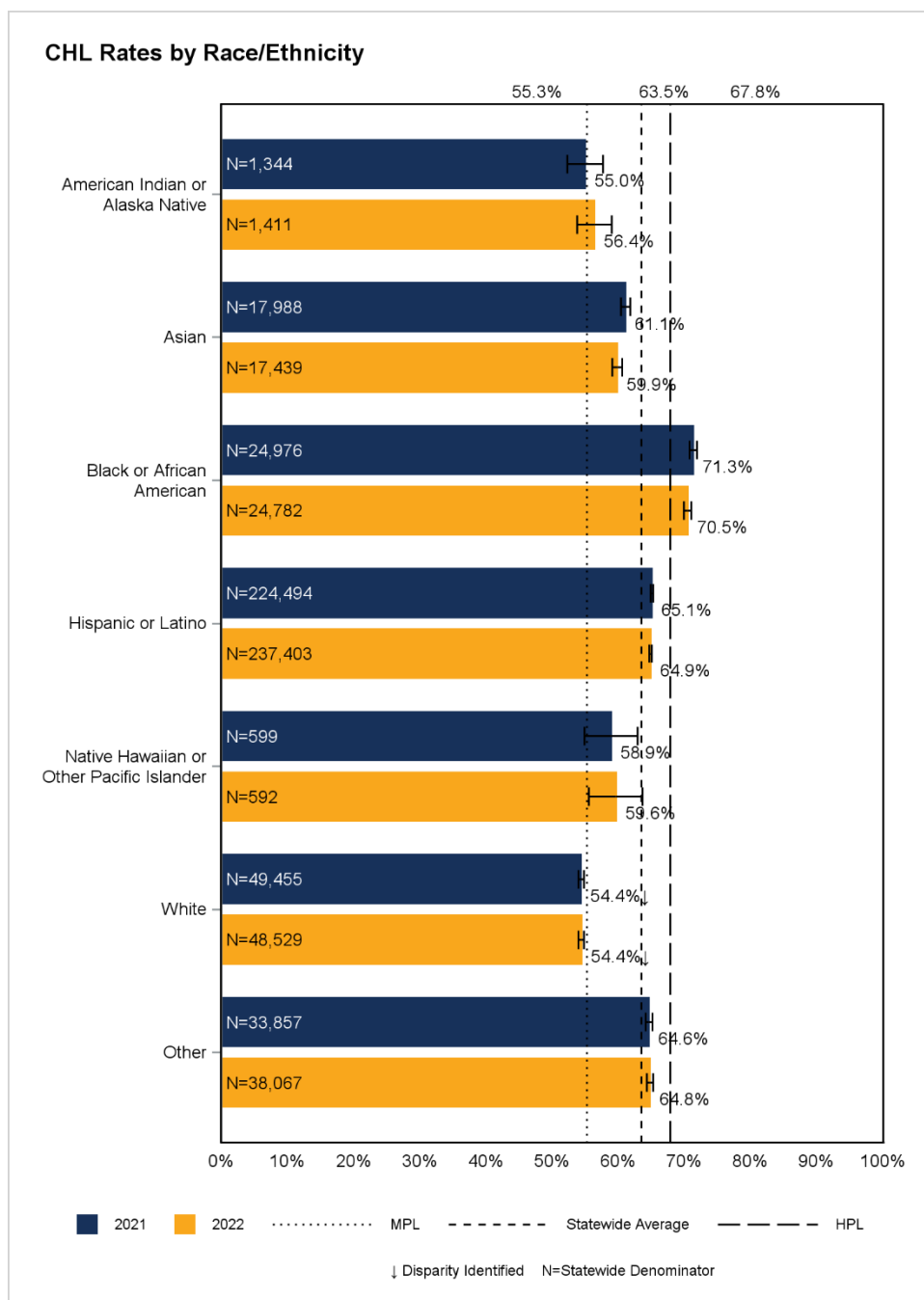
Figure 2.38—Chlamydia Screening in Women—Total (CHL) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 59.2 percent (N=8,017) and 60.0 percent (N=9,279), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 66.2 percent, respectively.

The statewide aggregate for measurement year 2021 was 63.6 percent.



The following key findings were identified for the *Chlamydia Screening in Women—Total* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for one of seven (14.3 percent) racial/ethnic groups (White) had a persistent, worsening disparity identified, and no persistent disparities improved.
- ◆ No new, eliminated, widespread, large, or emerging disparities were identified for the *Chlamydia Screening in Women—Total* indicator.

Figure 2.39—Chlamydia Screening in Women—Total (CHL)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for CHL—White

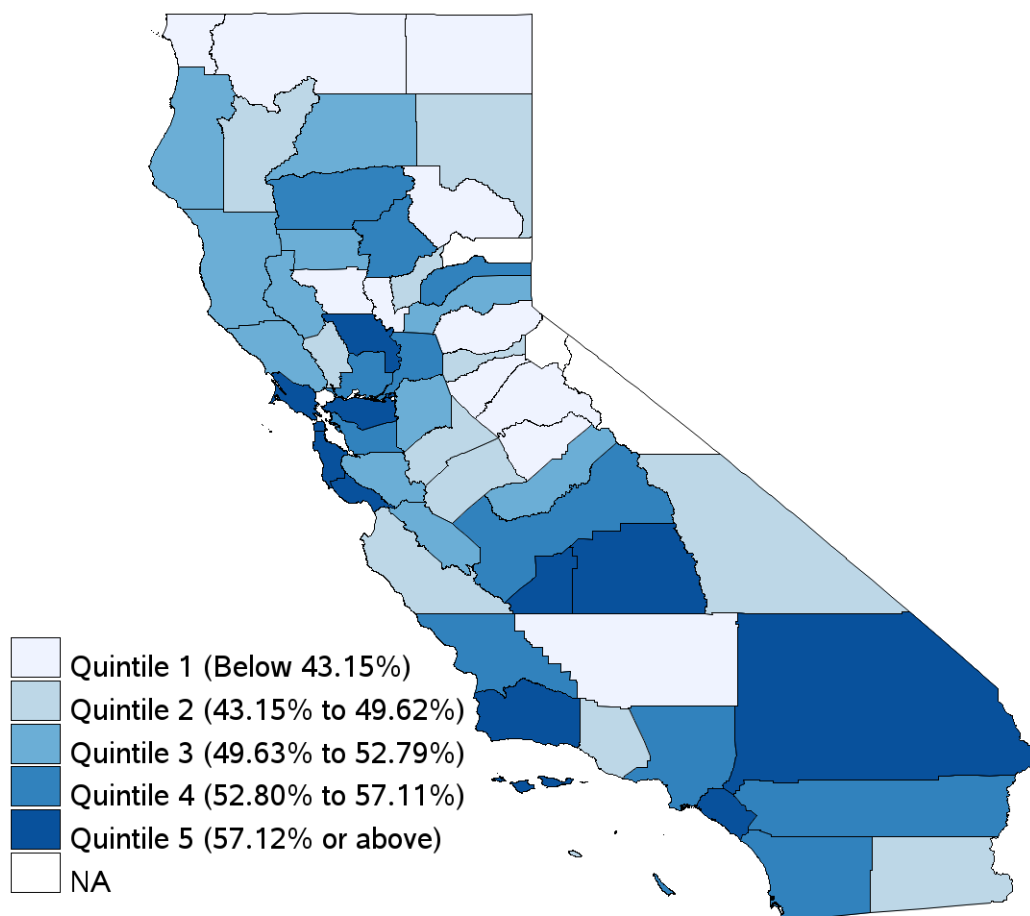
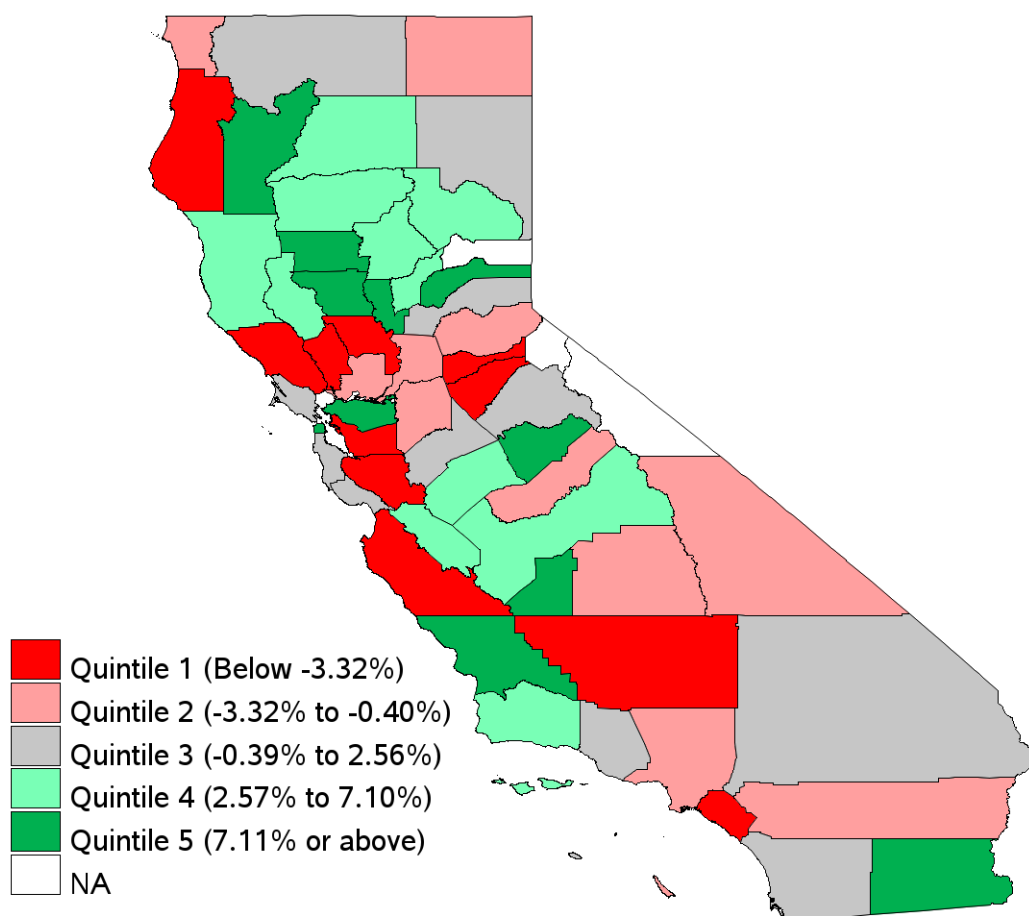


Figure 2.40—Chlamydia Screening in Women—Total (CHL)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for CHL—White



The following are the key findings for the *Chlamydia Screening in Women—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain region had low performance for the *Chlamydia Screening in Women—Total—White* indicator-racial/ethnic group combination.
 - Rates for 15 of 25 (60.0 percent) counties with reportable rates (Amador, Calaveras, Colusa, Del Norte, El Dorado, Inyo, Lassen, Mariposa, Modoc, Plumas, Siskiyou, Sutter, Trinity, Tuolumne, and Yuba) were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level by at least a 10 percent relative difference for current year performance. Of note, despite improving from measurement year 2021 to measurement year 2022, the rate for Plumas County was below the minimum performance level by more than a 40 percent relative difference.

- ◆ Counties in the Central Coast, San Francisco Bay/Sacramento, Southeastern, and Southern Coast regions had high performance for the *Chlamydia Screening in Women—Total*—White indicator-racial/ethnic group combination.
 - Rates for three of six (50.0 percent) counties (San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Two of these three (66.7 percent) counties (San Luis Obispo and Santa Barbara) in the Central Coast were in the top two quintiles for trending results.
 - Rates for seven of 10 (70.0 percent) counties (Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Mateo, and Solano) in the San Francisco Bay/Sacramento region were in the top two quintiles for current year performance. Two of these seven (28.6 percent) counties (Contra Costa and San Francisco) were in the top two quintiles for trending results.
 - Rates for two of three (66.7 percent) counties (Riverside and San Bernardino) in the Southeastern region were in the top two quintiles for current year performance. Of note, the rate for Imperial County improved from measurement year 2021 to measurement year 2022; however, the rate is still below the minimum performance level by a 10 percent relative difference.
 - Rates for all three counties (Los Angeles, Orange, and San Diego) in the Southern Coast region were in the top two quintiles for current year performance. Rates for two of three (66.7 percent) of these counties (Los Angeles and Orange) were in the bottom two quintiles for trending results.

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 7 and 84 days after delivery. Figure 2.41 through Figure 2.45 display the statewide racial/ethnic and applicable regional-level results for the *Prenatal and Postpartum Care—Postpartum Care* indicator in addition to identified health disparities.

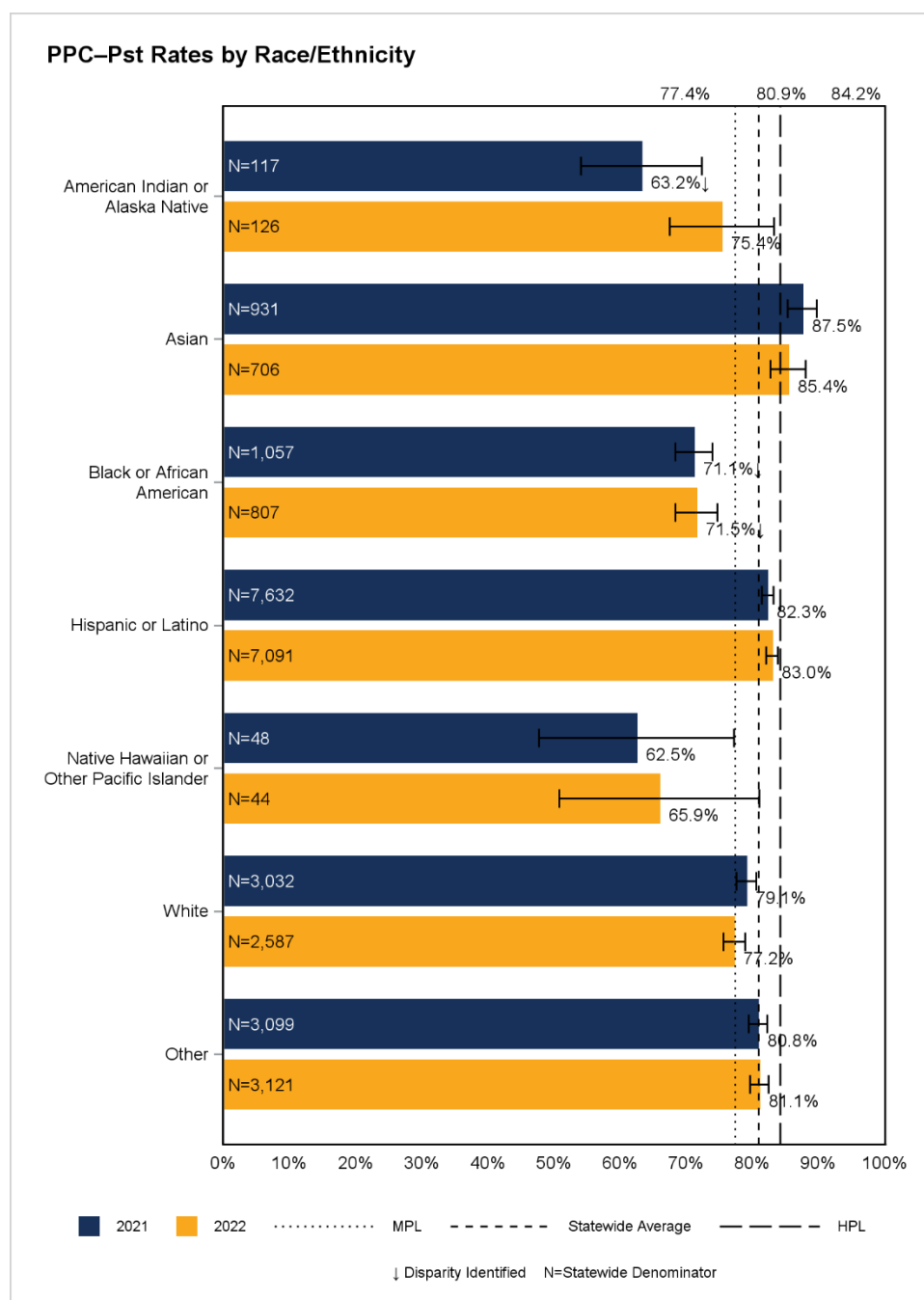
Figure 2.41—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 83.6 percent (N=409) and 81.9 percent (N=419), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.4 percent and 83.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 80.8 percent.



The following key findings were identified for the *Prenatal and Postpartum Care—Postpartum Care* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for one of seven (14.3 percent) racial/ethnic groups (Black or African American) had a persistent, worsening disparity identified, and no persistent disparities improved.
- ◆ While the American Indian or Alaska Native racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.

- ◆ While the White racial/ethnic group did not have a disparity identified in measurement year 2021 or measurement year 2022, the White racial/ethnic group is at risk of having a disparity emerge in measurement year 2023.
- ◆ No new, widespread, or large disparities were identified for the *Prenatal and Postpartum Care—Postpartum Care* indicator.

Figure 2.42—Prenatal and Postpartum Care—Postpartum Care (PPC-Pst)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for PPC-Pst—Black or African American

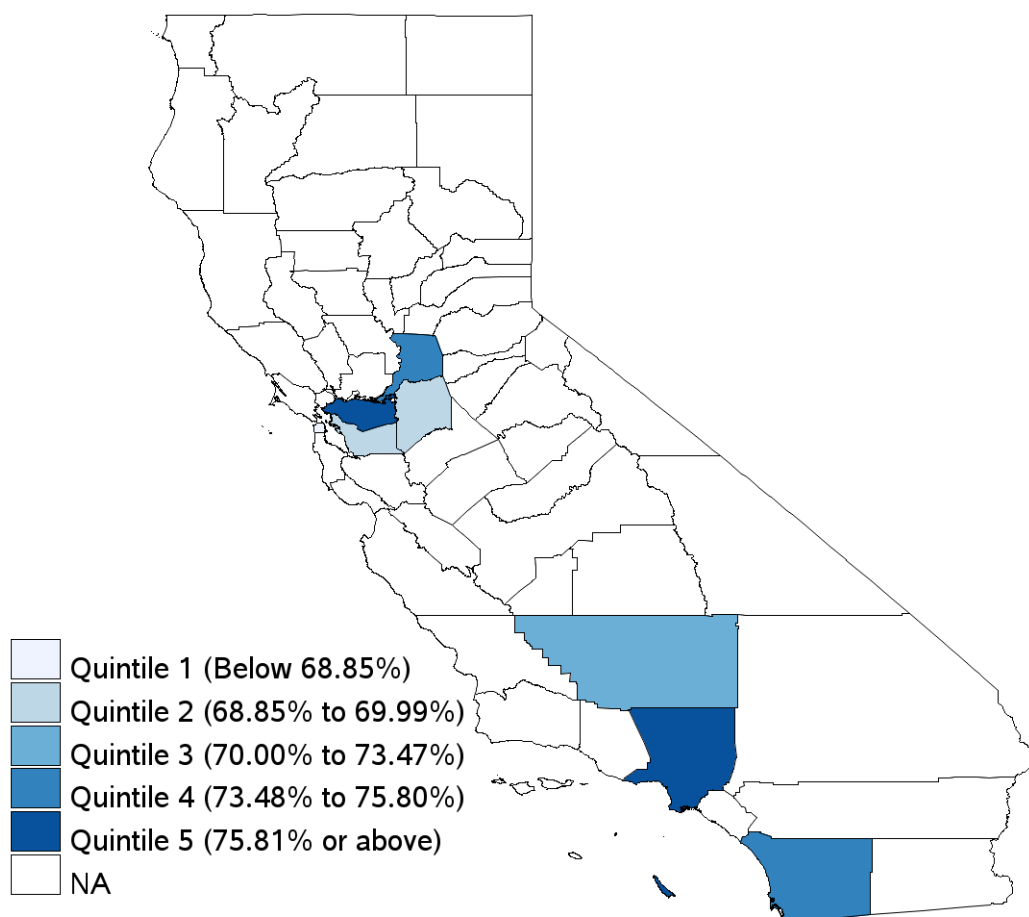
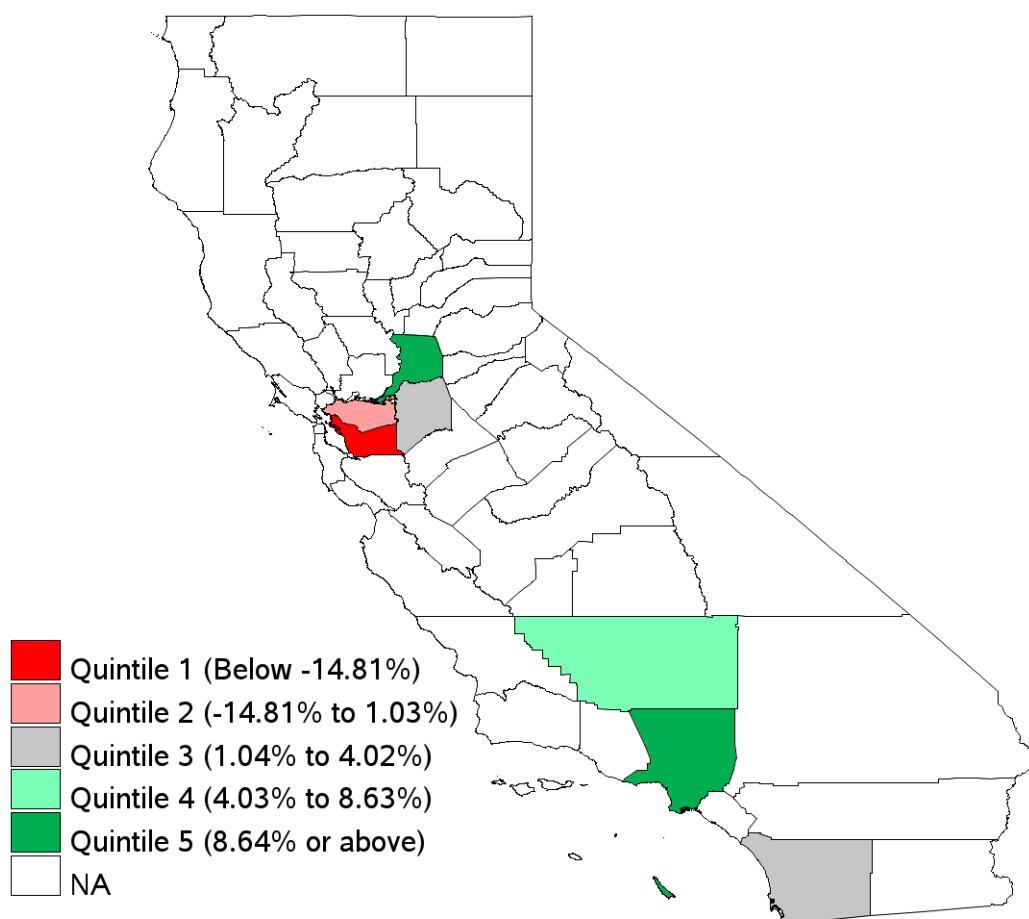


Figure 2.43—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for PPC-Pst—Black or African American



The following are the key findings for the *Prenatal and Postpartum Care—Postpartum Care—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Francisco Bay/Sacramento region had low performance for the *Prenatal and Postpartum Care—Postpartum Care—Black or African American* indicator-racial/ethnic group combination.
 - Two of four (50.0 percent) counties with reportable rates (Contra Costa and San Francisco) were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Of note, while the rate for Contra Costa County was in Quintile 5 for current year performance, the rate was in Quintile 2 for trending results.

- ◆ Counties in the Southern Coast region had high performance for the *Prenatal and Postpartum Care—Postpartum Care—Black or African American* indicator-racial/ethnic group combination.
 - Both counties with reportable rates (Los Angeles and San Diego) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Despite the high performance of these two counties, their rates did not meet the minimum performance level for measurement year 2022.

Figure 2.44—Prenatal and Postpartum Care—Postpartum Care (PPC-Pst)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for PPC-Pst—White

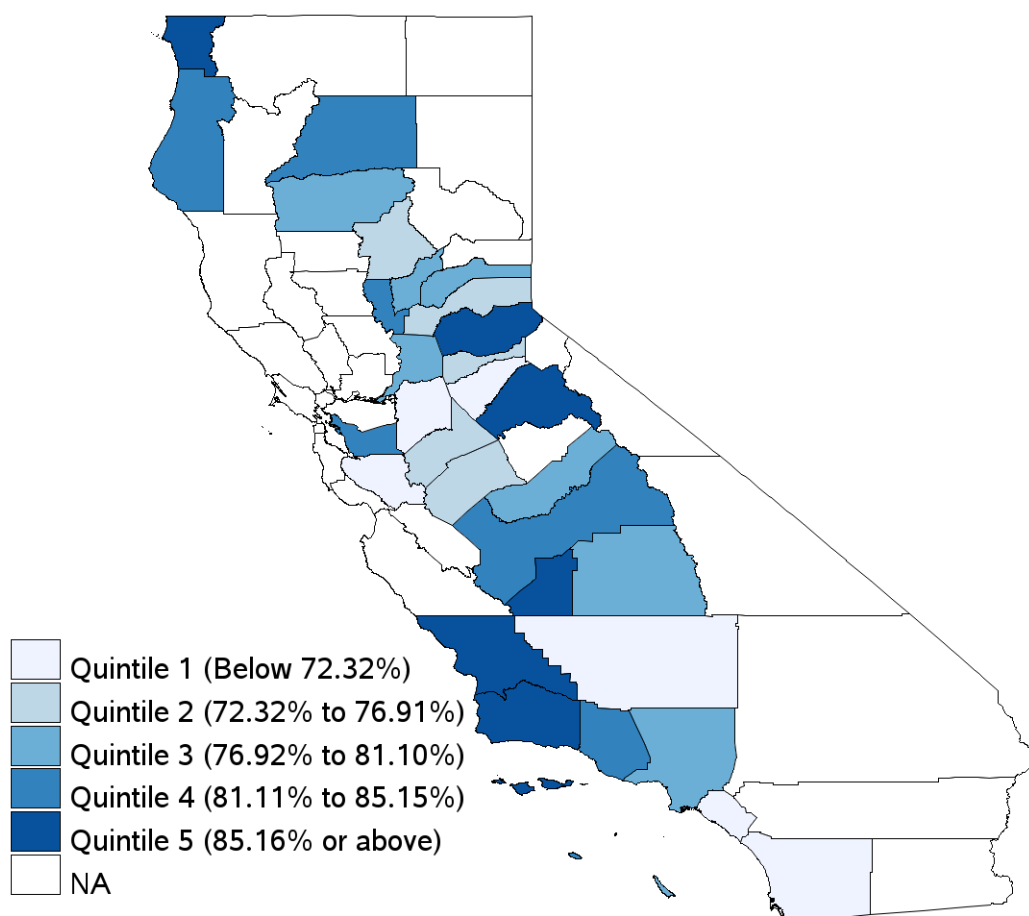
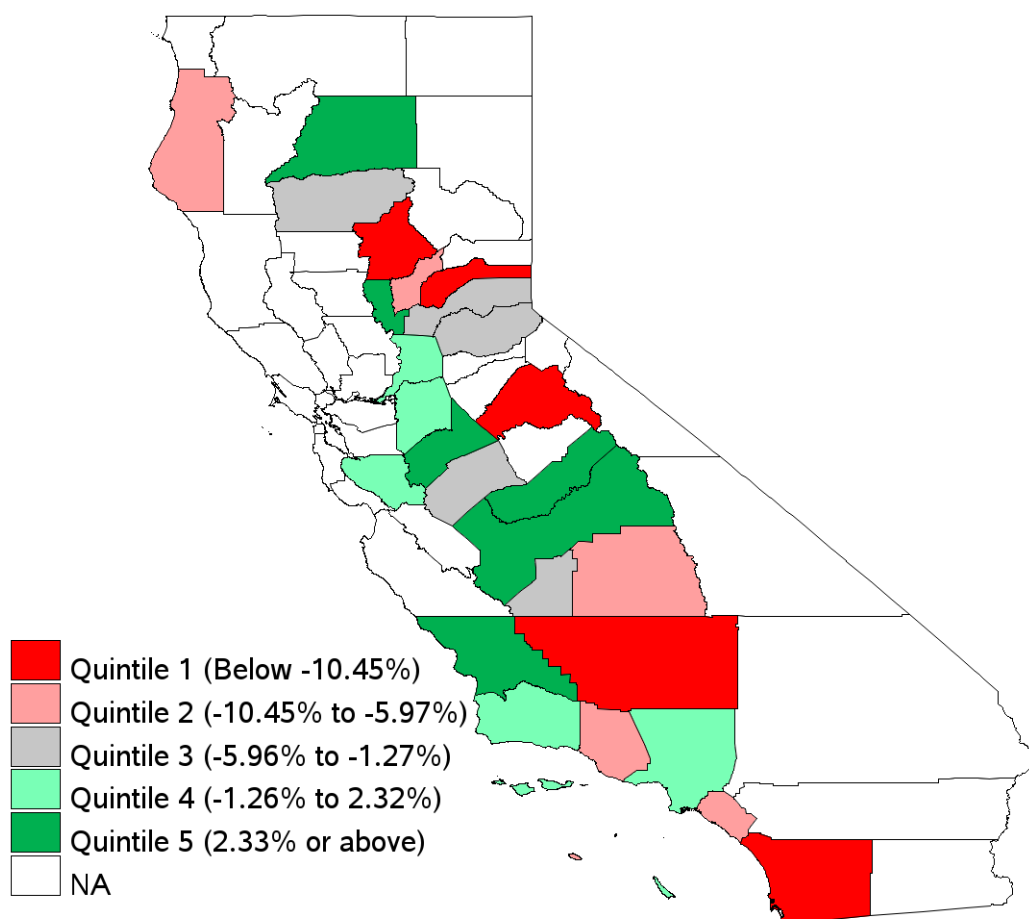


Figure 2.45—Prenatal and Postpartum Care—Postpartum Care (PPC-Pst)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for PPC-Pst—White



The following are the key findings for the *Prenatal and Postpartum Care—Postpartum Care—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southern Coast regions had low performance for the *Prenatal and Postpartum Care—Postpartum Care—White* indicator-racial/ethnic group combination.
 - Rates for four of eight (50.0 percent) counties (Kern, Merced, San Joaquin, and Stanislaus) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Two of these four (50.0 percent) counties (San Joaquin and Stanislaus) were in the top two quintiles (i.e., Quintiles 4 and 5) for trending results. Of note, the rate for Kern County was below the minimum performance level by more than a 20 percent relative difference.

- Rates for two of three (66.7 percent) counties (Orange and San Diego) in the Southern Coast region were in Quintile 1 for current year performance and were in the bottom two quintiles for trending results. Of note, the rate for San Diego County declined by more than a 20 percent relative difference from measurement year 2021 to measurement year 2022.
- ◆ Counties in the Central Coast region had high performance for the *Prenatal and Postpartum Care—Postpartum Care—White indicator-racial/ethnic group combination*.
 - All three counties with reportable rates (San Luis Obispo, Santa Barbara, and Ventura) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Two of these three (66.7 percent) counties (San Luis Obispo and Santa Barbara) were also in the top two quintiles for trending results. Of note, the rate for Santa Barbara County was above the minimum performance level by more than a 20 percent relative difference.

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 2.46 through Figure 2.48 display the statewide racial/ethnic and applicable regional-level results for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator in addition to identified health disparities.

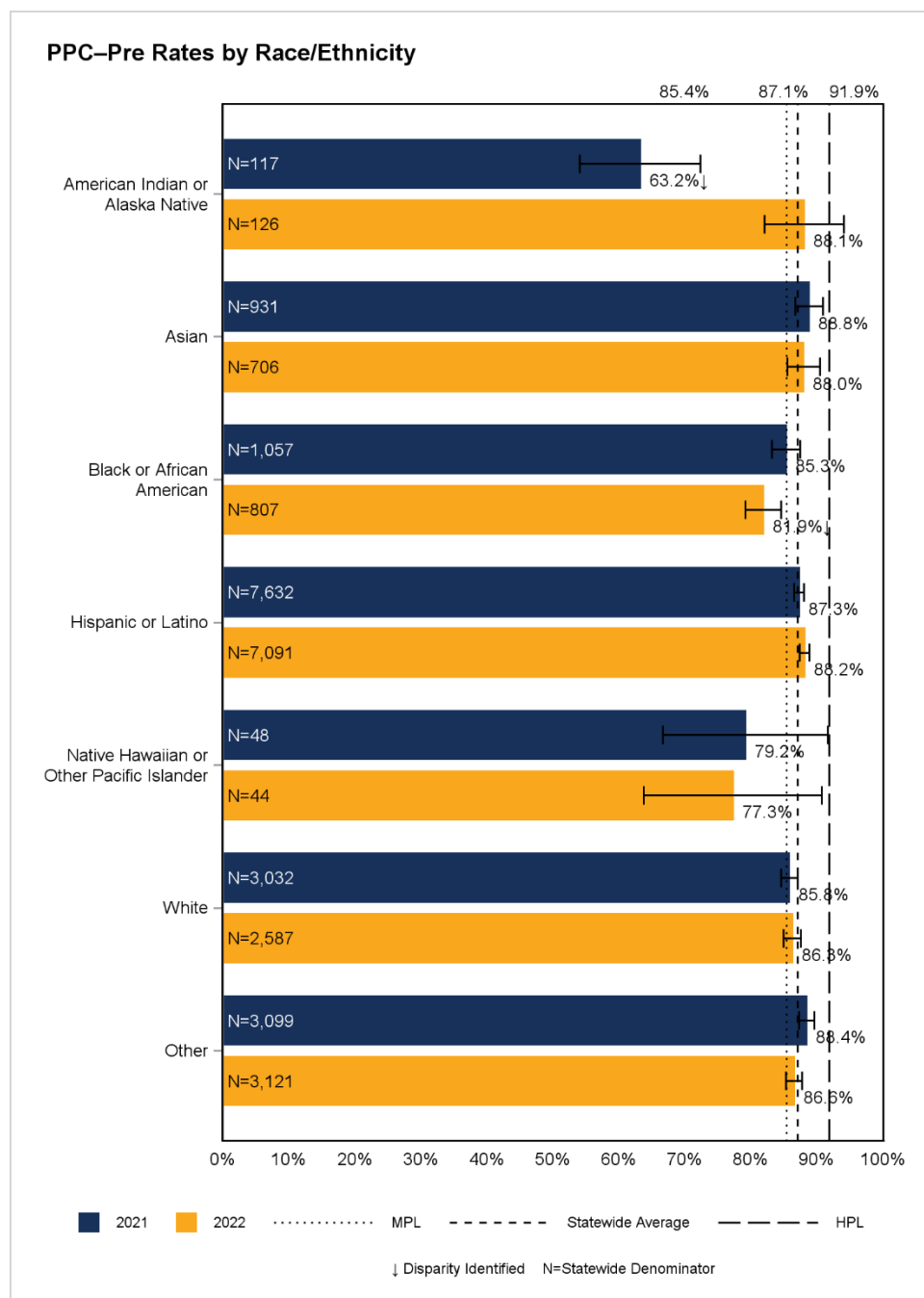
Figure 2.46—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 89.5 percent (N=409) and 88.5 percent (N=419), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 85.9 percent and 92.2 percent, respectively.

The statewide aggregate for measurement year 2021 was 87.1 percent.



The following key findings were identified for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator:

- ◆ One of seven (14.3 percent) racial/ethnic group rates (Black or African American) had a new disparity identified in measurement year 2022.
- ◆ While the American Indian or Alaska Native racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.

- ◆ No persistent, widespread, large, or emerging disparities were identified for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator.

Figure 2.47—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC-Pre)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for PPC-Pre—Black or African American

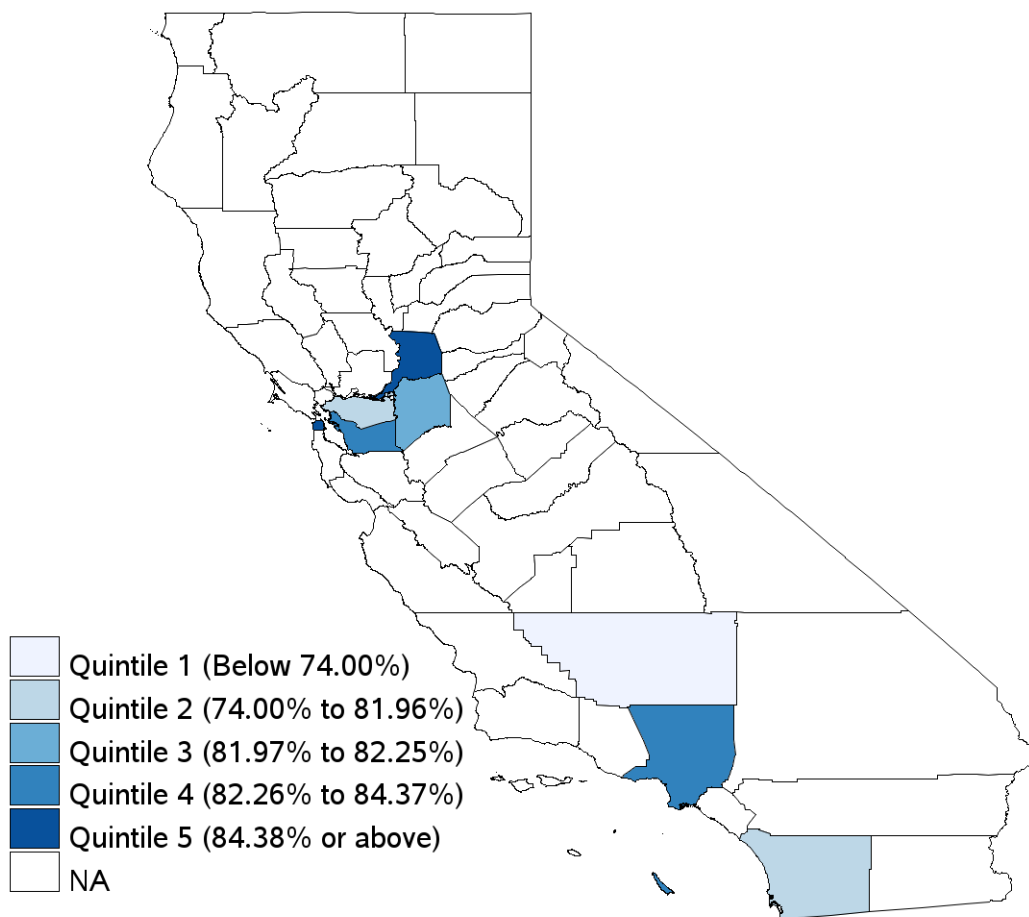
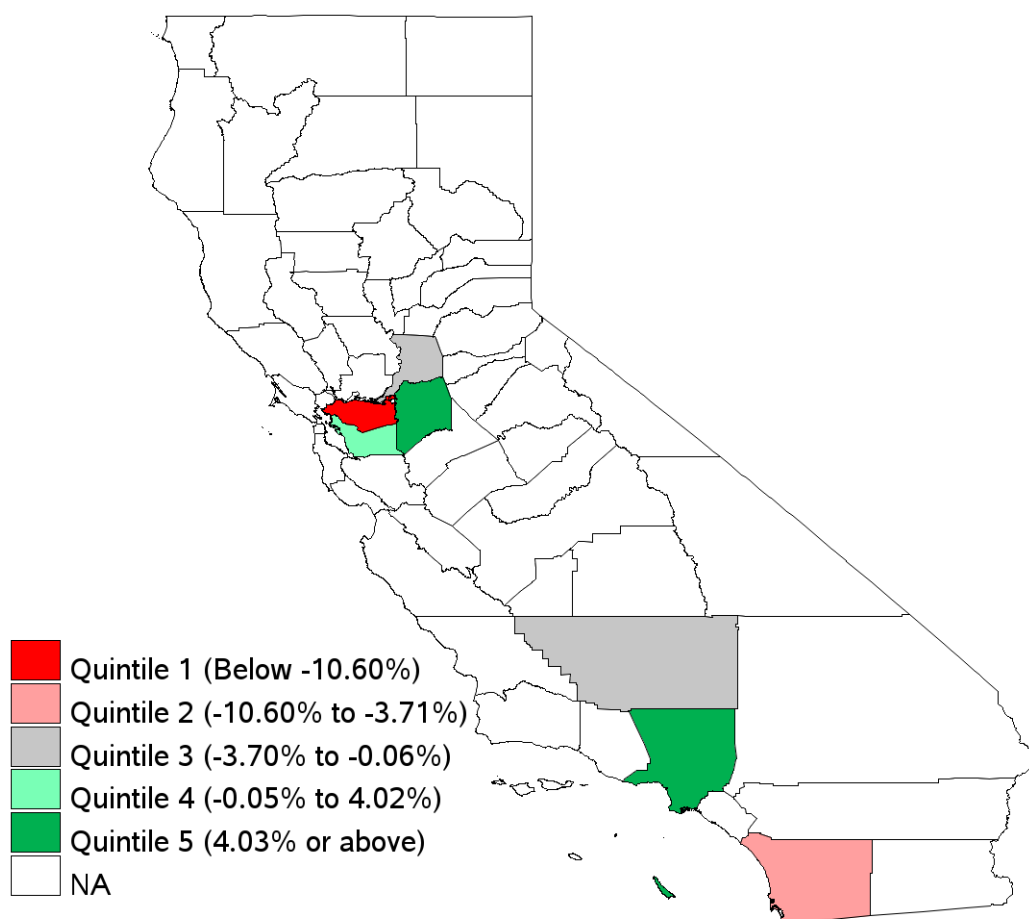


Figure 2.48—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC-Pre)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for PPC-Pre—Black or African American



The following are the key findings for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southern Coast regions had low performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care—Black or African American* indicator-racial/ethnic group combination.
 - The rate for one of the two (50.0 percent) counties with reportable rates (Kern) in the San Joaquin Valley region was in Quintile 1 for current year performance. The rate for Kern County declined from measurement year 2021 to measurement year 2022 and was below the minimum performance level by more than a 15 percent relative difference.

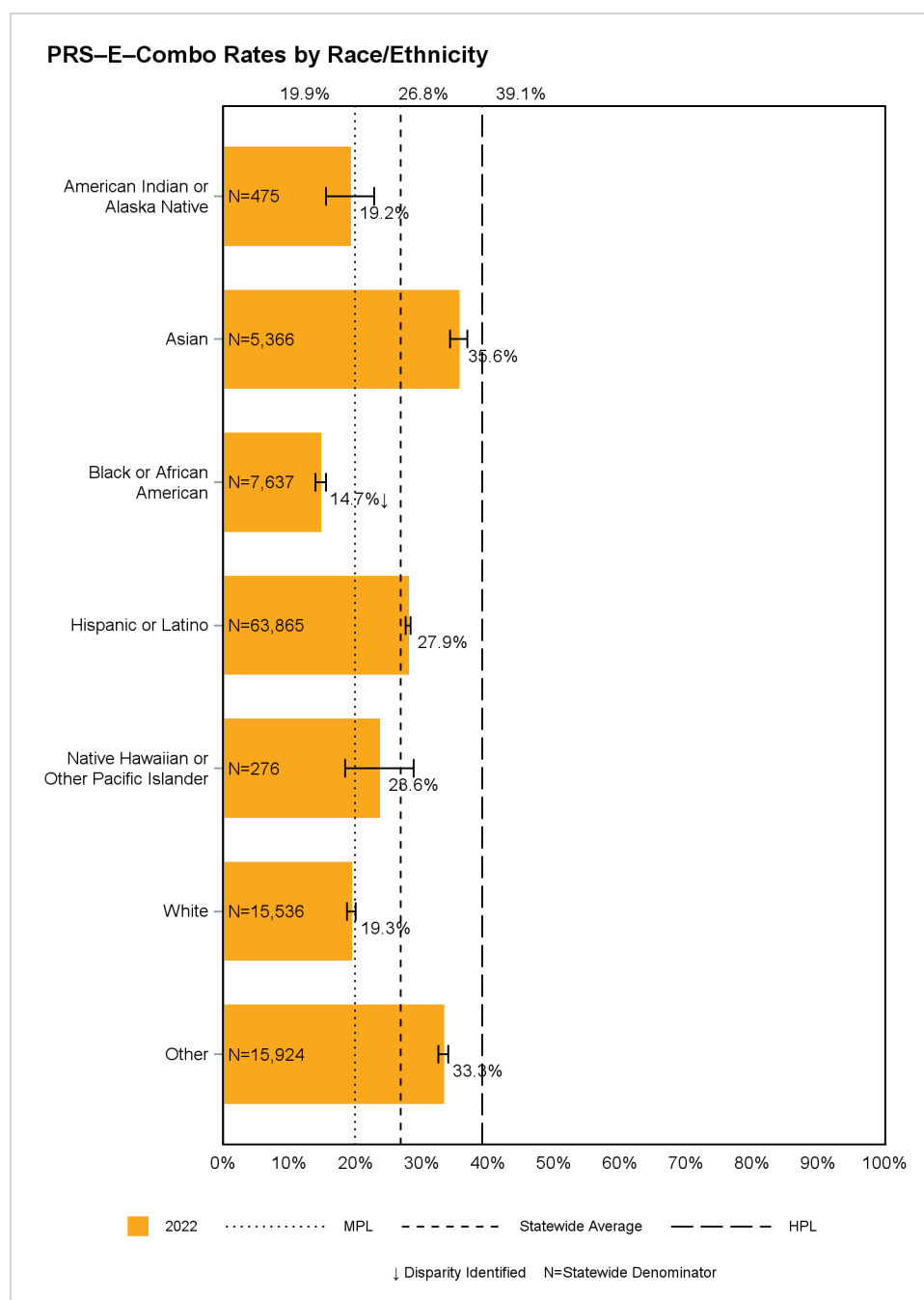
- The rate for one of the two (50.0 percent) counties with reportable rates (San Diego) in the Southern Coast region was in Quintile 2 for both current year performance and trending results. Of note, the rate for San Diego County declined by more than a 10 percent relative difference from measurement year 2021 to measurement year 2022.
- ◆ Counties in the San Francisco Bay/Sacramento region had high performance for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care—Black or African American* indicator-racial/ethnic group combination.
 - Rates for three of four (75.0 percent) counties with reportable rates (Alameda, Sacramento, and San Francisco) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Of note, despite declining from measurement year 2021 to measurement year 2022, the rate for Sacramento County was the only rate to meet the minimum performance level for this indicator-racial/ethnic group combination in measurement year 2022.

Prenatal Immunization Status—Combination (PRS–E–Combo)

The *Prenatal Immunization Status—Combination (PRS–E–Combo)* indicator measures the percentage of deliveries in the measurement year in which women received influenza and Tdap vaccinations. Figure 2.49 and Figure 2.50 display the statewide racial/ethnic and applicable regional-level results for the *Prenatal Immunization Status—Combination (PRS–E–Combo)* indicator in addition to identified health disparities.

Figure 2.49—Prenatal Immunization Status—Combination (Influenza and Tdap) (PRS–E–Combo) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 25.7 percent (N=3,548).



The following key findings were identified for the *Prenatal Immunization Status—Combination* indicator:

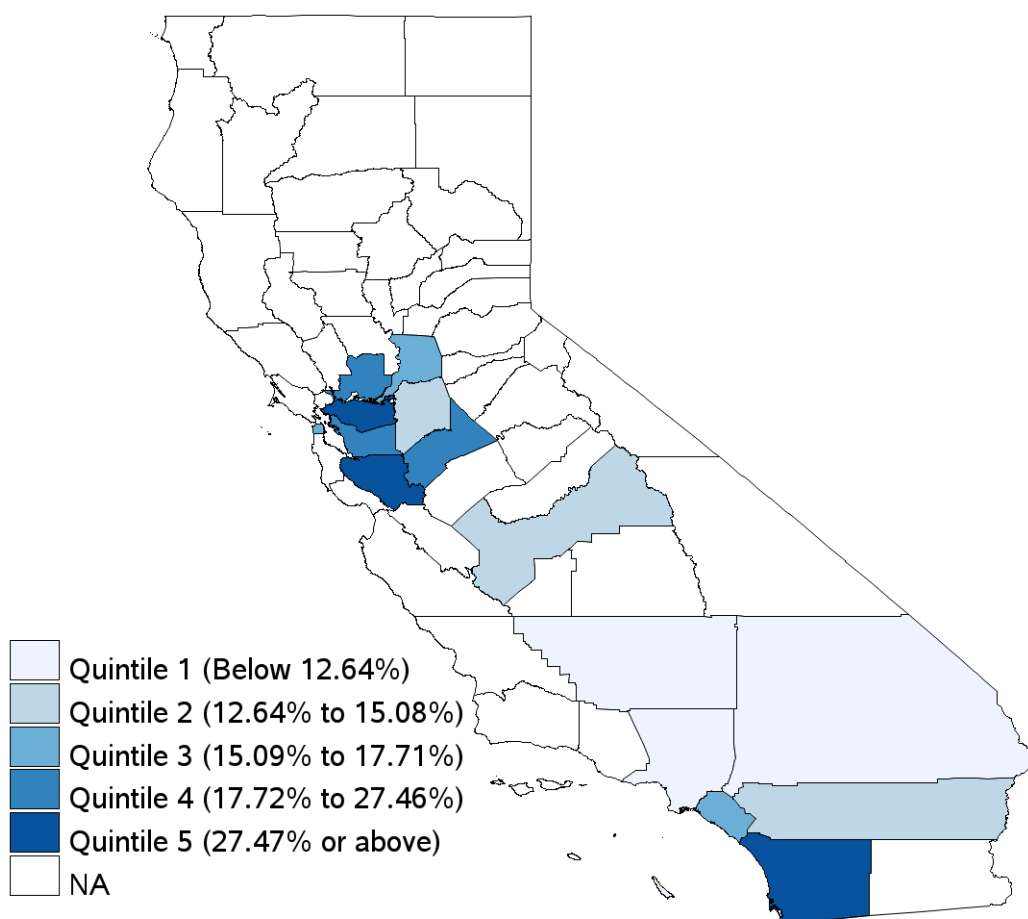
- ◆ As this indicator was new for measurement year 2022, all disparities identified were considered new. One of seven (14.3 percent) racial/ethnic groups (Black or African American) had a new, large disparity identified in measurement year 2022.
- ◆ No widespread or emerging disparities were identified for the *Prenatal Immunization Status—Combination* indicator.

Figure 2.50—Prenatal Immunization Status—Combination (PRS–E–Combo)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for PRS–E–Combo—Black or African American



The following are the key findings for the *Prenatal Immunization Status—Combination—Black or African American* indicator-racial/ethnic group combination regional analysis:

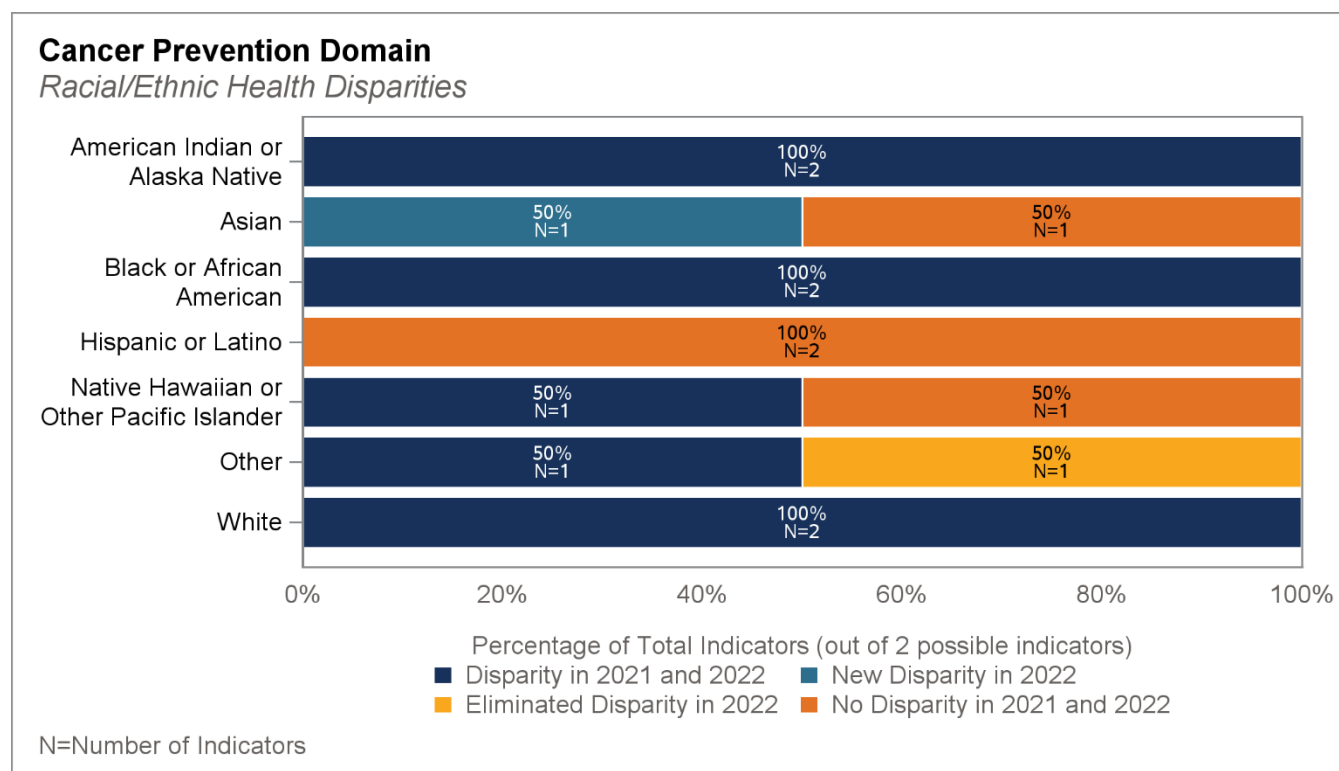
- ◆ Counties in the San Joaquin Valley and Southeastern regions had low performance for the *Prenatal Immunization Status—Combination—Black or African American* indicator-racial/ethnic group combination.
 - Rates for three of four (75.0 percent) counties with reportable rates (Fresno, Kern, and San Joaquin) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2). Of note, the rate for Kern County was below the minimum performance level by more than a 55 percent relative difference.

- Both counties with reportable rates (Riverside and San Bernardino) in the Southeastern region were in the bottom two quintiles. Of note, the rate for San Bernardino County was below the minimum performance level by more than a 65 percent relative difference.
- ◆ Counties in the San Francisco Bay/Sacramento region had high performance for the *Prenatal Immunization Status—Combination—Black or African American* indicator-racial/ethnic group combination.
 - Rates for four of six (66.7 percent) counties with reportable rates (Alameda, Contra Costa, Santa Clara, and Solano) were in the top two quintiles (i.e., Quintiles 4 and 5). Of note, the rates for Contra Costa, Santa Clara, and Solano counties exceeded the minimum performance level by more than a 30 percent relative difference.

Racial/Ethnic Health Disparities: Cancer Prevention Domain

Health disparities were identified when indicator rates for racial/ethnic groups were below the minimum performance level/median state performance rate (i.e., the upper bound of the 95 percent confidence interval for the rate was below the national reference rate). If a racial/ethnic group's indicator rate was equal to or higher than the minimum performance level/median state performance rate, then no health disparity was identified.

Figure 2.51 displays the percentage and number of Cancer Prevention domain indicators (out of two possible indicators) for which disparities were identified or were not identified for each racial/ethnic group in addition to newly identified and eliminated disparities within the Cancer Prevention domain.

Figure 2.51—Racial/Ethnic Health Disparities Summary: Cancer Prevention Domain

The following key findings were identified for the Cancer Prevention domain:

- ◆ The following persistent disparities improved from measurement year 2021 to measurement year 2022:
 - **Breast Cancer Screening—Total** indicator rates for four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had a persistent, improving disparity identified.
 - **Cervical Cancer Screening** indicator rates for one of seven (14.3 percent) racial/ethnic groups (White) had a persistent, improving disparity identified.
- ◆ The following persistent disparities worsened from measurement year 2021 to measurement year 2022:
 - **Cervical Cancer Screening** indicator rates for three of seven (42.6 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and Other) had a persistent, worsening disparity identified.
- ◆ A new disparity was identified for one indicator in the Cancer Prevention domain:
 - **Cervical Cancer Screening** indicator rates for one of seven (14.3 percent) racial/ethnic groups (Asian) had a new disparity identified.

- ◆ An eliminated disparity was identified for one indicator in the Cancer Prevention domain:
 - *Breast Cancer Screening—Total* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Other) had an eliminated disparity identified.
- ◆ Widespread disparities were identified for both measures in the Cancer Prevention domain.
 - For measurement year 2022, *Breast Cancer Screening—Total* and *Cervical Cancer Screening* indicator rates for three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and White) had disparities identified.
- ◆ Large disparities were identified for both indicators in the Cancer Prevention domain:
 - The *Breast Cancer Screening—Total* indicator rates for two of seven (28.6 percent) racial/ethnic groups (American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander) had large disparities identified for both measurement years 2021 and 2022.
 - The *Cervical Cancer Screening* indicator rates for two of seven (28.6 percent) racial/ethnic groups (American Indian or Alaska Native and White) had large disparities identified for both measurement years 2021 and 2022.
- ◆ No emerging disparities were identified for the Cancer Prevention domain.

Racial/Ethnic Health Disparities: Cancer Prevention Domain Key Findings

For the indicators in the Cancer Prevention domain, there are no corresponding Bold Goals. Based on evaluating the results of the key findings above, the following indicators were determined to be key findings for the Cancer Prevention domain:

- ◆ *Breast Cancer Screening—Total (BCS)*
- ◆ *Cervical Cancer Screening (CCS)*

Please note, the results for the *Colorectal Cancer Screening—Total* indicator were not considered to be a key finding given that benchmarks were unavailable and disparities could not be identified. Please refer to Appendix C. Demographic Stratification Results for the racial/ethnic rates for this indicator.

Racial/Ethnic Health Disparities: Cancer Prevention Domain Indicator Results

Figure 2.52 through Figure 2.65 display the racial/ethnic health disparities and applicable regional results for indicators with results determined to be key findings in the Cancer Prevention domain. For each figure, the denominator, rate, and confidence interval for each racial/ethnic group are displayed. A downward arrow is displayed when a disparity is identified. Additionally, the measurement year 2022 statewide average, high performance level, where applicable, and minimum performance level/median state performance rate, where applicable, are displayed as rates on top of the figure and as dotted lines in the figure.

Breast Cancer Screening—Total (BCS)

The *Breast Cancer Screening—Total (BCS)* indicator measures the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer. Figure 2.52 through Figure 2.58 display the statewide racial/ethnic and applicable regional-level results for the *Breast Cancer Screening—Total (BCS)* indicator in addition to identified health disparities.

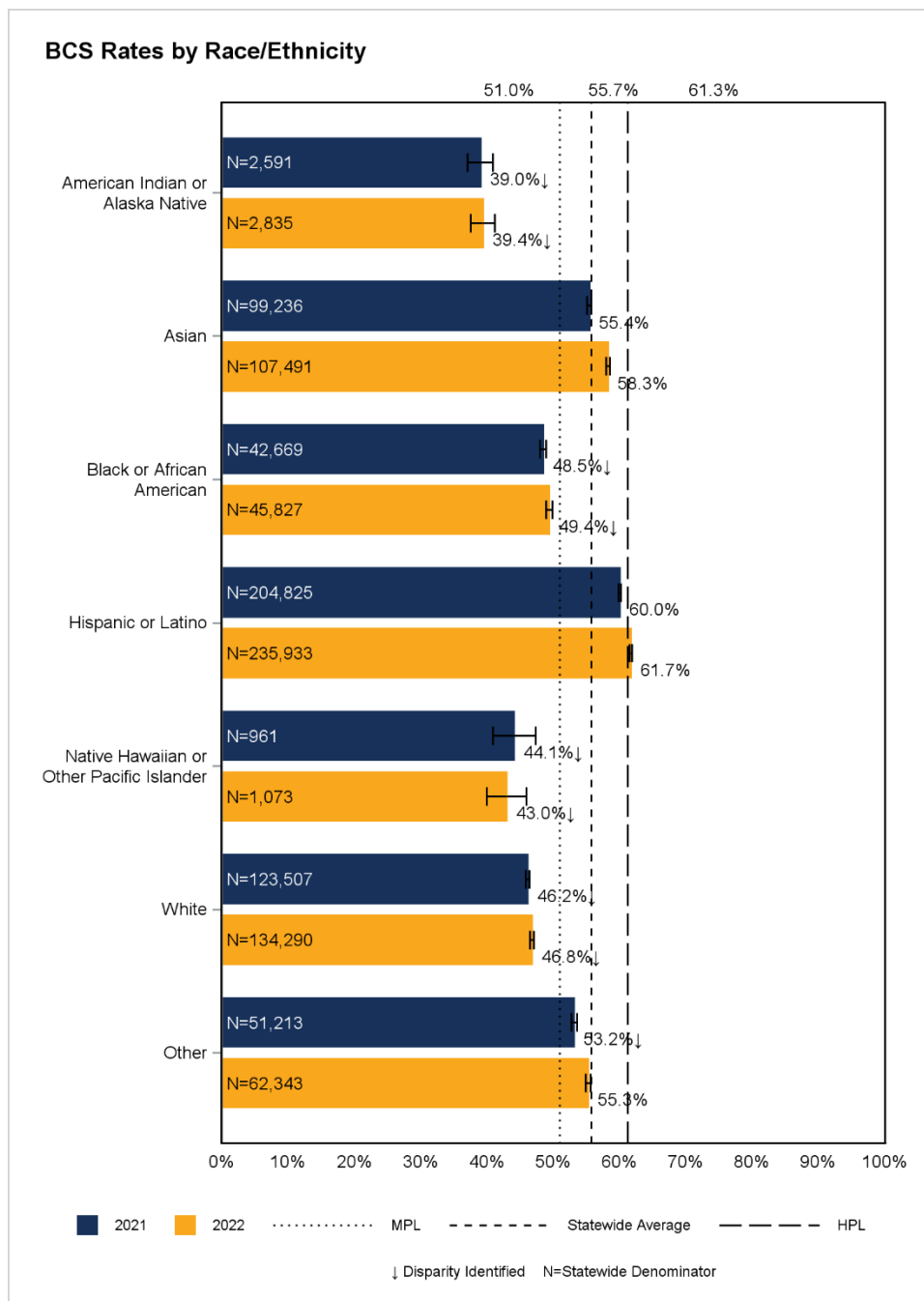
Figure 2.52—Breast Cancer Screening—Total (BCS) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 49.9 percent (N=21,325) and 51.2 percent (N=24,324), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.9 percent and 63.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 54.0 percent.



The following key findings were identified for the *Breast Cancer Screening—Total* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) had a persistent, improving disparity identified, and no disparities worsened.

- ◆ Widespread disparities were identified, with four of seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Native Hawaiian or Other Pacific Islander, and White) having disparities identified for measurement year 2022.
- ◆ Two of seven (28.6 percent) racial/ethnic group rates (American Indian or Alaska Native and Native Hawaiian or Other Pacific Islander) had large disparities identified for measurement years 2021 and 2022.
- ◆ While the Other racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.
- ◆ No new or emerging disparities were identified for the *Breast Cancer Screening—Total* indicator.

Figure 2.53—Breast Cancer Screening—Total (BCS)—American Indian or Alaska Native—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for BCS—American Indian or Alaska Native

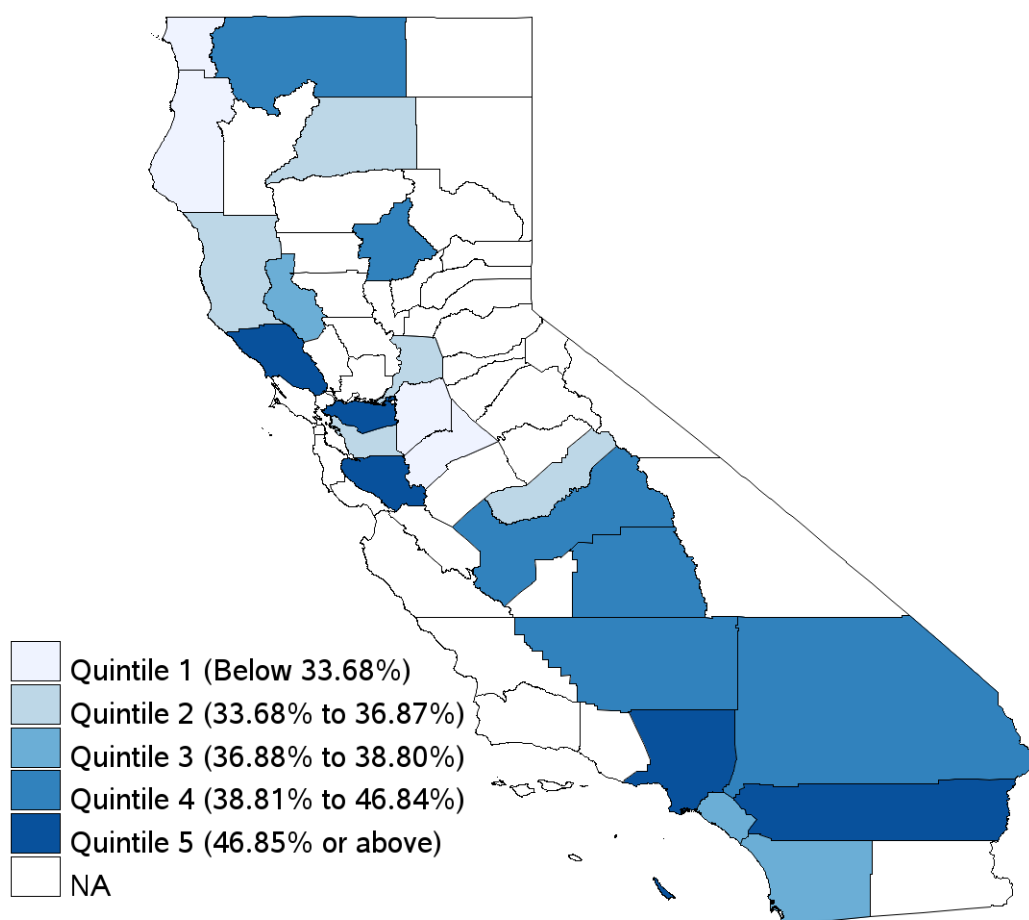
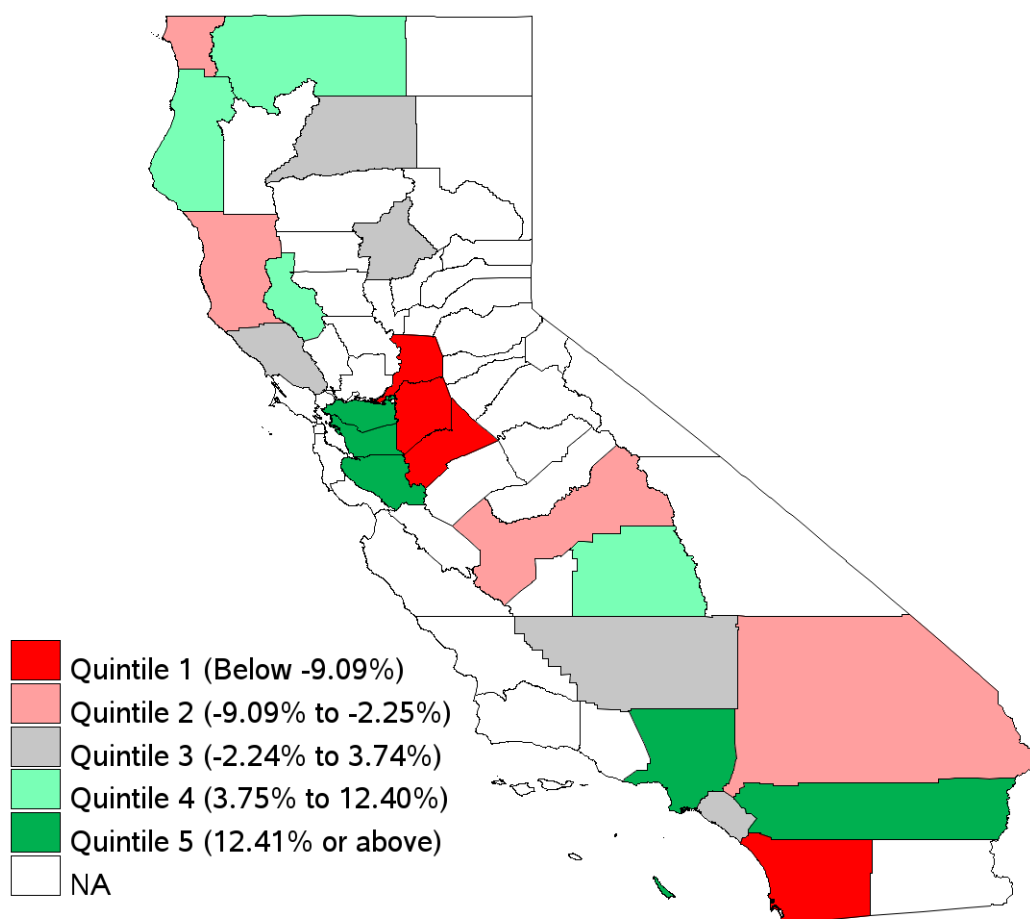


Figure 2.54—Breast Cancer Screening—Total (BCS)—American Indian or Alaska Native—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for BCS—American Indian or Alaska Native



The following are the key findings for the *Breast Cancer Screening—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain region had low performance for the *Breast Cancer Screening—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.
 - Rates for four of seven (57.1 percent) counties (Del Norte, Humboldt, Mendocino, and Shasta) were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Of note, all seven counties were below the minimum performance level by more than a 20 percent relative difference.

- ◆ Counties in the San Francisco Bay/Sacramento and Southeastern regions had high performance for the *Breast Cancer Screening—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (Contra Costa, Santa Clara, and Sonoma) in the San Francisco Bay/Sacramento region were in Quintile 5 for current year performance. Two of these three (66.7 percent) counties (Contra Costa and Santa Clara) were in Quintile 5 for trending results. Of note, the rate for Contra Costa County was the only rate to meet the minimum performance level for the *Breast Cancer Screening—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.
 - Both counties with reportable rates (Riverside and San Bernardino) in the Southeastern region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Despite this, the rates for these counties did not meet the minimum performance level for measurement year 2022.

Figure 2.55—Breast Cancer Screening—Total (BCS)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for BCS—Black or African American

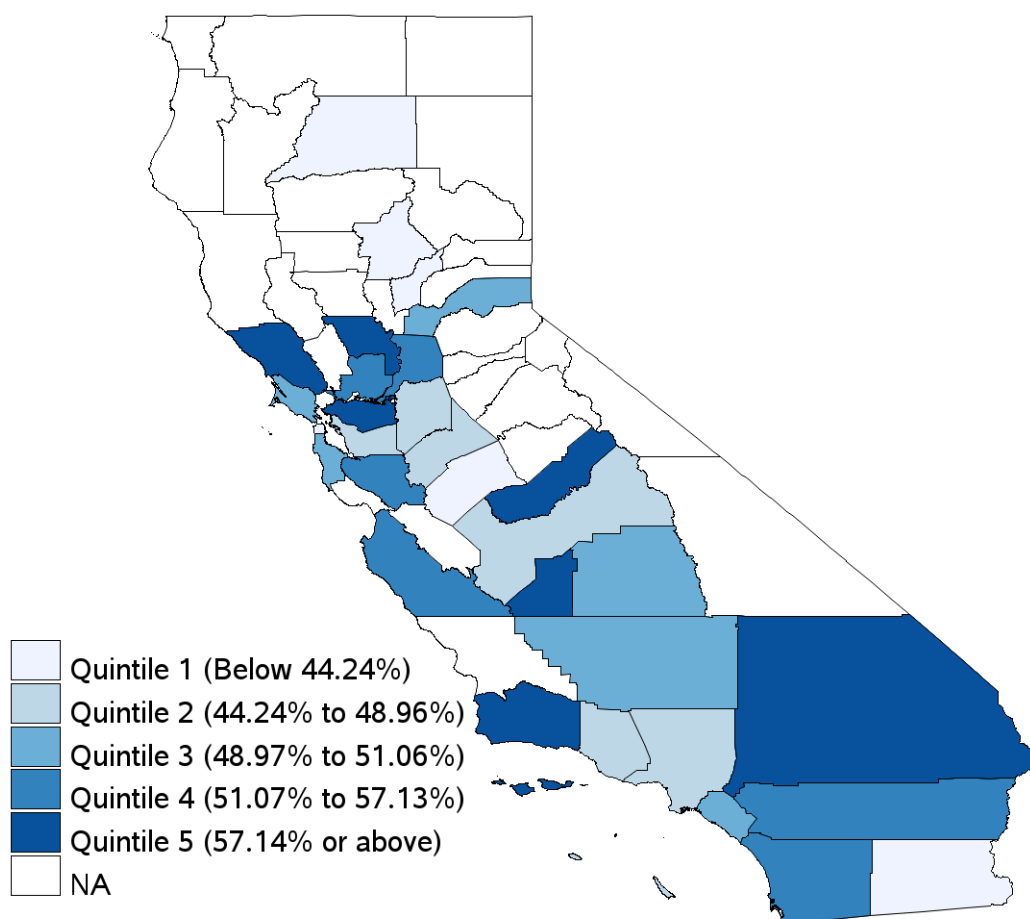
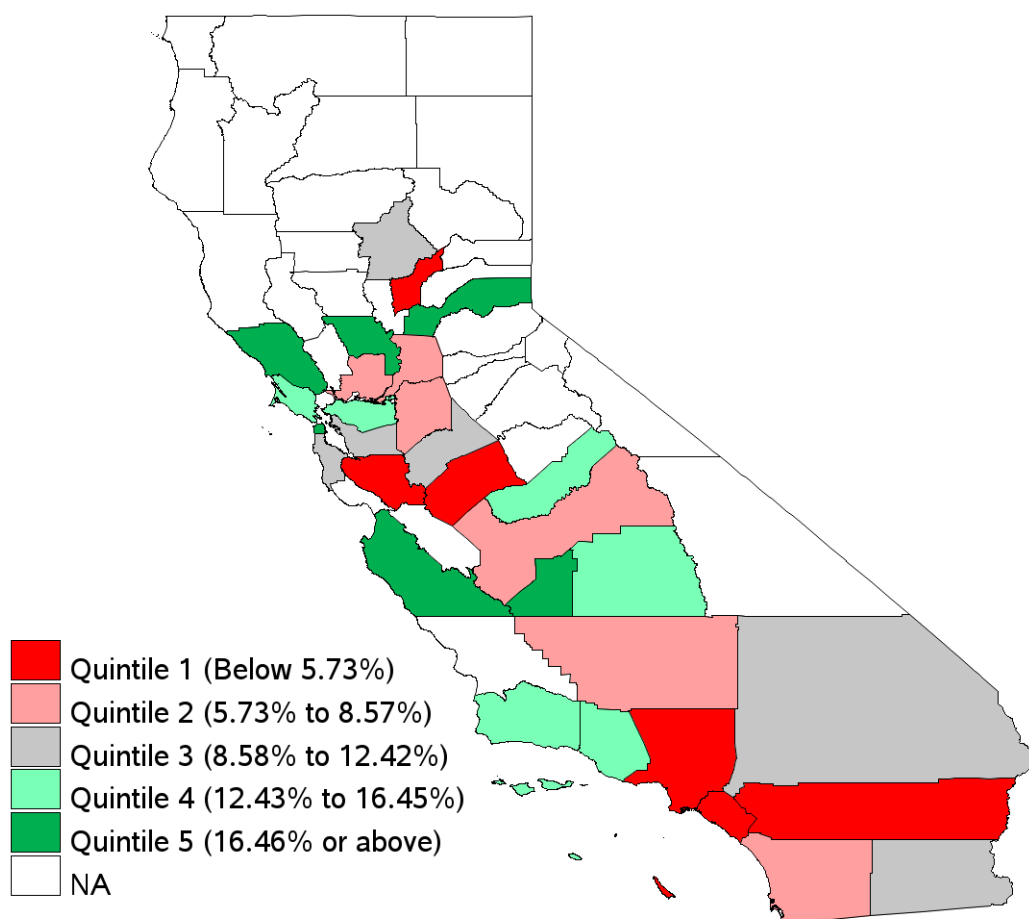


Figure 2.56—Breast Cancer Screening—Total (BCS)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for BCS—Black or African American



The following are the key findings for the *Breast Cancer Screening—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain and San Joaquin Valley regions had low performance for the *Breast Cancer Screening—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (Butte, Shasta, and Yuba) in the North/Mountain region were in Quintile 1 for current year performance and were below the minimum performance level by at least a 15 percent relative difference.
 - Rates for four of eight (50.0 percent) counties (Fresno, Merced, San Joaquin, and Stanislaus) in the San Joaquin Valley region were in the bottom two quintiles (i.e.,

Quintiles 1 and 2) for current year performance. Three of these four (75.0 percent) counties (Fresno, Merced, and San Joaquin) were in the bottom two quintiles for trending results. Of note, the rate for Merced County was below the minimum performance level by more than a 20 percent relative difference.

- ◆ Counties in the Central Coast, San Francisco Bay/Sacramento, and Southeastern regions had high performance for the *Breast Cancer Screening—Total*—Black or African American indicator-racial/ethnic group combination.
 - Rates for two of three (66.7 percent) counties with reportable rates (Monterey and Santa Barbara) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance and trending results.
 - Rates for five of nine (55.6 percent) counties with reportable rates (Contra Costa, Sacramento, Santa Clara, Solano, and Sonoma) in the San Francisco Bay/Sacramento region were in the top two quintiles for current year performance.
 - Rates for two of three (66.7 percent) counties (Riverside and San Bernardino) in the Southeastern region were in the top two quintiles for current year performance.

Figure 2.57—Breast Cancer Screening—Total (BCS)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

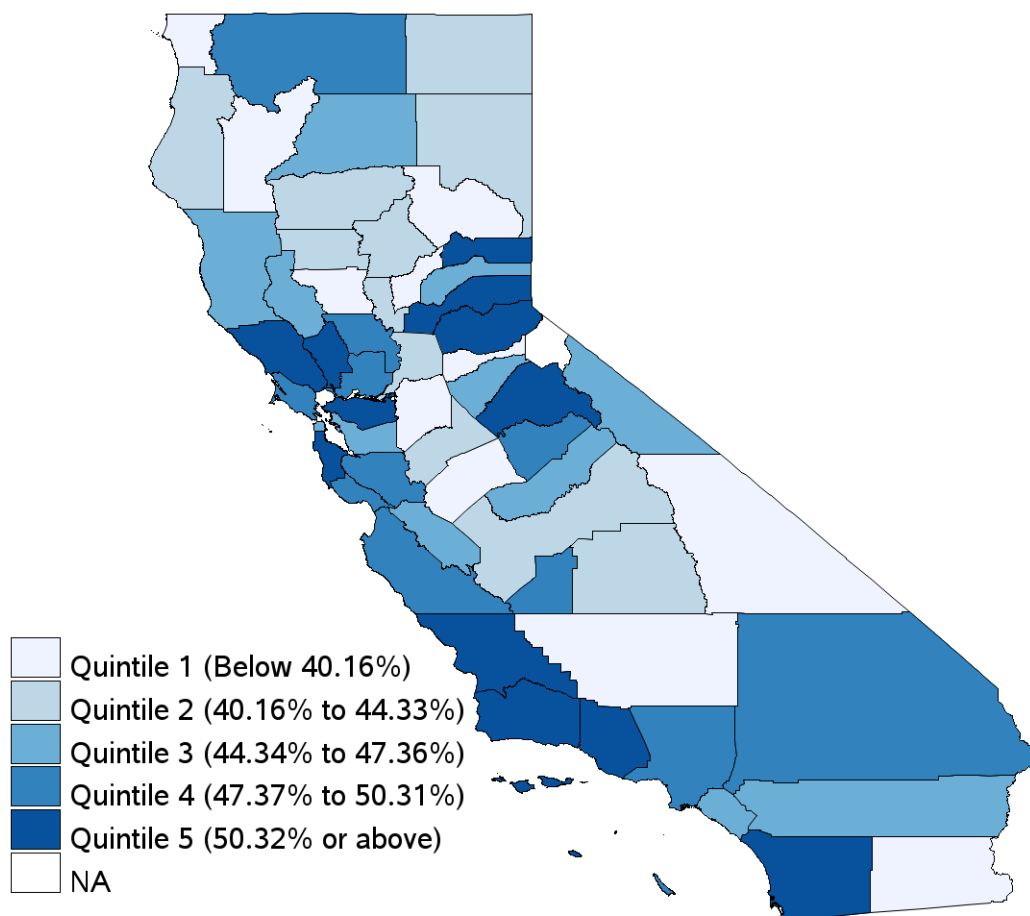
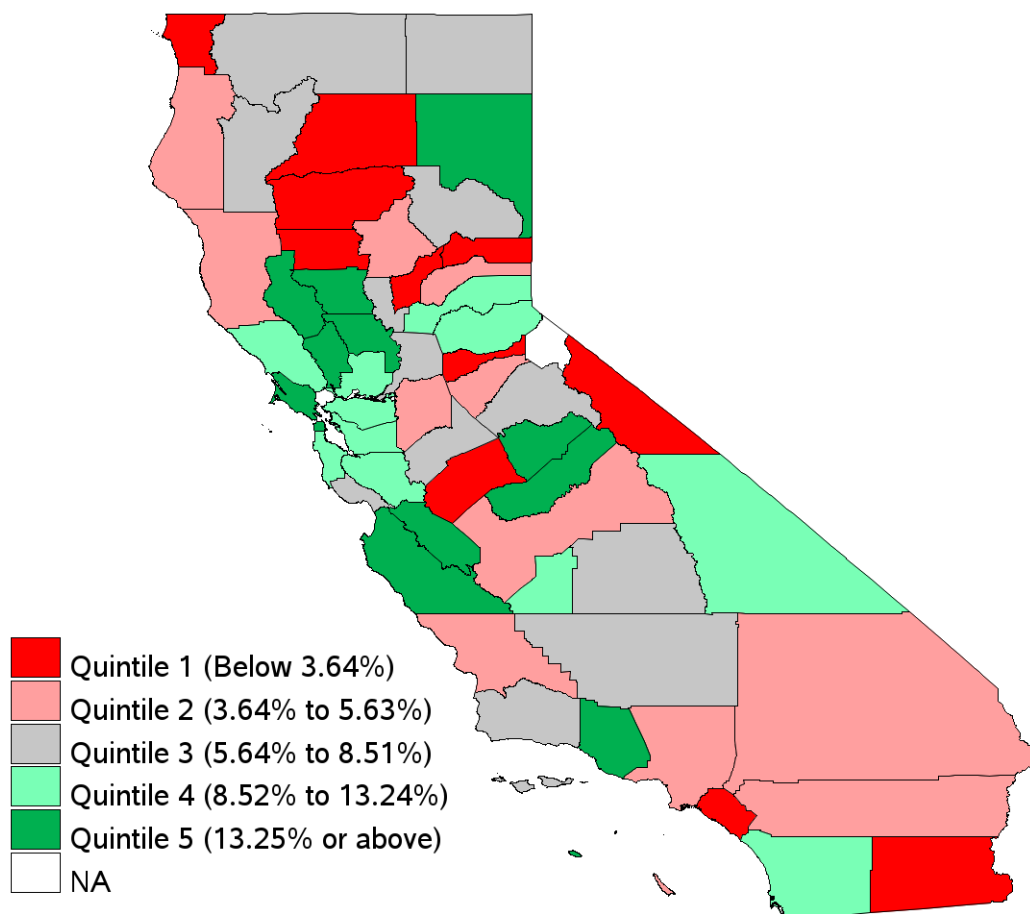
Current Rates by County for BCS—White

Figure 2.58—Breast Cancer Screening—Total (BCS)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for BCS—White



The following are the key findings for the *Breast Cancer Screening—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain and San Joaquin Valley regions had low performance for the *Breast Cancer Screening—Total—White* indicator-racial/ethnic group combination.
 - Rates for 14 of 27 (51.9 percent) counties with reportable rates (Amador, Butte, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lassen, Modoc, Plumas, Sutter, Tehama, Trinity, and Yuba) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance and were below the minimum performance level by at least a 15 percent relative difference. Seven of these 14 (50.0 percent) counties (Amador, Butte, Del Norte, Glenn, Humboldt, Tehama, and Yuba) were in the bottom two quintiles for trending results.

- Rates for six of eight (75.0 percent) counties (Fresno, Kern, Merced, San Joaquin, Stanislaus, and Tulare) in the San Joaquin Valley region were in the bottom two quintiles for current year performance and were below the minimum performance level by at least a 10 percent relative difference.
- ◆ Counties in the Central Coast, San Francisco Bay/Sacramento, and Southern Coast regions had high performance for the *Breast Cancer Screening—Total—White* indicator-racial/ethnic group combination.
 - Rates for five of six (83.3 percent) counties (Monterey, San Luis Obispo, Santa Barbara, Santa Cruz, and Ventura) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance.
 - Rates for seven of 10 (70.0 percent) counties (Contra Costa, Marin, Napa, San Mateo, Santa Clara, Solano, and Sonoma) in the San Francisco Bay/Sacramento region were in the top two quintiles for current year performance. Of note, rates for nine of 10 (90.0 percent) counties (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma) were in the top two quintiles for trending results.
 - Rates for two of three (66.7 percent) counties (Los Angeles and San Diego) in the Southern Coast region were in the top two quintiles for current year performance.

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 2.59 through Figure 2.65 display the statewide racial/ethnic and applicable regional-level results for the *Cervical Cancer Screening—Total (CCS)* indicator in addition to identified health disparities.

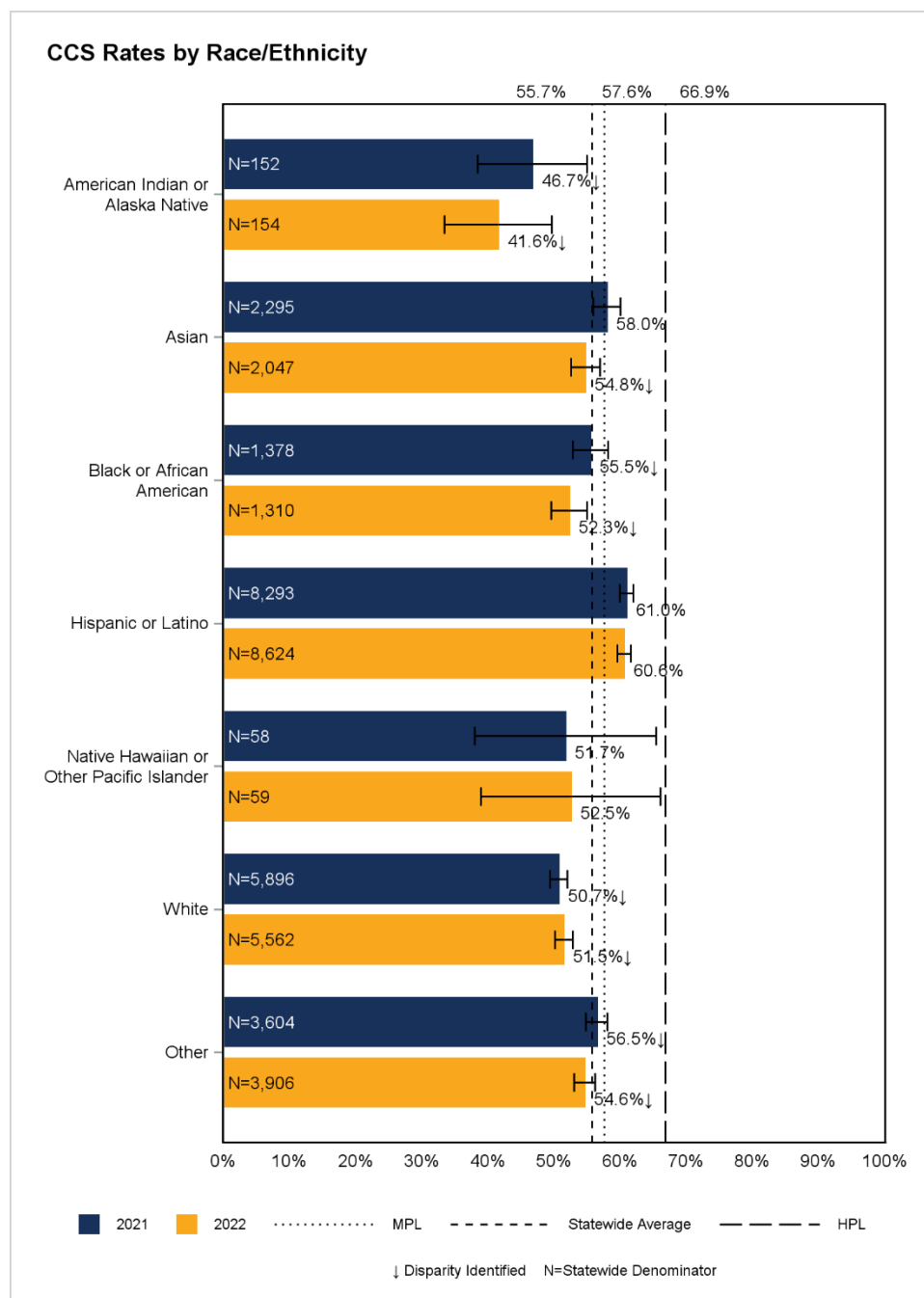
Figure 2.59—Cervical Cancer Screening (CCS) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 51.3 percent (N=729) and 48.7 percent (N=764), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 59.1 percent and 68.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 56.5 percent.



The following key findings were identified for the *Cervical Cancer Screening* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and Other) had a persistent, worsening disparity identified, and one of seven (14.3 percent) racial/ethnic groups (White) had a persistent, improving disparity identified.
- ◆ One of seven (14.3 percent) racial/ethnic group rates (Asian) had a new disparity identified in measurement year 2022.

- ◆ Widespread disparities were identified, with five of seven (71.4 percent) racial/ethnic groups (American Indian or Alaska Native, Asian, Black or African American, Other, and White) having disparities identified for measurement year 2022.
- ◆ Two of seven (28.6 percent) racial/ethnic group rates (American Indian or Alaska Native and White) had large disparities identified for measurement years 2021 and 2022.
- ◆ No eliminated or emerging disparities were identified for the *Cervical Cancer Screening—Total* indicator.

Figure 2.60—Cervical Cancer Screening (CCS)—Asian—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for CCS—Asian

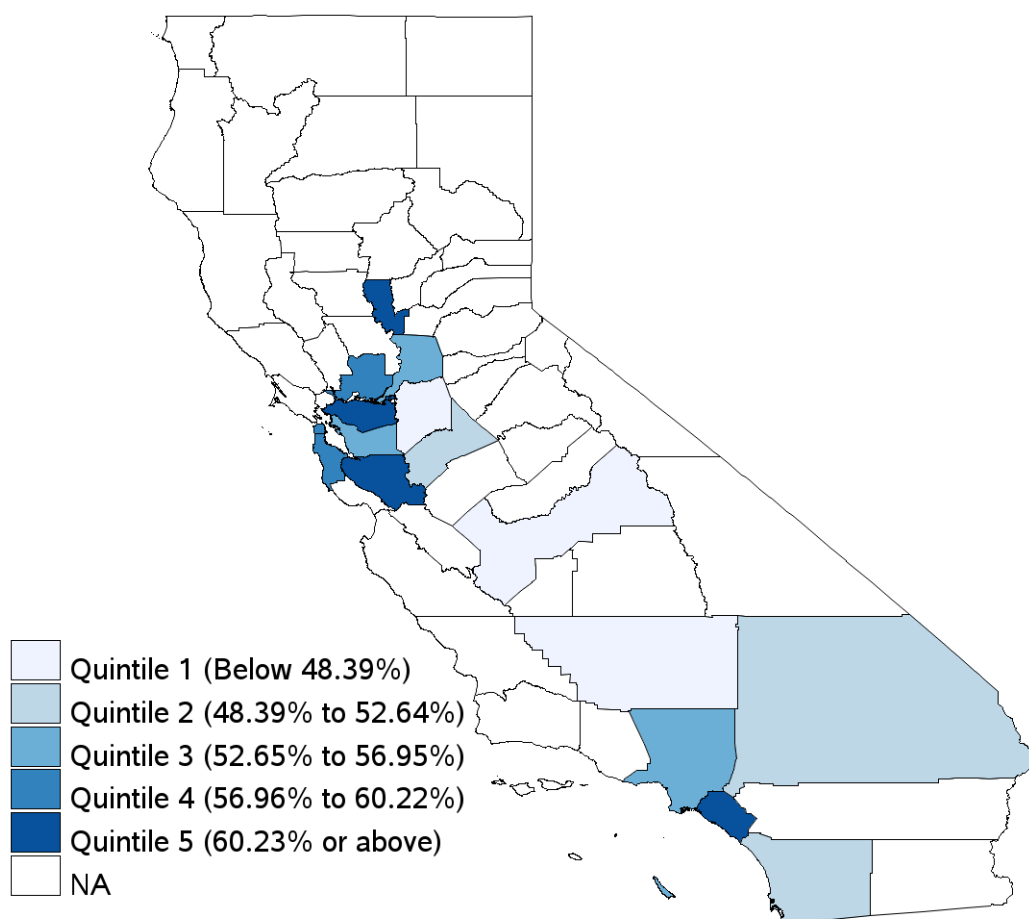
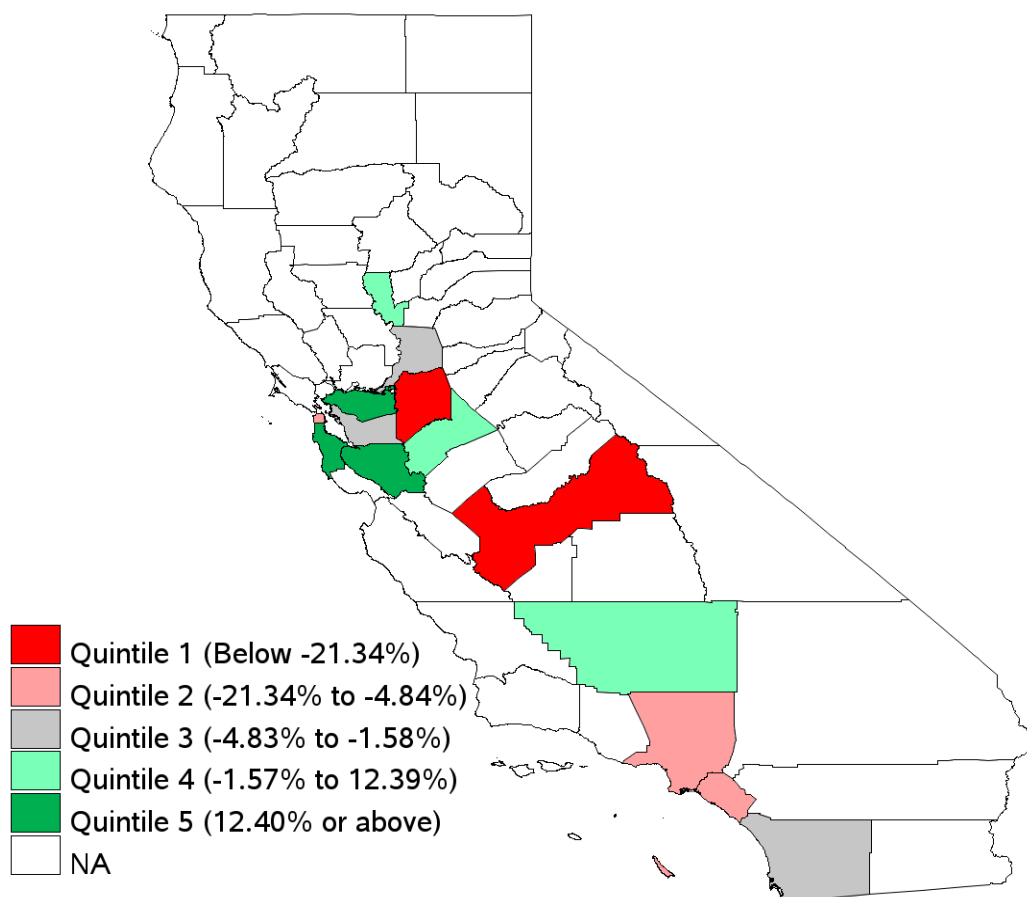


Figure 2.61—Cervical Cancer Screening (CCS)—Asian—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for CCS—Asian



The following are the key findings for the *Cervical Cancer Screening—Total—Asian* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley region had low performance for the *Cervical Cancer Screening—Total—Asian* indicator-racial/ethnic group combination.
 - Rates for all four counties with reportable rates (Fresno, Kern, San Joaquin, and Stanislaus) were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Two of these four (50.0 percent) counties (Fresno and San Joaquin) were in Quintile 1 for trending results and were below the minimum performance level by more than a 25 percent relative difference.
- ◆ Counties in the San Francisco Bay/Sacramento region had high performance for the *Cervical Cancer Screening—Total—Asian* indicator-racial/ethnic group combination.

- Rates for five of seven (71.4 percent) counties with reportable rates (Contra Costa, San Francisco, San Mateo, Santa Clara, and Solano) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Of note, the rates for Contra Costa and Santa Clara counties were above the minimum performance level by at least a 10 percent relative difference.

Figure 2.62—Cervical Cancer Screening (CCS)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for CCS—Black or African American

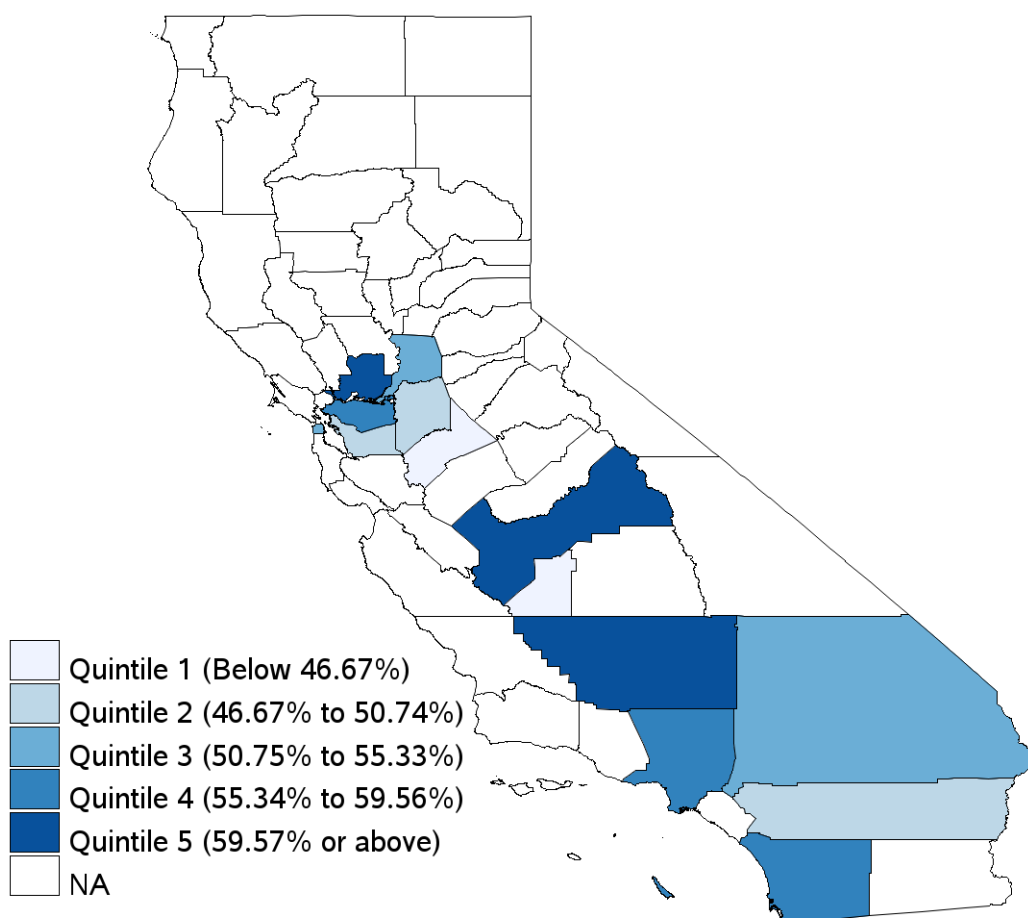
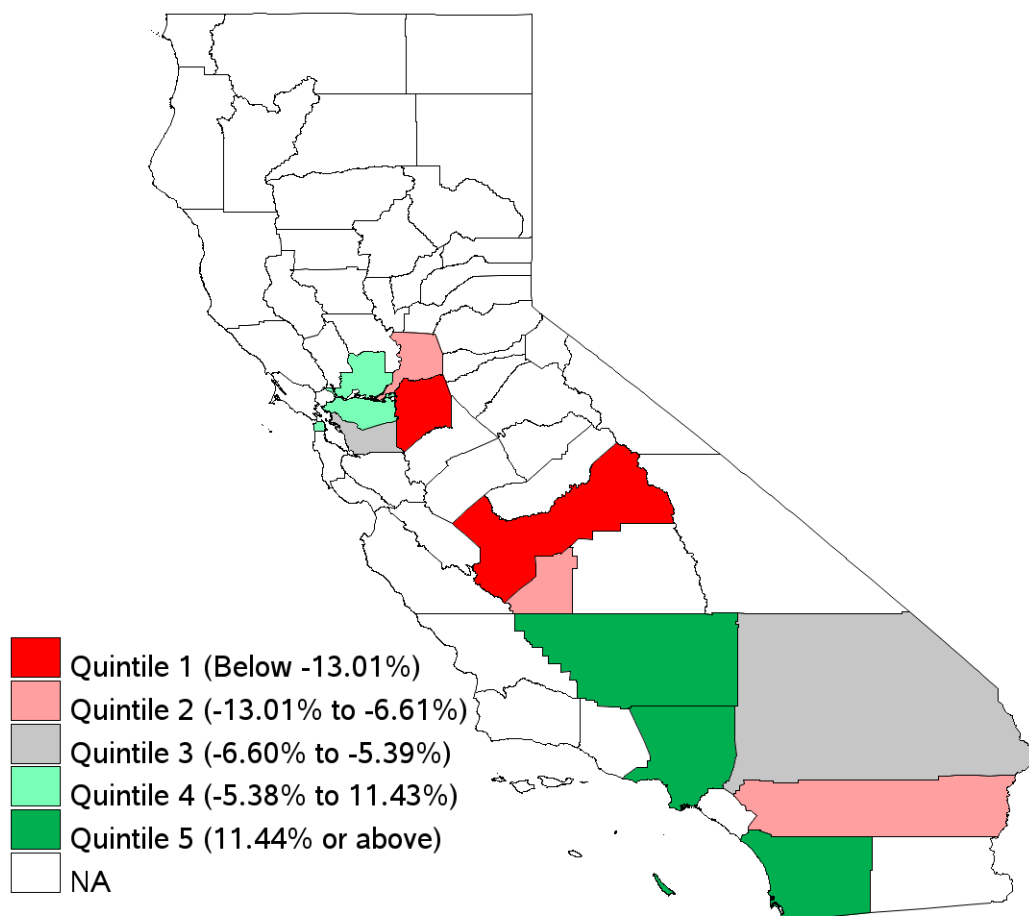


Figure 2.63—Cervical Cancer Screening (CCS)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for CCS—Black or African American



The following are the key findings for the *Cervical Cancer Screening—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley region had low performance for the *Cervical Cancer Screening—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (Kings, San Joaquin, and Stanislaus) were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Rates for two of three (66.7 percent) counties with reportable rates (Kings and San Joaquin) were in the bottom two quintiles for trending results. Of note, the rate for Stanislaus County was below the minimum performance level by more than a 40 percent relative difference.

- ◆ Counties in the Southern Coast region had high performance for the *Cervical Cancer Screening—Total—Black or African American* indicator-racial/ethnic group combination.
 - Both counties with reportable rates (Los Angeles and San Diego) were in Quintile 4 for current year performance and Quintile 5 for trending results; however, neither county rate met the minimum performance level in measurement year 2022.

Figure 2.64—Cervical Cancer Screening (CCS)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for CCS—White

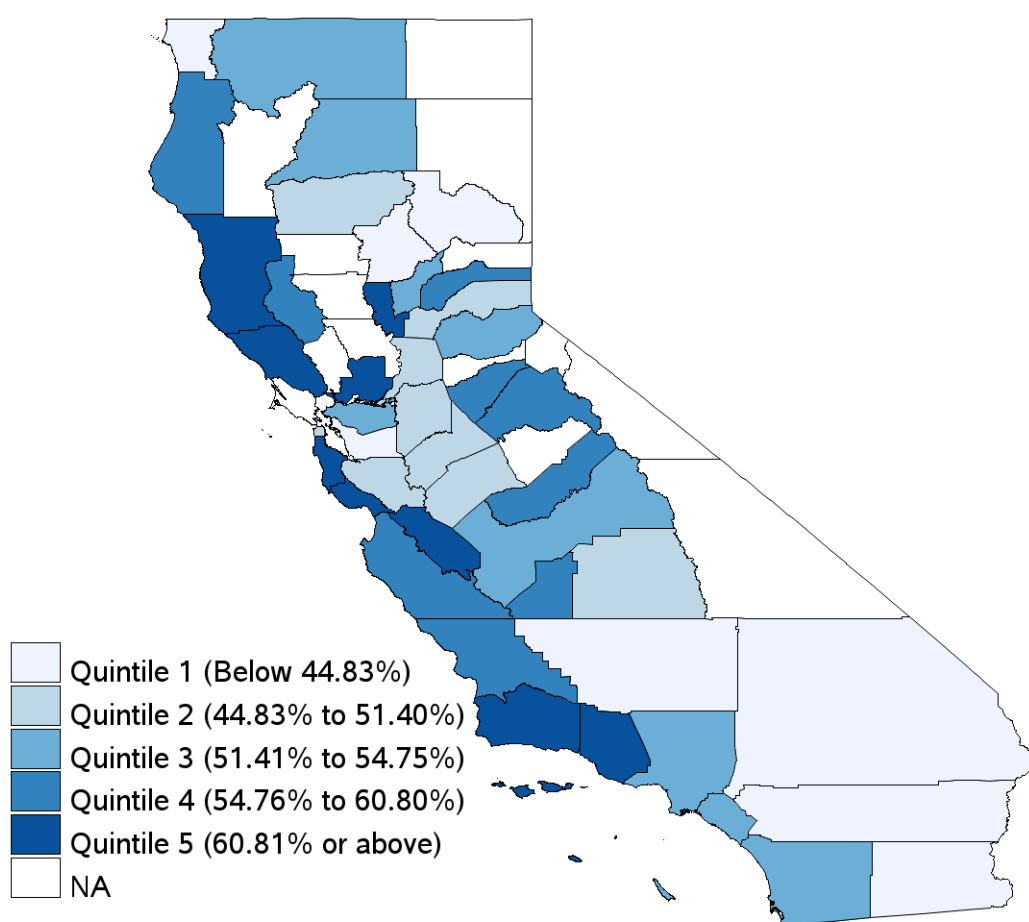
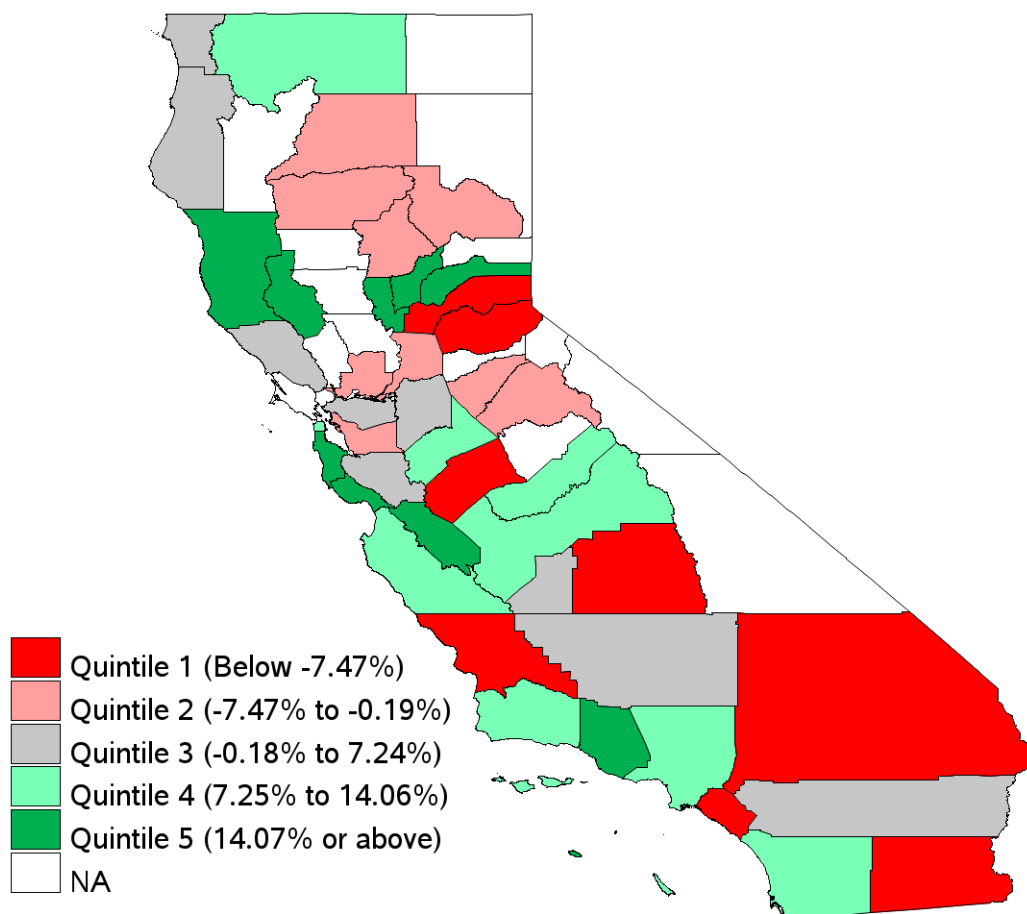


Figure 2.65—Cervical Cancer Screening (CCS)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for CCS—White



The following are the key findings for the *Cervical Cancer Screening—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Francisco Bay/Sacramento, San Joaquin Valley, and Southeastern regions had low performance for the *Cervical Cancer Screening—Total—White* indicator-racial/ethnic group combination.
 - Rates for four of eight (50.0 percent) counties with reportable rates (Alameda, Sacramento, San Francisco, and Santa Clara) in the San Francisco Bay/Sacramento region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance and were below the minimum performance level by at least a 10 percent relative difference.

- Rates for five of eight (62.5 percent) counties (Kern, Merced, San Joaquin, Stanislaus, and Tulare) in the San Joaquin Valley region were in the bottom two quintiles for current year performance. Of note, the rate for Kern County was below the minimum performance level by more than a 25 percent relative difference.
- Rates for all three counties (Imperial, Riverside, and San Bernardino) in the Southeastern region were in Quintile 1 for current year performance and were below the minimum performance level by more than a 30 percent relative difference. Two of these three (66.7 percent) counties (Imperial and San Bernardino) were in Quintile 1 for trending results.
- ◆ Counties in the Central Coast region had high performance for the *Cervical Cancer Screening—Total—White* indicator-racial/ethnic group combination.
 - Rates for five of six (83.3 percent) counties (Monterey, San Benito, Santa Barbara, Santa Cruz, and Ventura) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance and trend results. Of note, while the current year rate for San Luis Obispo County was in Quintile 4, the rate declined by more than a 10 percent relative difference from measurement year 2021 to measurement year 2022.

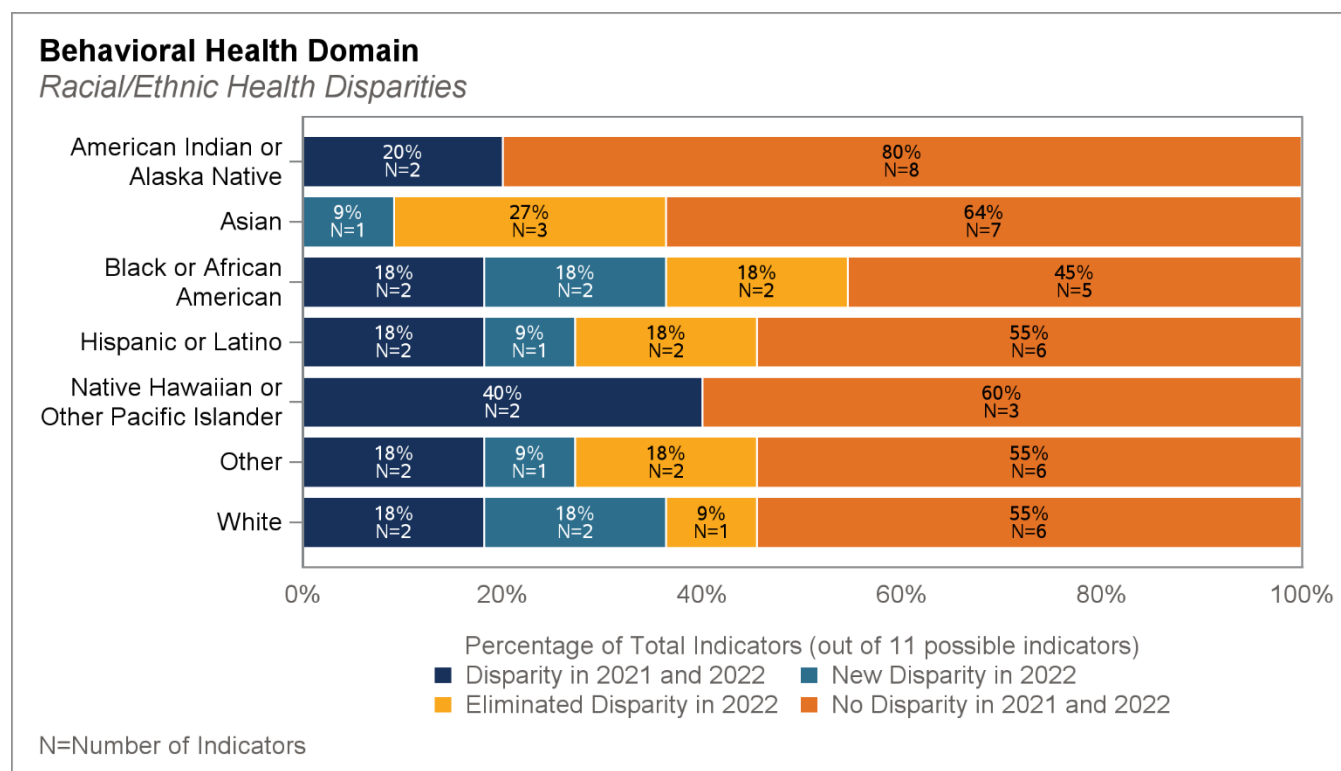
Racial/Ethnic Health Disparities: Behavioral Health Domain

Health disparities were identified when indicator rates for racial/ethnic groups were below the minimum performance level/median state performance rate (i.e., the upper bound of the 95 percent confidence interval for the rate was below the national reference rate). If a racial/ethnic group's indicator rate was equal to or higher than the minimum performance level/median state performance rate, then no health disparity was identified.

Figure 2.66 displays the percentage and number of Behavioral Health domain indicators (out of 11 possible indicators) for which disparities were identified or were not identified for each racial/ethnic group in addition to newly identified and eliminated disparities within the Behavioral Health domain.

Figure 2.66—Racial/Ethnic Health Disparities Summary: Behavioral Health Domain

Note: Due to small numerators or denominators, the American Indian or Alaska Native (N=10) and Native Hawaiian or Other Pacific Islander (N=5) groups were not evaluated for health disparities for all 11 possible indicators.



The following key findings were identified for the Behavioral Health domain:

- ◆ The following persistent disparities improved from measurement year 2021 to measurement year 2022:
 - *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* indicator rates for six of seven (85.7 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had a persistent, improving disparity identified.
- ◆ No persistent, worsening disparities were identified from measurement year 2021 to measurement year 2022 in the Behavioral Health domain.
- ◆ New disparities were identified for one indicator within the Behavioral Health domain.
 - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* indicator rates for three of seven (42.9 percent) racial/ethnic groups (Asian, Black or African American, and White) had new disparities identified.

- ◆ Eliminated disparities were identified for four indicators in the Behavioral Health domain.
 - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* indicator rates for three of seven (42.9 percent) racial/ethnic groups (Black or African American, Hispanic or Latino, and Other) had eliminated disparities identified.
 - *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* indicator rates for five of seven (71.4 percent) racial/ethnic groups (Asian, Black or African American, Hispanic or Latino, Other, and White) had eliminated disparities identified.
 - *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Asian) had an eliminated disparity identified.
- ◆ Widespread disparities were identified for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up*, *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up*, and *Pharmacotherapy for Opioid Use Disorder* indicators. None of the seven racial/ethnic groups had widespread disparities identified in the Behavioral Health domain.
 - For measurement year 2022, *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* indicator rates for six of seven (85.7 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had disparities identified.
 - For measurement year 2022, *Pharmacotherapy for Opioid Use Disorder* indicator rates for four of seven (57.1 percent) racial/ethnic groups (Black or African American, Hispanic or Latino, Other, and White) had disparities identified.
- ◆ Large disparities were identified for three indicators in the Behavioral Health domain.
 - The *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up* indicator rates for six of seven (85.7 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had large disparities identified across both measurement years 2021 and 2022.
 - *Pharmacotherapy for Opioid Use Disorder* indicator rates for four of seven (57.1 percent) racial/ethnic groups (Black or African American, Hispanic or Latino, Other, and White) had large disparities identified for measurement year 2022.
- ◆ Emerging disparities were identified for the following racial/ethnic group indicator rates:
 - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total—Other*
 - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total—White*
 - *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total—Black or African American*

- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total—Other*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total—White*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total—Black or African American*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total—Other*
- *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total—White*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—American Indian or Alaska Native*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Hispanic or Latino*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Native Hawaiian or Other Pacific Islander*

Racial/Ethnic Health Disparities: Behavioral Health Domain Key Findings

Based on evaluating the results of the key findings above, the following indicators were determined to be key findings for the Behavioral Health domain. Please note, none of the key finding indicators have a corresponding Bold Goal.¹⁴

- ◆ *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- ◆ *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up*
- ◆ *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up*
- ◆ *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- ◆ *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*
- ◆ *Pharmacotherapy for Opioid Use Disorder*

¹⁴ While the *Depression Screening and Follow-Up for Adolescents and Adults* and *Follow-Up After Emergency Department Visit for Substance Use* indicators have a corresponding Bold Goal (i.e., improve follow-up for mental health and substance use disorder by 50 percent), these indicators were not tested for disparities for measurement year 2022.

Please note, the results for the *Depression Remission or Response for Adolescents and Adults*, *Depression Screening and Follow-Up for Adolescents and Adults*, and *Follow-Up After Emergency Department Visit for Substance Use* indicators were not considered to be key findings given that benchmarks were unavailable and disparities could not be identified.

Please note, the results for the *Antidepressant Medication Management*, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*, and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total* indicators were not considered to be key findings given that disparities were not identified for measurement year 2022. Please refer to Appendix C. Demographic Stratification Results for the racial/ethnic rates for these indicators.

Racial/Ethnic Health Disparities: Behavioral Health Domain Indicator Results

Figure 2.67 through Figure 2.94 display the racial/ethnic health disparities and applicable regional results for indicators with results determined to be key findings in the Behavioral Health domain. For each figure, the denominator, rate, and confidence interval for each racial/ethnic group are displayed. A downward arrow is displayed when a disparity is identified. Additionally, the measurement year 2022 statewide average, high performance level, where applicable, and minimum performance level/median state performance rate, where applicable, are displayed as rates on top of the figure and as dotted lines in the figure.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* indicator measures the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test. Figure 2.67 through Figure 2.73 display the statewide racial/ethnic and applicable regional-level results for the *Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* indicator in addition to identified health disparities.

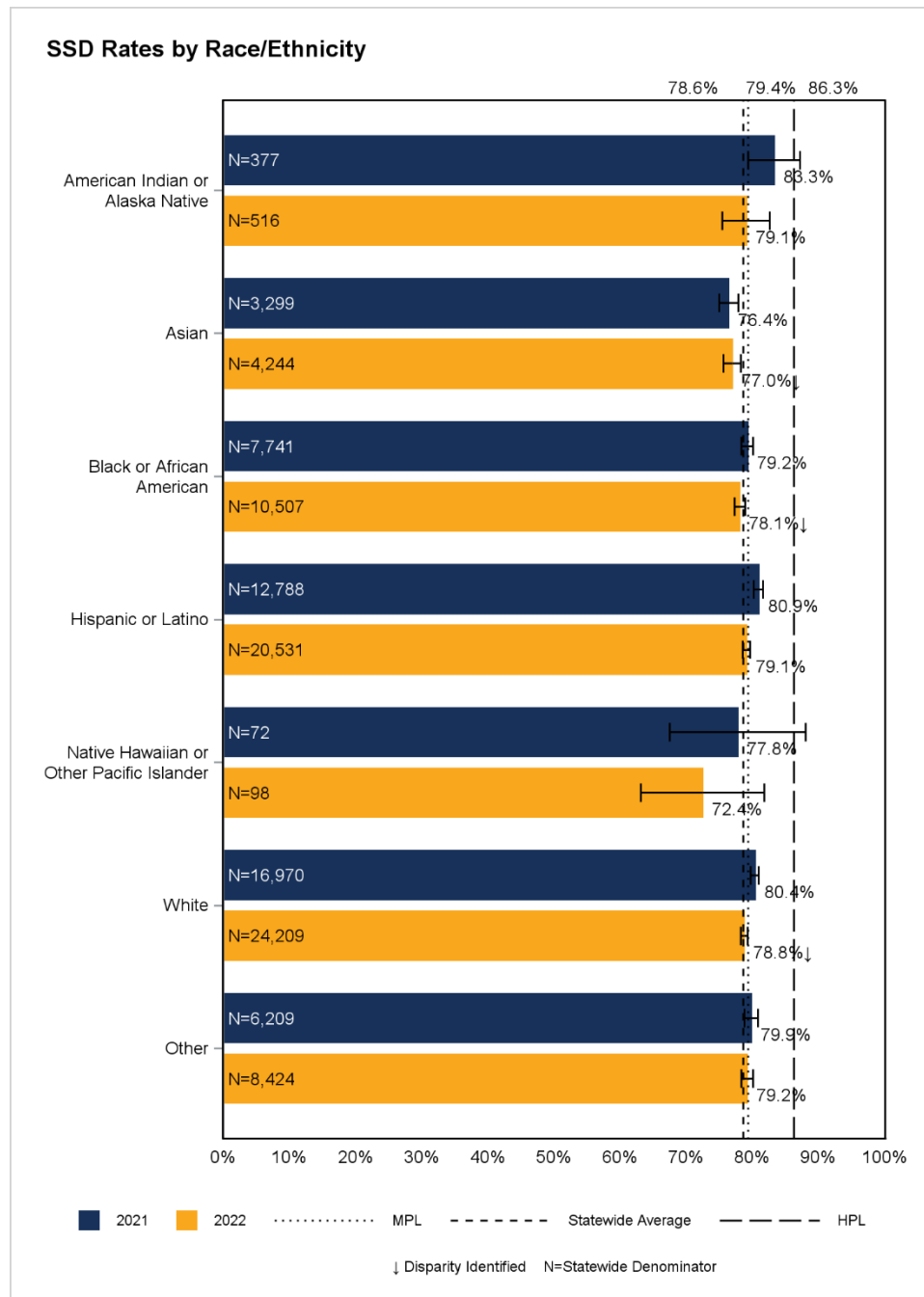
Figure 2.67—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 78.1 percent (N=3,037) and 77.6 percent (N=4,669), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.6 percent and 82.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 79.9 percent.



The following key findings were identified for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* indicator:

- ◆ Three of seven (42.9 percent) racial/ethnic group rates (Asian, Black or African American, and White) had new disparities identified in measurement year 2022.
- ◆ While four of seven (57.1 percent) racial/ethnic group rates (American Indian or Alaska Native, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Other) did not have a disparity identified for measurement year 2022, the American Indian or Alaska Native, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander groups are at risk of having a disparity emerge in measurement year 2023.
- ◆ No persistent, widespread, large, or eliminated disparities were identified for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* indicator.

Figure 2.68—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)—Asian—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for SSD—Asian

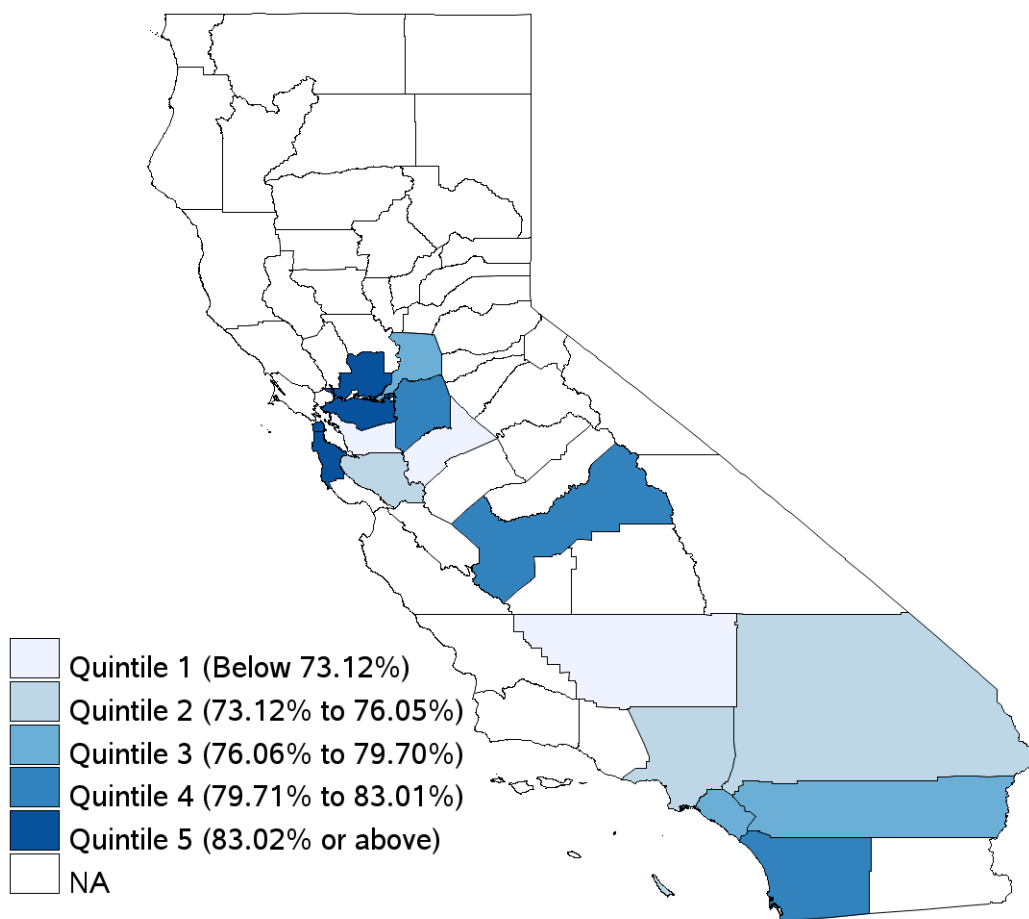
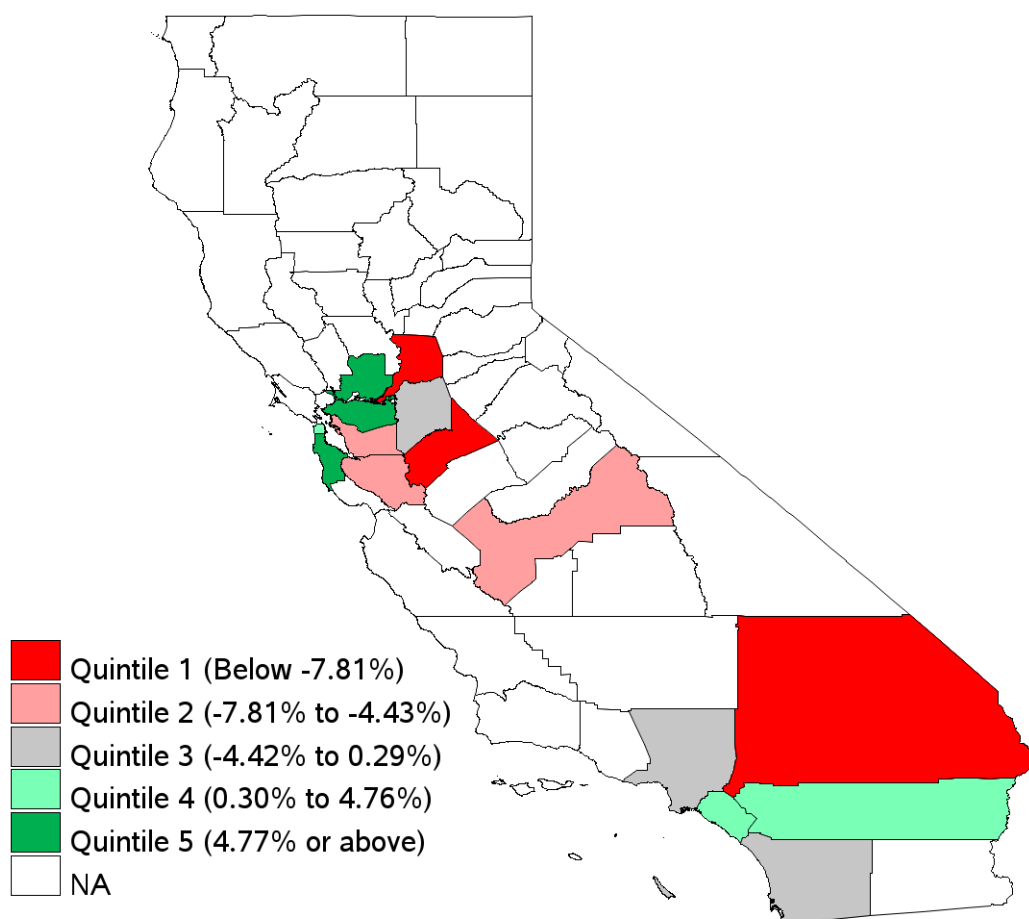


Figure 2.69—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)—Asian—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for SSD—Asian



The following are the key findings for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Asian* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southeastern regions had low performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Asian* indicator-racial/ethnic group combination.
 - Rates for two of four (50.0 percent) counties with reportable rates (Kern and Stanislaus) in the San Joaquin Valley region were in Quintile 1 for current year performance. Of note, the rate for Stanislaus County declined by more than a 20 percent relative difference from measurement year 2021 to measurement year 2022 and was below the

minimum performance level by nearly a 15 percent relative difference in measurement year 2022.

- The rate for one of two (50.0 percent) counties with reportable rates (San Bernardino) in the Southeastern region was in Quintile 2 for current year performance and Quintile 1 for trending results.
- ◆ Counties in the San Francisco Bay/Sacramento region had high performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*—Asian indicator-racial/ethnic group combination.
 - Rates for four of seven (57.1 percent) counties with reportable rates (Contra Costa, San Francisco, San Mateo, and Solano) were in Quintile 5 for current year performance and in the top two quintiles (i.e., Quintiles 4 and 5) for trending performance.

Figure 2.70—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for SSD—Black or African American

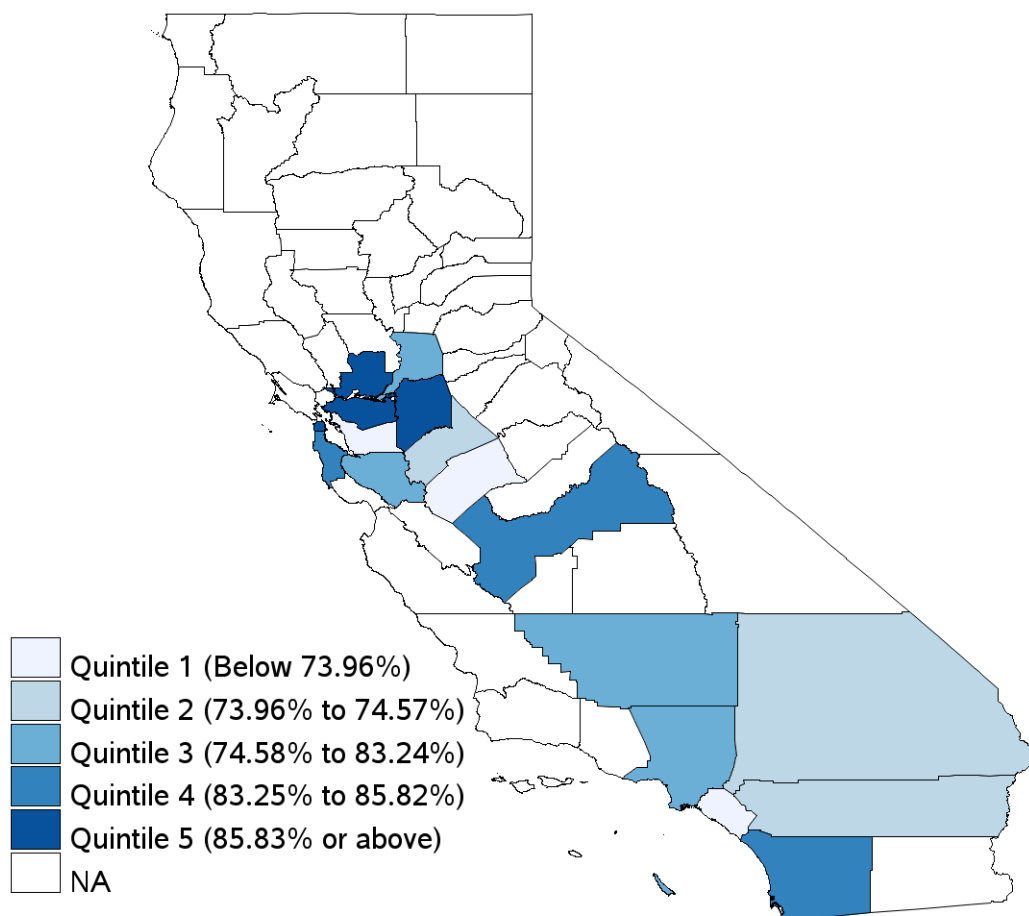
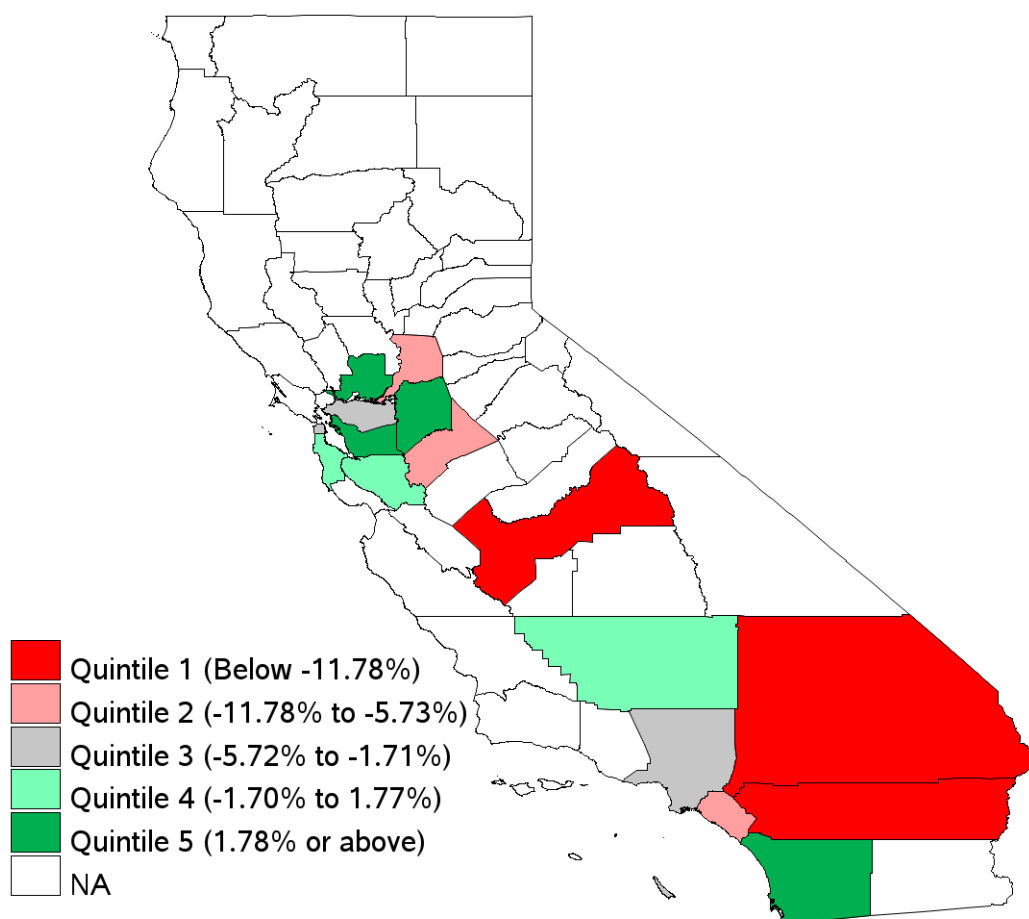


Figure 2.71—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for SSD—Black or African American



The following are the key findings for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Southeastern region had low performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Black or African American* indicator-racial/ethnic group combination.
 - Both counties with reportable rates (Riverside and San Bernardino) were in Quintile 2 for current year performance and Quintile 1 for trending performance.
- ◆ Counties in the San Francisco Bay/Sacramento region had high performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using*

Antipsychotic Medications—Black or African American indicator-racial/ethnic group combination.

- Rates for four of seven (57.1 percent) counties with reportable rates (Contra Costa, San Francisco, San Mateo, and Solano) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance.

Figure 2.72—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for SSD—White

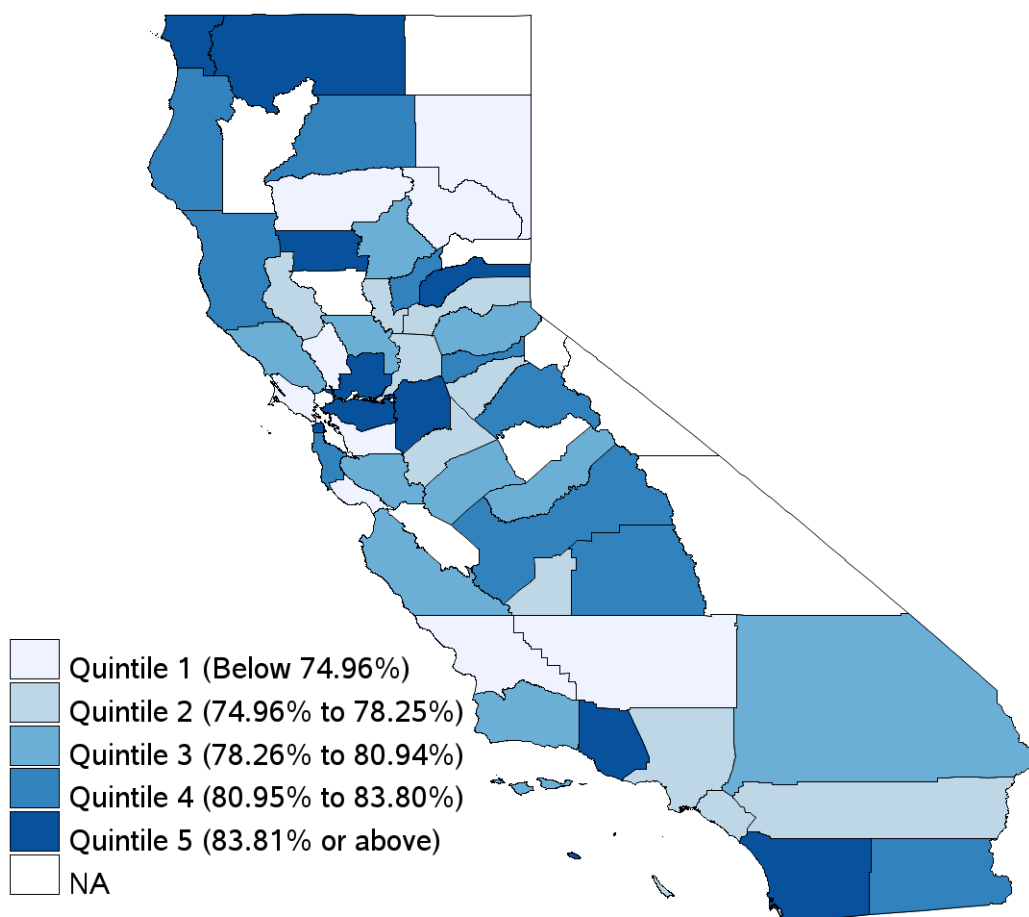
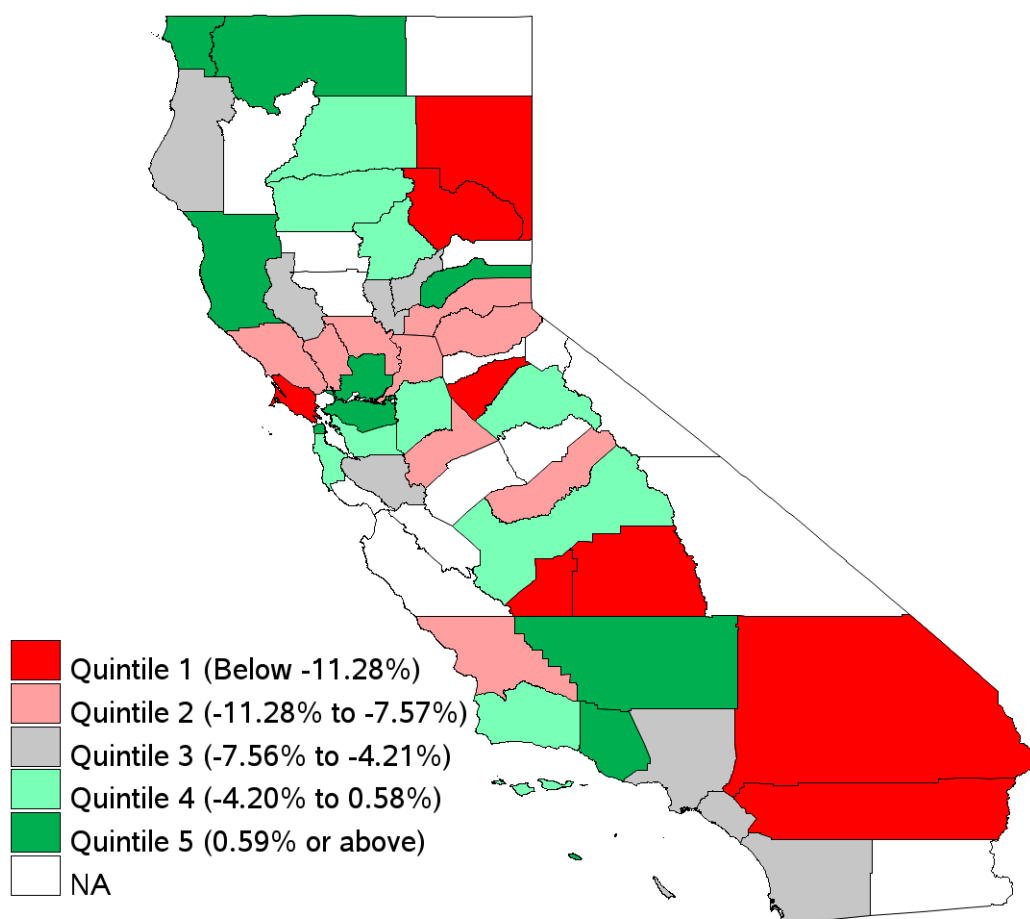


Figure 2.73—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for SSD—White



The following are the key findings for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Southern Coast region had low performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—White* indicator-racial/ethnic group combination.
 - Rates for two of three (66.7 percent) counties (Los Angeles and Orange) were in Quintile 2 for current year performance.

- ◆ Counties in the North/Mountain region had high performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—White indicator-racial/ethnic group combination*.
 - Rates for 10 of 20 (50.0 percent) counties with reportable rates (Amador, Del Norte, Glenn, Humboldt, Mendocino, Nevada, Shasta, Siskiyou, Tuolumne, and Yuba) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Additionally, the rates for six of the 10 (60.0 percent) counties (Del Norte, Mendocino, Nevada, Shasta, Siskiyou, and Tuolumne) were in the top two quintiles for trending results.

Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM–7)

The *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (FUM–7)* indicator measures the percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 7 days of the emergency department visit. Figure 2.74 through Figure 2.80 display the statewide racial/ethnic and applicable regional-level results for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (FUM–7)* indicator in addition to identified health disparities.

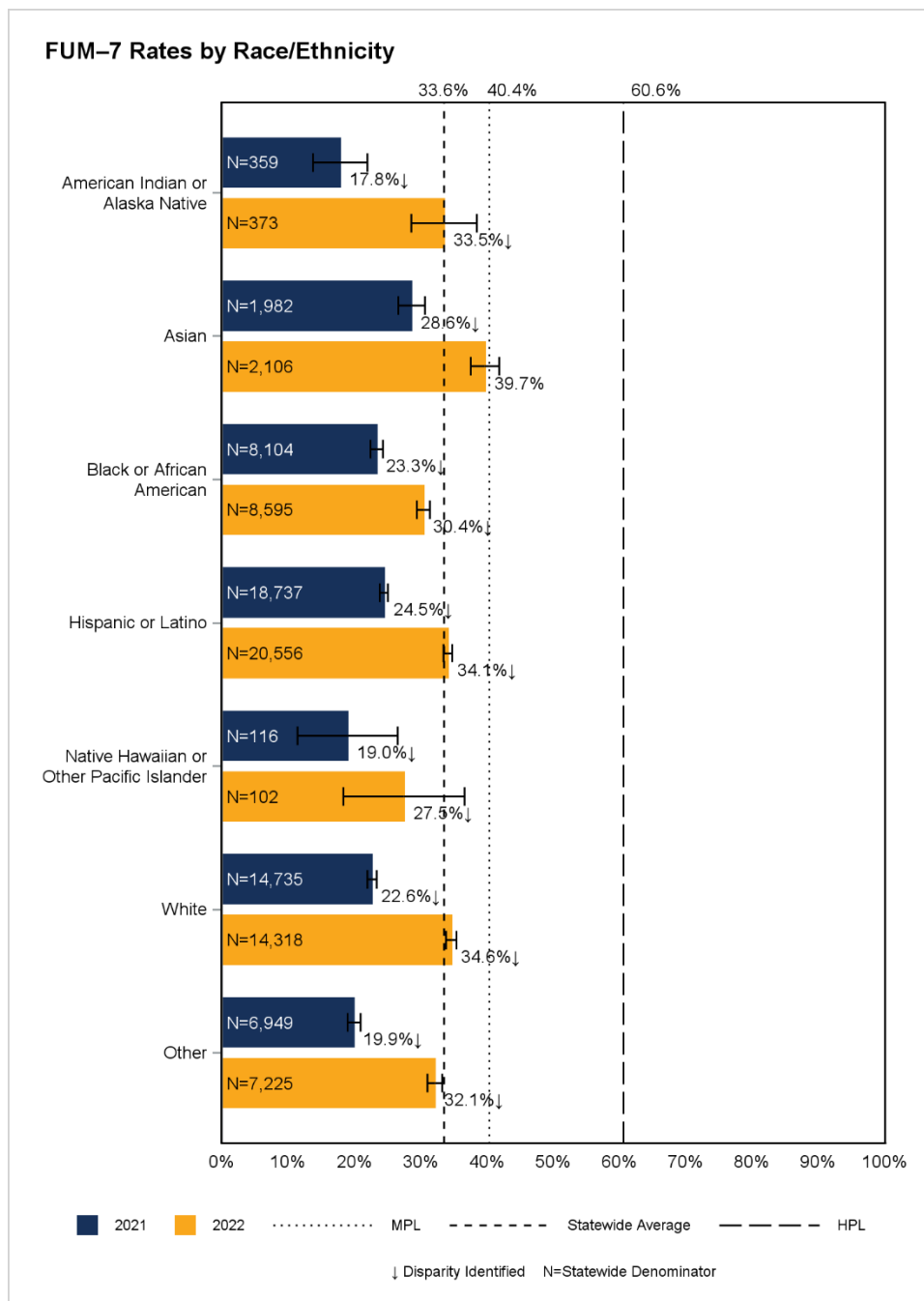
Figure 2.74—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM–7) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 23.6 percent (N=2,380) and 33.8 percent (N=2,492), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.6 percent and 61.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 23.3 percent.



The following key findings were identified for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for six of seven (85.7 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had a persistent, improving disparity identified, and no persistent disparities worsened.

- ◆ While the Asian racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.
- ◆ Widespread disparities were identified, with six of seven (85.7 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) having disparities identified for measurement year 2022.
- ◆ Six of seven (85.7 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had large disparities identified for measurement years 2021 and 2022.
- ◆ No new or emerging disparities were identified for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* indicator.

Figure 2.75—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for FUM-7—Black or African American

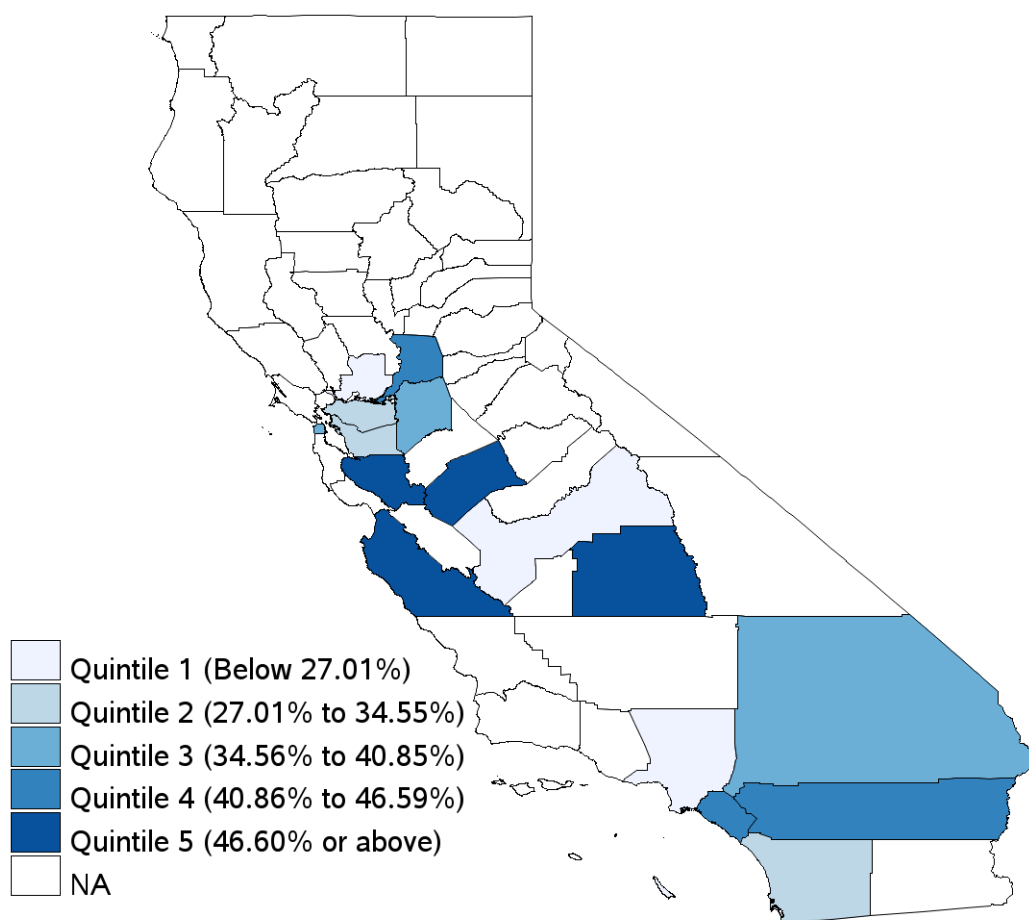
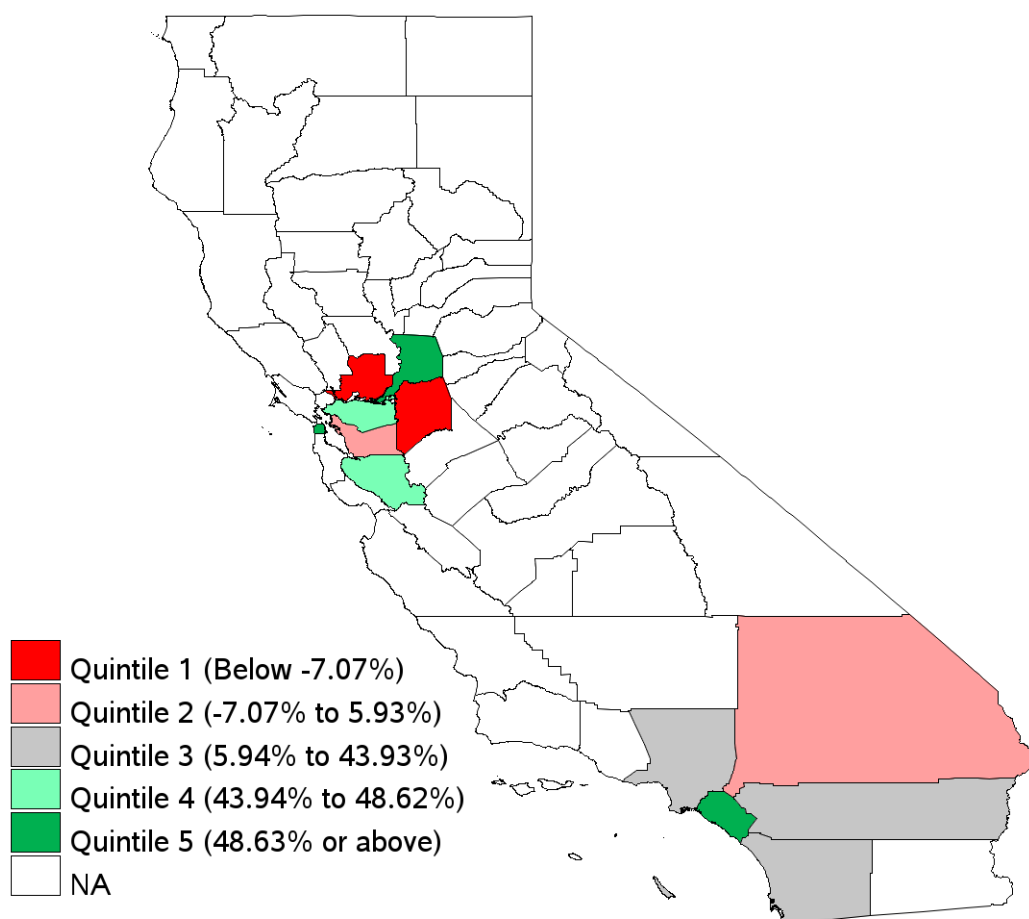


Figure 2.76—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for FUM-7—Black or African American



The following are the key findings for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Francisco Bay/Sacramento and Southern Coast regions had low performance for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for three of six (50.0) counties with reportable rates (Alameda, Contra Costa, and Solano) in the San Francisco Bay/Sacramento region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Additionally, rates for two of these three (66.7 percent) counties with reportable rates (Solano and Alameda) were in the

bottom two quintiles for trending results. Of note, the rate for Solano County was below the minimum performance level by more than a 75 percent relative difference.

- Rates for two of three (66.7 percent) counties (Los Angeles and San Diego) in the Southern Coast region were in the bottom two quintiles for current year performance. Despite the rates for these counties improving from measurement year 2021 to measurement year 2022, the rates were below the minimum performance level by more than a 25 percent relative difference.
- ◆ Counties in the San Joaquin Valley region had high performance for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for two of four (50.0 percent) counties with reportable rates (Merced and Tulare) were in Quintile 5 for current year performance. Of note, Merced County was above the minimum performance level by a 45 percent relative difference.

Figure 2.77—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7)—Hispanic or Latino—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for FUM-7—Hispanic or Latino

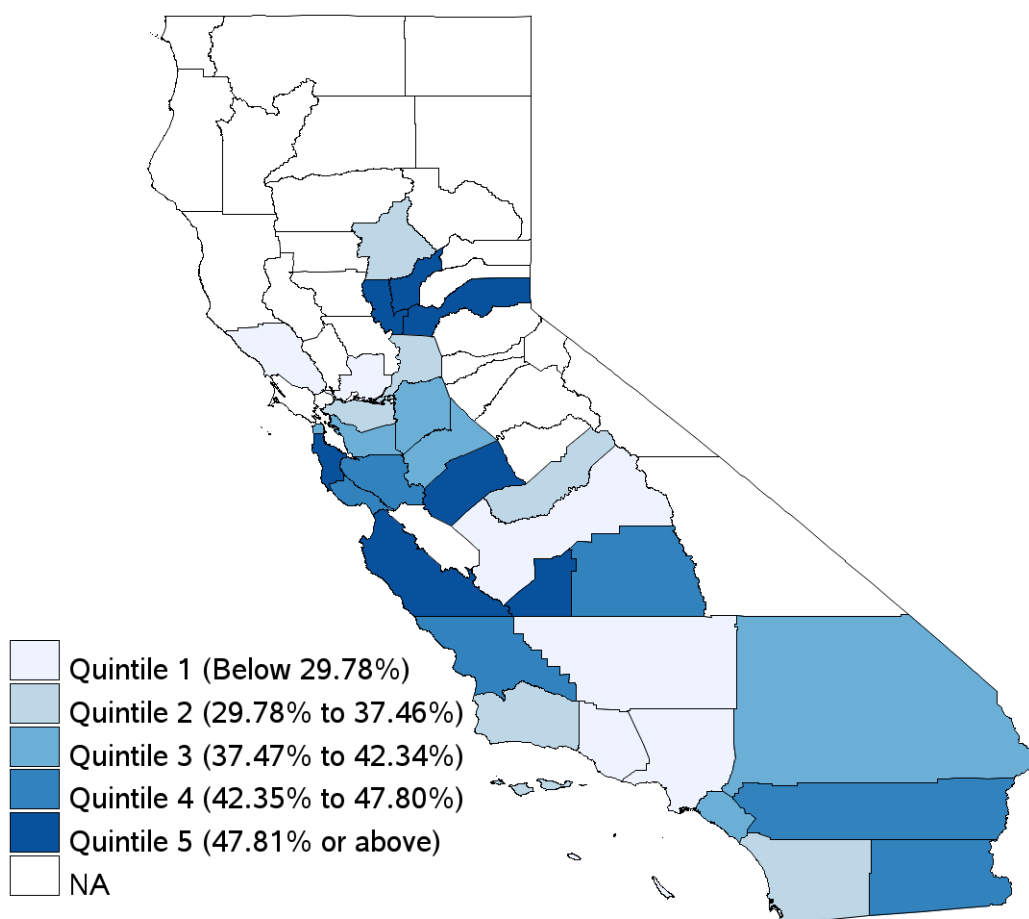
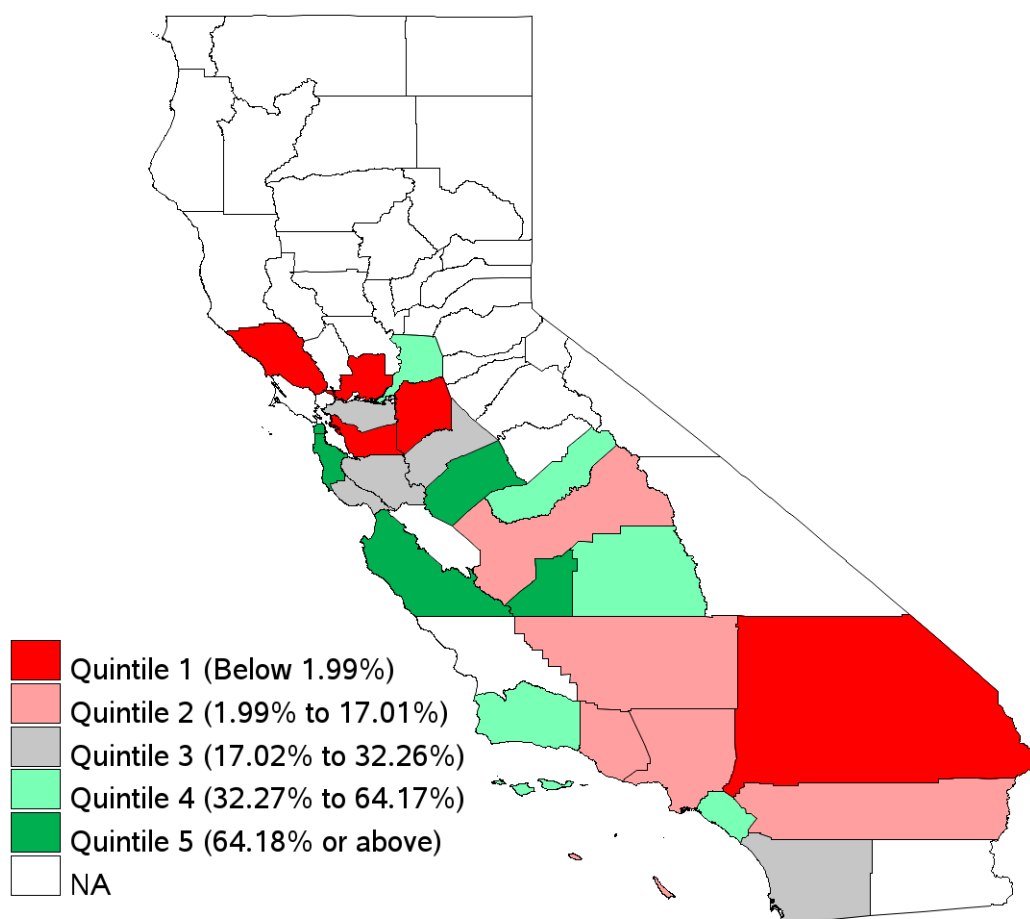


Figure 2.78—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7)—Hispanic or Latino—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for FUM-7—Hispanic or Latino



The following are the key findings for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—Hispanic or Latino* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Francisco Bay/Sacramento and Southern Coast regions had low performance for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—Hispanic or Latino* indicator-racial/ethnic group combination.
 - Rates for four of eight (50.0 percent) counties with reportable rates (Contra Costa, Sacramento, Solano, and Sonoma) in the San Francisco Bay/Sacramento region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Rates for two of the four (50.0 percent) counties with reportable rates (Solano and Sonoma)

were in Quintile 1 for trending results and were below the minimum performance level by more than a 40 percent relative difference.

- Rates for two of three (66.7 percent) counties (Los Angeles and San Diego) in the Southern Coast region were in the bottom two quintiles for current year performance. Of note, despite the rate for Los Angeles County improving from measurement year 2021 to measurement year 2022 by nearly a 10 percent relative difference, the rate was below the minimum performance level by more than a 35 percent relative difference.
- ◆ Counties in the Central Coast, North/Mountain, and Southeastern regions had high performance for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—Hispanic or Latino indicator-racial/ethnic group* combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (Monterey, San Luis Obispo, and Santa Cruz) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance.
 - Rates for three of four (75.0 percent) counties with reportable rates (Placer, Sutter, and Yuba) in the North/Mountain region were in Quintile 5 for current year performance and were above the minimum performance level by more than a 30 percent relative difference.
 - Rates for two of three (66.7 percent) counties (Imperial and Riverside) in the Southeastern region were in Quintile 4 for current year performance. Additionally, both counties with reportable rates (Riverside and San Bernardino) were in the bottom two quintiles for trending performance.

Figure 2.79—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for FUM-7—White

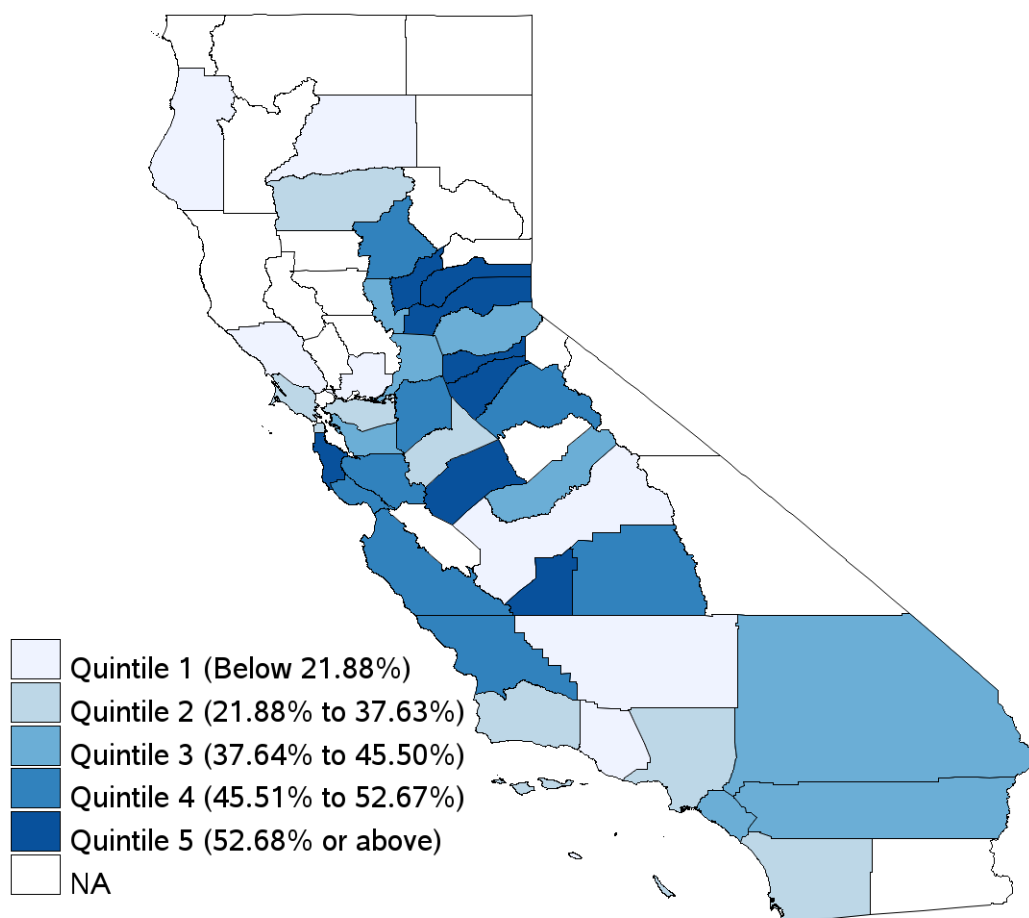
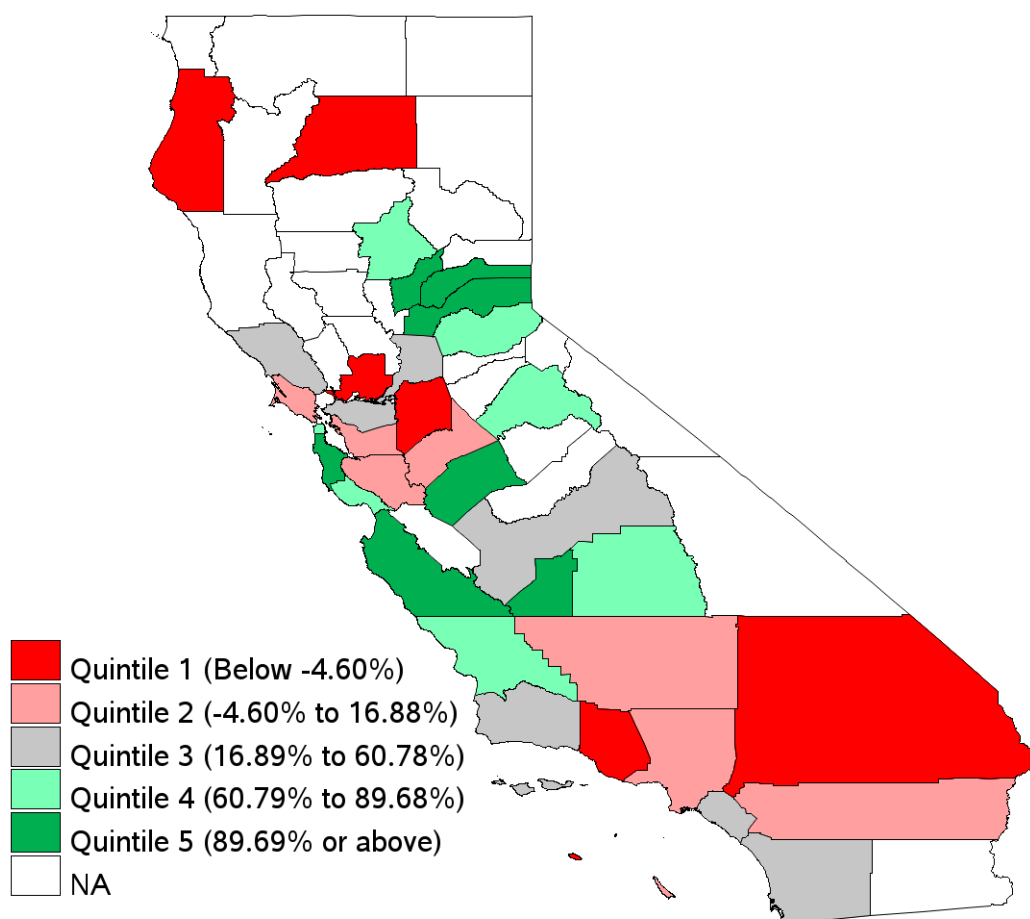


Figure 2.80—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for FUM-7—White



The following are the key findings for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Francisco Bay/Sacramento and Southern Coast regions had low performance for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—White* indicator-racial/ethnic group combination.
 - Rates for five of nine (55.6 percent) counties with reportable rates (Contra Costa, Marin, San Francisco, Solano, and Sonoma) in the San Francisco Bay/Sacramento region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Of note, the rates for Marin, Solano, and Sonoma counties were below the minimum performance level by more than a 45 percent relative difference.

- Rates for two of three (66.7 percent) counties (Los Angeles and San Diego) in the Southern Coast region were in Quintile 2 for current year performance. Of note, Los Angeles County was below the minimum performance level by more than a 40 percent relative difference.
- ◆ Counties in the Central Coast, North/Mountain, and San Joaquin Valley regions had high performance for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total—White* indicator-racial/ethnic group combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (Monterey, San Luis Obispo, and Santa Cruz) in the Central Coast region were in Quintile 4 for current year performance and were in the top two quintiles (i.e., Quintiles 4 and 5) for trending performance. Of note, rates for all three counties were above the minimum performance level by more than a 15 percent relative difference.
 - Rates for seven of 12 (58.3 percent) counties with reportable rates (Amador, Butte, Calaveras, Nevada, Placer, Tuolumne, and Yuba) in the North/Mountain region were in the top two quintiles for both current year and trending performance. Of note, the rates for Calaveras and Nevada counties were above the minimum performance level by more than a 65 percent relative difference.
 - Rates for four of eight (50.0 percent) counties (Kings, Merced, San Joaquin, and Tulare) in the San Joaquin Valley region were in the top two quintiles for current year performance. Additionally, rates for three of these four (75.0 percent) counties (Kings, Merced, and Tulare) were in the top two quintiles for trending performance.

Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM–30)

The *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total (FUM–30)* indicator measures the percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 30 days of the emergency department visit. Figure 2.81 through Figure 2.87 display the statewide racial/ethnic and applicable regional-level results for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total (FUM–30)* indicator in addition to identified health disparities.

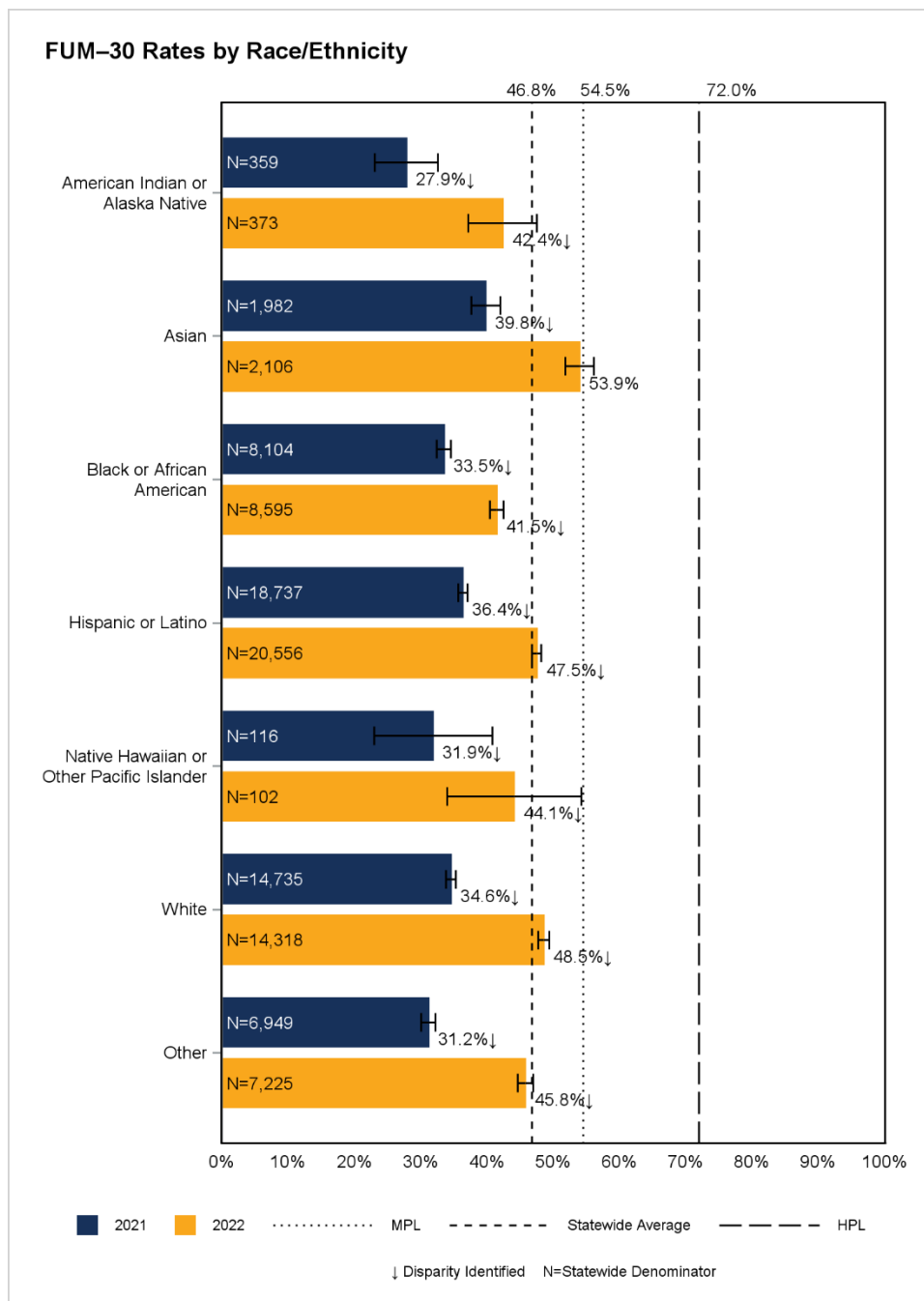
Figure 2.81—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM–30) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 35.4 percent (N=2,380) and 47.4 percent (N=2,492), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.5 percent and 74.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 34.8 percent.



The following key findings were identified for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* indicator:

- ◆ From measurement year 2021 to measurement year 2022, rates for six of seven (85.7 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had a persistent, improving disparity identified, and no persistent disparities worsened.

- ◆ While the Asian racial/ethnic group had a disparity identified for measurement year 2021, this disparity was eliminated in measurement year 2022.
- ◆ Widespread disparities were identified, with six of seven (85.7 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) having disparities identified for measurement year 2022.
- ◆ Six of seven (85.7 percent) racial/ethnic group rates (American Indian or Alaska Native, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, Other, and White) had large disparities identified for measurement years 2021 and 2022.
- ◆ No new or emerging disparities were identified for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* indicator.

Figure 2.82—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for FUM-30—Black or African American

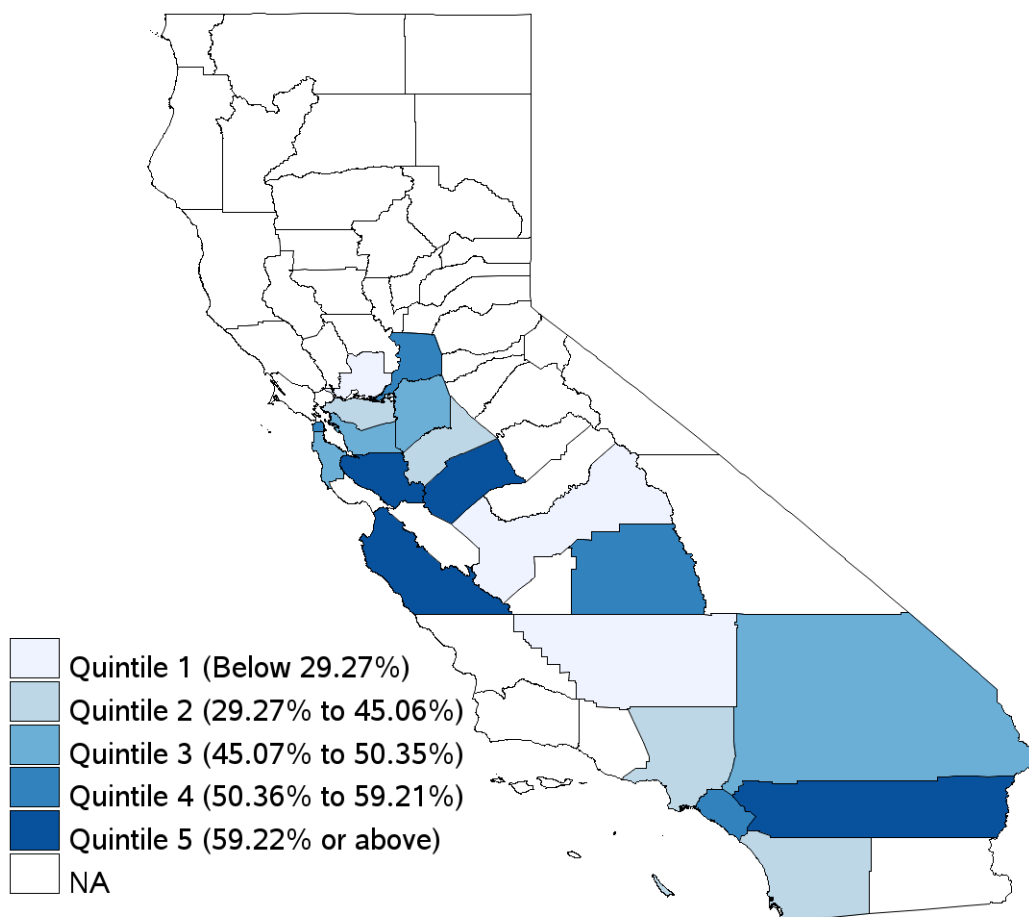
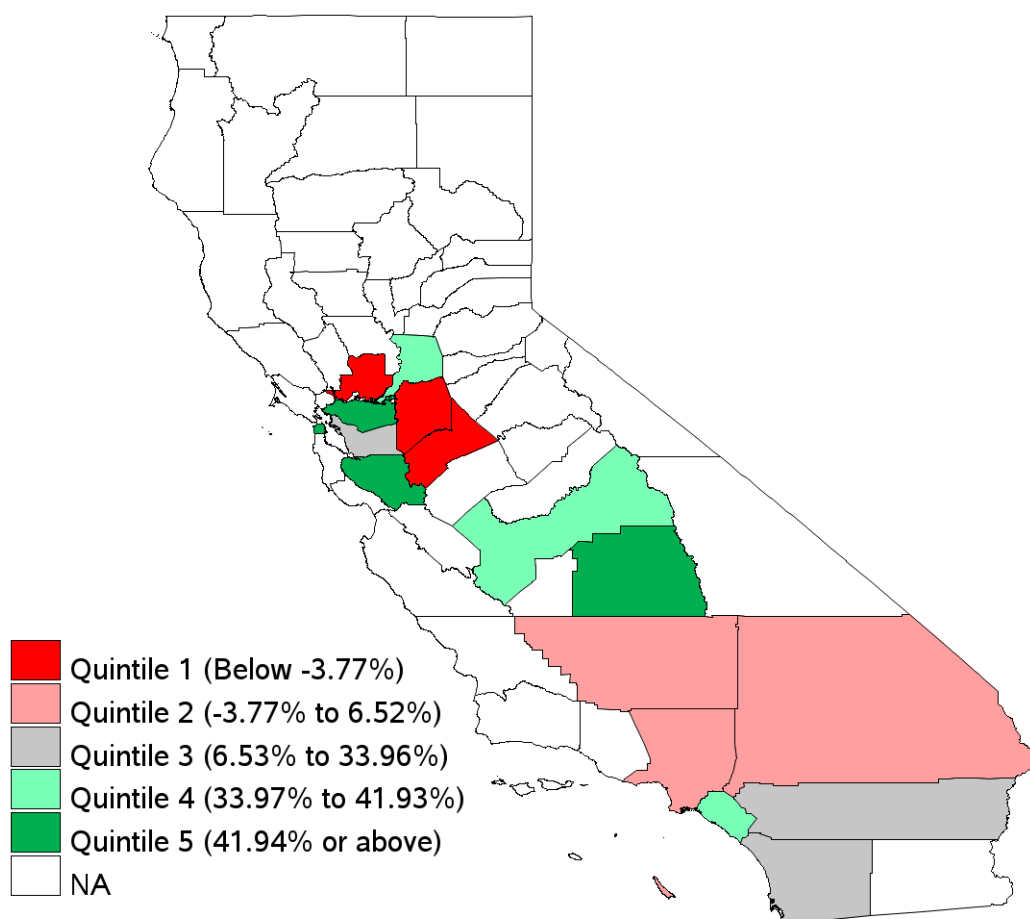


Figure 2.83—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for FUM-30—Black or African American



The following are the key findings for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the San Joaquin Valley and Southern Coast regions had low performance for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for three of six (50.0 percent) counties with reportable rates (Fresno, Kern, and Stanislaus) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Rates for two of these three (66.7 percent) counties with reportable rates (Kern and Stanislaus) were also in the bottom

two quintiles for trending results. Of note, the rate for Kern County was below the minimum performance level by more than a 70 percent relative difference.

- Rates for two of three (66.7 percent) counties (Los Angeles and San Diego) in the Southern Coast region were in Quintile 2 for current year performance and were below the minimum performance level by at least a 20 percent relative difference.

Figure 2.84—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)—Hispanic or Latino—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for FUM-30—Hispanic or Latino

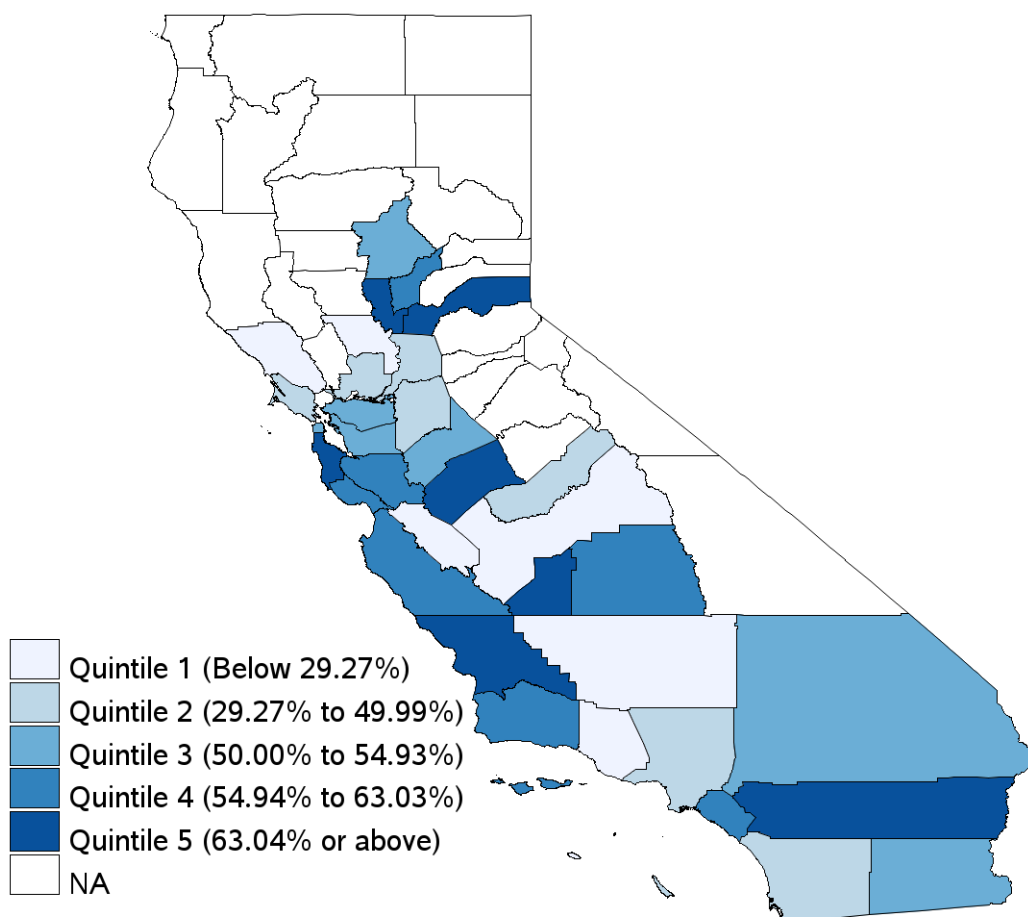
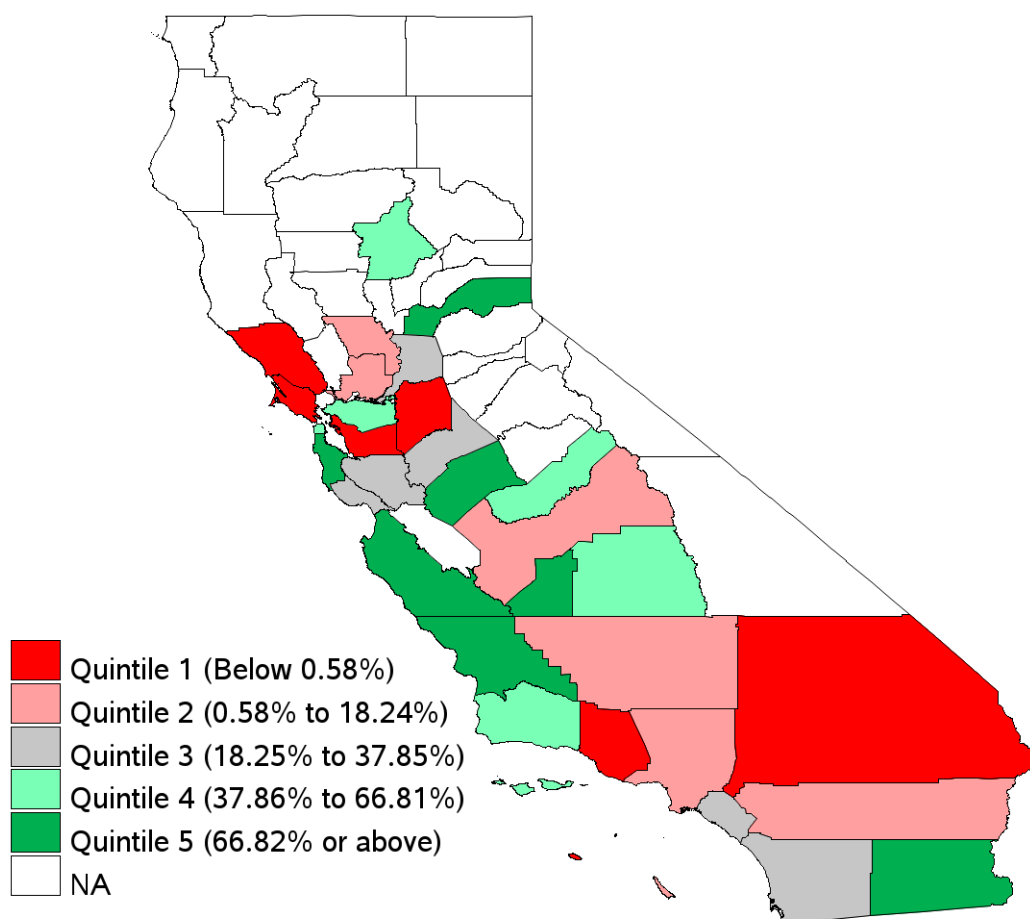


Figure 2.85—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)—Hispanic or Latino—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for FUM-30—Hispanic or Latino



The following are the key findings for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total—Hispanic or Latino indicator-racial/ethnic group combination regional analysis*:

- ◆ Counties in the San Joaquin Valley and Southern Coast regions had low performance for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total—Hispanic or Latino indicator-racial/ethnic group combination*.
 - Rates for four of eight (50.0 percent) counties (Fresno, Kern, Madera, and San Joaquin) in the San Joaquin Valley region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance. Rates for three of these four (75.0 percent) counties (Fresno, Kern, and San Joaquin) were in the bottom two quintiles for trending

performance. Of note, rates for Fresno and Kern counties were below the minimum performance level by more than a 50 percent relative difference.

- Rates for two of three (66.7 percent) counties (Los Angeles and San Diego) in the Southern Coast region were in Quintile 2 for current year performance. Of note, Los Angeles County was below the minimum performance level by more than a 30 percent relative difference.
- ◆ Counties in the Central Coast and North/Mountain regions had high performance for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*—Hispanic or Latino indicator-racial/ethnic group combination.
 - Rates for four of six (66.7 percent) counties (Monterey, San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Additionally, rates for three of these four (75.0 percent) counties (Monterey, San Luis Obispo, and Santa Barbara) were in the top two quintiles for trending performance. Of note, the rates for Monterey and San Luis Obispo counties were above the minimum performance level by more than a 10 percent relative difference.
 - Rates for three of five (60.0 percent) counties with reportable rates (Placer, Sutter, and Yuba) in the North/Mountain region were in the top two quintiles and above the minimum performance level by more than a 10 percent relative difference.

Figure 2.86—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for FUM-30—White

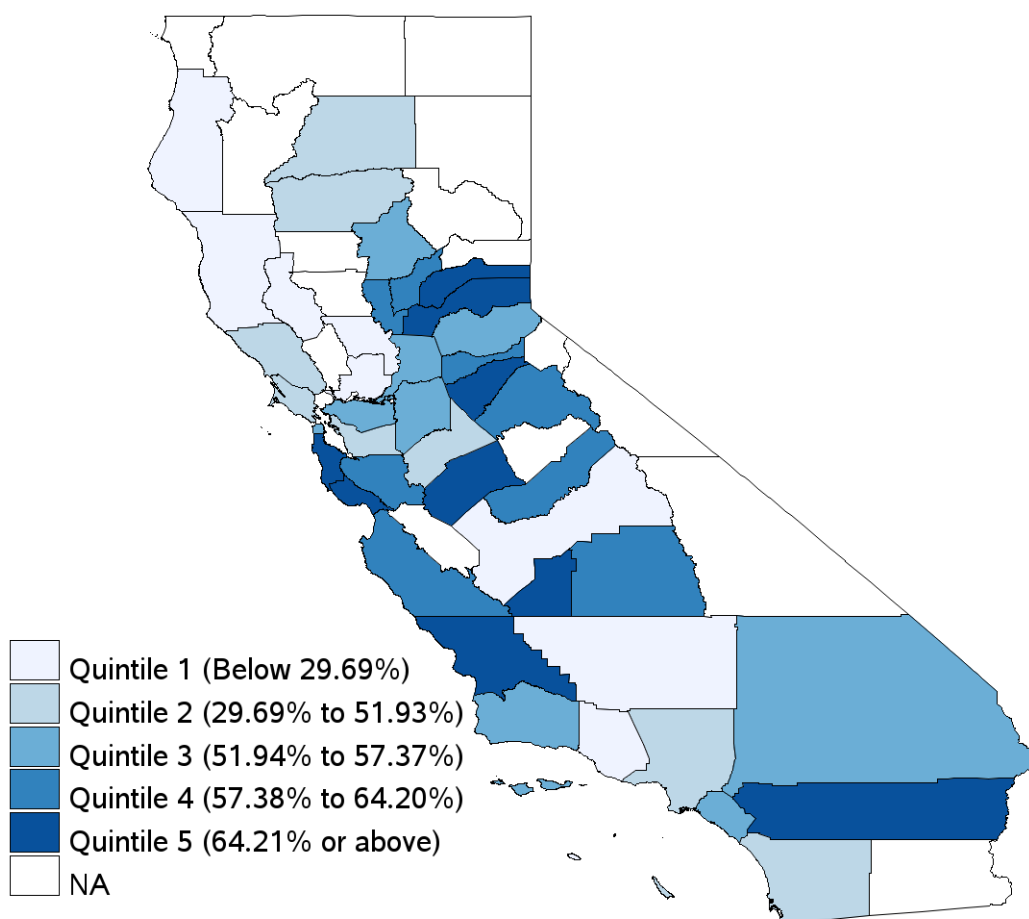
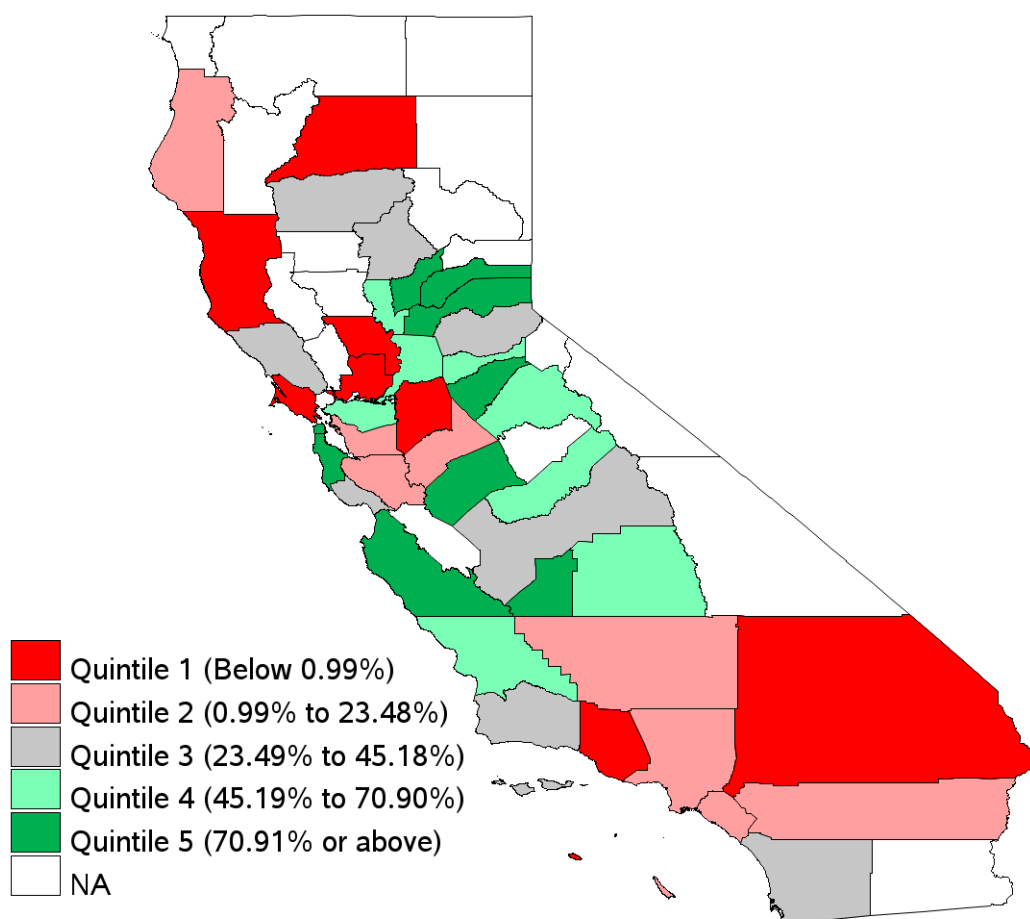


Figure 2.87—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for FUM-30—White



The following are the key findings for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Southern Coast region had low performance for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total—White* indicator-racial/ethnic group combination.
 - Rates for two of three (66.7 percent) counties (Los Angeles and San Diego) were in Quintile 2 for current year performance. Additionally, both counties had rates below the minimum performance level by more than a 10 percent relative difference.

- ◆ Counties in the Central Coast and San Joaquin Valley regions had high performance for the *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*—White indicator-racial/ethnic group combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (Monterey, San Luis Obispo, and Santa Cruz) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Rates for two of these three (66.7 percent) counties (Monterey and San Luis Obispo) were also in the top two quintiles for trending performance.
 - Rates for four of eight (50.0 percent) counties (Kings, Madera, Merced, and Tulare) in the San Joaquin Valley region were in the top two quintiles for both current year and trending performance. Of note, the rates for Kings and Merced counties were above the minimum performance level by more than a 25 percent relative difference.

Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD–C&M)

The *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD–C&M)* indicator measures the percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the initiation phase ended. Figure 2.88 displays the statewide racial/ethnic and applicable regional-level results for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD–C&M)* indicator in addition to identified health disparities.

Figure 2.88—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD–C&M) Rates by Race/Ethnicity

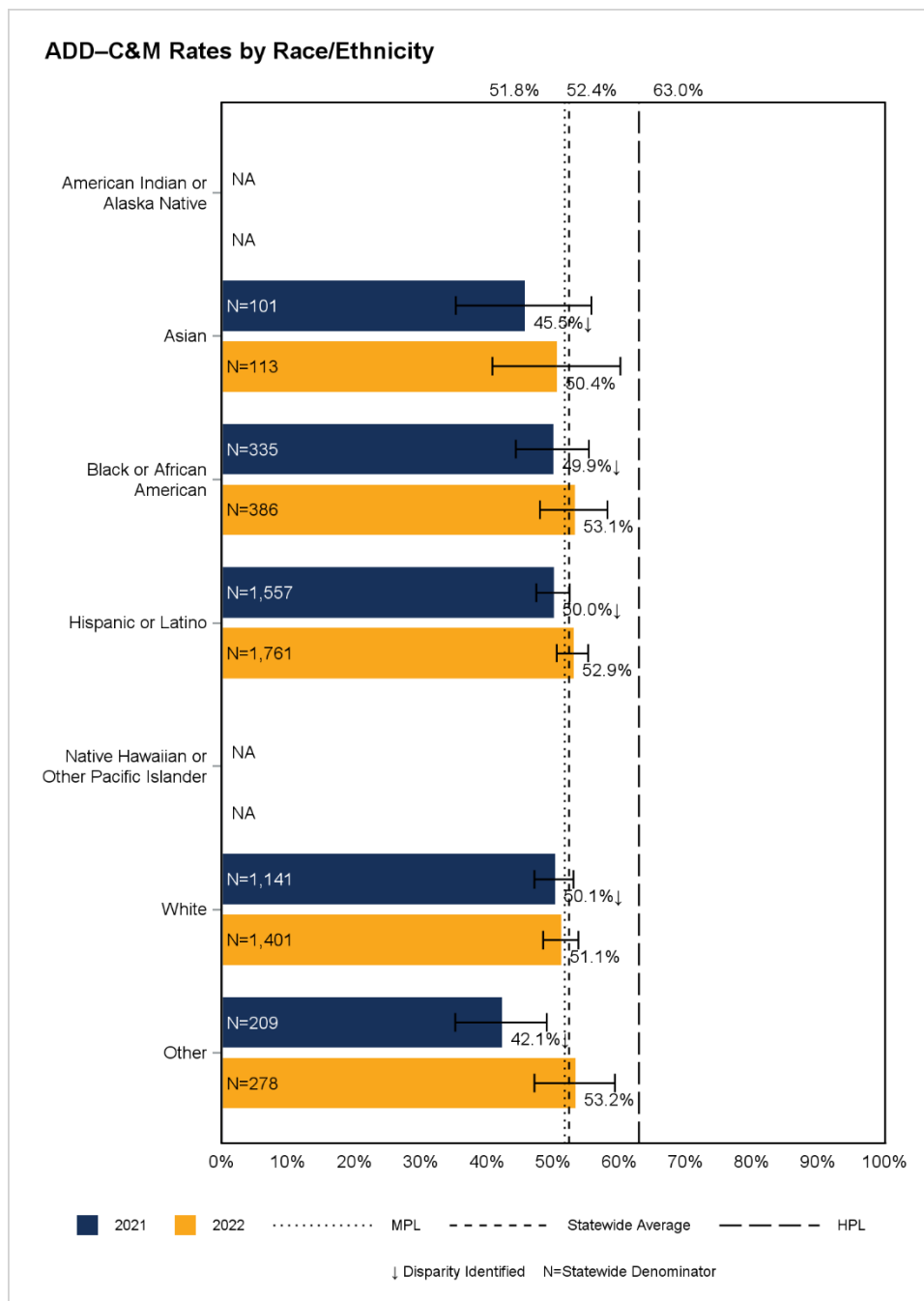
Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 49.7 percent (N=183) and 54.9 percent (N=266), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.0 percent and 67.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 49.4 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).



The following key findings were identified for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* indicator:

- ◆ Five of seven (71.4 percent) racial/ethnic group rates (Asian, Black or African American, Hispanic or Latino, Other, and White) had eliminated disparities identified for measurement year 2022.

- ◆ No persistent, new, widespread, large, or emerging disparities were identified for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* indicator.

Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC)

The *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC)* indicator measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and received blood glucose and cholesterol testing. Figure 2.89 through Figure 2.91 display the statewide racial/ethnic and applicable regional-level results for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC)* indicator in addition to identified health disparities.

Figure 2.89—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC) Rates by Race/Ethnicity

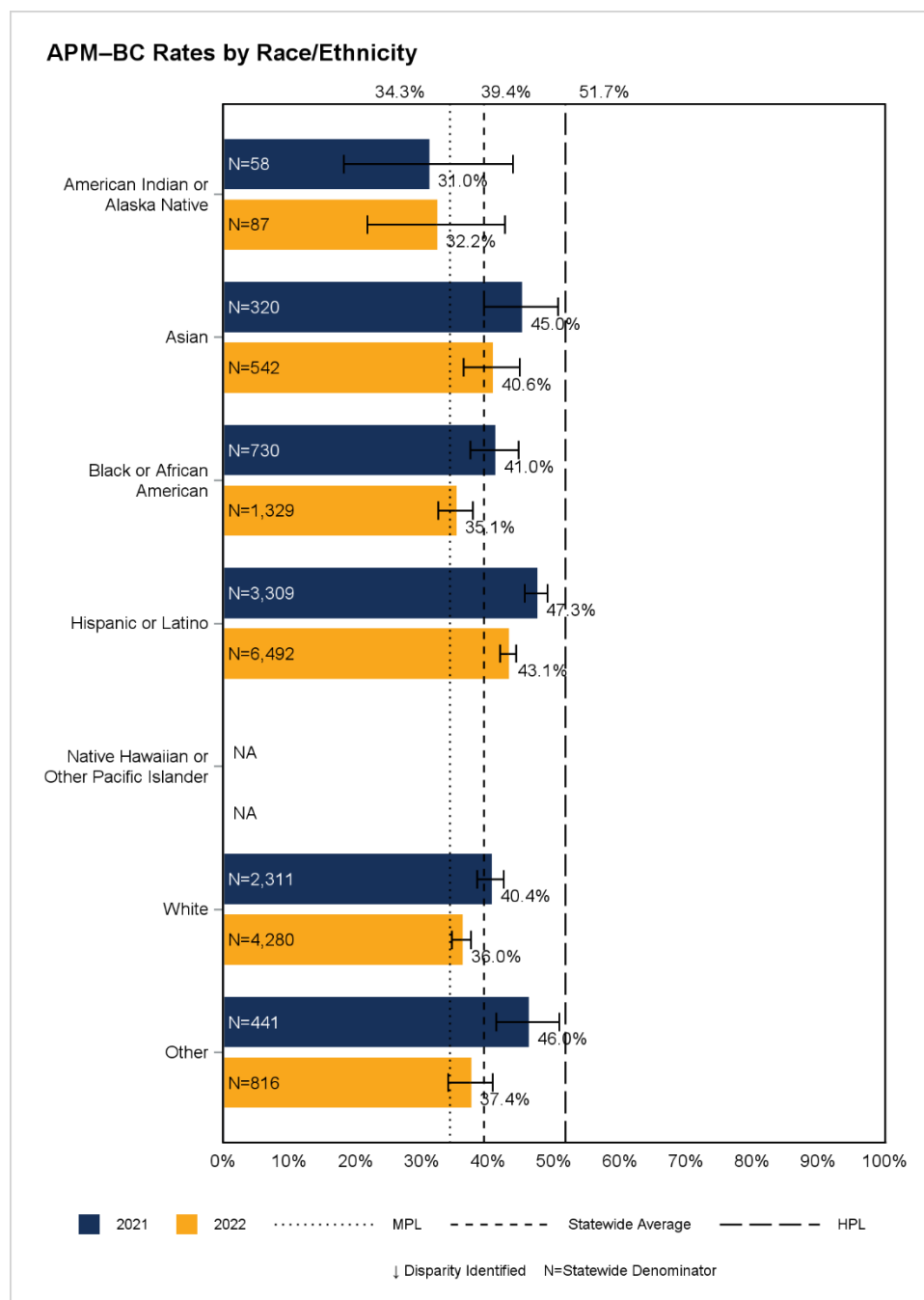
Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 40.3 percent (N=335) and 35.6 percent (N=663), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 30.6 percent and 44.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 44.0 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).



The following key findings were identified for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* indicator:

- While none of the racial/ethnic group rates had a disparity identified in either measurement year, the Black or African American, Other, and White racial/ethnic groups are at risk of having a disparity emerge in measurement year 2023.

- ◆ No persistent, new, eliminated, widespread, or large disparities were identified for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* indicator.

Figure 2.90—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM-BC)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for APM-BC—White

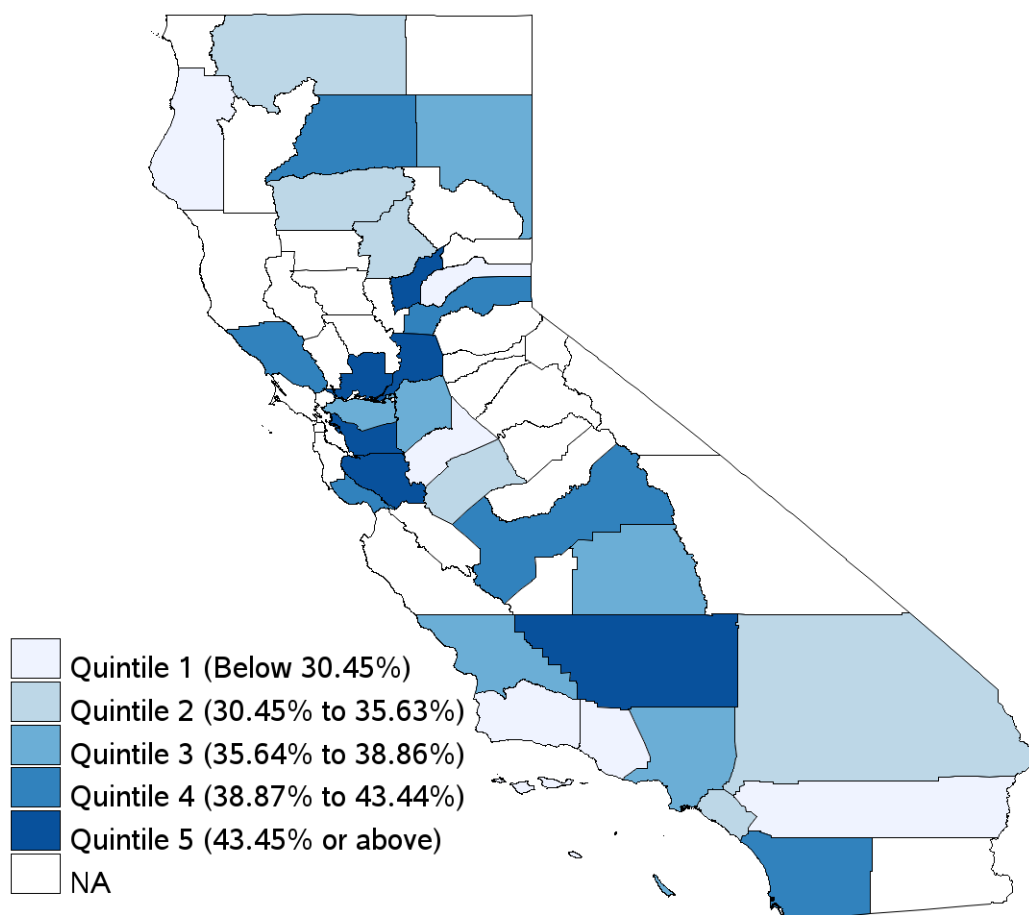
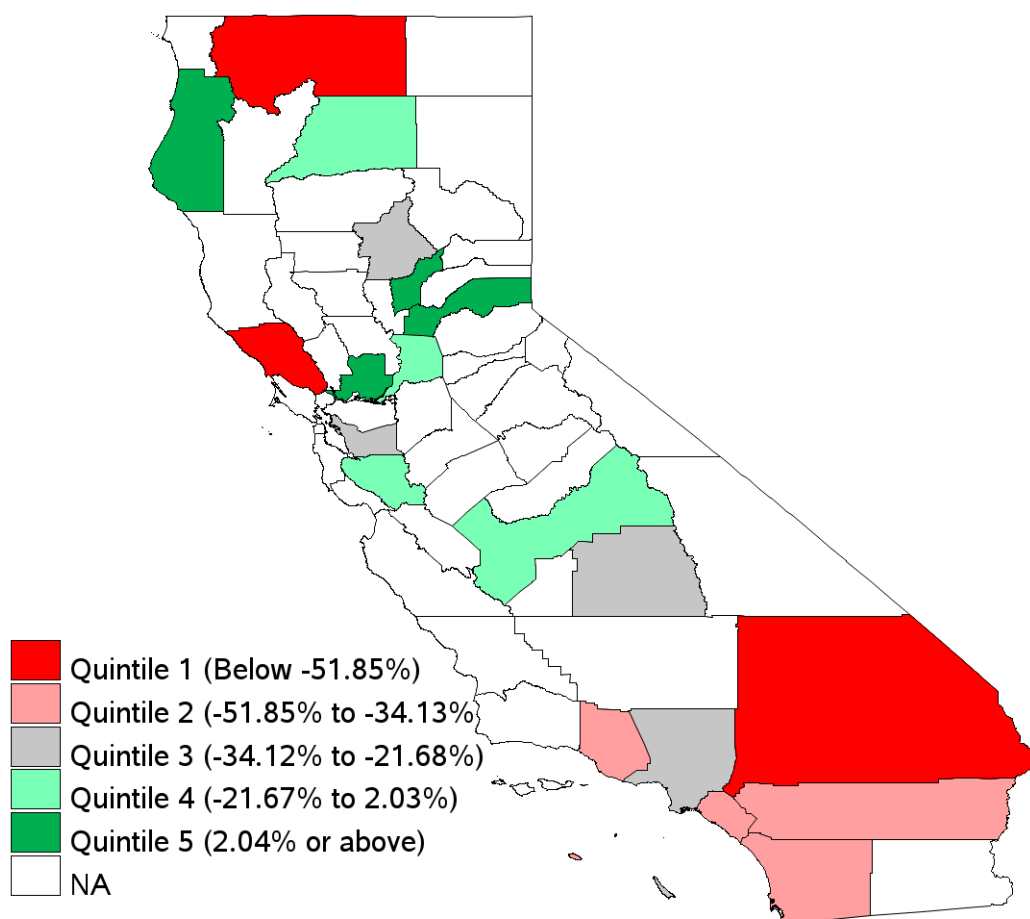


Figure 2.91—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM-BC)—White—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for APM-BC—White



The following are the key findings for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Central Coast, North/Mountain, and Southeastern regions had low performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total—White* indicator-racial/ethnic group combination.
 - Rates for two of four (50.0 percent) counties with reportable rates (Santa Barbara and Ventura) in the Central Coast region were in Quintile 1 for current year performance and were below the minimum performance level by more than a 20 percent relative difference.

- Rates for five of nine (55.6 percent) counties with reportable rates (Butte, Humboldt, Nevada, Siskiyou, and Tehama) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2) for current year performance.
- Rates for both counties with reportable rates (Riverside and San Bernardino) in the Southeastern region were in the bottom two quintiles for current year performance and trending results. Of note, the rate for Riverside County was below the minimum performance level by more than a 15 percent relative difference in measurement year 2022.
- ◆ Counties in the San Francisco Bay/Sacramento region had high performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total—White* indicator-racial/ethnic group combination.
 - Rates for five of six (83.3 percent) counties with reportable rates (Alameda, Sacramento, Santa Clara, Solano, and Sonoma) were in the top two quintiles for current year performance. Rates for three of these five (60.0 percent) counties (Sacramento, Santa Clara, and Solano) were in the top two quintiles for trending performance. Of note, the rate for Solano County was above the minimum performance level by more than a 65 percent relative difference.

Pharmacotherapy for Opioid Use Disorder (POD)

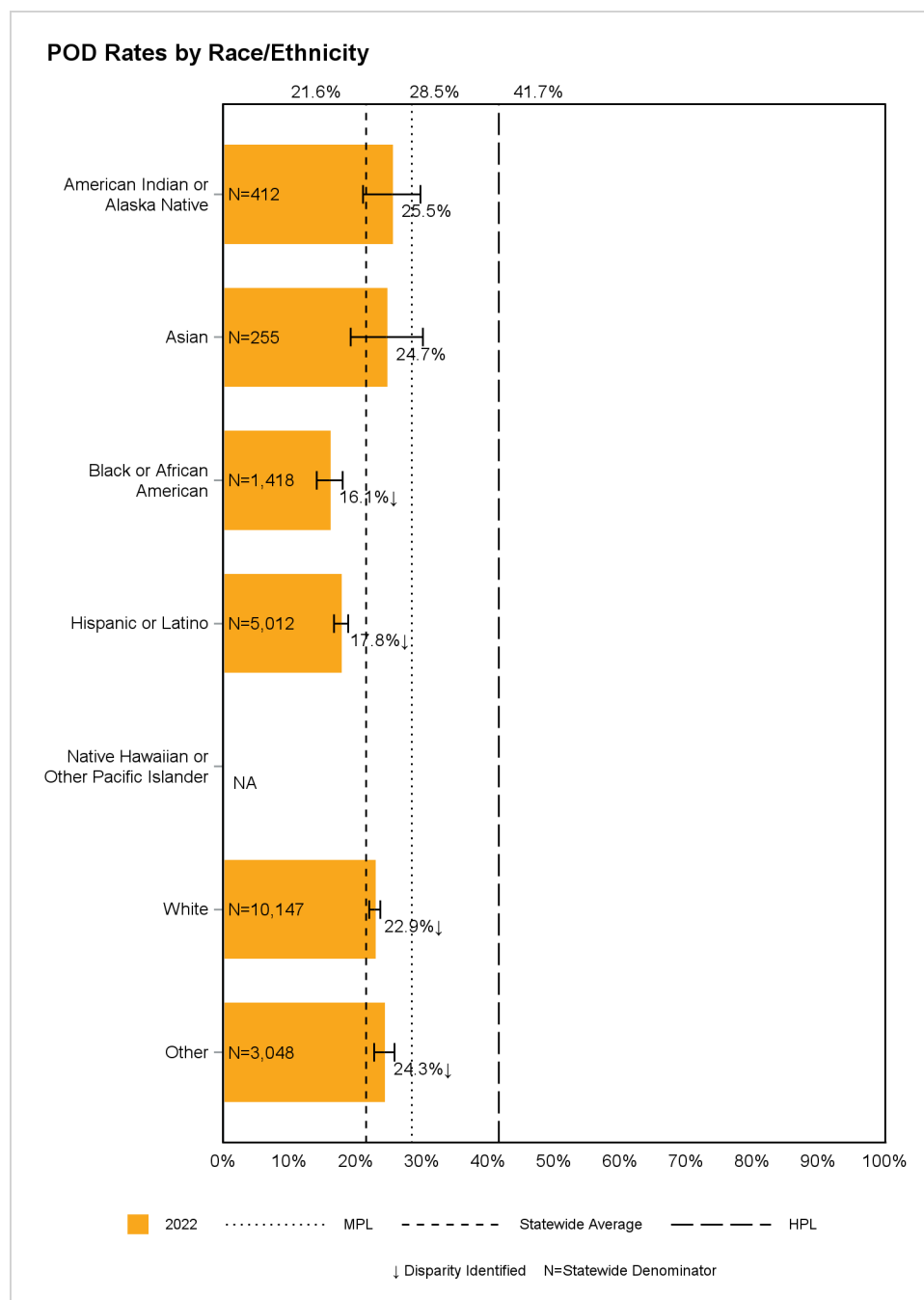
The *Pharmacotherapy for Opioid Use Disorder (POD)* indicator measures the percentage of new opioid use disorder pharmacotherapy events with opioid use disorder pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of opioid use disorder. Figure 2.92 through Figure 2.94 display the statewide racial/ethnic and applicable regional-level results for the *Pharmacotherapy for Opioid Use Disorder (POD)* indicator in addition to identified health disparities.

Figure 2.92—Pharmacotherapy for Opioid Use Disorder (POD) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 26.3 percent (N=729).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).



The following key findings were identified for the *Pharmacotherapy for Opioid Use Disorder* indicator:

- ◆ As this indicator was new for measurement year 2022, all disparities identified were considered new. Four of seven (57.1 percent) racial/ethnic groups (Black or African American, Hispanic or Latino, Other, and White) had new, large disparities identified in measurement year 2022.

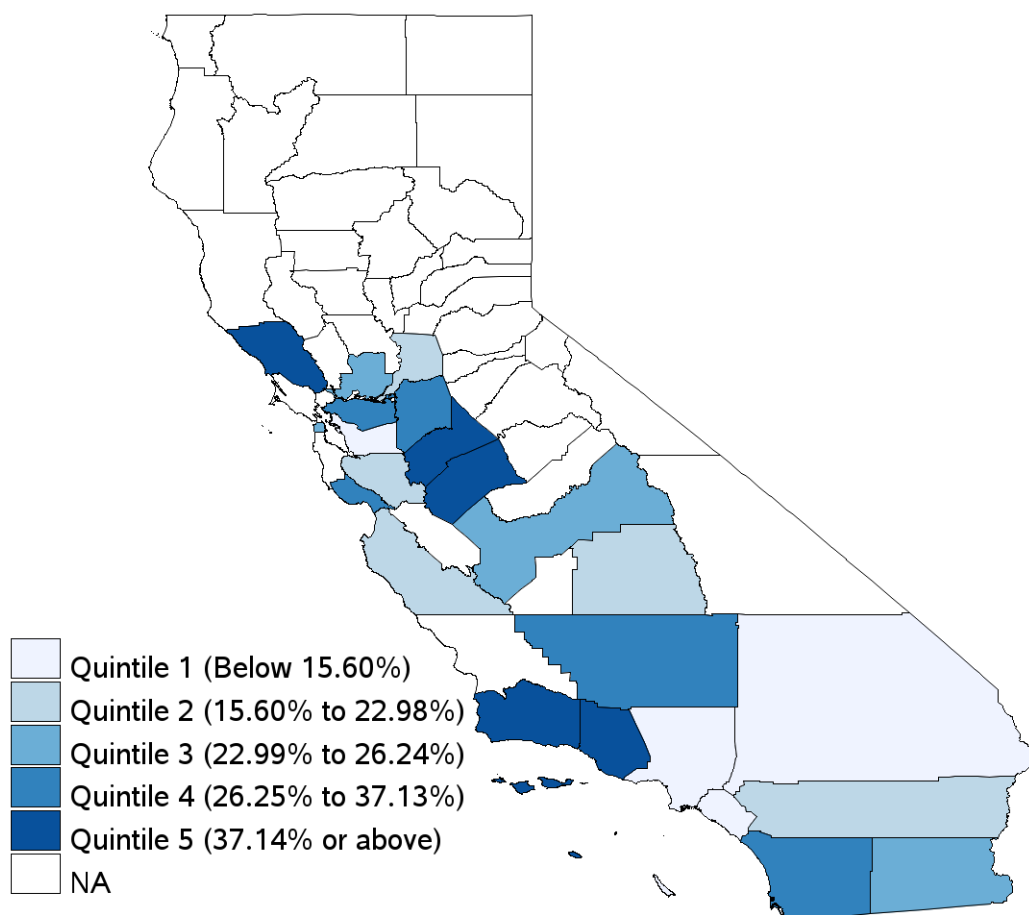
- ◆ Widespread disparities were identified, with four of seven (57.1 percent) racial/ethnic group rates (Black or African American, Hispanic or Latino, Other, and White) having disparities identified for measurement year 2022.

Figure 2.93—Pharmacotherapy for Opioid Use Disorder (POD)—Hispanic or Latino—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for POD—Hispanic or Latino



The following are the key findings for the *Pharmacotherapy for Opioid Use Disorder—Hispanic or Latino* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Southeastern and Southern Coast regions had low performance for the *Pharmacotherapy for Opioid Use Disorder—Hispanic or Latino* indicator-racial/ethnic group combination.
 - Rates for two of three (66.7 percent) counties (Riverside and San Bernardino) in the Southeastern region were in the bottom two quintiles (i.e., Quintiles 1 and 2). Of note,

rates for these counties were below the minimum performance level by more than a 40 percent relative difference.

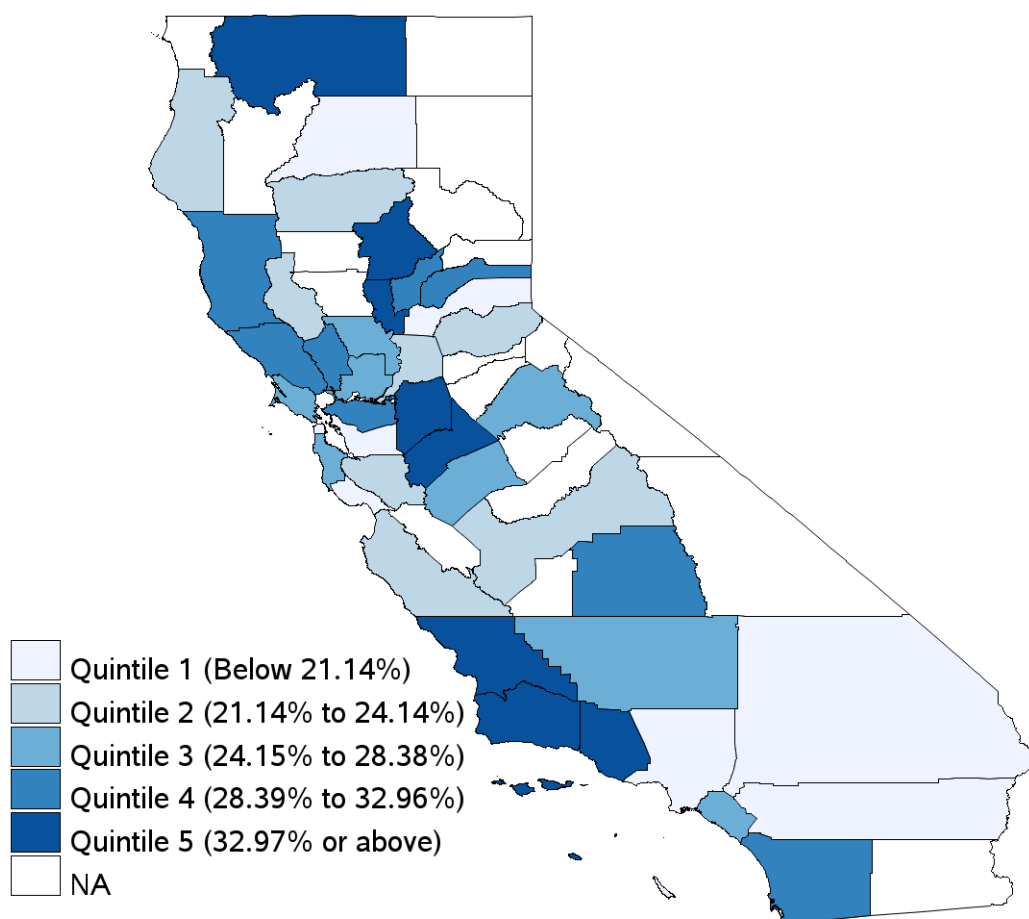
- Rates for two of three (66.7 percent) counties (Los Angeles and Orange) in the Southern Coast region were in Quintile 1. Of note, the rates for these two counties were below the minimum performance level by more than a 55 percent relative difference.
- ◆ Counties in the Central Coast and San Joaquin Valley regions had high performance for the *Pharmacotherapy for Opioid Use Disorder*—Hispanic or Latino indicator-racial/ethnic group combination.
 - Rates for three of four (75.0 percent) counties with reportable rates (Santa Barbara, Santa Cruz, and Ventura) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5). Of note, rates for Santa Barbara and Ventura counties were above the minimum performance level by more than a 40 percent relative difference.
 - Rates for four of six (66.7 percent) counties with reportable rates (Kern, Merced, San Joaquin, and Stanislaus) in the San Joaquin Valley region were in the top two quintiles. Of note, the rate for Merced County was above the minimum performance level by more than a 135 percent relative difference.

Figure 2.94—Pharmacotherapy for Opioid Use Disorder (POD)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for POD—White



The following are the key findings for the *Pharmacotherapy for Opioid Use Disorder—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Southeastern region had low performance for the *Pharmacotherapy for Opioid Use Disorder—White* indicator-racial/ethnic group combination.
 - Both counties with reportable rates (Riverside and San Bernardino) were in Quintile 1 and were below the minimum performance level by more than a 25 percent relative difference.
- ◆ Counties in the Central Coast and San Joaquin Valley regions had high performance for the *Pharmacotherapy for Opioid Use Disorder—White* indicator-racial/ethnic group combination.

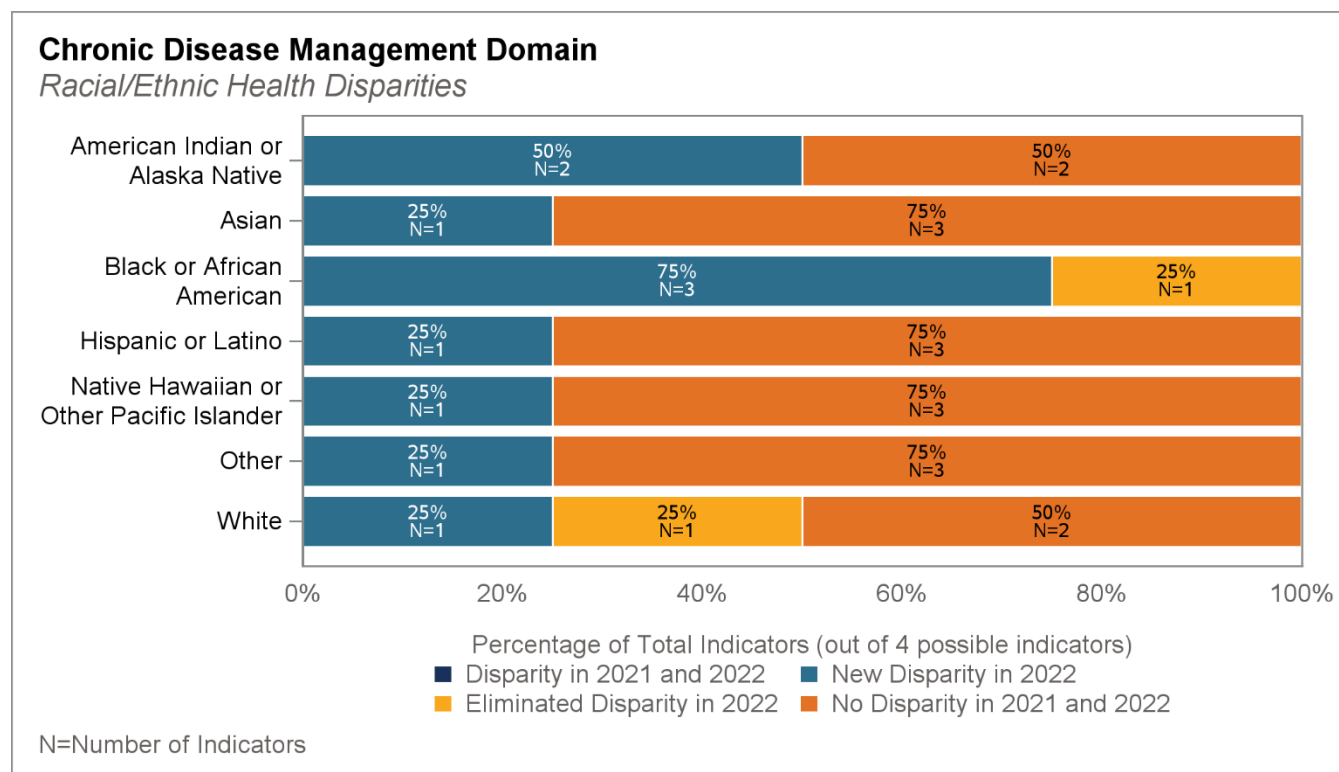
- Rates for three of five (60.0 percent) counties with reportable rates (San Luis Obispo, Santa Barbara, and Ventura) in the Central Coast region were in Quintile 5. Of note, the rate for San Luis Obispo County was above the minimum performance level by more than a 105 percent relative difference.
- Rates for three of six (50.0 percent) counties with reportable rates (San Joaquin, Stanislaus, and Tulare) in the San Joaquin Valley region were in the top two quintiles (i.e., Quintiles 4 and 5). Of note, the rate for San Joaquin County was above the minimum performance level by more than an 80 percent relative difference.

Racial/Ethnic Health Disparities: Chronic Disease Management Domain

Health disparities were identified when indicator rates for racial/ethnic groups were below the minimum performance level/median state performance rate (i.e., the upper bound of the 95 percent confidence interval for the rate was below the national reference rate). If a racial/ethnic group's indicator rate was equal to or higher than the minimum performance level/median state performance rate, then no health disparity was identified.

Figure 2.95 displays the percentage and number of Chronic Disease Management domain indicators (out of four possible indicators) for which disparities were identified or were not identified for each racial/ethnic group in addition to newly identified and eliminated disparities within the Chronic Disease Management domain.

Figure 2.95—Racial/Ethnic Health Disparities Summary: Chronic Disease Management Domain



The following key findings were identified for the Chronic Disease Management domain:

- ◆ No persistent disparities were identified from measurement year 2021 to measurement year 2022 within the Chronic Disease Management domain.
- ◆ New disparities were identified for two indicators within the Chronic Disease Management domain.
 - *Controlling High Blood Pressure—Total* indicator rates for one of seven (14.3 percent) racial/ethnic groups (Black or African American) had a new disparity identified.
 - *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)* indicator rates for two of seven (28.6 percent) racial/ethnic groups (Black or African American and Native Hawaiian or Other Pacific Islander) had a new disparity identified.
- ◆ Eliminated disparities were identified for one indicator in the Chronic Disease Management domain.
 - *Asthma Medication Ratio—Total* indicator rates for two of seven (28.6 percent) racial/ethnic groups (Black or African American and White) had eliminated disparities identified.
- ◆ Widespread disparities were identified for the *Adults' Access to Preventive/Ambulatory Health Services—Total* indicator and the American Indian or Alaska Native and Black or African American racial/ethnic groups.

- For measurement year 2022, *Adults' Access to Preventive/Ambulatory Health Services—Total* indicator rates for all seven racial/ethnic groups had disparities identified.
- For measurement year 2022, the American Indian or Alaska Native racial/ethnic group had disparities identified for two of four (50.0 percent) indicators in the Chronic Disease Management domain.
- For measurement year 2022, the Black or African American racial/ethnic group had disparities identified for three of four (75.0 percent) indicators in the Chronic Disease Management domain.
- ◆ Large disparities were identified for two indicators in the Chronic Disease Management domain.
 - The *Adults' Access to Preventive/Ambulatory Health Services—Total* indicator rates for all seven racial/ethnic groups had a large disparity identified for measurement year 2022.
 - The *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)* indicator rates for one of seven (14.3 percent) racial/ethnic groups (American Indian or Alaska Native) had a large disparity identified for measurement year 2022.
- ◆ An emerging disparity was identified for the *Asthma Medication Ratio—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.

Racial/Ethnic Health Disparities: Chronic Disease Management Domain Key Findings

For the indicators in the Chronic Disease Management domain, there are no corresponding Bold Goals. Based on evaluating the results of the key findings above, the following indicators were determined to be key findings for the Chronic Disease Management domain:

- ◆ *Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)*
- ◆ *Asthma Medication Ratio—Total (AMR)*
- ◆ *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD—H9)*

Please note, the results for the *Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total* and *Plan All-Cause Readmissions—Observed Readmission Rate—Total* indicators were not considered to be key findings given that benchmarks were unavailable and disparities could not be identified. The results for the *Controlling High Blood Pressure—Total* indicator were not considered to be a key finding given that widespread disparities were not identified. Please refer to Appendix C. Demographic Stratification Results for the racial/ethnic rates for these indicators.

Racial/Ethnic Health Disparities: Chronic Disease Management Domain Indicator Results

Figure 2.96 through Figure 2.106 display the racial/ethnic health disparities and applicable regional results for indicators with results determined to be key findings in the Chronic Disease Management domain. For each figure, the denominator, rate, and confidence interval for each racial/ethnic group are displayed. A downward arrow is displayed when a disparity is identified. Additionally, the measurement year 2022 statewide average, high performance level, where applicable, and minimum performance level/median state performance rate, where applicable, are displayed as rates on top of the figure and as dotted lines in the figure.

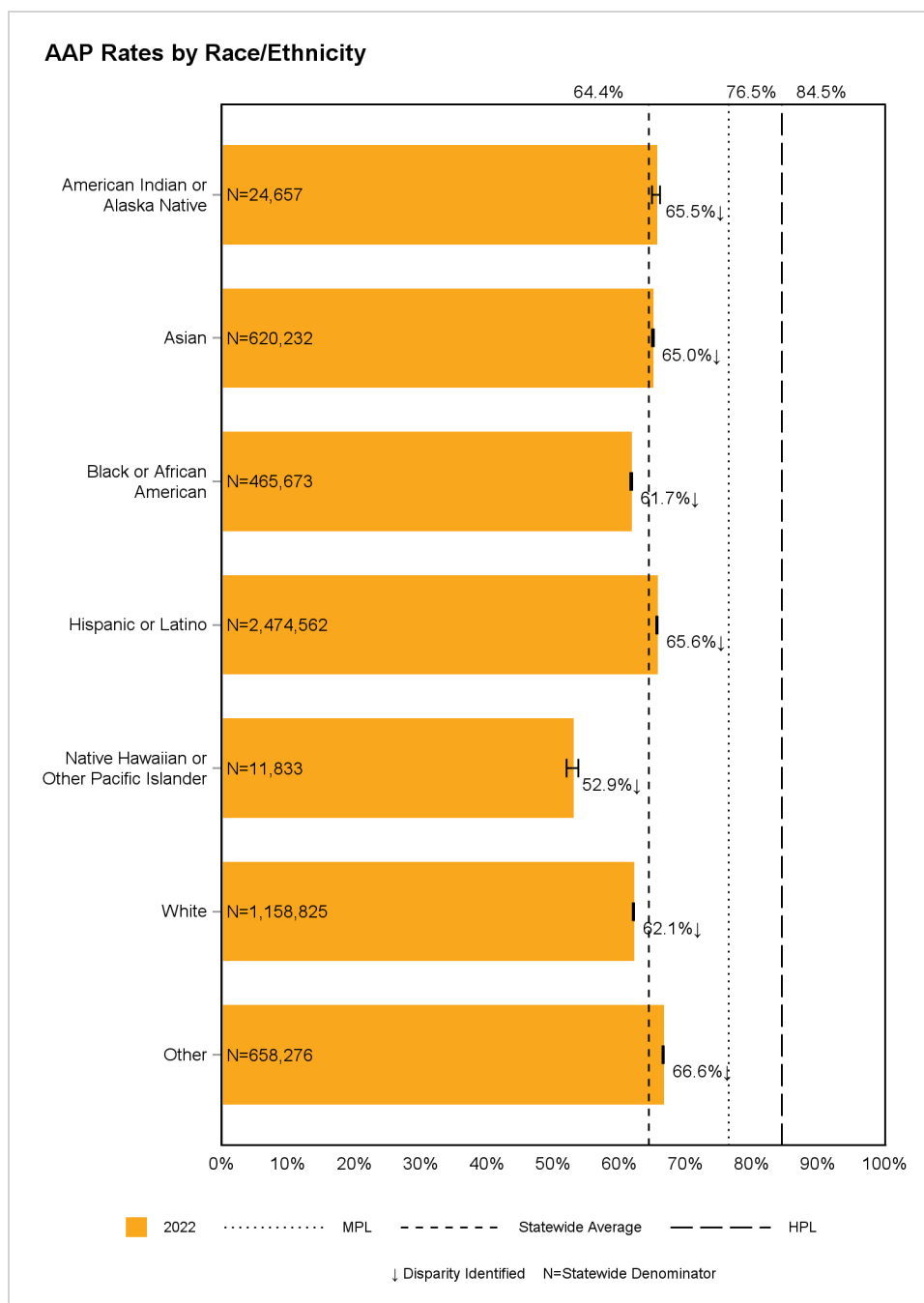
Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)

The *Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)* indicator measures the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year. Figure 2.96 through Figure 2.102 display the statewide racial/ethnic and applicable regional-level results for the *Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)* indicator in addition to identified health disparities.

Figure 2.96—Adults' Access to Preventive/Ambulatory Health Services—Total (AAP) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 61.5 percent (N=236,916).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.



The following key findings were identified for the *Adults' Access to Preventive/Ambulatory Health Services—Total* indicator:

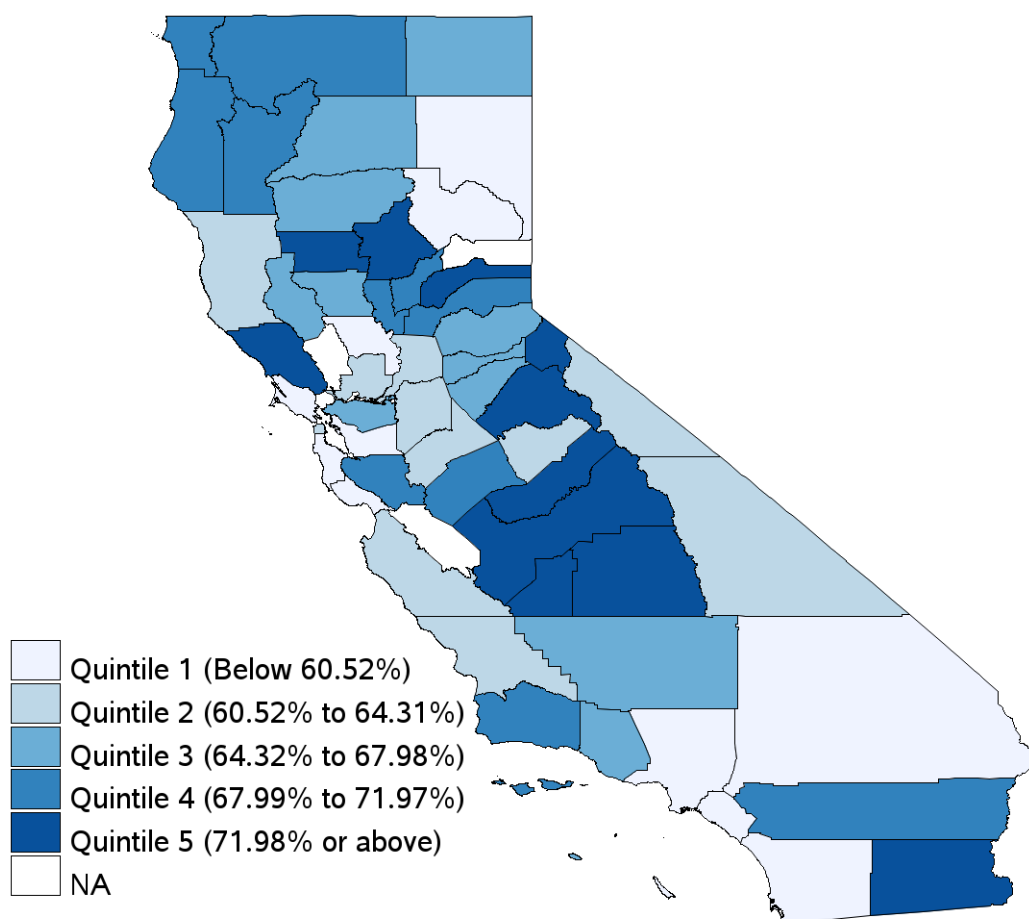
- ◆ As this indicator was new for measurement year 2022, all disparities identified were considered new. All seven racial/ethnic groups had new, large disparities identified in measurement year 2022.
- ◆ Widespread disparities were identified, with all seven racial/ethnic group rates having disparities identified for measurement year 2022.

Figure 2.97—Adults’ Access to Preventive/Ambulatory Health Services—Total (AAP)—American Indian or Alaska Native—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for AAP—American Indian or Alaska Native



The following are the key findings for the *Adults’ Access to Preventive/Ambulatory Health Services—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Central Coast, San Francisco Bay/Sacramento, and Southern Coast regions had low performance for the *Adults’ Access to Preventive/Ambulatory Health Services—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (Monterey, San Luis Obispo, and Santa Cruz) in the Central Coast region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level by more than a 15 percent relative difference.

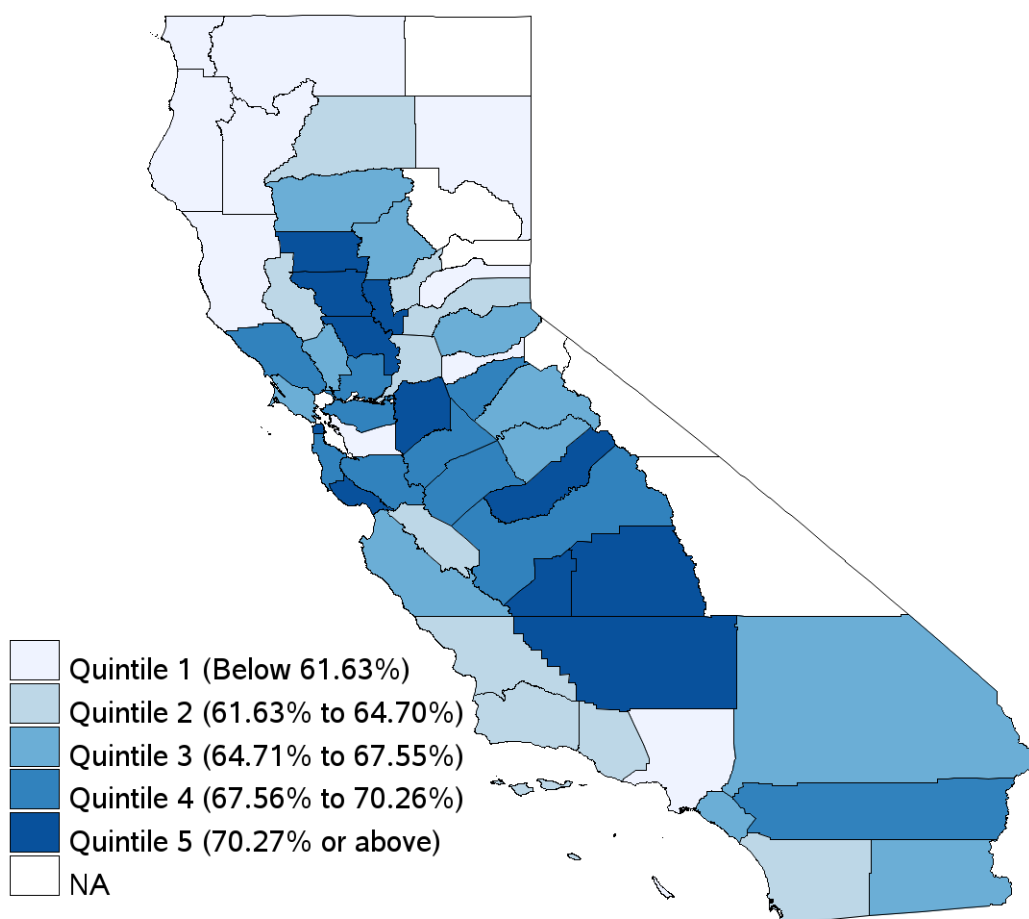
- Rates for six of nine (66.7 percent) counties with reportable rates (Alameda, Marin, Sacramento, San Francisco, San Mateo, and Solano) in the San Francisco Bay/Sacramento region were in the bottom two quintiles and were below the minimum performance level by more than a 15 percent relative difference.
- All three counties (Los Angeles, Orange, and San Diego) in the Southern Coast region were in Quintile 1 and were below the minimum performance level by more than a 20 percent relative difference.
- ◆ Counties in the San Joaquin Valley and Southeastern regions had high performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.
 - Rates for five of eight (62.5 percent) counties (Fresno, Kings, Madera, Merced, and Tulare) in the San Joaquin Valley region were in the top two quintiles (i.e., Quintiles 4 and 5); however, none of the county rates met the minimum performance level.
 - Rates for two of three (66.7 percent) counties (Imperial and Riverside) in the Southeastern region were in the top two quintiles.
- ◆ Of note, Alpine and Butte counties in the North/Mountain region were the only counties to meet the minimum performance level for the *Adults' Access to Preventive/Ambulatory Health Services—Total—American Indian or Alaska Native* indicator-racial/ethnic group combination.

Figure 2.98—Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)—Asian—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for AAP—Asian



The following are the key findings for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Asian* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the Central Coast, North/Mountain, and Southern Coast regions had low performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Asian* indicator-racial/ethnic group combination.
 - Rates for four of six (66.7 percent) counties (San Benito, San Luis Obispo, Santa Barbara, and Ventura) in the Central Coast region were in Quintile 2 and were below the minimum performance level by more than a 15 percent relative difference.
 - Rates for 12 of 22 (54.5 percent) counties with reportable rates (Amador, Del Norte, Humboldt, Lake, Lassen, Mendocino, Nevada, Placer, Shasta, Siskiyou, Trinity, and

Yuba) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2). Of note, the rate for Lassen County was below the minimum performance level by more than a 45 percent relative difference.

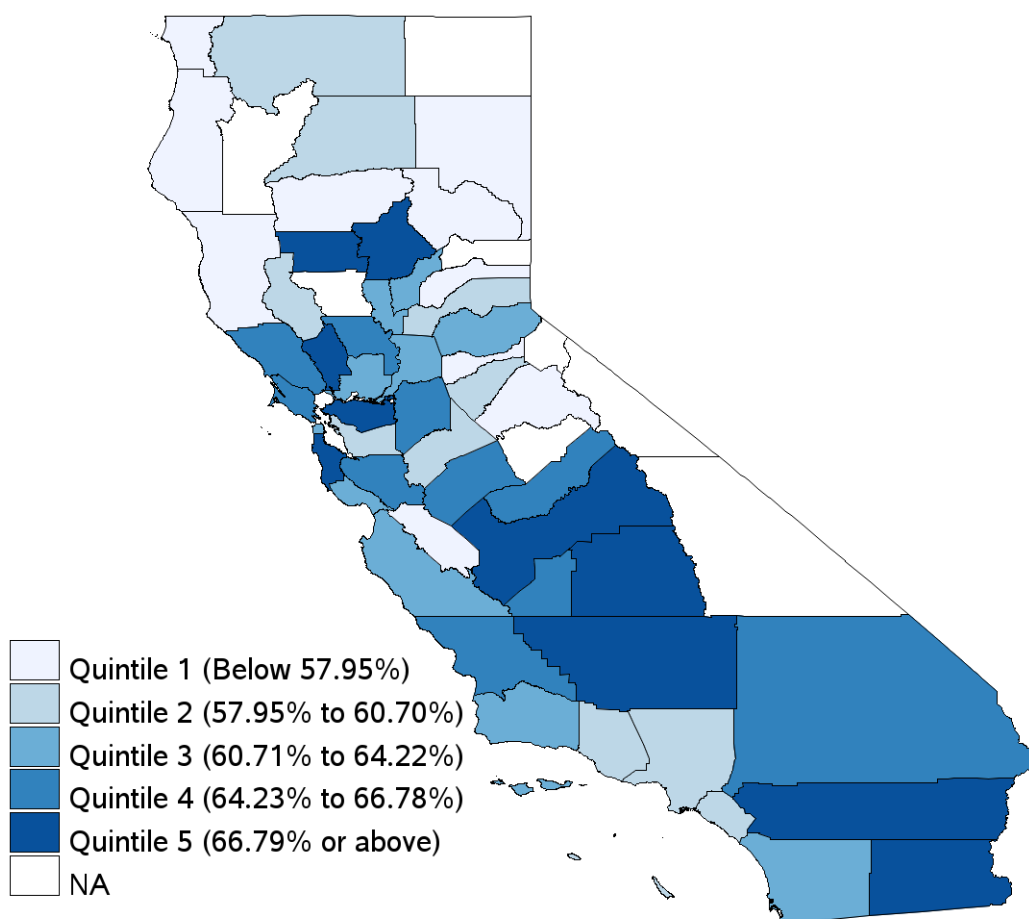
- Rates for two of three (66.7 percent) counties (Los Angeles and San Diego) in the Southern Coast region were in the bottom two quintiles and were below the minimum performance level by more than a 15 percent relative difference.
- ◆ Counties in the San Francisco Bay/Sacramento and San Joaquin Valley regions had high performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Asian* indicator-racial/ethnic group combination.
 - Rates for six of 10 (60.0 percent) counties (Contra Costa, San Francisco, San Mateo, Santa Clara, Solano, and Sonoma) in the San Francisco Bay/Sacramento region were in the top two quintiles (i.e., Quintiles 4 and 5).
 - Rates for all eight counties (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare) in the San Joaquin Valley region were in the top two quintiles.
- ◆ Of note, Colusa and Sutter counties in the North/Mountain region and Madera County in the San Joaquin Valley region were the only counties to meet the minimum performance level for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Asian* indicator-racial/ethnic group combination.

Figure 2.99—Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for AAP—Black or African American



The following are the key findings for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Black or African American* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain and Southern Coast regions had low performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for 14 of 20 (70.0 percent) counties with reportable rates (Amador, Calaveras, Del Norte, Humboldt, Lake, Lassen, Mendocino, Nevada, Placer, Plumas, Shasta, Siskiyou, Tehama, and Tuolumne) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level by more than a 20 percent relative difference.

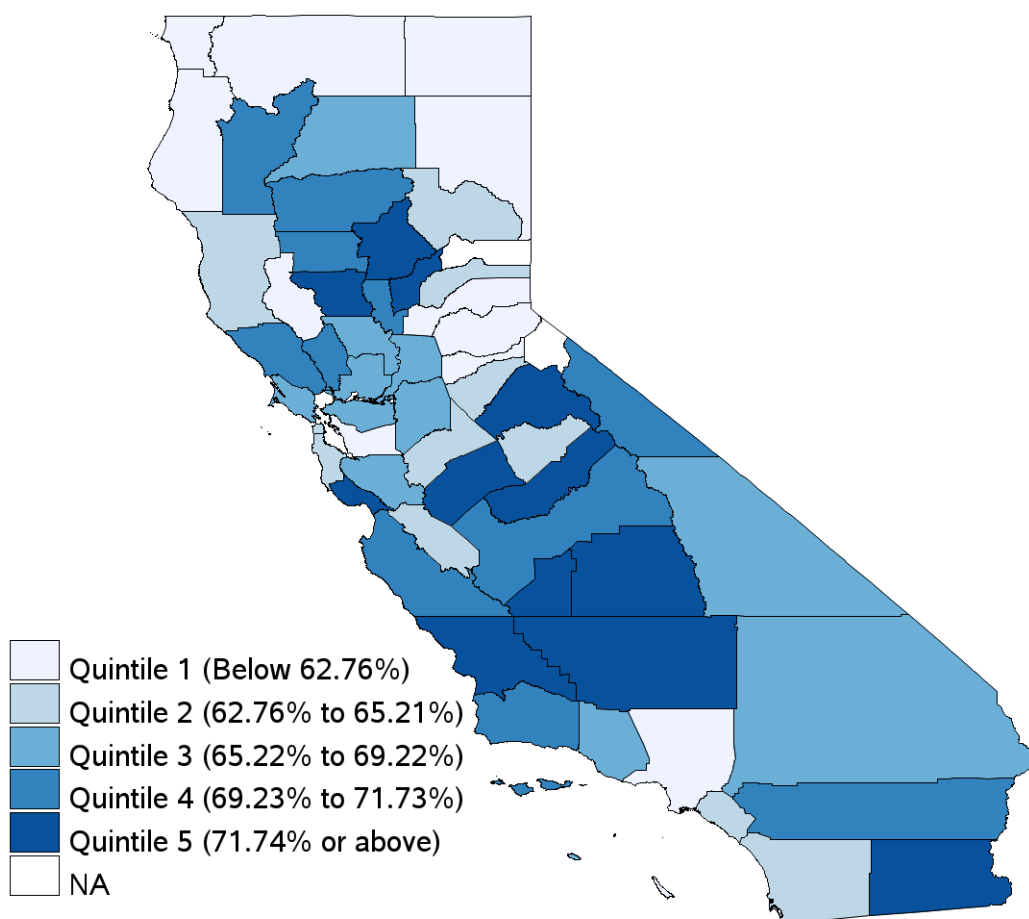
- Rates for two of three (66.7 percent) counties (Los Angeles and Orange) in the Southern Coast region were in Quintile 2.
- ◆ Counties in the San Francisco Bay/Sacramento, San Joaquin Valley, and Southeastern regions had high performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Black or African American* indicator-racial/ethnic group combination.
 - Rates for six of 10 (60.0 percent) counties (Contra Costa, Marin, Napa, San Mateo, Santa Clara, and Sonoma) in the San Francisco Bay/Sacramento region were in the top two quintiles (i.e., Quintiles 4 and 5).
 - Rates for seven of eight (87.5 percent) counties (Fresno, Kern, Kings, Madera, Merced, San Joaquin, and Tulare) in the San Joaquin Valley region were in the top two quintiles.
 - Rates for all three counties (Imperial, Riverside, and San Bernardino) in the Southeastern region were in the top two quintiles.
- ◆ Of note, no counties had rates that met the minimum performance level for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Black or African American* indicator-racial/ethnic group combination.

Figure 2.100—Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)—Hispanic or Latino—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for AAP—Hispanic or Latino



The following are the key findings for the *Adults' Access to Preventive/Ambulatory Health Services—Total*—Hispanic or Latino indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain and Southern Coast regions had low performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total*—Hispanic or Latino indicator-racial/ethnic group combination.
 - Rates for 14 of 26 (53.8 percent) counties with reportable rates (Amador, Calaveras, Del Norte, El Dorado, Humboldt, Lake, Lassen, Mariposa, Mendocino, Modoc, Nevada, Placer, Plumas, and Siskiyou) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level by more than a 15 percent relative difference.

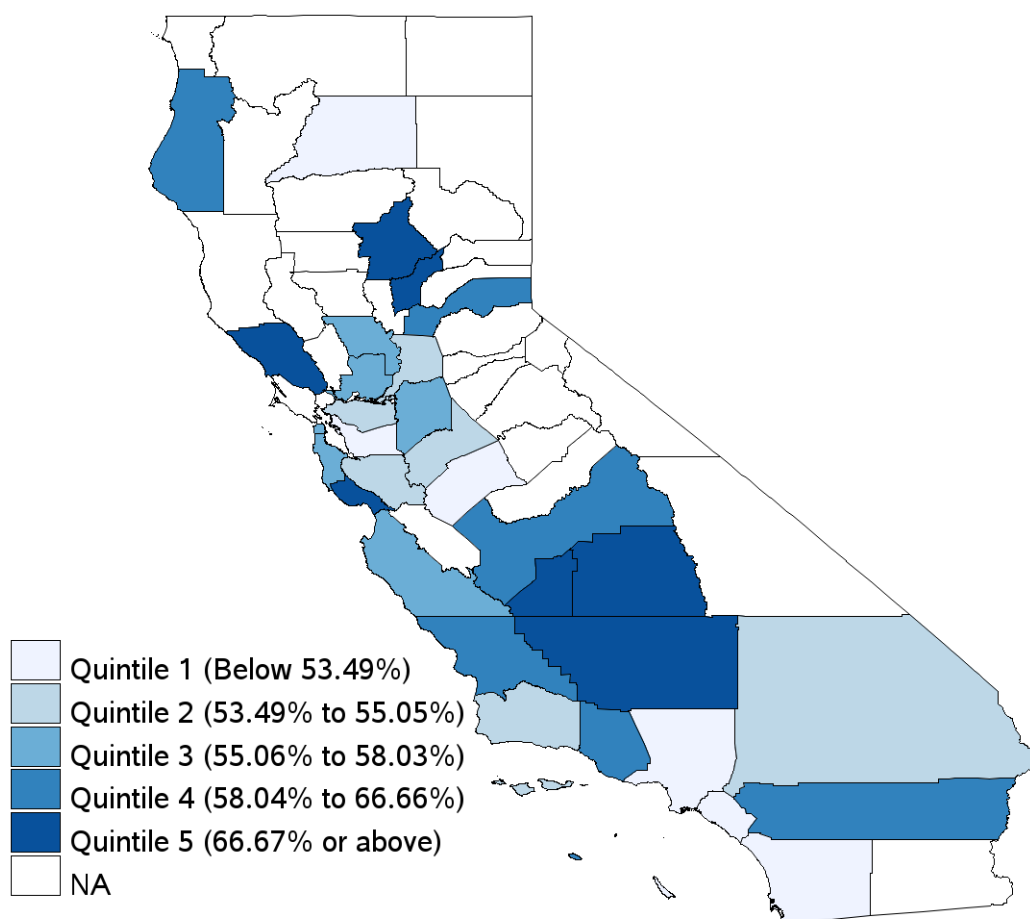
- Rates for all three counties (Los Angeles, Orange, and San Diego) in the Southern Coast region were in the bottom two quintiles and were below the minimum performance level by more than a 15 percent relative difference.
- ◆ Counties in the Central Coast, San Joaquin Valley, and Southeastern regions had high performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Hispanic or Latino* indicator-racial/ethnic group combination.
 - Rates for four of six (66.7 percent) counties (Monterey, San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5).
 - Rates for six of eight (75.0 percent) counties (Fresno, Kern, Kings, Madera, Merced, and Tulare) in the San Joaquin Valley region were in the top two quintiles. Of note, the rate for Tulare County was the only rate to meet the minimum performance level.
 - Rates for two of three (66.7 percent) counties (Imperial and Riverside) in the Southeastern region were in the top two quintiles.

Figure 2.101—Adults’ Access to Preventive/Ambulatory Health Services—Total (AAP)—Native Hawaiian or Other Pacific Islander—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for AAP—Native Hawaiian or Other Pacific Islander



The following are the key findings for the *Adults’ Access to Preventive/Ambulatory Health Services—Total*—Native Hawaiian or Other Pacific Islander indicator-racial/ethnic group combination regional analysis:

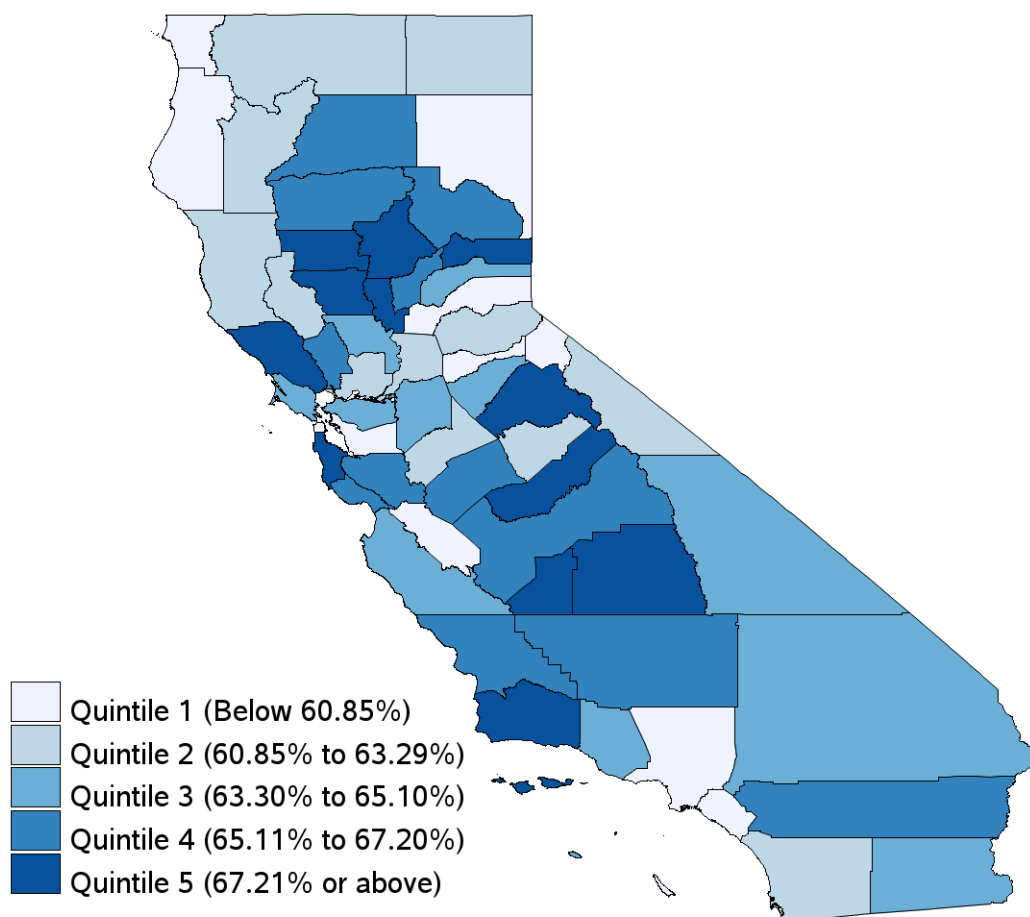
- ◆ Counties in the San Francisco Bay/Sacramento and Southern Coast regions had low performance for the *Adults’ Access to Preventive/Ambulatory Health Services—Total*—Native Hawaiian or Other Pacific Islander indicator-racial/ethnic group combination.
 - Rates for four of eight (50.0 percent) counties with reportable rates (Alameda, Contra Costa, Sacramento, and Santa Clara) in the San Francisco Bay/Sacramento region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level by more than a 25 percent relative difference.

- The rates for all three counties (Los Angeles, Orange, and San Diego) in the Southern Coast region were in Quintile 1 and were below the minimum performance level by more than a 30 percent relative difference.
- ◆ Counties in the Central Coast, North/Mountain, and San Joaquin Valley regions had high performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Native Hawaiian or Other Pacific Islander* indicator-racial/ethnic group combination.
 - Rates for three of five (60.0 percent) counties with reportable rates (San Luis Obispo, Santa Cruz, and Ventura) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5).
 - Rates for four of six (66.7 percent) counties with reportable rates (Butte, Humboldt, Placer, and Yuba) in the North/Mountain region were in the top two quintiles.
 - Rates for four of seven (57.1 percent) counties with reportable rates (Fresno, Kern, Kings, and Tulare) in the San Joaquin Valley region were in the top two quintiles.
- ◆ Of note, no counties had rates that met the minimum performance level for the *Adults' Access to Preventive/Ambulatory Health Services—Total—Native Hawaiian or Other Pacific Islander* indicator-racial/ethnic group combination.

Figure 2.102—Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)—White—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

Current Rates by County for AAP—White



The following are the key findings for the *Adults' Access to Preventive/Ambulatory Health Services—Total—White* indicator-racial/ethnic group combination regional analysis:

- ◆ Counties in the North/Mountain and Southern Coast regions had low performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—White* indicator-racial/ethnic group combination.
 - Rates for 14 of 28 (50.0 percent) counties (Alpine, Amador, Del Norte, El Dorado, Humboldt, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Placer, Siskiyou, and Trinity) in the North/Mountain region were in the bottom two quintiles (i.e., Quintiles 1 and 2) and were below the minimum performance level by more than a 15 percent relative difference.
 - Rates for all three counties (Los Angeles, Orange, and San Diego) in the Southern Coast region were in the bottom two quintiles and were below the minimum performance level by more than a 15 percent relative difference.

- ◆ Counties in the Central Coast and San Joaquin Valley regions had high performance for the *Adults' Access to Preventive/Ambulatory Health Services—Total—White* indicator-racial/ethnic group combination.
 - Rates for three of six (50.0 percent) counties (San Luis Obispo, Santa Barbara, and Santa Cruz) in the Central Coast region were in the top two quintiles (i.e., Quintiles 4 and 5).
 - Rates for six of eight (75.0 percent) counties (Fresno, Kern, Kings, Madera, Merced, and Tulare) in the San Joaquin Valley region were in the top two quintiles.
- ◆ Of note, no counties had rates that met the minimum performance level for the *Adults' Access to Preventive/Ambulatory Health Services—Total—White* indicator-racial/ethnic group combination.

Asthma Medication Ratio—Total (AMR)

The *Asthma Medication Ratio—Total (AMR)* indicator measures the percentage of members 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 2.103 displays the statewide racial/ethnic and applicable regional-level results for the *Asthma Medication Ratio—Total (AMR)* indicator in addition to identified health disparities.

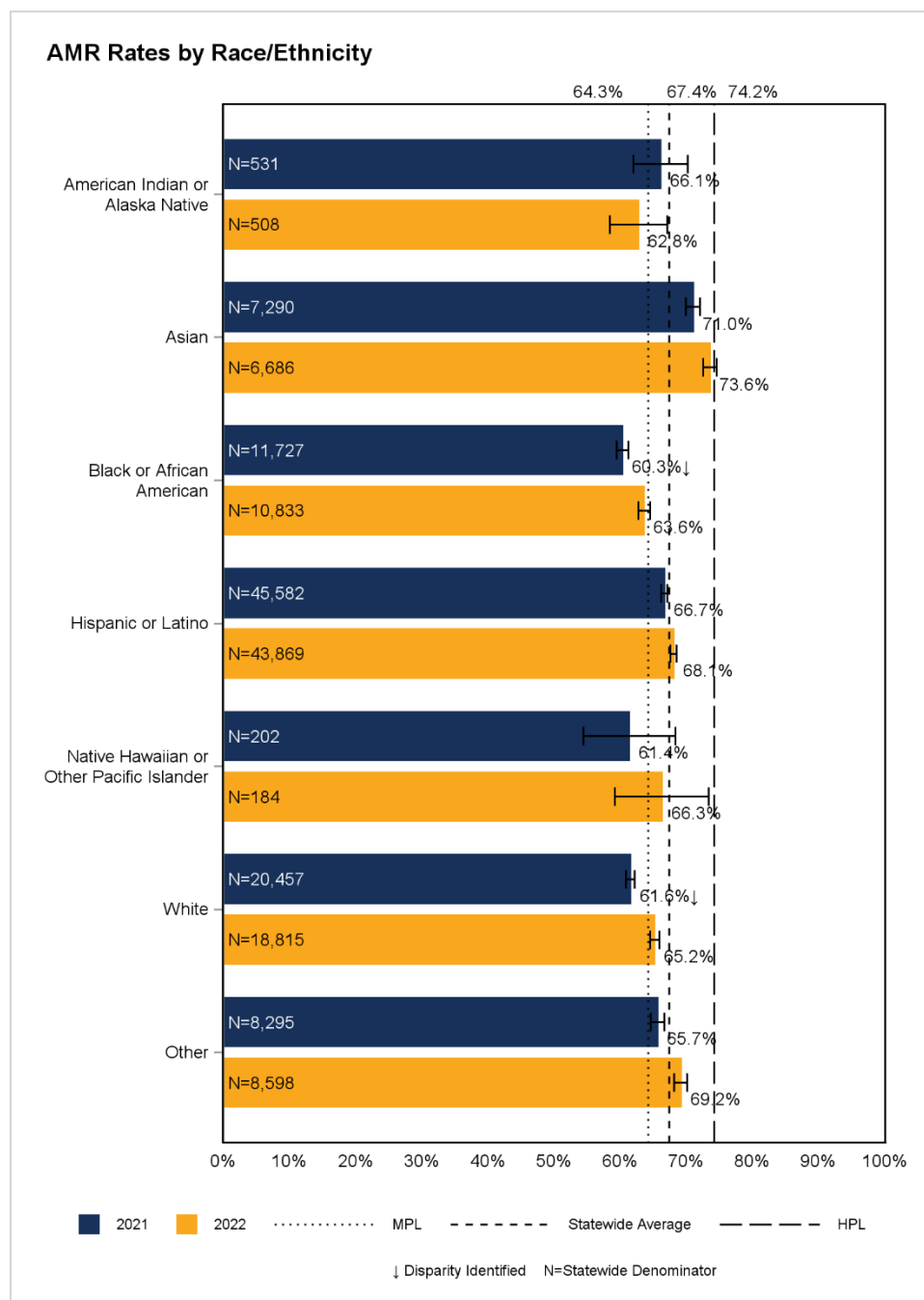
Figure 2.103—Asthma Medication Ratio—Total (AMR) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 65.9 percent (N=3,529) and 68.0 percent (N=3,606), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 64.8 percent and 75.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.0 percent.



The following key findings were identified for the *Asthma Medication Ratio—Total* indicator:

- ◆ Two of seven (28.6 percent) racial/ethnic group rates (Black or African American and White) had eliminated disparities identified for measurement year 2022.
- ◆ While five of seven (71.4 percent) racial/ethnic group rates (American Indian or Alaska Native, Asian, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Other) did not have a disparity identified in either measurement year, the American Indian or Alaska

Native racial/ethnic group is at risk of having a disparity emerge in measurement year 2023.

- ◆ No persistent, new, widespread, or large disparities were identified for the *Asthma Medication Ratio—Total* indicator.

HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)

The *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)* indicator measures the percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose most recently documented HbA1c level was greater than 9.0 percent. Figure 2.104 through Figure 2.106 display the statewide racial/ethnic and applicable regional-level results for the *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)* indicator in addition to identified health disparities.

Figure 2.104—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9) Rates by Race/Ethnicity

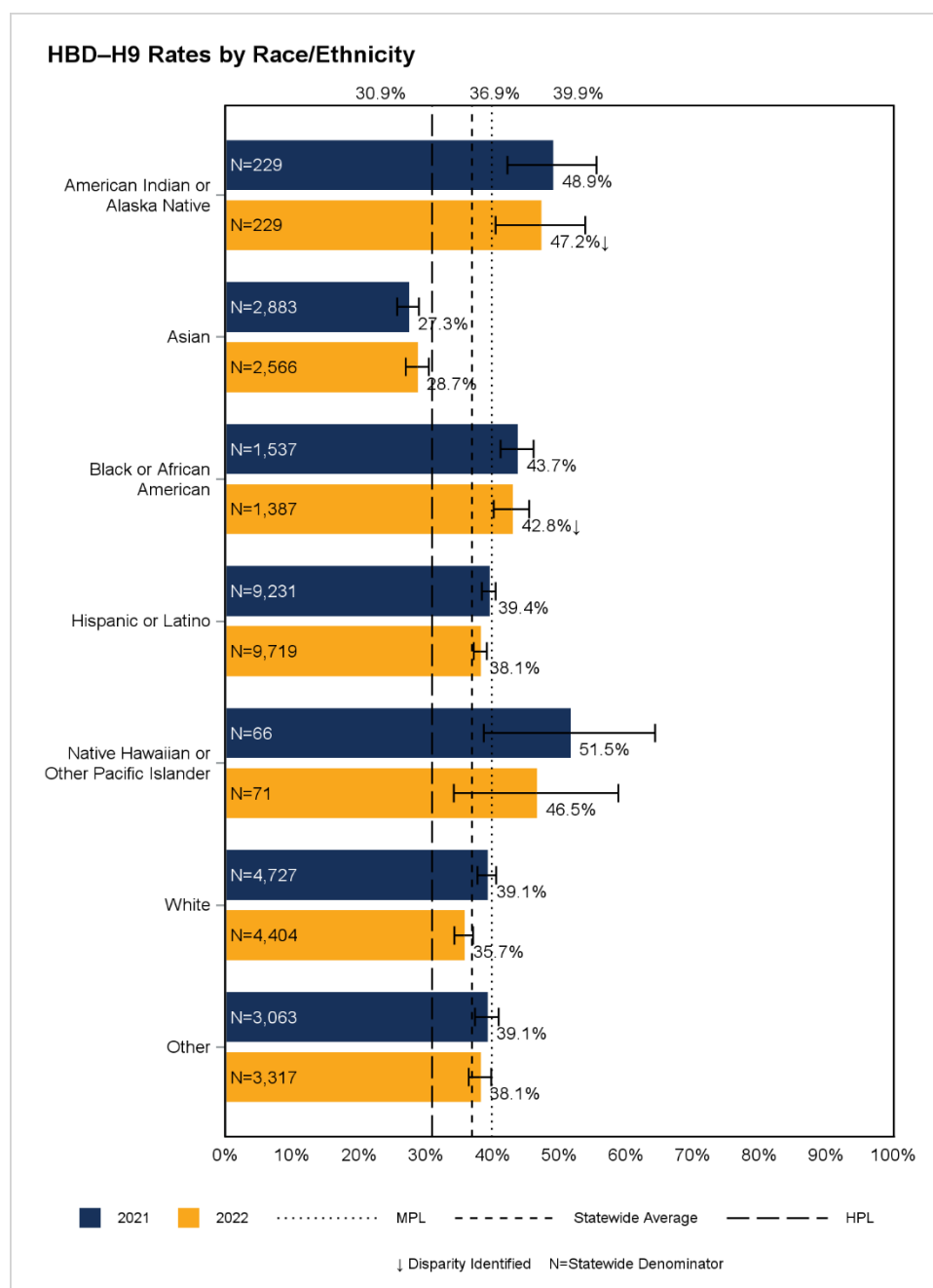
Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 37.0 percent (N=808) and 36.6 percent (N=872), respectively.

A lower rate indicates more favorable performance for this indicator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 43.2 percent and 34.1 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.1 percent.



The following key findings were identified for the *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)* indicator:

- ◆ Two of seven (28.6 percent) racial/ethnic group rates (American Indian or Alaska Native and Black or African American) had new disparities identified in measurement year 2022.
- ◆ One of seven (14.3 percent) racial/ethnic group rates (American Indian or Alaska Native) had a large disparity identified in measurement year 2022.
- ◆ No persistent, widespread, eliminated, or emerging disparities were identified for the *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)* indicator.

Figure 2.105—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)—Black or African American—Current Year Map

Please refer to Appendix E for maps labeled by county and region.

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

Current Rates by County for HBD–H9—Black or African American

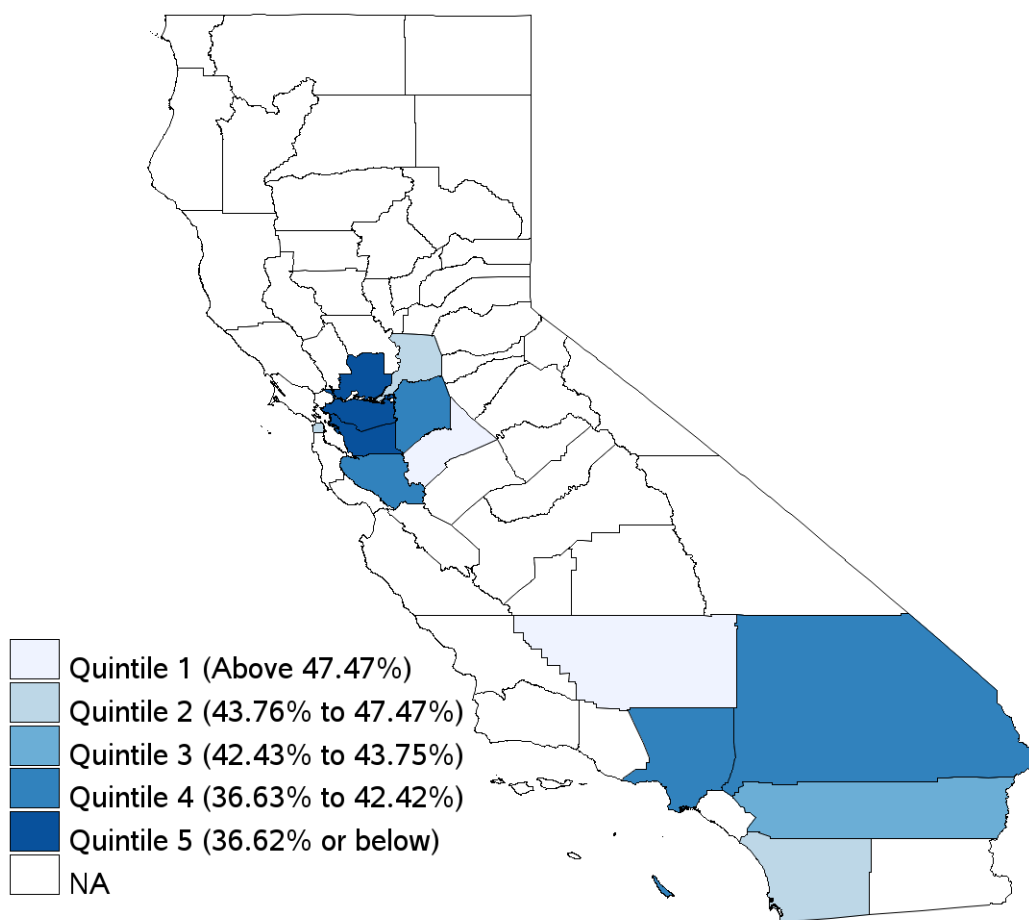
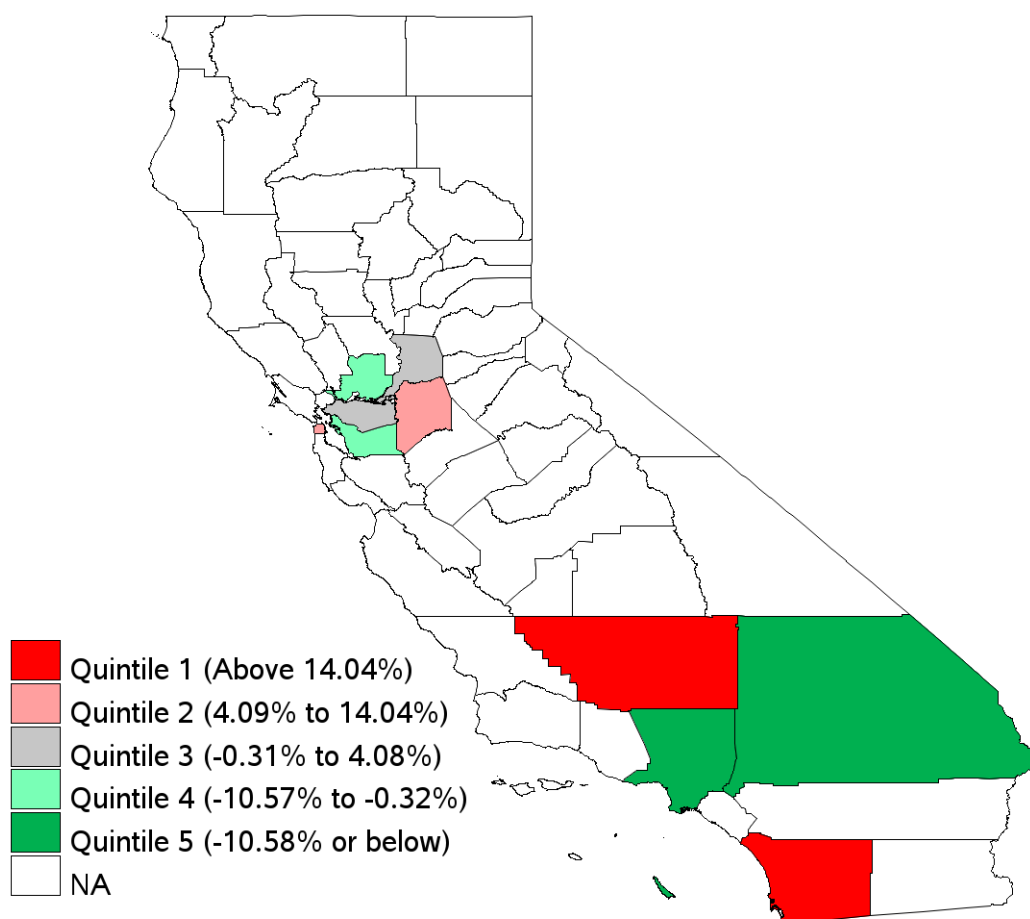


Figure 2.106—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)—Black or African American—Trending Map

Please refer to Appendix E for maps labeled by county and region.

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

Relative Difference by County for HBD–H9—Black or African American



The following are the key findings for the *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)—Black or African American indicator-racial/ethnic group combination regional analysis*:

- ◆ Counties in the San Joaquin Valley region had low performance for the *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)—Black or African American indicator-racial/ethnic group combination*.
 - Rates for two of three (66.7 percent) counties with reportable rates (Kern and Stanislaus) were in Quintile 1 for current year performance. Of note, the rate for Kern County was also in Quintile 1 for trending results.

- ◆ Counties in the San Francisco Bay/Sacramento region had high performance for the *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)—Black or African American* indicator-racial/ethnic group combination.
 - Rates for four of six (66.7 percent) counties with reportable rates (Alameda, Contra Costa, Santa Clara, and Solano) were in the top two quintiles (i.e., Quintiles 4 and 5) for current year performance. Three of the four (75.0 percent) counties had reportable rates (Alameda, Contra Costa, and Solano) in both measurement years 2021 and 2022, with two of the three (66.7 percent) counties (Alameda and Solano) having rates in Quintile 4 for trending results. Of note, the rate for Solano County exceeded the minimum performance level by more than a 25 percent relative difference.

Appendix A. Highest Performing Group Analysis

HSAG performed a statewide-level racial/ethnic highest performing analysis for each MCAS indicator. Specifically, HSAG calculated the proportion of each racial/ethnic group's rate from the highest performing group rate using the following formula:

$$\frac{\text{Racial Ethnic Rate}}{\text{Highest Performing Racial Ethnic Rate}}$$

For lower-is-better indicators, HSAG used the following formula:

$$\frac{1 - \text{Racial Ethnic Rate}}{1 - \text{Highest Performing Racial Ethnic Rate}}$$

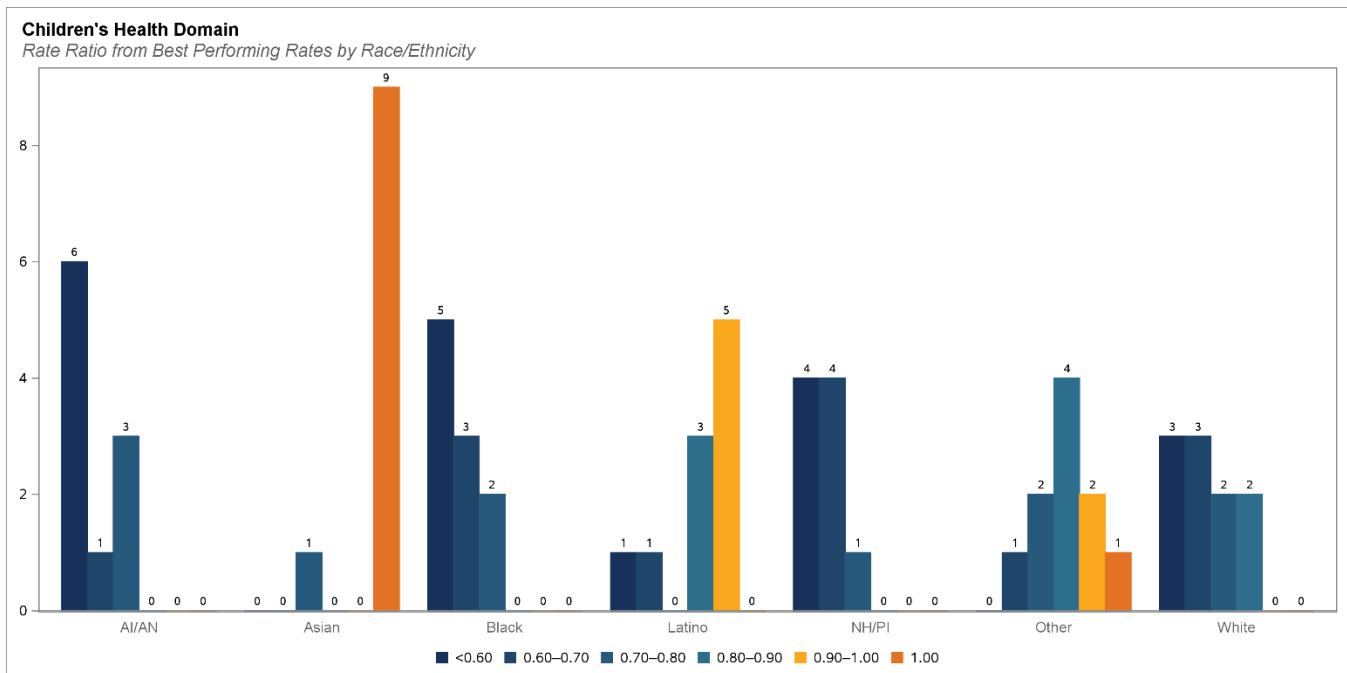
Please note, the *Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total* indicator was not included in the highest performing group analysis as a higher or lower rate is not indicative of better or worse performance for this indicator. Additionally, the Unknown/Missing group was excluded from consideration as the highest performing group for each indicator due to the inability to provide further context or conclusions for this group because of the unknown demographic composition of this population.

For the highest performing group analysis, HSAG displays summary figures for each domain that highlight each racial/ethnic group's performance compared to the highest performing group for each indicator. HSAG also displays individual indicator figures organized by domain that display rate ratios.

Highest Performing Racial/Ethnic Group: Children's Health Domain

Figure A.1—Highest Performing Group Summary: Children's Health Domain

Note: Within the figure, the following racial/ethnic groups have been shortened: American Indian or Alaska Native (AI/AN), Black or African American (Black), Hispanic or Latino (Latino), and Native Hawaiian or Other Pacific Islander (NH/PI).



- ◆ The Asian racial/ethnic group had the highest performing rate for nine of 10 (90.0 percent) indicators in the Children's Health domain, with the remaining indicator rate between 70 and 80 percent of the rates for the highest performing group.
- ◆ The following racial/ethnic groups did not have the highest performing rate for any indicators in the Children's Health domain:
 - American Indian or Alaska Native
 - Black or African American
 - Hispanic or Latino
 - Native Hawaiian or Other Pacific Islander
 - White
- ◆ The following racial/ethnic groups had a majority of their indicator rates below 70 percent of the rates for the highest performing group in the Children's Health domain:
 - American Indian or Alaska Native (70.0 percent)
 - Black or African American (80.0 percent)
 - Native Hawaiian or Other Pacific Islander (88.9 percent)
 - White (60.0 percent)
- ◆ The following racial/ethnic groups had at least one indicator rate in the Children's Health domain that was below 60 percent of the rate for the highest performing group:
 - American Indian or Alaska Native (six rates)
 - Black or African American (five rates)
 - Hispanic or Latino (one rate)
 - Native Hawaiian or Other Pacific Islander (four rates)
 - White (three rates)

- ◆ For the *Childhood Immunization Status—Combination 10* indicator, three of six (50.0 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and White) had rates below 60 percent of the rate for the highest performing group (i.e., the Asian group).

Figure A.2—Child and Adolescent Well-Care Visits—Total (WCV) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 50.9 percent. The rate ratio for the Unknown/Missing group was 0.957 (N=211,890).

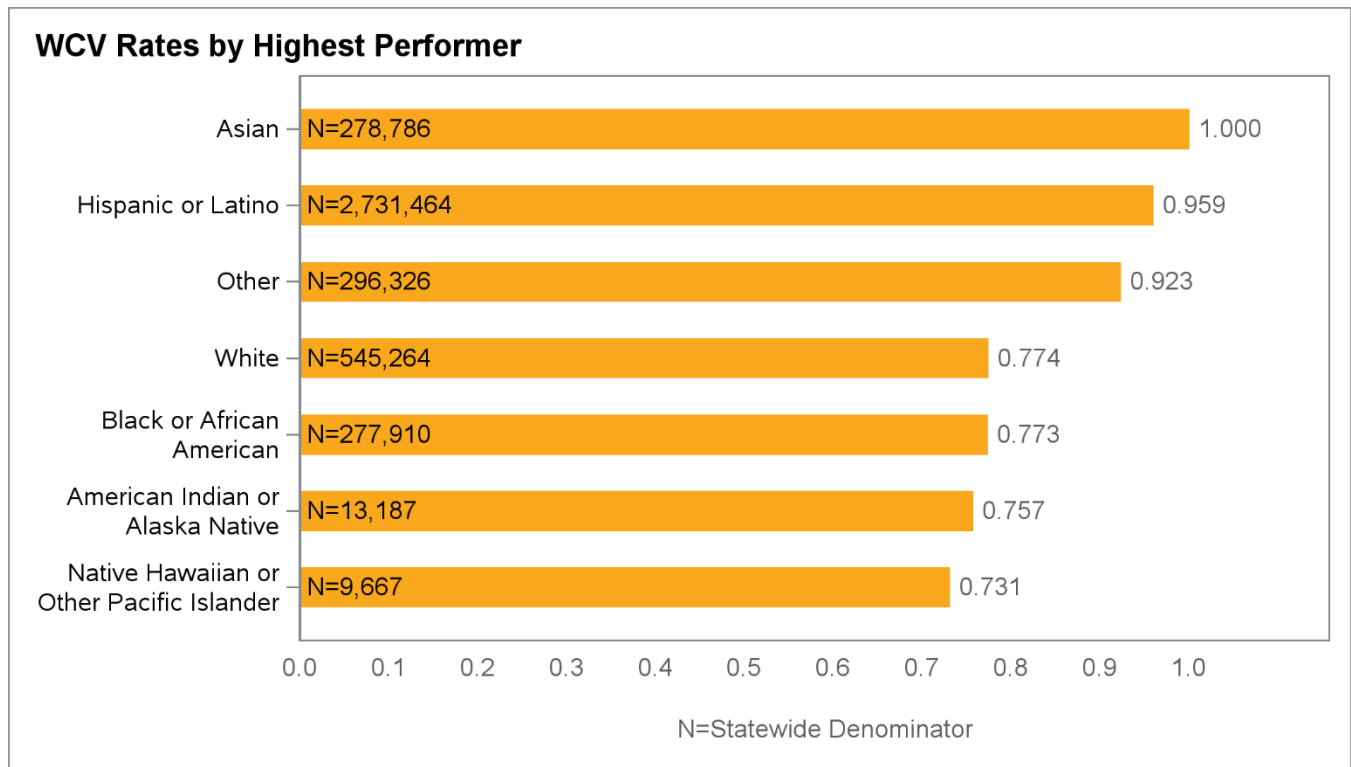


Figure A.3—Childhood Immunization Status—Combination 10 (CIS–10) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 56.9 percent.

The rate ratio for the Unknown/Missing group was 0.477 (N=3,539).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

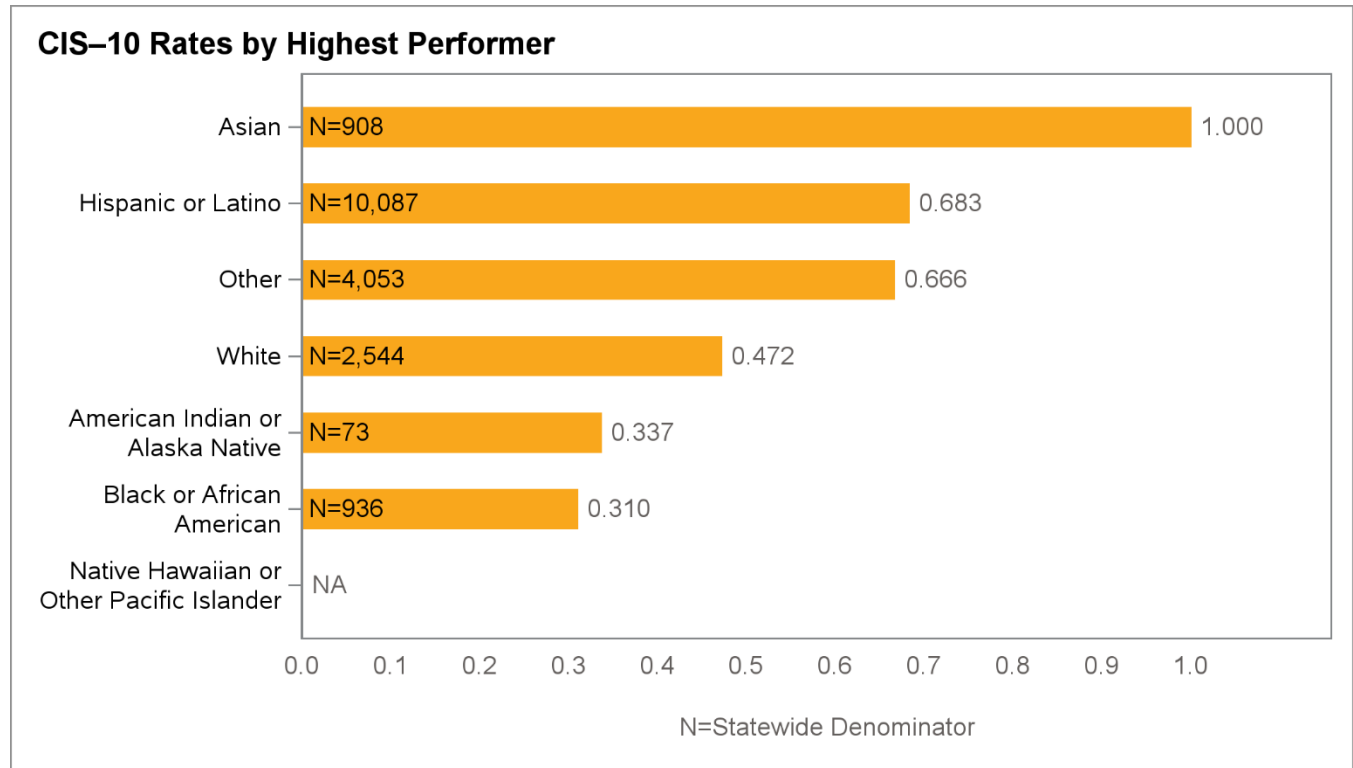


Figure A.4—Developmental Screening in the First Three Years of Life—Total (DEV) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 38.6 percent. The rate ratio for the Unknown/Missing group was 0.776 (N=65,084).

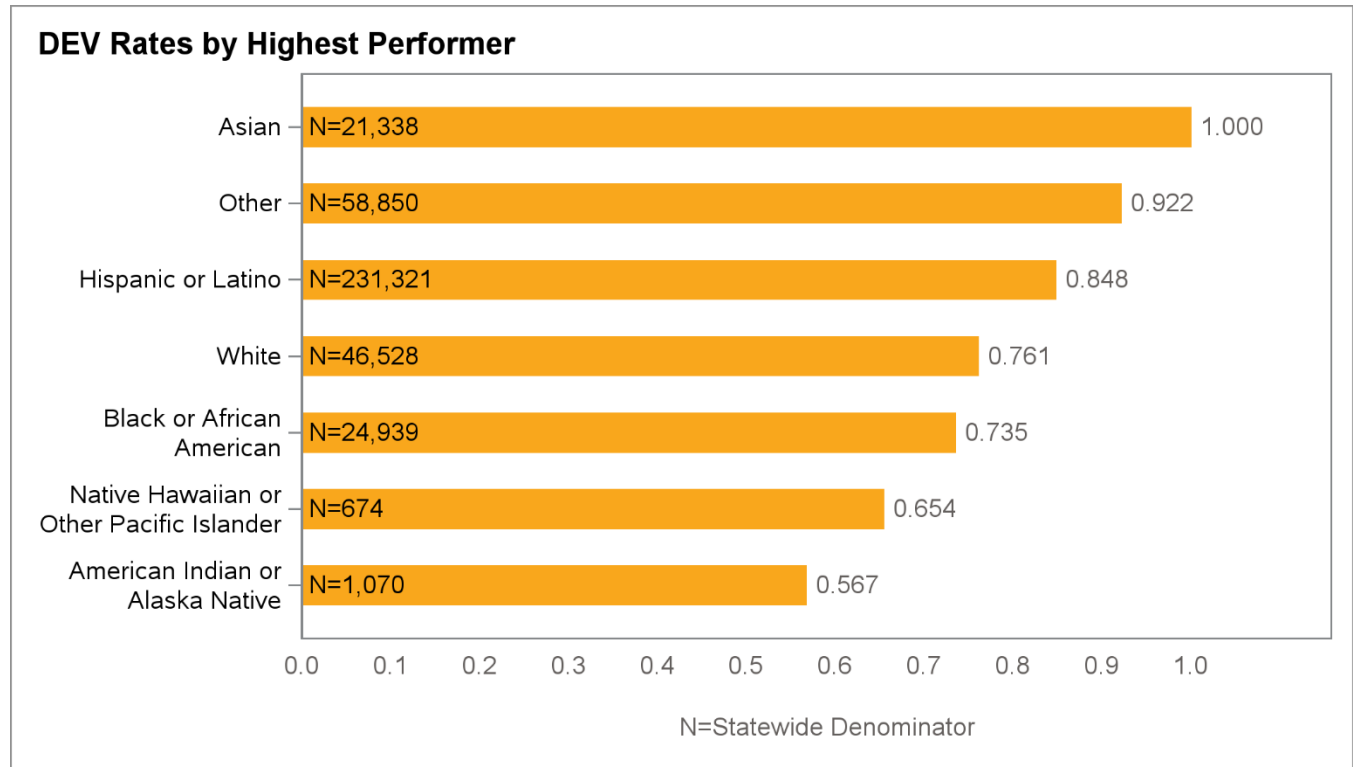


Figure A.5—Immunization for Adolescents—Combination 2 (IMA-2) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 46.4 percent. The rate ratio for the Unknown/Missing group was 0.600 (N=586).

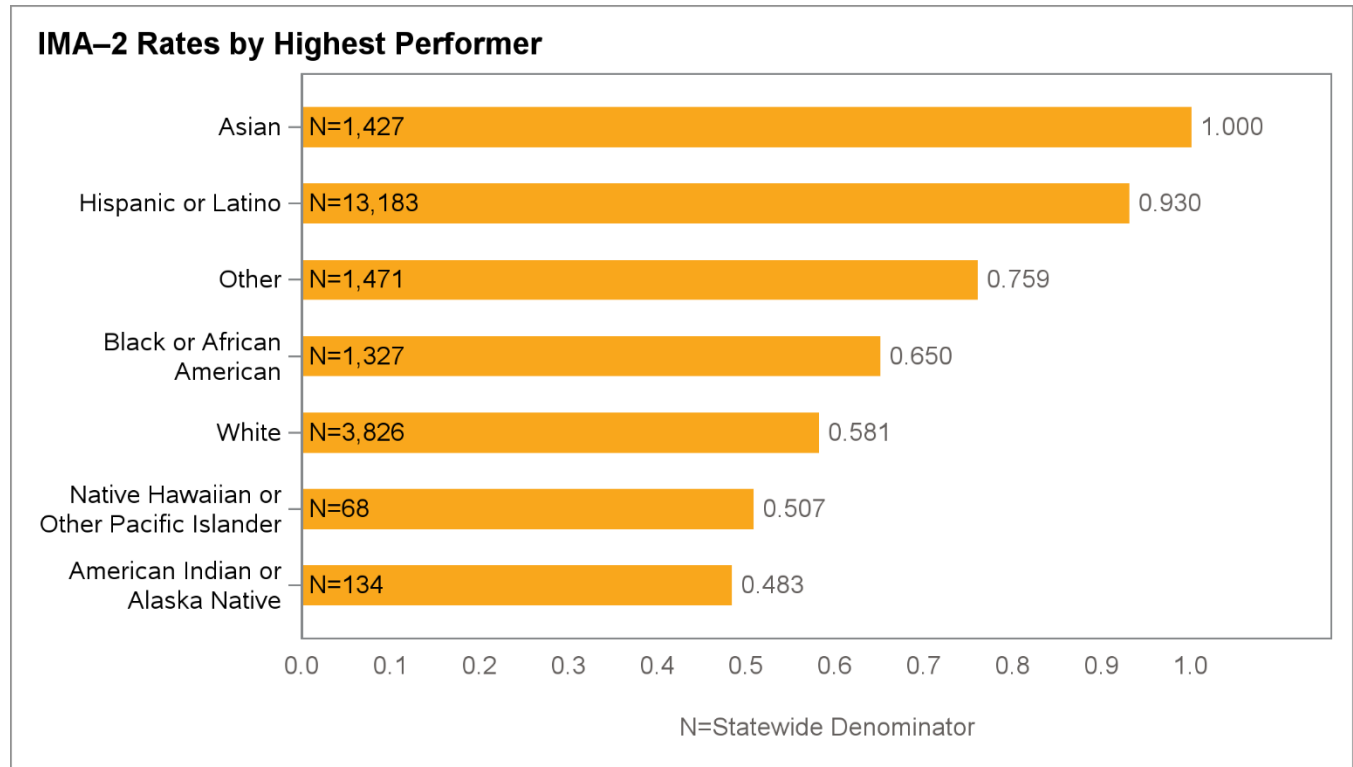


Figure A.6—Lead Screening in Children (LSC) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 61.4 percent. The rate ratio for the Unknown/Missing group was 0.760 (N=3,561).

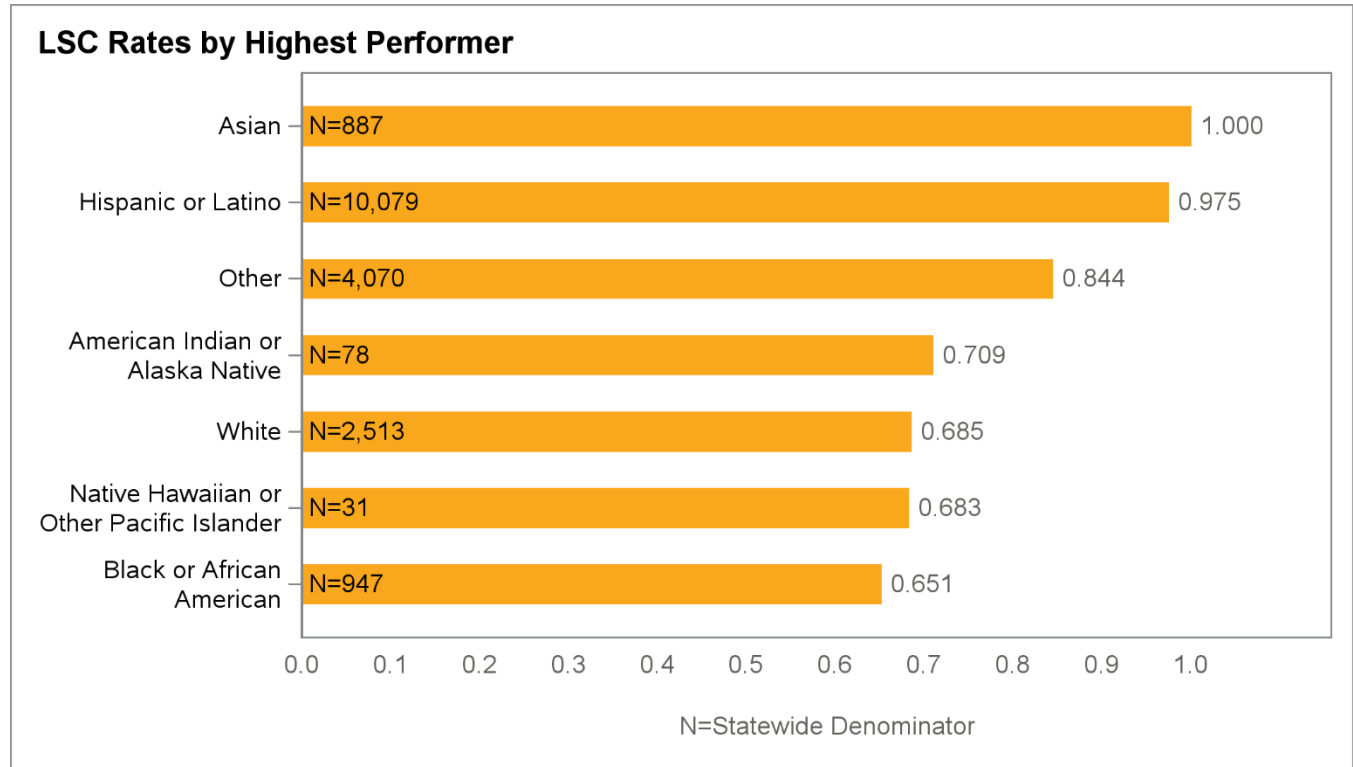


Figure A.7—Topical Fluoride for Children—Dental Services—Total (TFL–DS) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 8.8 percent. The rate ratio for the Unknown/Missing group was 0.986 (N=263,801).

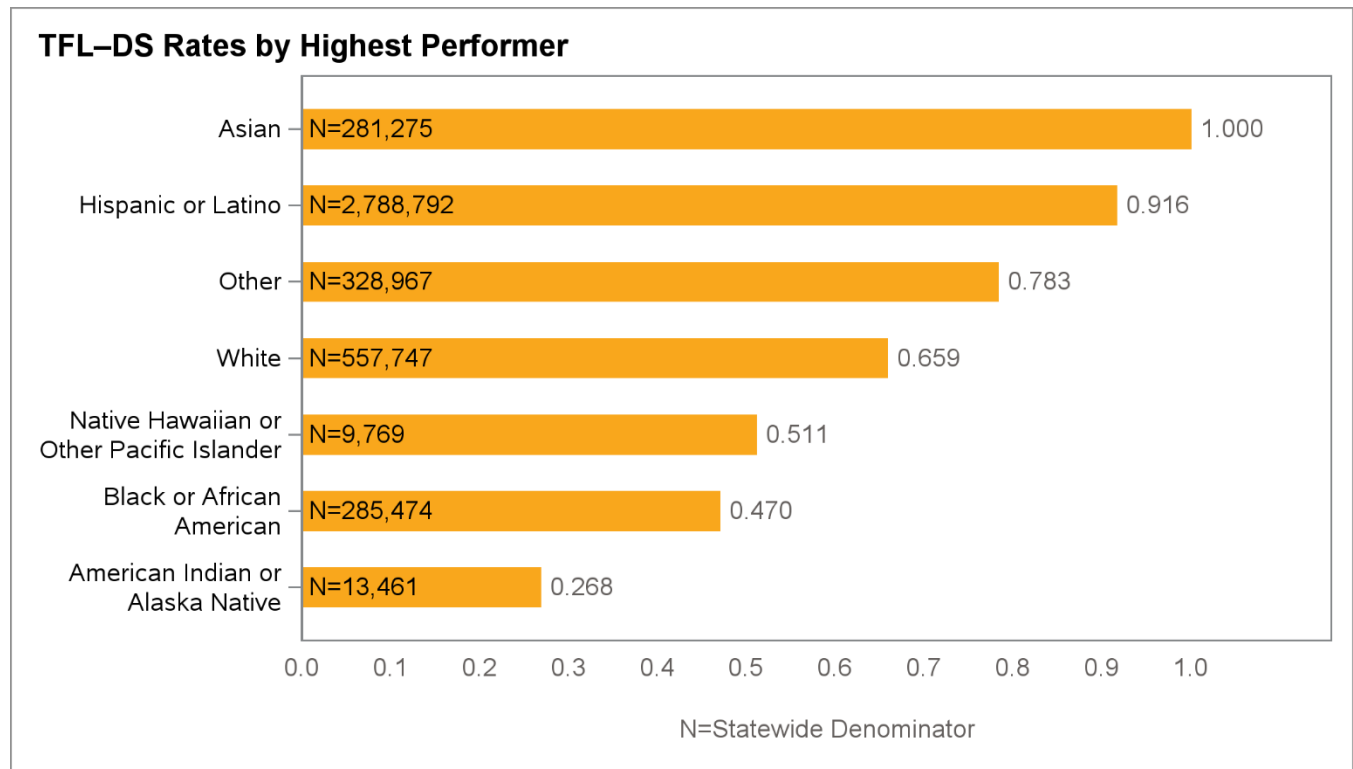


Figure A.8—Topical Fluoride for Children—Oral Health Services—Total (TFL–OH) by Highest Performing Group

Note: The highest performing group (i.e., the Other group) had a rate of 1.1 percent. The rate ratio for the Unknown/Missing group was 1.122 (N=263,801).

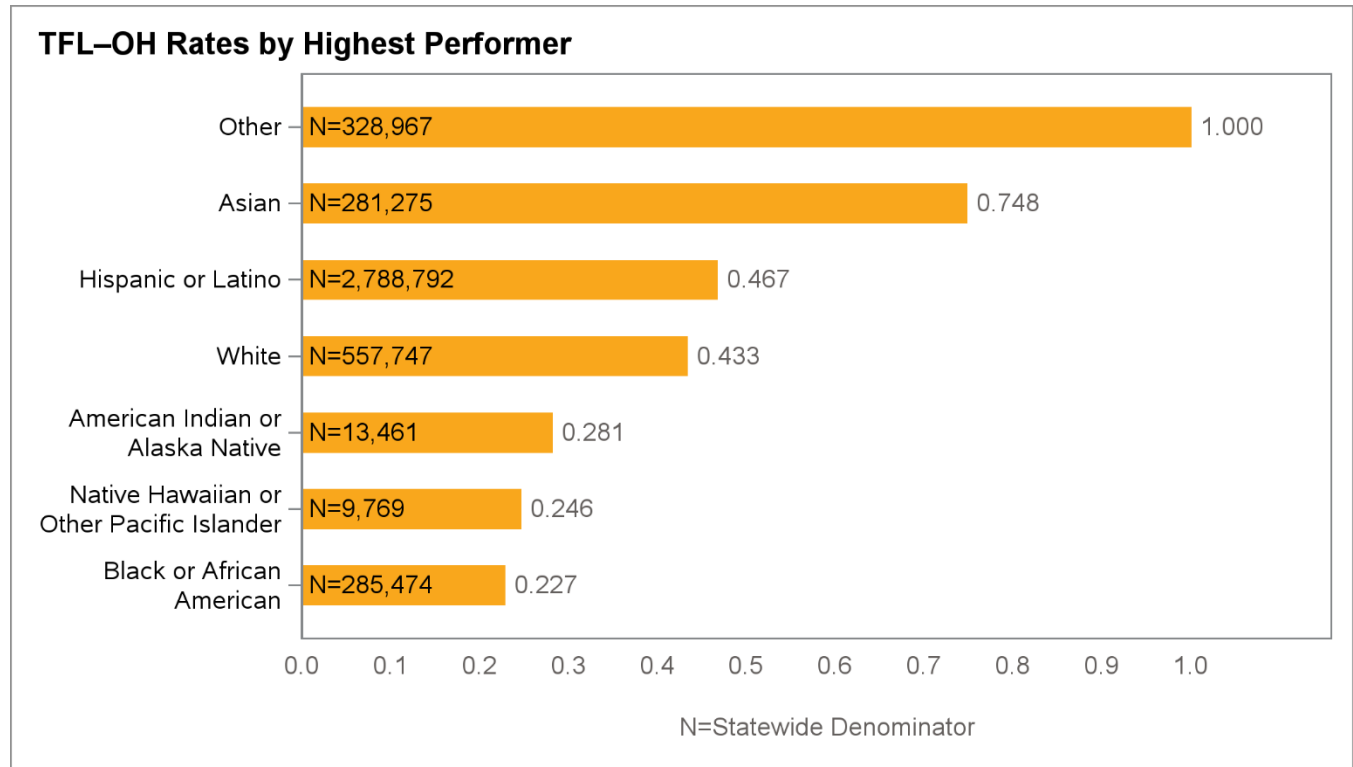


Figure A.9—Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL–DO) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 11.4 percent. The rate ratio for the Unknown/Missing group was 1.111 (N=263,801).

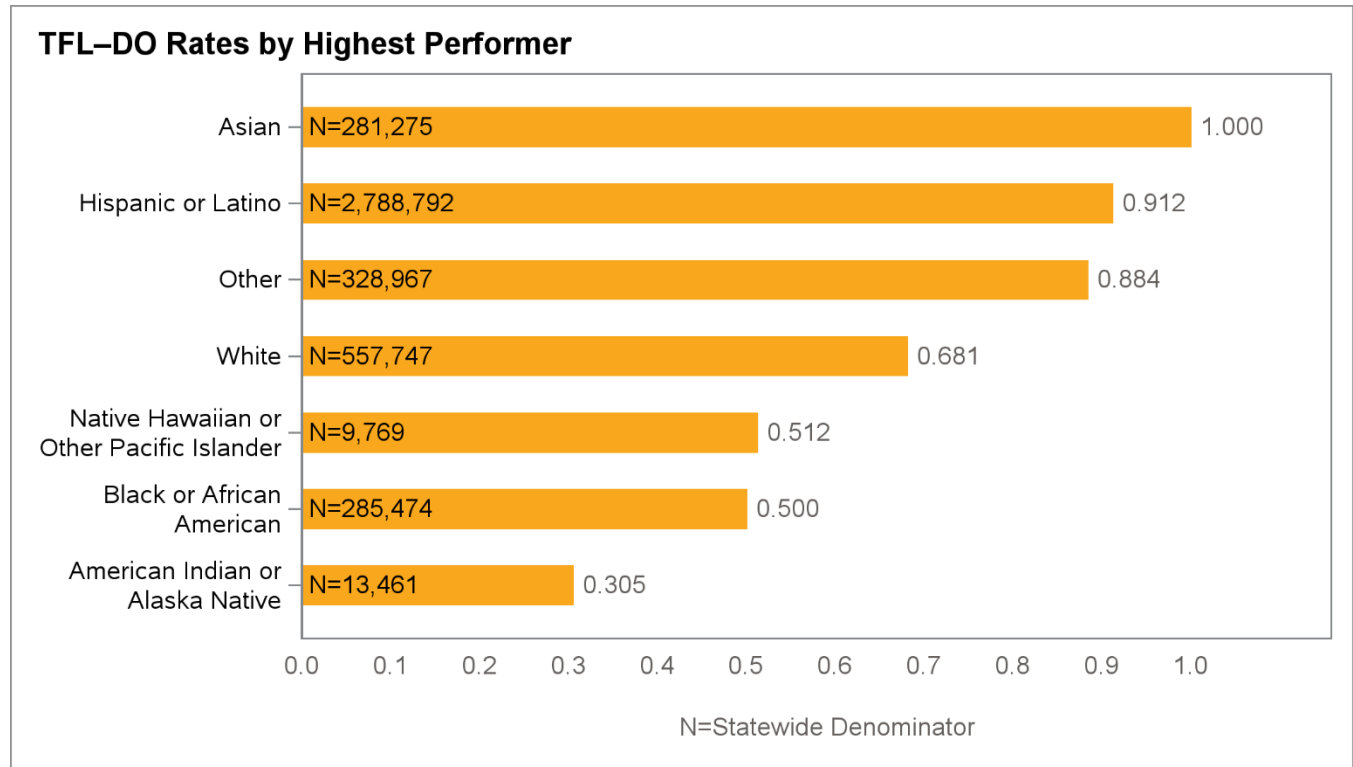


Figure A.10—Well-Child Visits in the First 30 Months—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 58.6 percent. The rate ratio for the Unknown/Missing group was 0.811 (N=16,328).

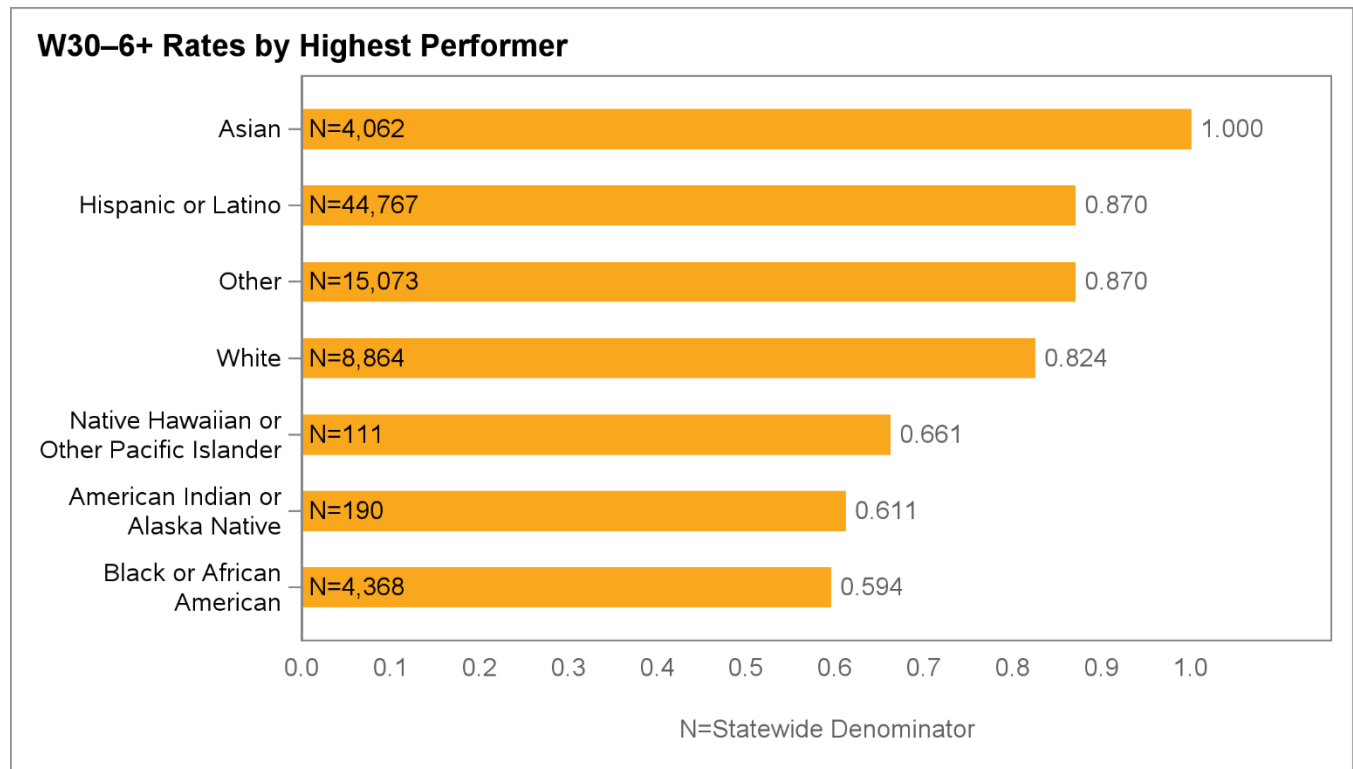
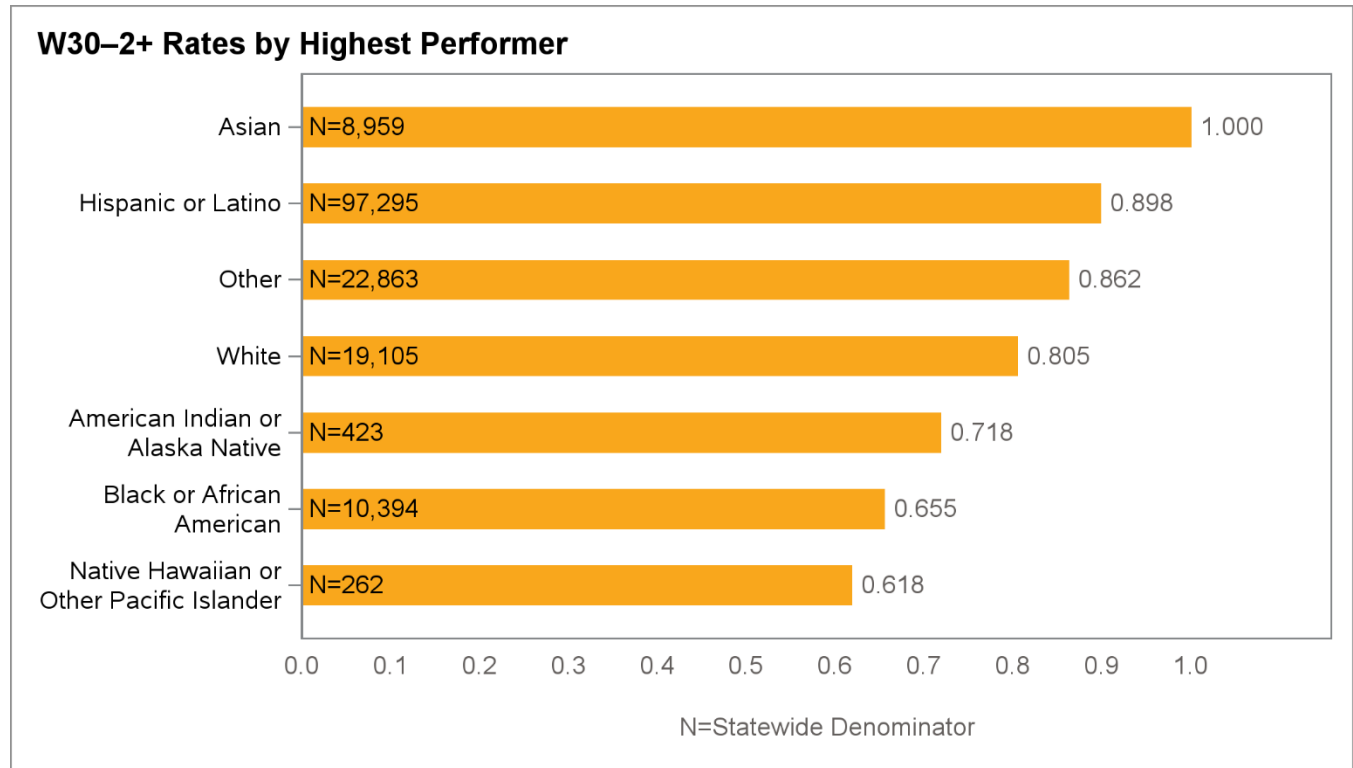


Figure A.11—Well-Child Visits in the First 30 Months—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+) by Highest Performing Group

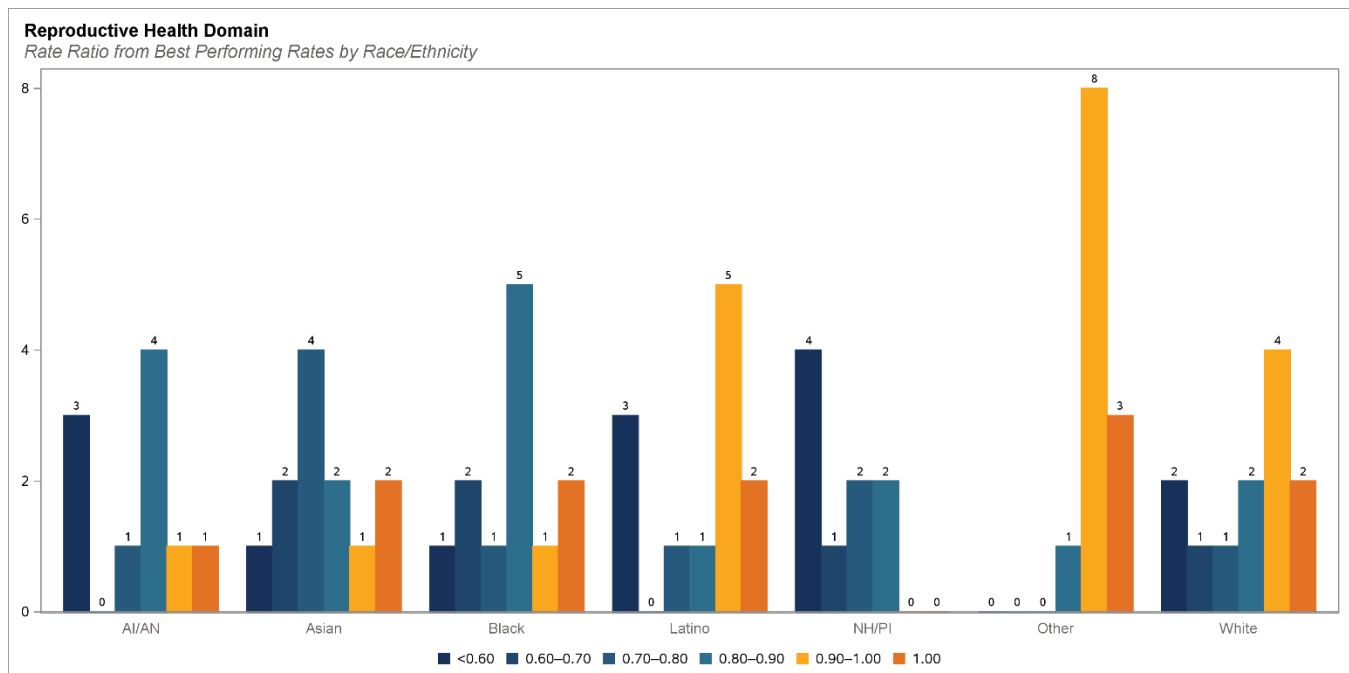
Note: The highest performing group (i.e., the Asian group) had a rate of 74.7 percent. The rate ratio for the Unknown/Missing group was 0.803 (N=25,447).



Highest Performing Racial/Ethnic Group: Reproductive Health Domain

Figure A.12—Highest Performing Group Summary: Reproductive Health Domain

Note: Within the figure, the following racial/ethnic groups have been shortened: American Indian or Alaska Native (AI/AN), Black or African American (Black), Hispanic or Latino (Latino), and Native Hawaiian or Other Pacific Islander (NH/PI).



- ◆ The Other racial/ethnic group had the highest performing rate for three of 12 (25.0 percent) indicators in the Reproductive Health domain, with eight of the nine (88.9 percent) remaining indicators at 90 percent or more of the rates for the highest performing group.
- ◆ The Native Hawaiian or Other Pacific Islander racial/ethnic group did not have the highest performing rate for any indicators in the Reproductive Health domain.
 - Indicator rates for five of the nine (55.6 percent) reportable rates for the Native Hawaiian or Other Pacific Islander racial/ethnic group were below 70 percent of the rates for the highest performing group in the Reproductive Health domain.
- ◆ The following racial/ethnic groups had at least one indicator rate in the Reproductive Health domain that was below 60 percent of the rate for the highest performing group:
 - American Indian or Alaska Native (three rates)
 - Asian (one rate)
 - Black or African American (one rate)
 - Hispanic or Latino (three rates)

- Native Hawaiian or Other Pacific Islander (four rates)
- White (two rates)
- ◆ For the *Postpartum Depression Screening and Follow-Up—Depression Screening*, four of the seven (57.1 percent) racial/ethnic groups (American Indian or Alaska Native, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and White) had rates below 60 percent of the rate for the highest performing group (i.e., the Other group).

Figure A.13—Chlamydia Screening in Women—Total (CHL) by Highest Performing Group

Note: The highest performing group (i.e., the Black or African American group) had a rate of 70.5 percent.

The rate ratio for the Unknown/Missing group was 0.850 (N=9,279).

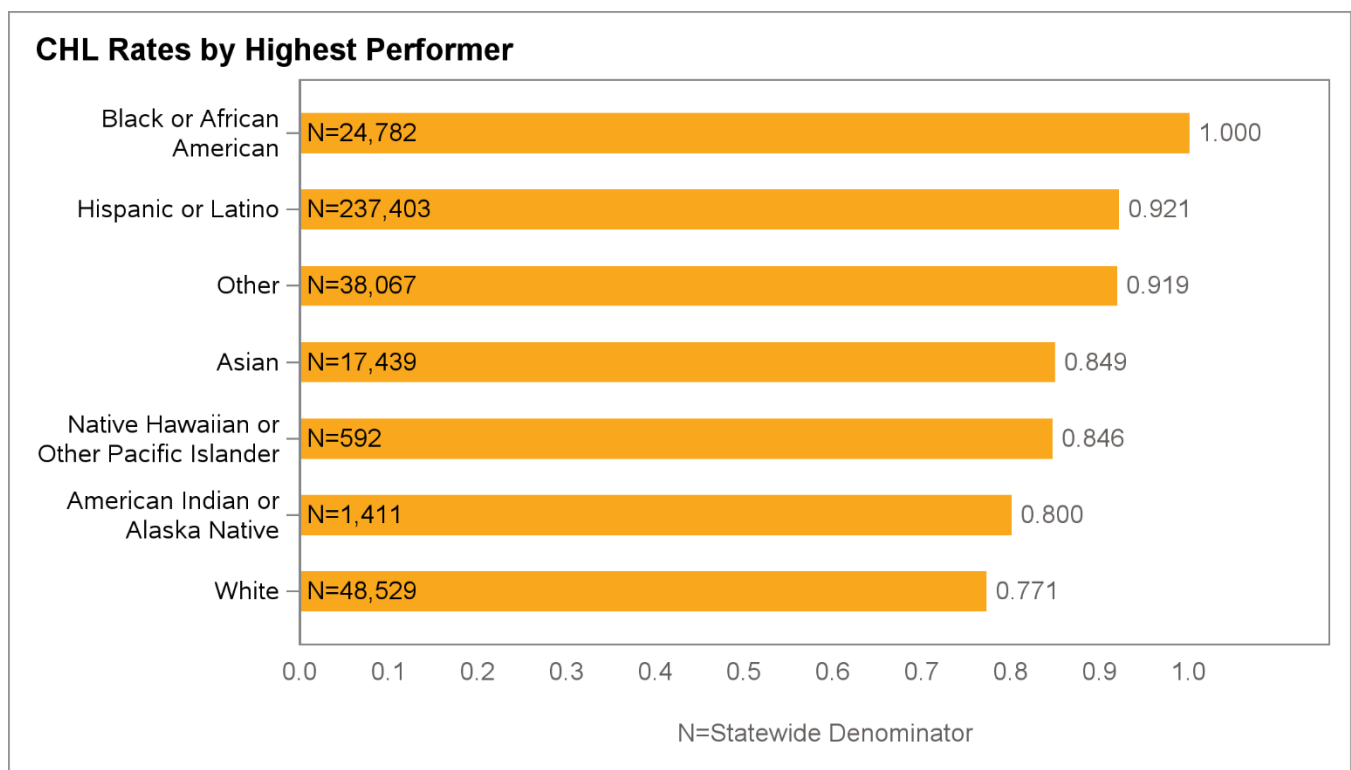


Figure A.14—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520) by Highest Performing Group

Note: The highest performing group (i.e., the American Indian or Alaska Native group) had a rate of 20.2 percent.

The rate ratio for the Unknown/Missing group was 0.640 (N=15,524).

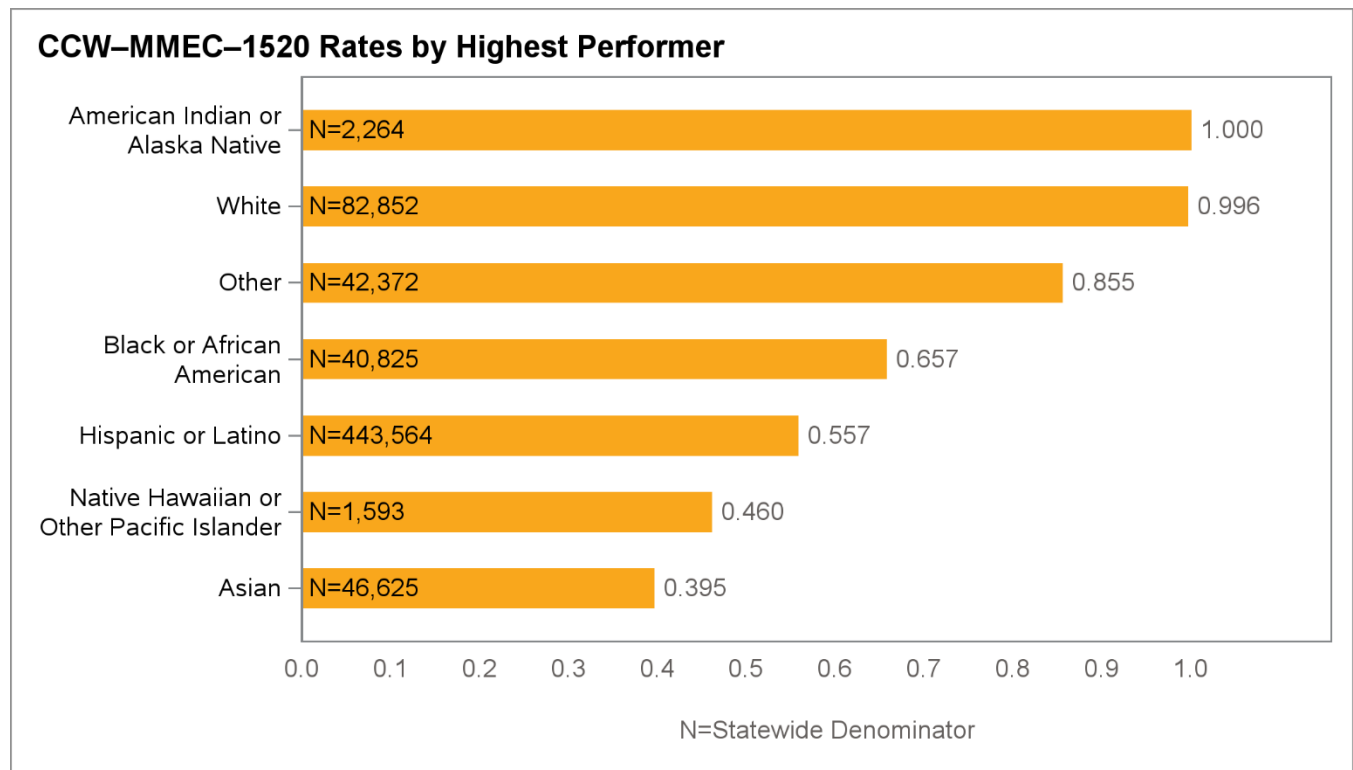


Figure A.15—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144) by Highest Performing Group

Note: The highest performing group (i.e., the Other group) had a rate of 22.8 percent. The rate ratio for the Unknown/Missing group was 0.843 (N=66,448).

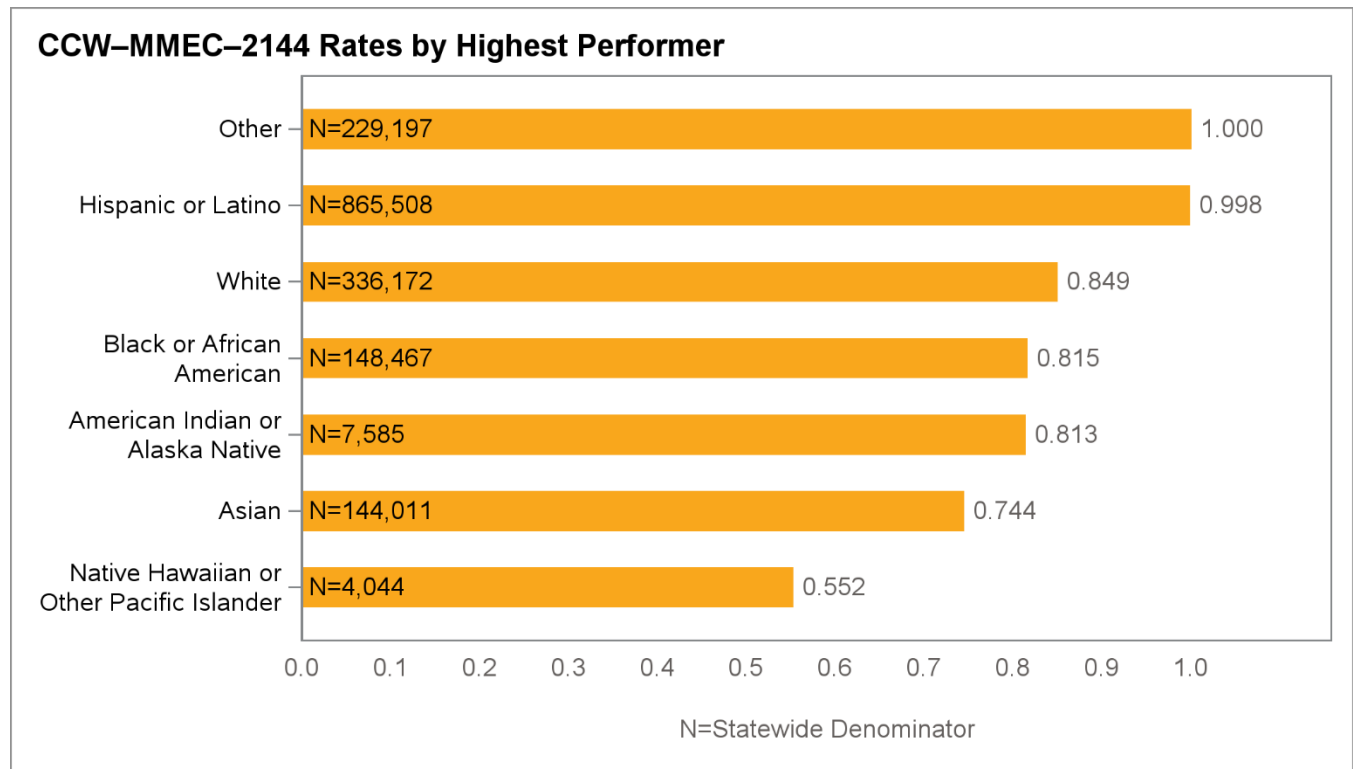


Figure A.16—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 (CCP–MMEC60–1520) by Highest Performing Group

Note: The highest performing group (i.e., the Other group) had a rate of 36.1 percent.

The rate ratio for the Unknown/Missing group was 1.000 (N=194).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

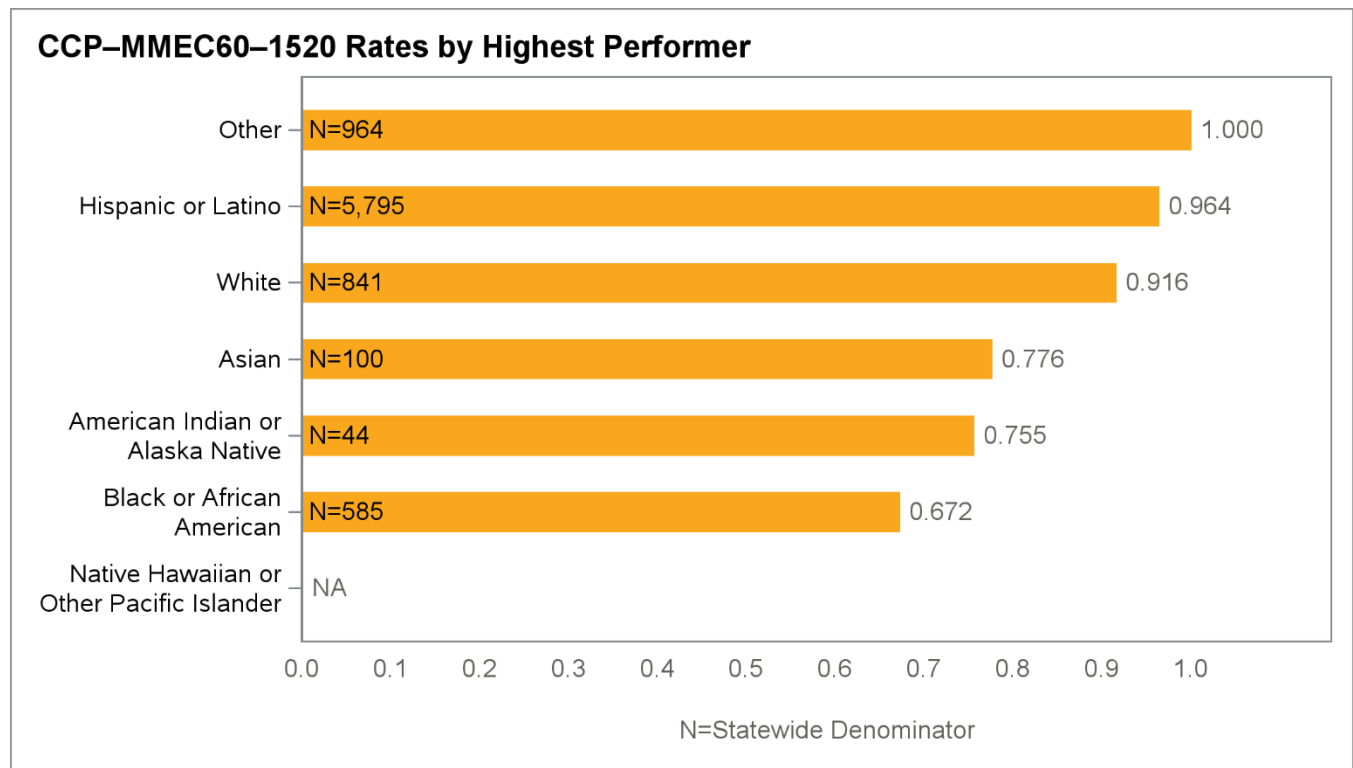


Figure A.17—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144) by Highest Performing Group

Note: The highest performing group (i.e., the Hispanic or Latino group) had a rate of 36.7 percent.

The rate ratio for the Unknown/Missing group was 0.871 (N=3,424).

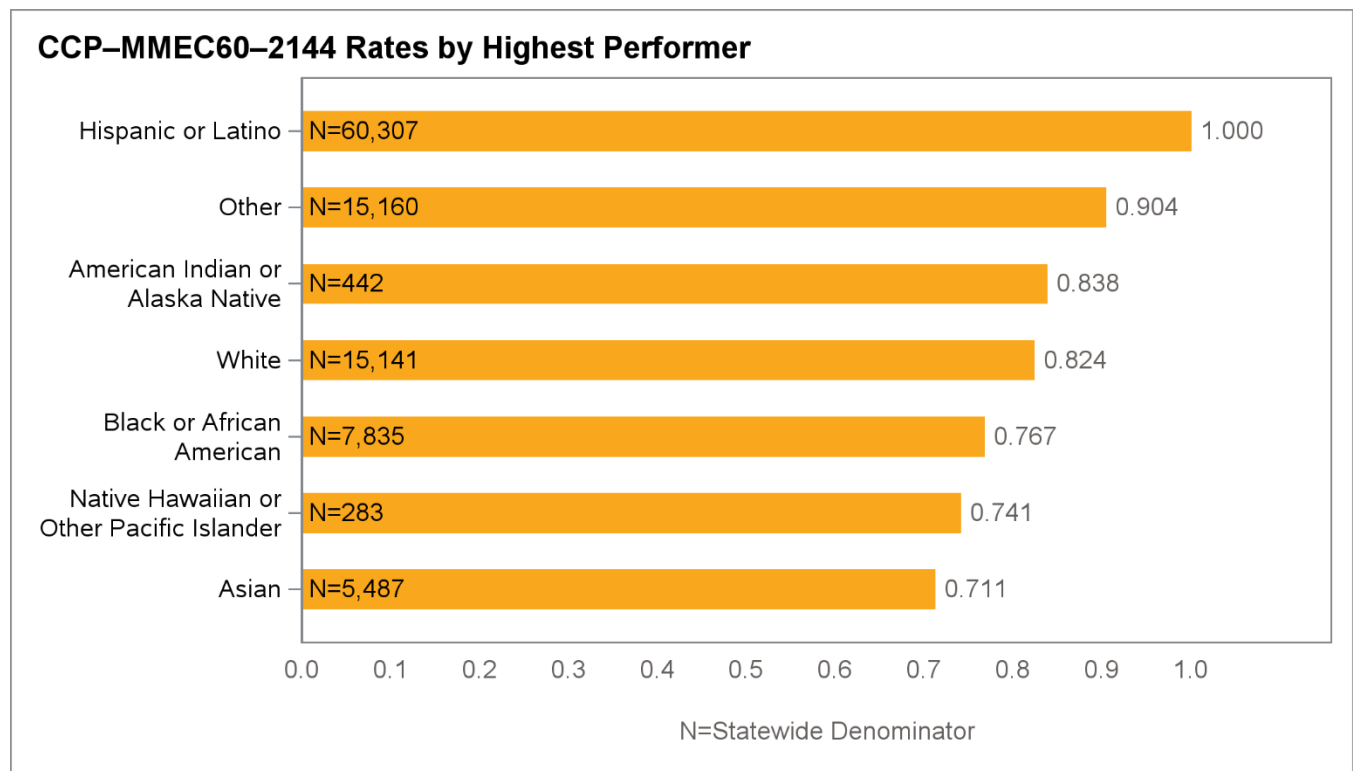


Figure A.18—Postpartum Depression Screening and Follow-Up—Depression Screening (PDS–E–DS) by Highest Performing Group

Note: The highest performing group (i.e., the Other group) had a rate of 12.0 percent. The rate ratio for the Unknown/Missing group was 0.538 (N=4,459).

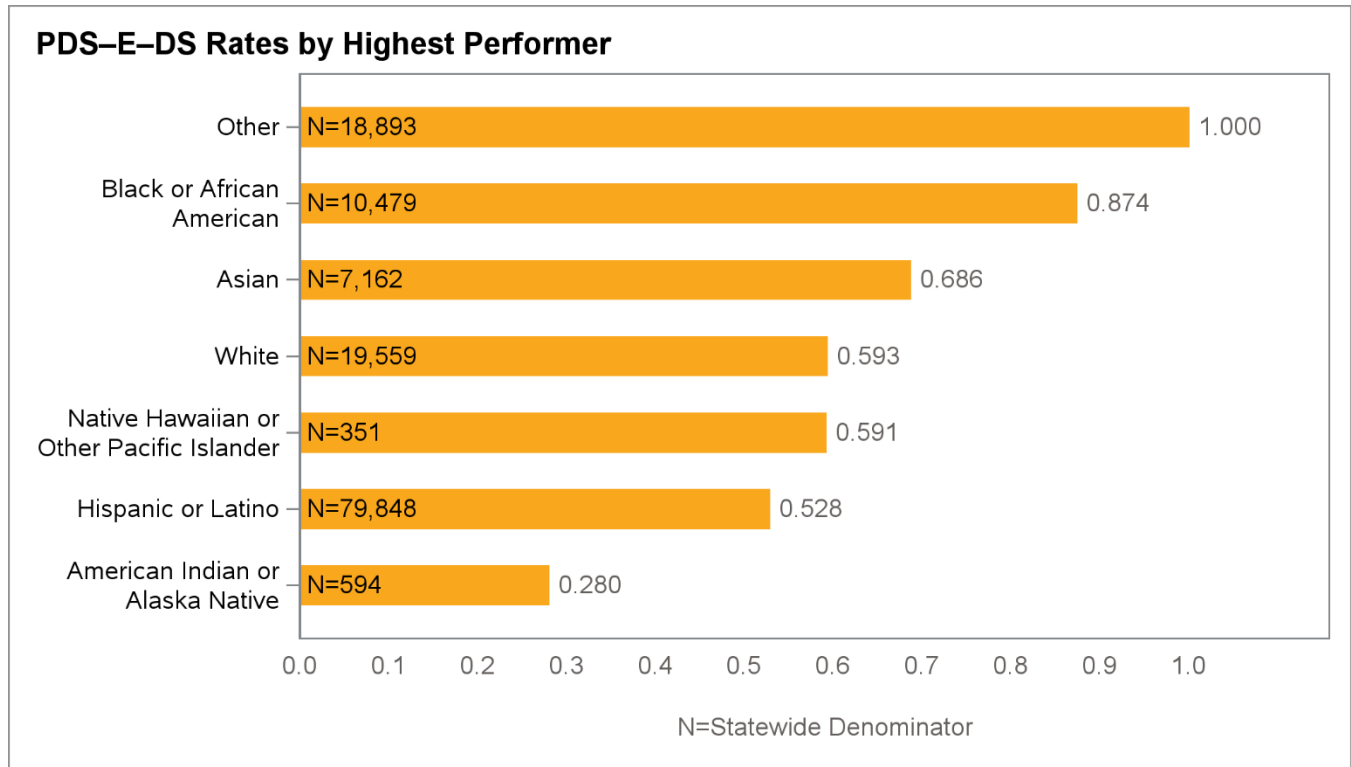


Figure A.19—Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen (PDS–E–FU) by Highest Performing Group

Note: The highest performing group (i.e., the White group) had a rate of 76.7 percent.

The rate ratio for the Unknown/Missing group was 1.137 (N=39).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

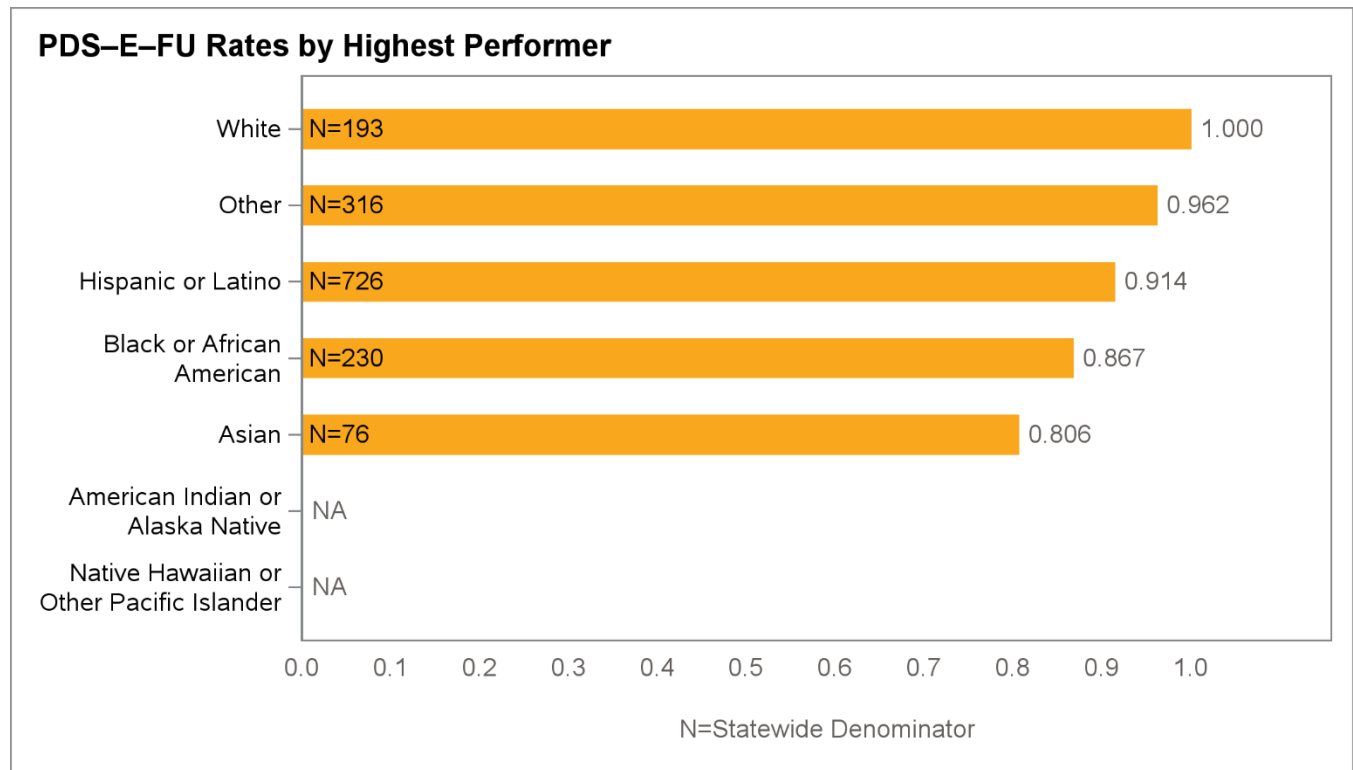


Figure A.20—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 85.4 percent. The rate ratio for the Unknown/Missing group was 0.958 (N=419).

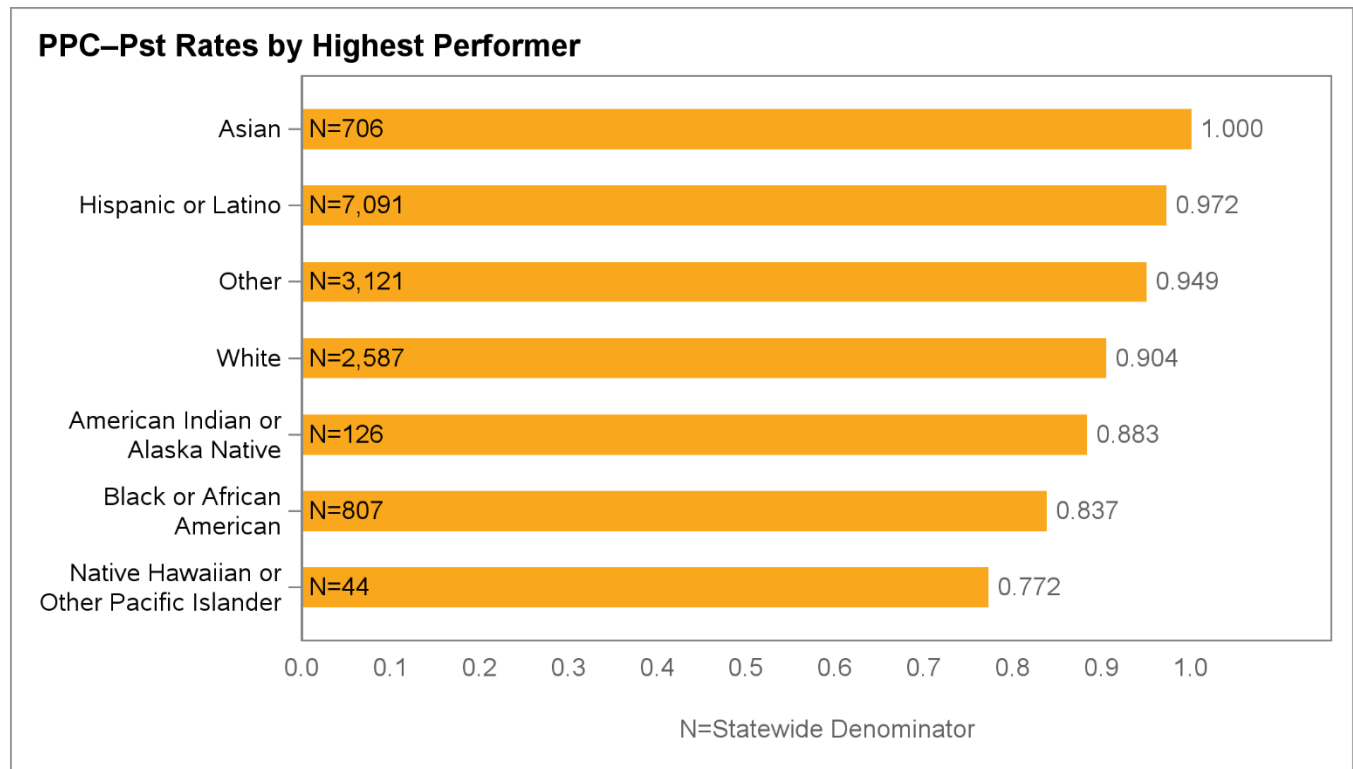


Figure A.21—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) by Highest Performing Group

Note: The highest performing group (i.e., the Hispanic or Latino group) had a rate of 88.2 percent.

The rate ratio for the Unknown/Missing group was 1.004 (N=419).

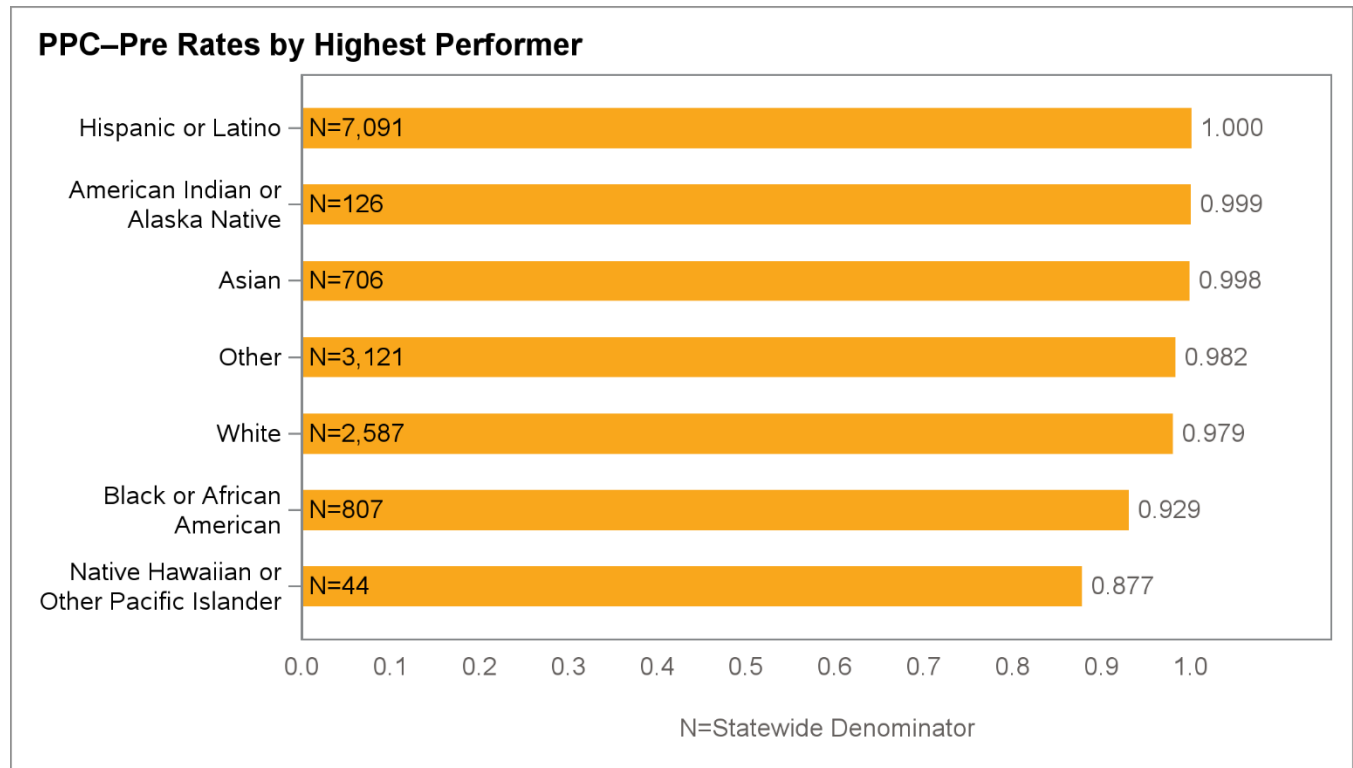


Figure A.22—Prenatal Depression Screening and Follow-Up—Depression Screening (PND–E–DS) by Highest Performing Group

Note: The highest performing group (i.e., the Black or African American group) had a rate of 16.6 percent.

The rate ratio for the Unknown/Missing group was 0.493 (N=3,505).

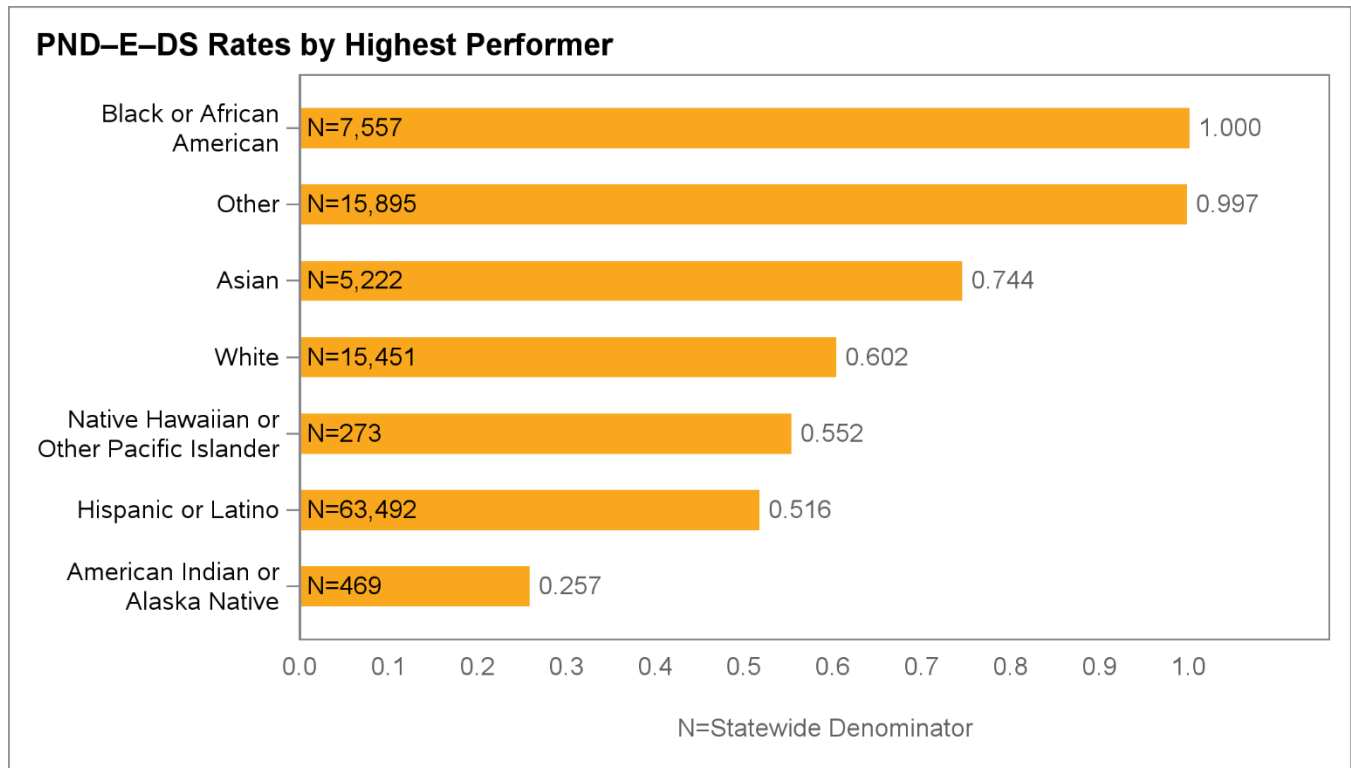


Figure A.23—Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen (PND–E–FU) by Highest Performing Group

Note: The highest performing group (i.e., the White group) had a rate of 59.1 percent.

The rate ratio for the Unknown/Missing group was 0.884 (N=44).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

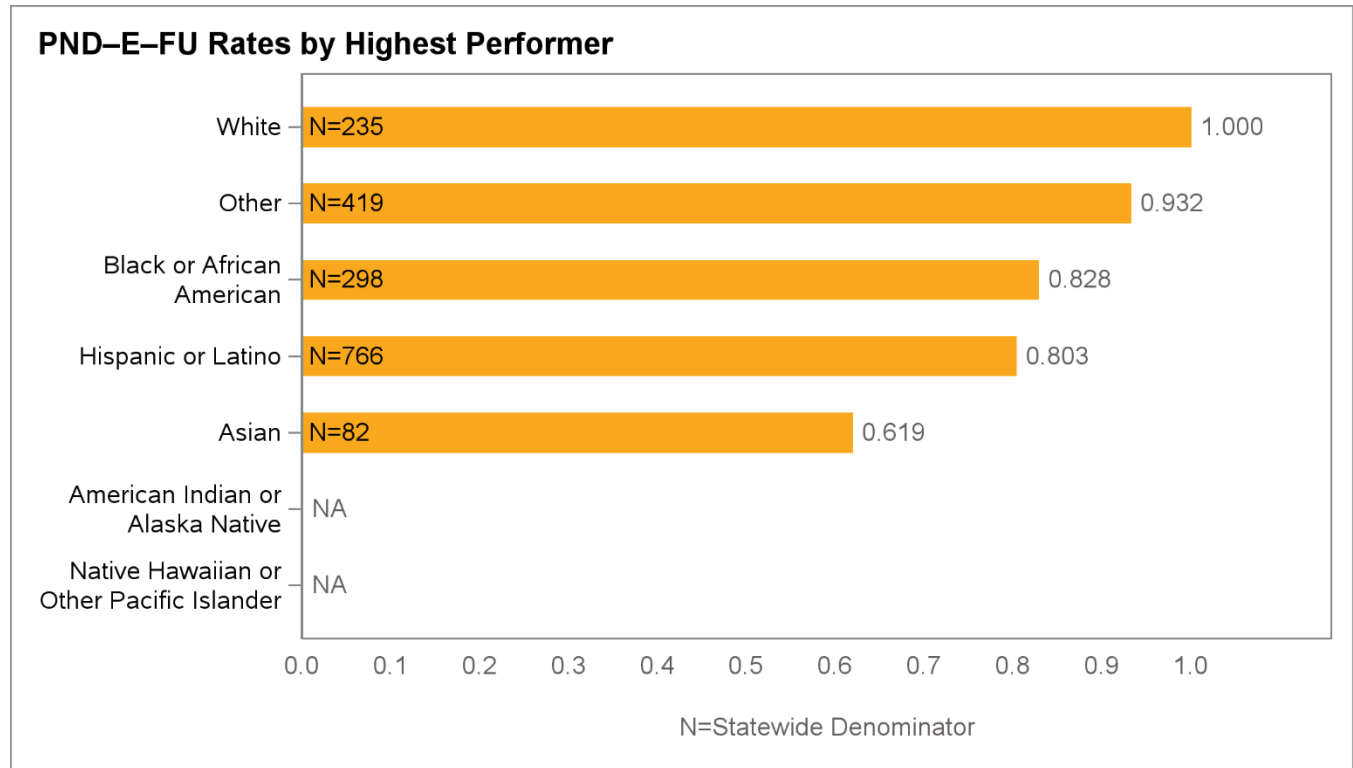
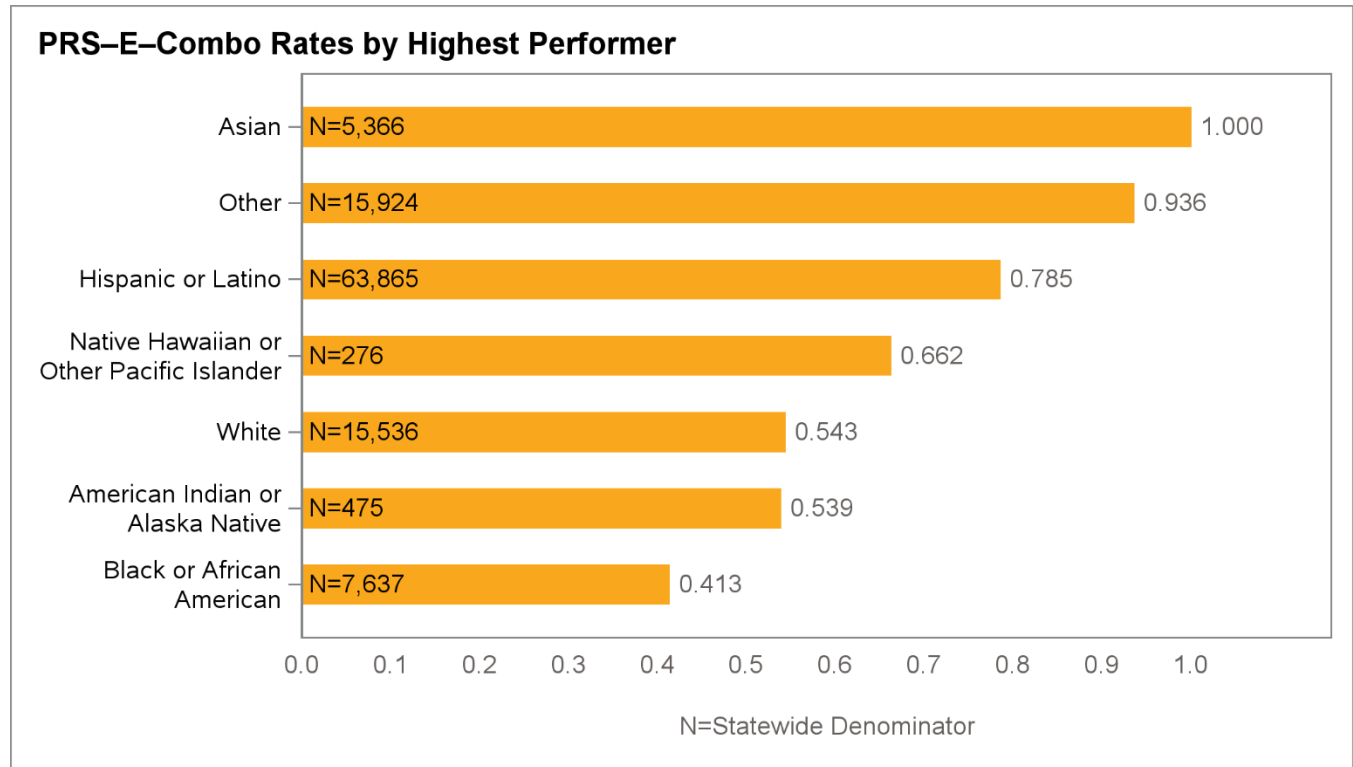


Figure A.24—Prenatal Immunization Status—Combination (PRS–E–Combo) by Highest Performing Group

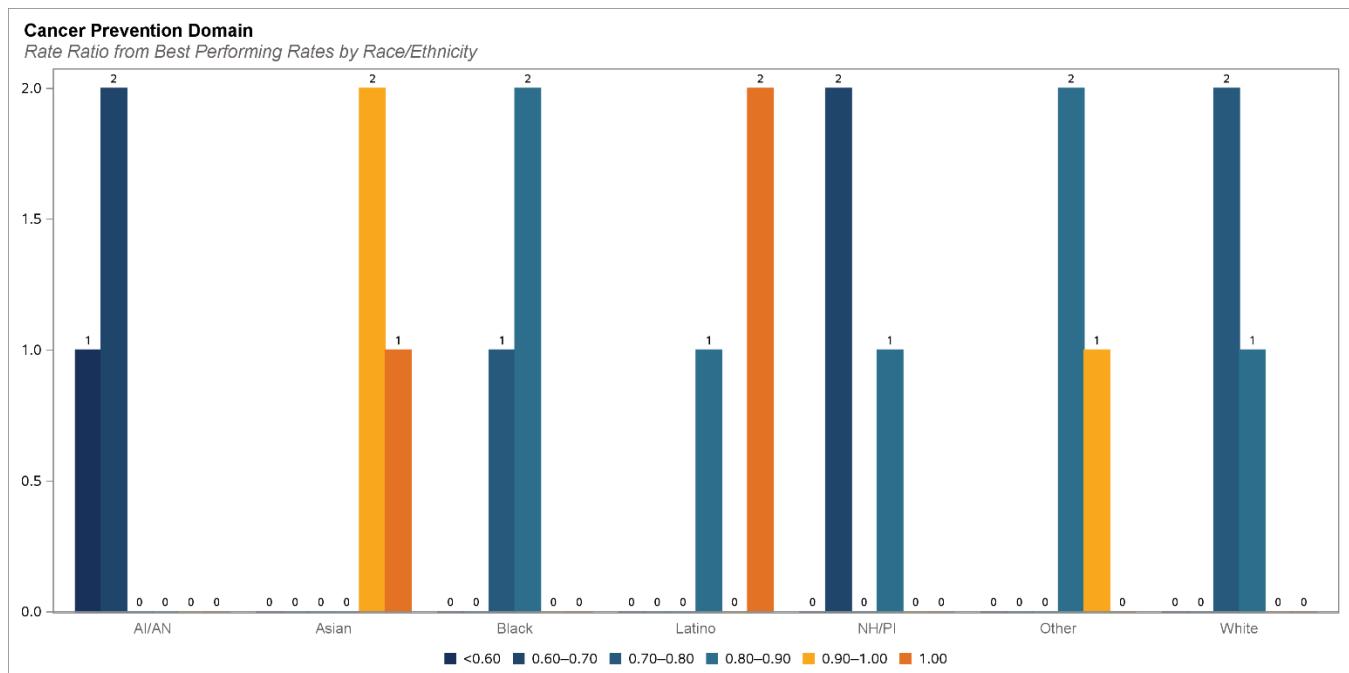
Note: The highest performing group (i.e., the Asian group) had a rate of 35.6 percent. The rate ratio for the Unknown/Missing group was 0.723 (N=3,548).



Highest Performing Racial/Ethnic Group: Cancer Prevention Domain

Figure A.25—Highest Performing Group Summary: Cancer Prevention Domain

Note: Within the figure, the following racial/ethnic groups have been shortened: American Indian or Alaska Native (AI/AN), Black or African American (Black), Hispanic or Latino (Latino), and Native Hawaiian or Other Pacific Islander (NH/PI).



- ◆ The Hispanic or Latino racial/ethnic group had the highest performing rate for two of three (66.7 percent) indicators in the Cancer Prevention domain, with the remaining indicator rate between 80 and 90 percent of the rates for the highest performing group.
- ◆ The Asian racial/ethnic group had the highest performing rate one of three (33.3 percent) indicators in the Cancer Prevention domain, with the two remaining indicator rates at 90 percent or more of the rates for the highest performing group.
- ◆ The following racial/ethnic groups did not have the highest performing rate for any indicators in the Cancer Prevention domain:
 - American Indian or Alaska Native
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - Other
 - White

- ◆ The following racial/ethnic groups had a majority of their indicator rates below 70 percent of the rates for the highest performing group in the Cancer Prevention domain:
 - American Indian or Alaska Native (100.0 percent)
 - Native Hawaiian or Other Pacific Islander (66.7 percent)

Figure A.26—Breast Cancer Screening—Total (BCS) by Highest Performing Group

Note: The highest performing group (i.e., the Hispanic or Latino group) had a rate of 61.7 percent.

The rate ratio for the Unknown/Missing group was 0.829 (N=24,324).

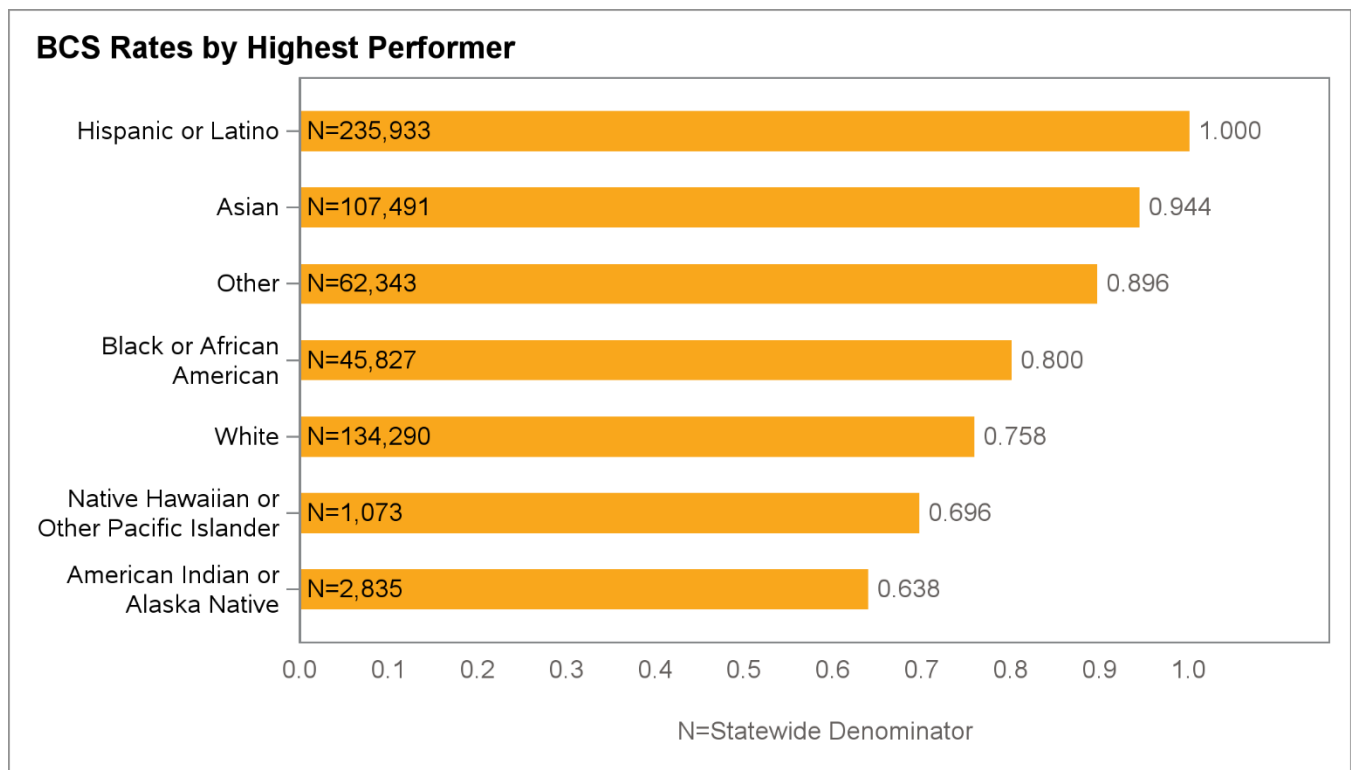


Figure A.27—Cervical Cancer Screening (CCS) by Highest Performing Group

Note: The highest performing group (i.e., the Hispanic or Latino group) had a rate of 60.6 percent.

The rate ratio for the Unknown/Missing group was 0.804 (N=764).

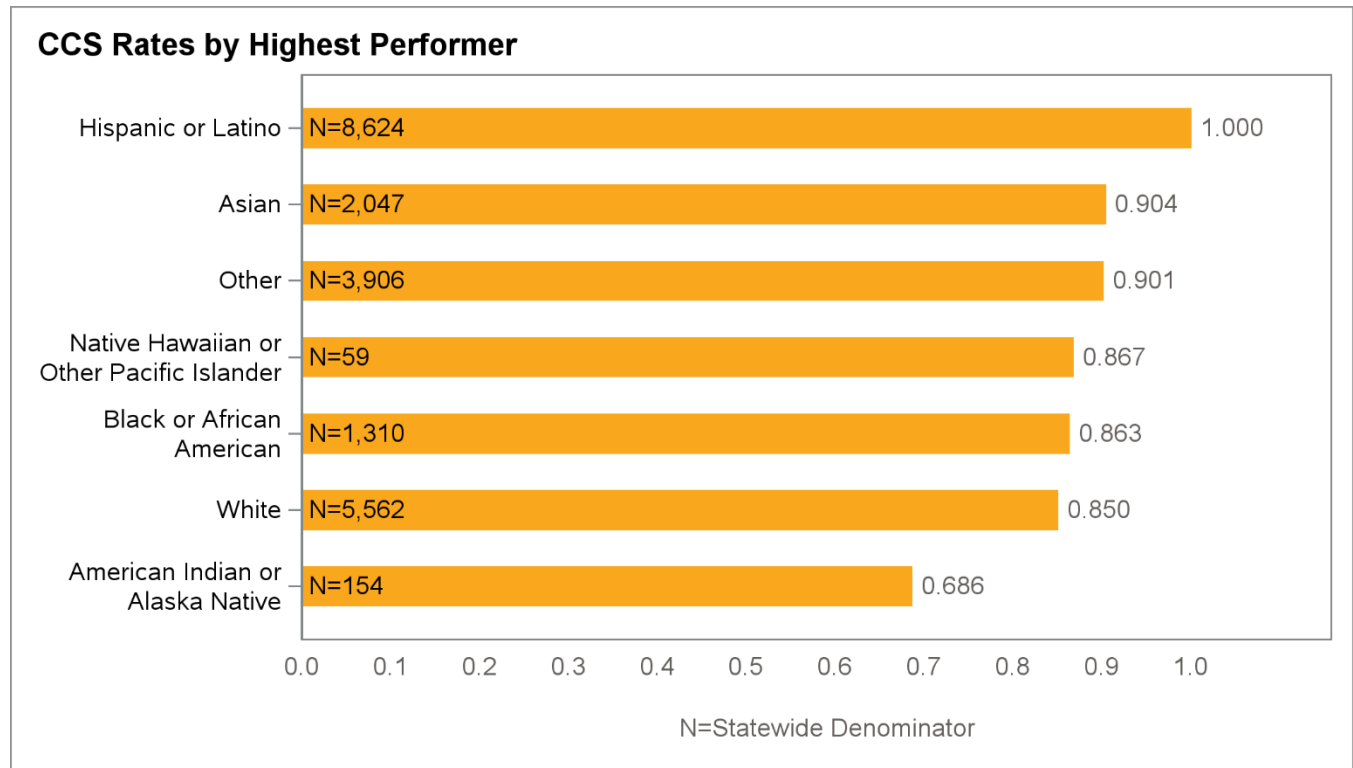
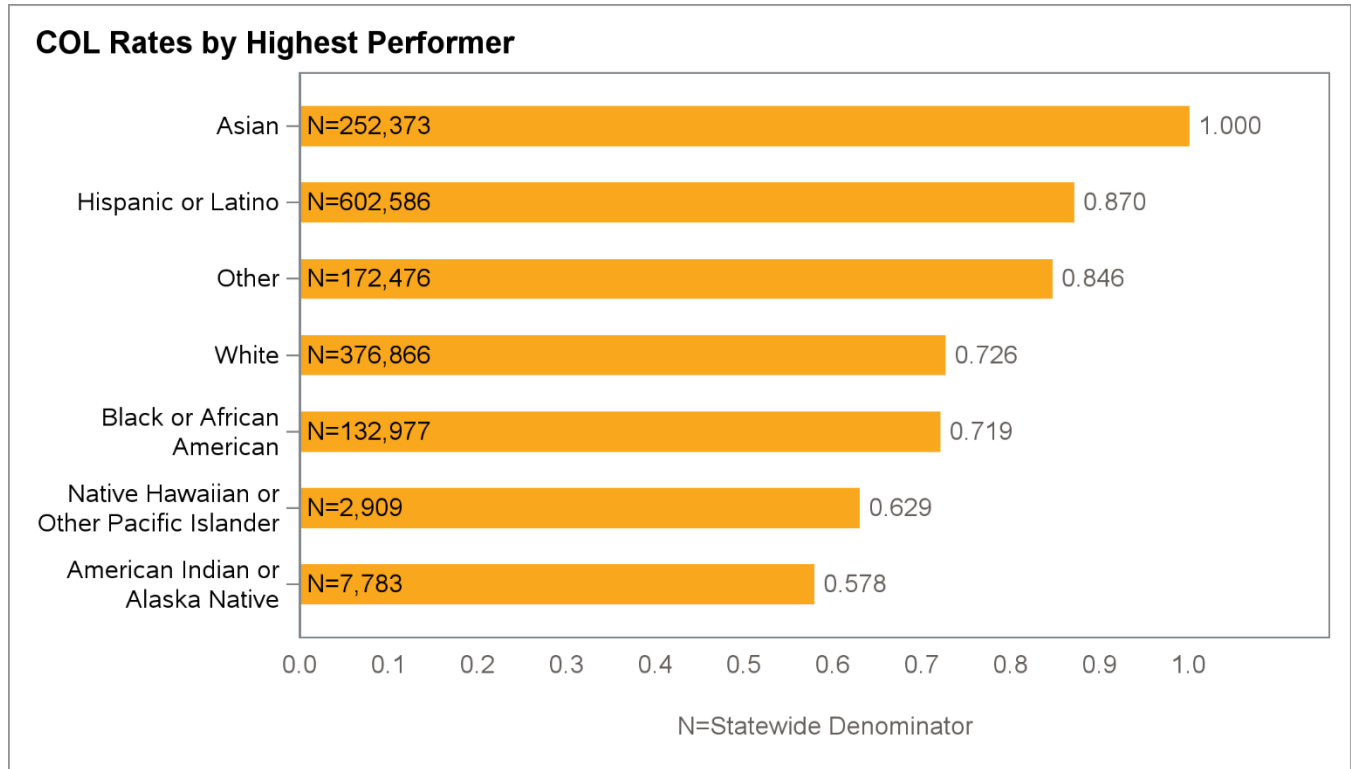


Figure A.28—Colorectal Cancer Screening—Total (COL) by Highest Performing Group

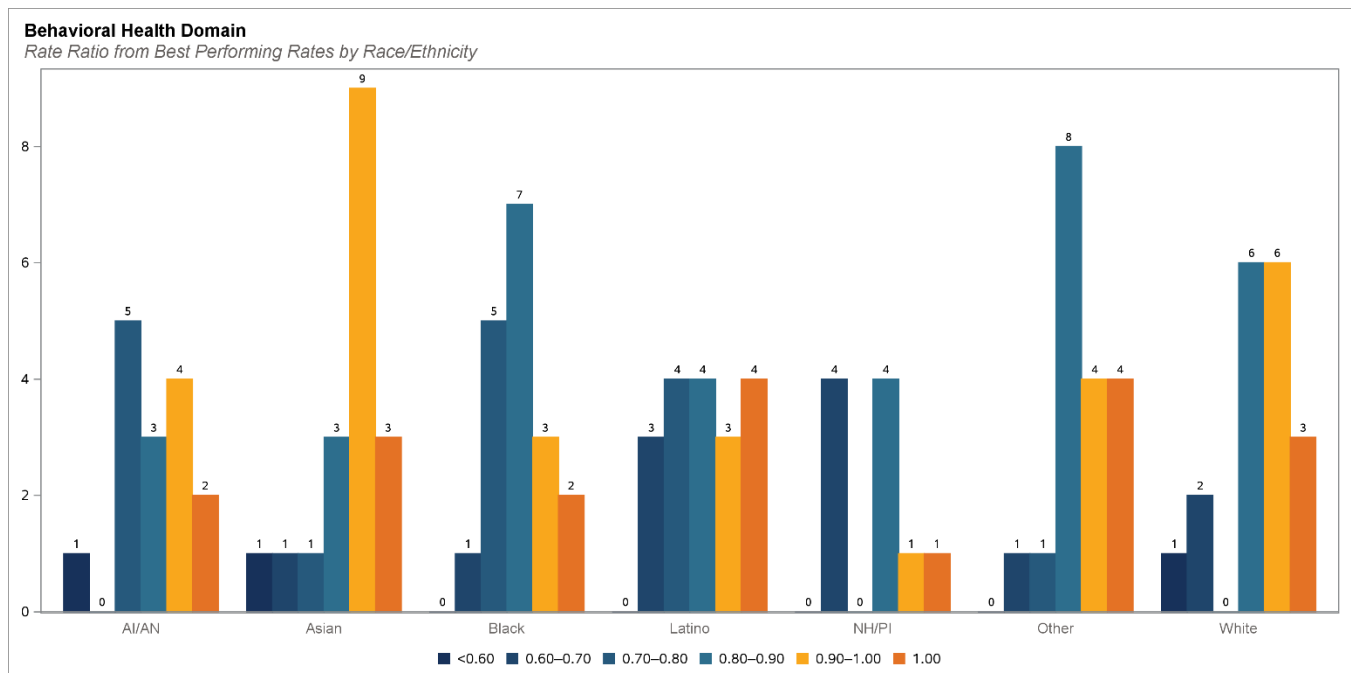
Note: The highest performing group (i.e., the Asian group) had a rate of 43.9 percent. The rate ratio for the Unknown/Missing group was 0.771 (N=67,331).



Highest Performing Racial/Ethnic Group: Behavioral Health Domain

Figure A.29—Highest Performing Group Summary: Behavioral Health Domain

Note: Within the figure, the following racial/ethnic groups have been shortened: American Indian or Alaska Native (AI/AN), Black or African American (Black), Hispanic or Latino (Latino), and Native Hawaiian or Other Pacific Islander (NH/PI).



- ◆ The Other racial/ethnic group also had the highest performing rate for four of 18 (22.2 percent) indicators in the Behavioral Health domain, with 12 of the 14 (85.7 percent) remaining indicators at 80 percent or more of the highest performing group.
- ◆ The Hispanic or Latino racial/ethnic group had the highest performing rate for four of 18 (22.2 percent) indicators in the Behavioral Health domain, with seven of the 14 (50.0 percent) remaining indicators at 80 percent or more of the highest performing group.
- ◆ The Asian racial/ethnic group had the highest performing rate for three of 18 (16.7 percent) indicators in the Behavioral Health domain, with 12 of the 15 (80.0 percent) remaining indicators at 80 percent or more of the highest performing group.
- ◆ All racial/ethnic groups had the highest performing rate for at least one indicator in the Behavioral Health domain.
- ◆ The following racial/ethnic groups had a least one indicator in the Behavioral Health domain that was below 60 percent of the rate for the highest performing group:
 - American Indian or Alaska Native (one rate)
 - Asian (one rate)

- White (one rate)
- ◆ For the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* indicator, all racial/ethnic groups had rates above 90 percent of the rate for the highest performing group (i.e., the Other group).

Figure A.30—Antidepressant Medication Management—Effective Acute Phase Treatment—Total (AMM–Acute) by Highest Performing Group

Note: The highest performing group (i.e., the White group) had a rate of 70.3 percent. The rate ratio for the Unknown/Missing group was 0.985 (N=4,546).

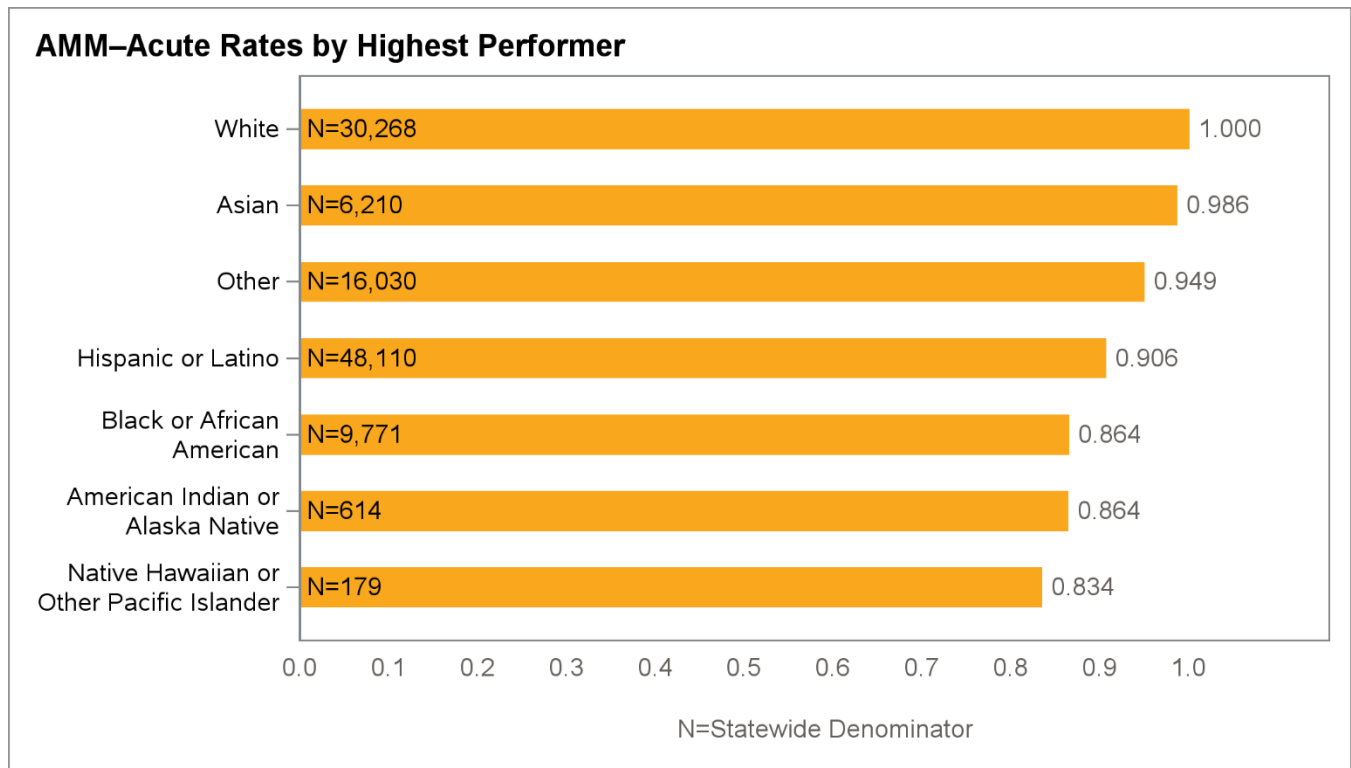


Figure A.31—Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (AMM–Cont) by Highest Performing Group

Note: The highest performing group (i.e., the White group) had a rate of 56.0 percent. The rate ratio for the Unknown/Missing group was 0.959 (N=4,586).

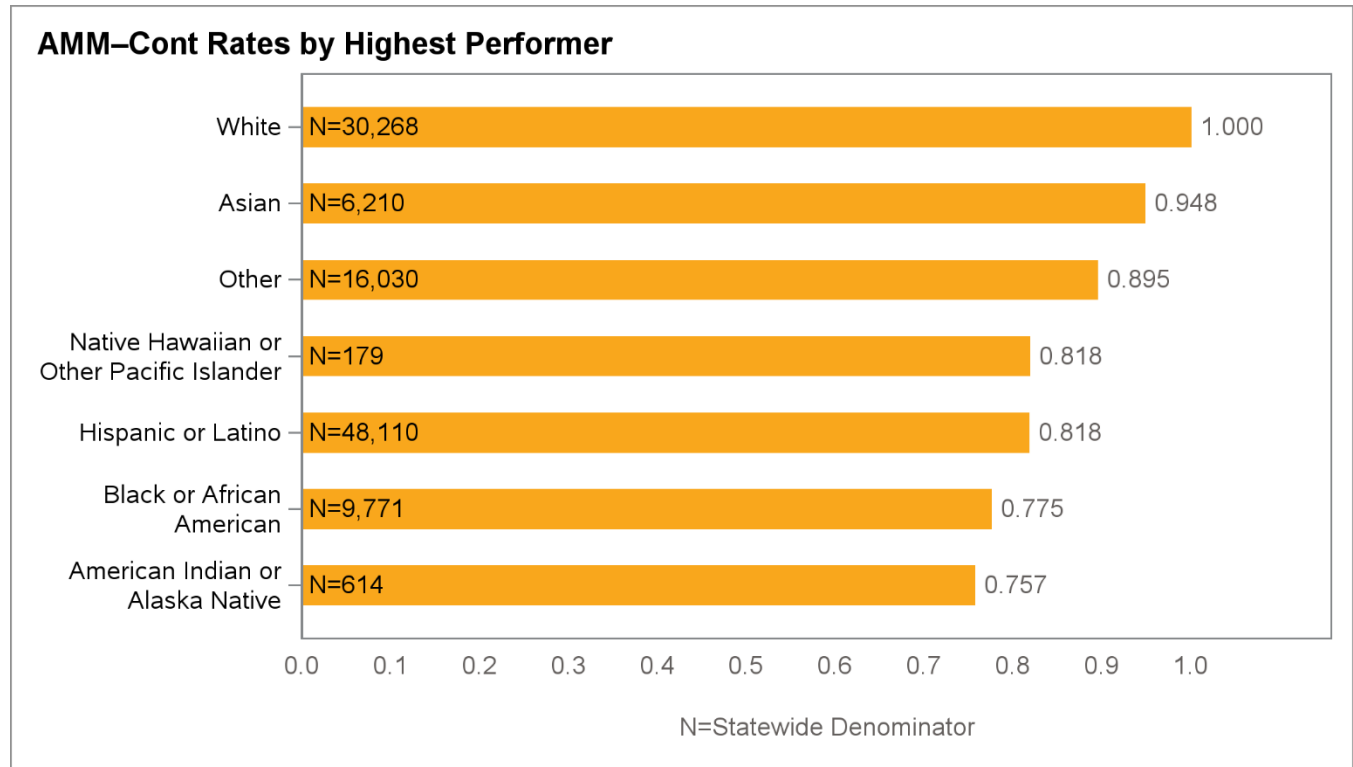


Figure A.32—Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR-E-PHQ) by Highest Performing Group

Note: The highest performing group (i.e., the Native Hawaiian or Other Pacific Islander group) had a rate of 51.4 percent.

The rate ratio for the Unknown/Missing group was 0.808 (N=190).

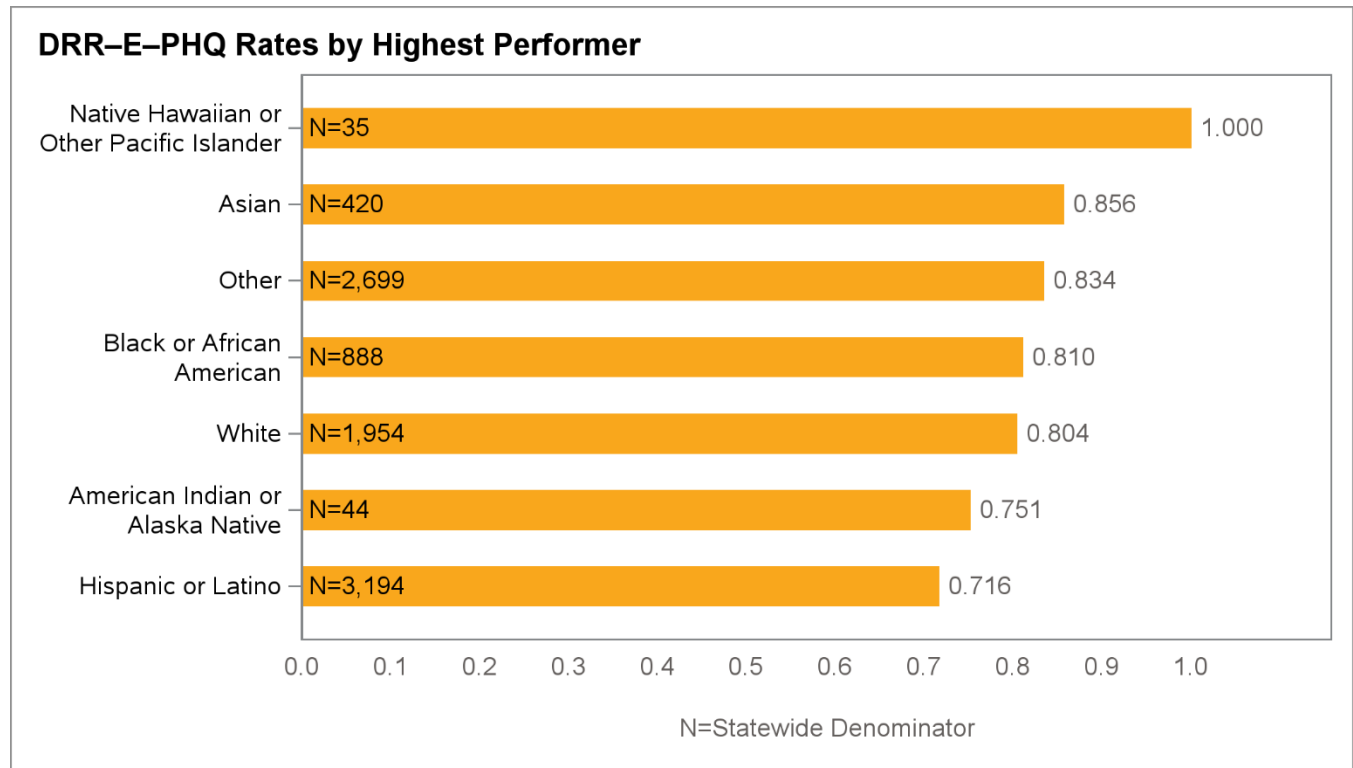


Figure A.33—Depression Remission or Response for Adolescents and Adults—Depression Remission—Total (DRR–E–RM) by Highest Performing Group

Note: The highest performing group (i.e., the Black or African American group) had a rate of 11.1 percent.

The rate ratio for the Unknown/Missing group was 0.519 (N=190).

S indicates fewer than 11 cases exist in the numerator for the racial/ethnic group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

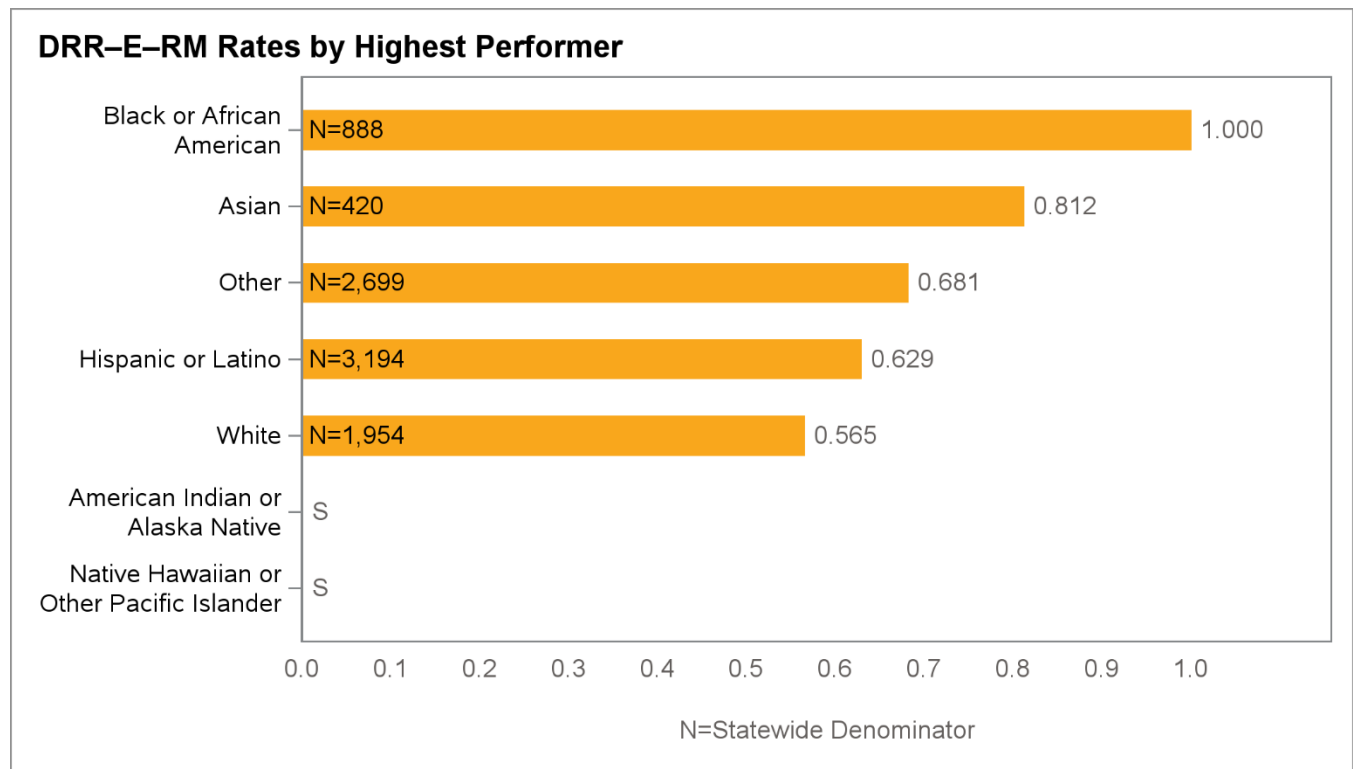
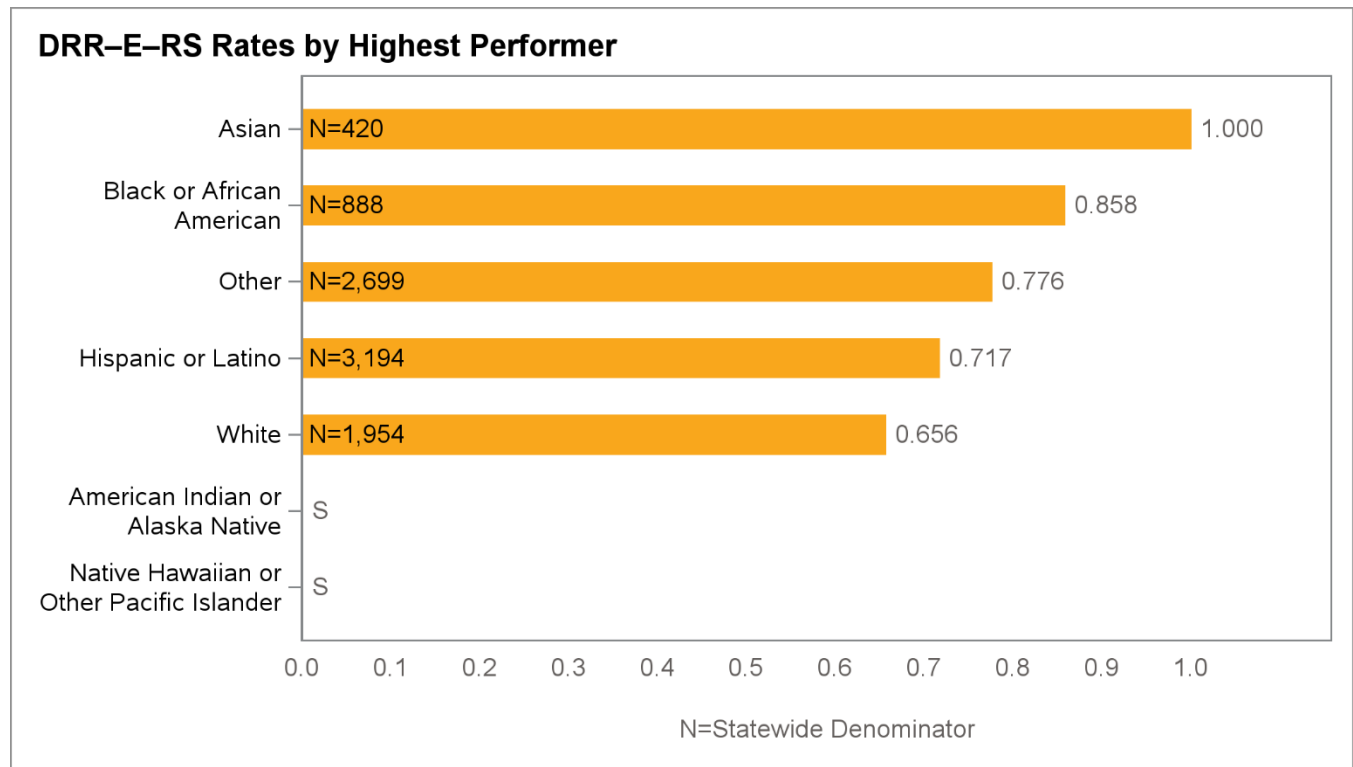


Figure A.34—Depression Remission or Response for Adolescents and Adults—Depression Response—Total (DRR–E–RS) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 17.9 percent.

The rate ratio for the Unknown/Missing group was 0.855 (N=190).

S indicates fewer than 11 cases exist in the numerator for the racial/ethnic group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.



**Figure A.35—Depression Screening and Follow-Up for Adolescents and Adults—
Depression Screening—Total (DSF–E–DS) by Highest Performing Group**

Note: The highest performing group (i.e., the Black or African American group) had a rate of 5.3 percent.

The rate ratio for the Unknown/Missing group was 0.568 (N=248,227).

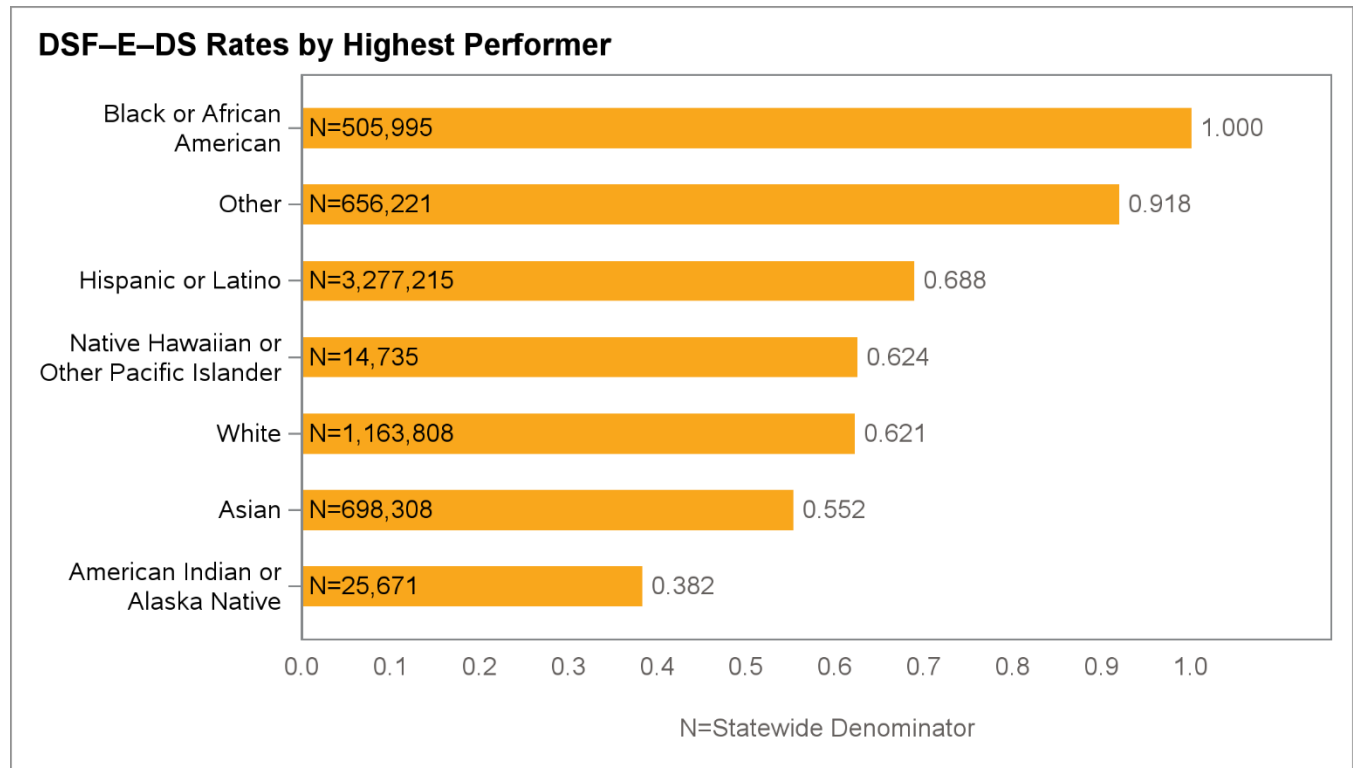


Figure A.36—Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total (DSF–E–FU) by Highest Performing Group

Note: The highest performing group (i.e., the Other group) had a rate of 80.5 percent. The rate ratio for the Unknown/Missing group was 0.829 (N=1,589).

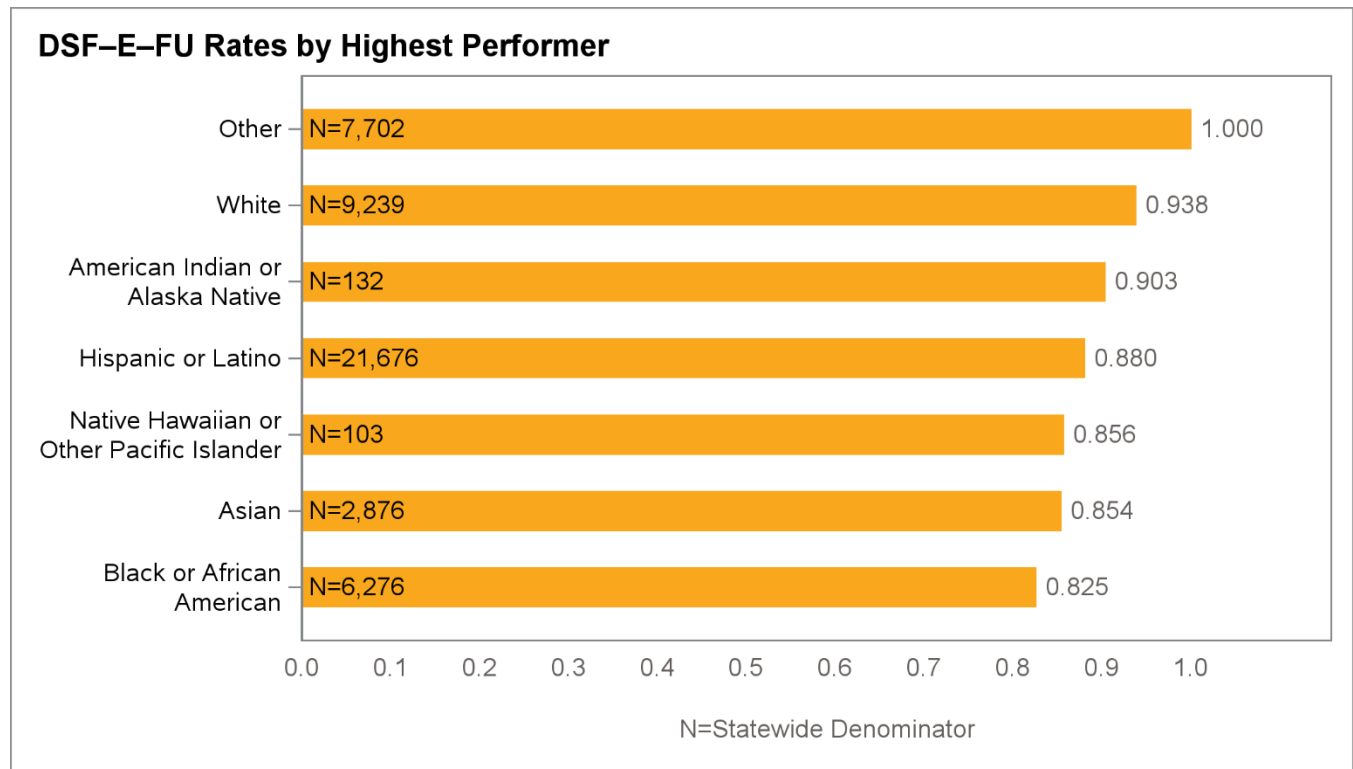


Figure A.37—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) by Highest Performing Group

Note: The highest performing group (i.e., the Other group) had a rate of 79.2 percent. The rate ratio for the Unknown/Missing group was 0.980 (N=4,669).

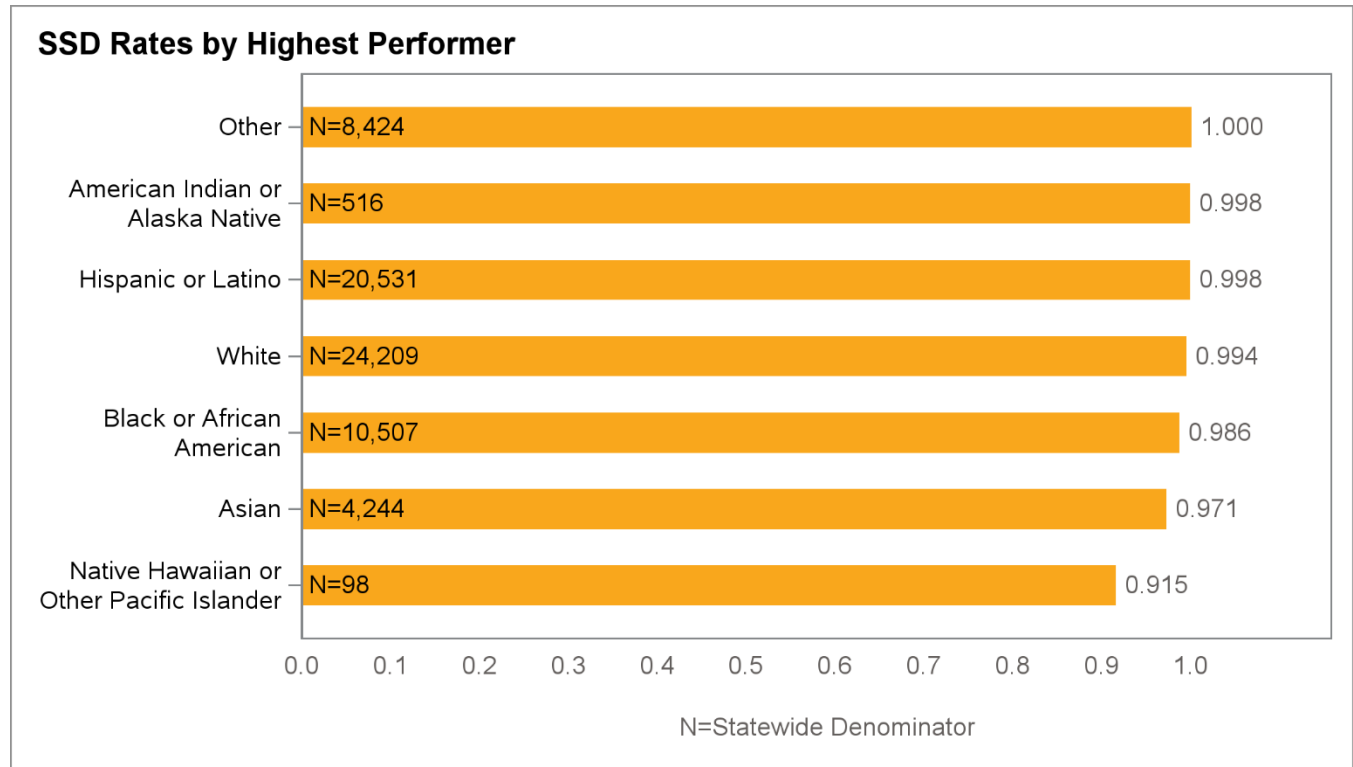


Figure A.38—Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA-7) by Highest Performing Group

Note: The highest performing group (i.e., the American Indian or Alaska Native group) had a rate of 22.5 percent.

The rate ratio for the Unknown/Missing group was 0.816 (N=2,256).

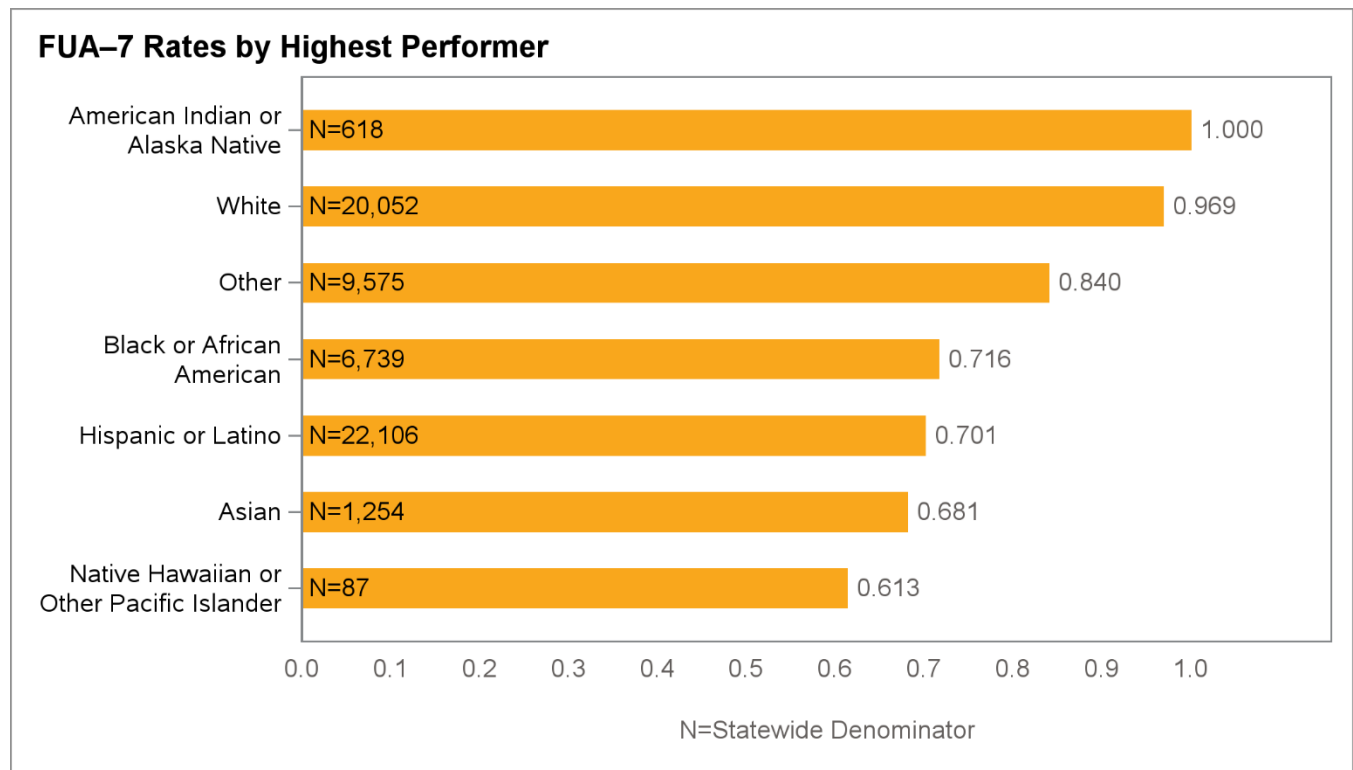


Figure A.39—Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30) by Highest Performing Group

Note: The highest performing group (i.e., the White group) had a rate of 33.4 percent. The rate ratio for the Unknown/Missing group was 0.838 (N=2,256).

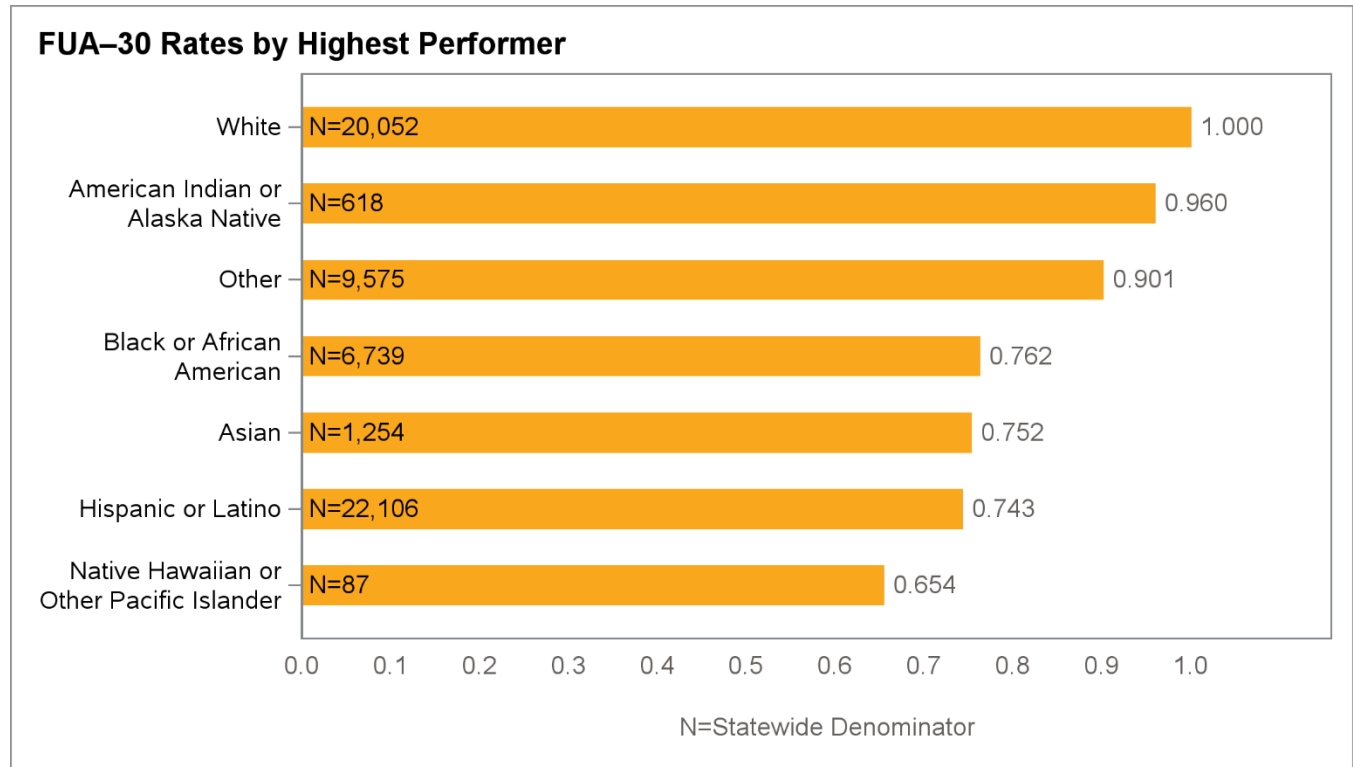


Figure A.40—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 39.7 percent. The rate ratio for the Unknown/Missing group was 0.851 (N=2,492).

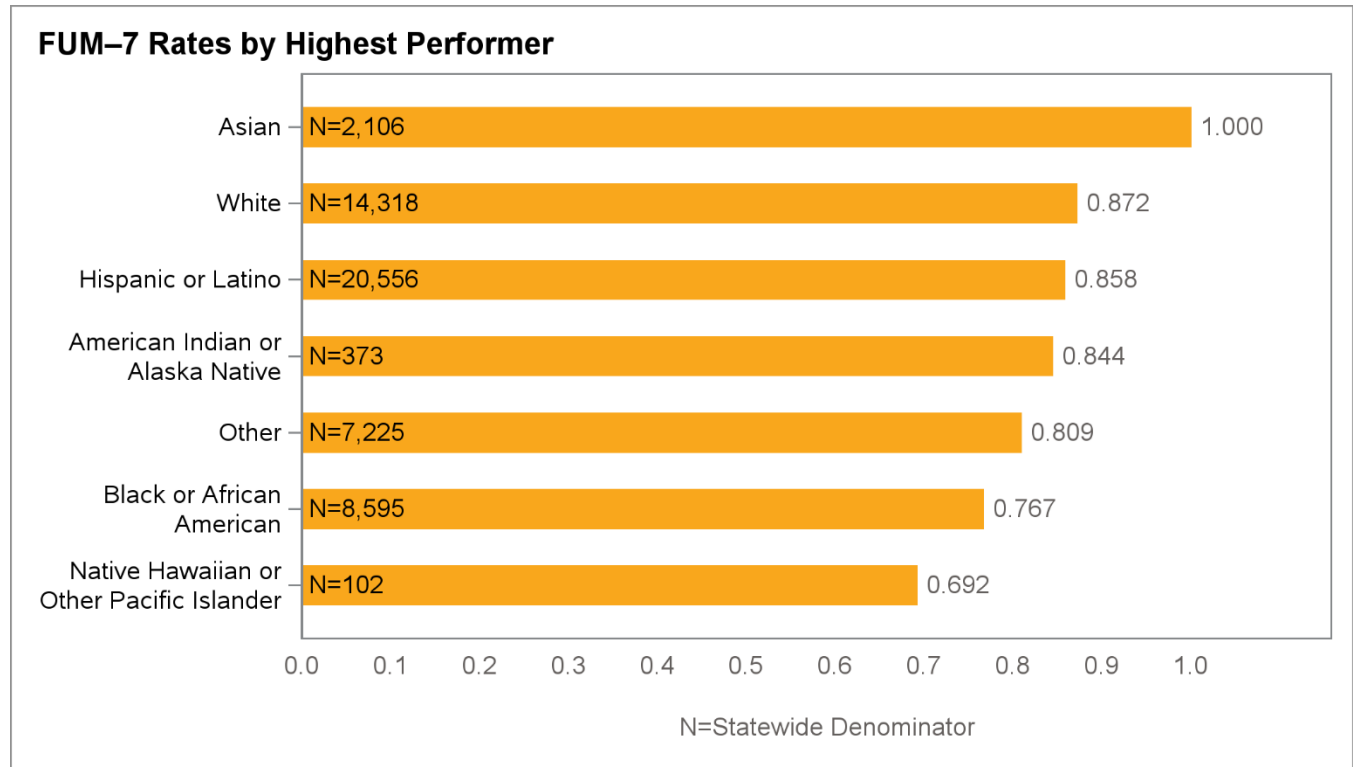


Figure A.41—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 53.9 percent. The rate ratio for the Unknown/Missing group was 0.879 (N=2,492).

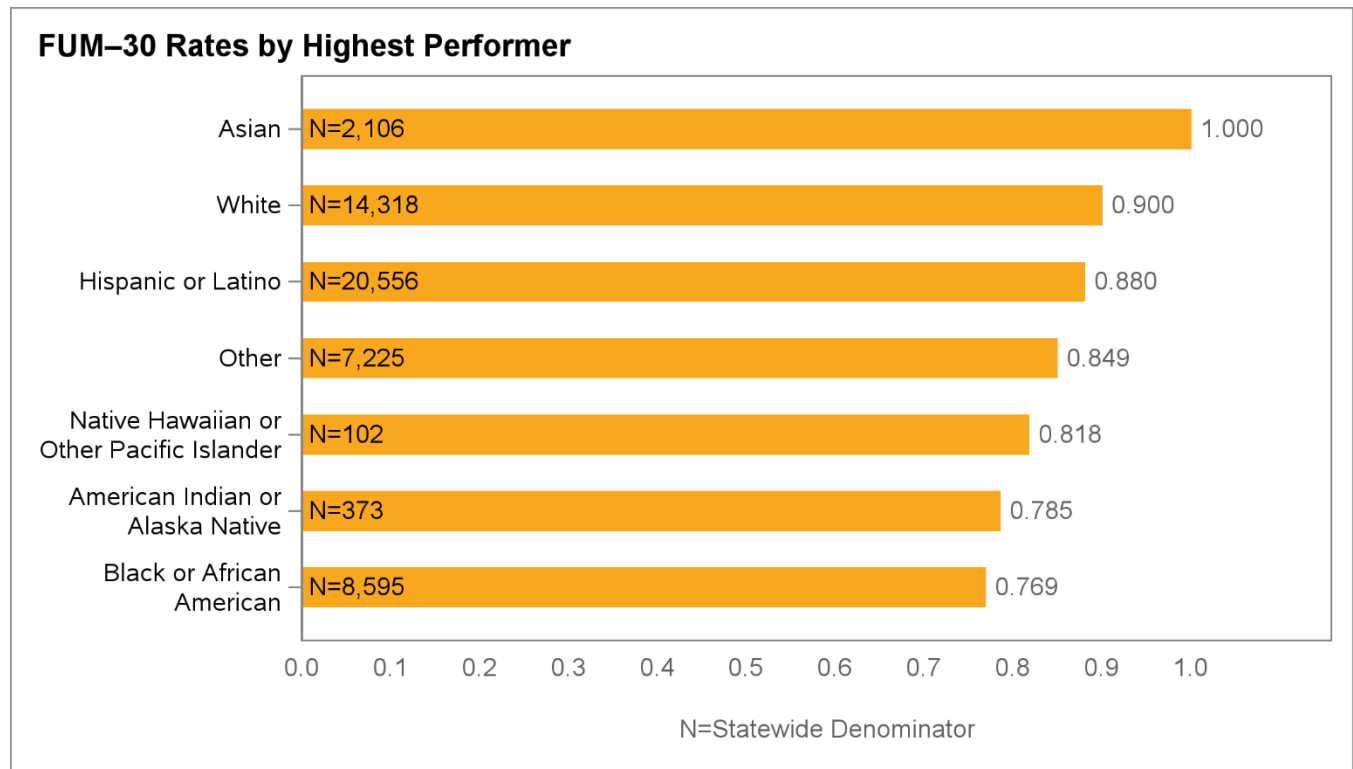


Figure A.42—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD–Init) by Highest Performing Group

Note: While both the Other and Hispanic or Latino racial/ethnic groups round to 1.000, the unrounded rate for the Other group is higher, identifying this racial/ethnic group at the highest performing group.

The highest performing groups (i.e., the Hispanic or Latino and Other groups) had had a rate of 47.7 percent.

The rate ratio for the Unknown/Missing group was 0.973 (N=844).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

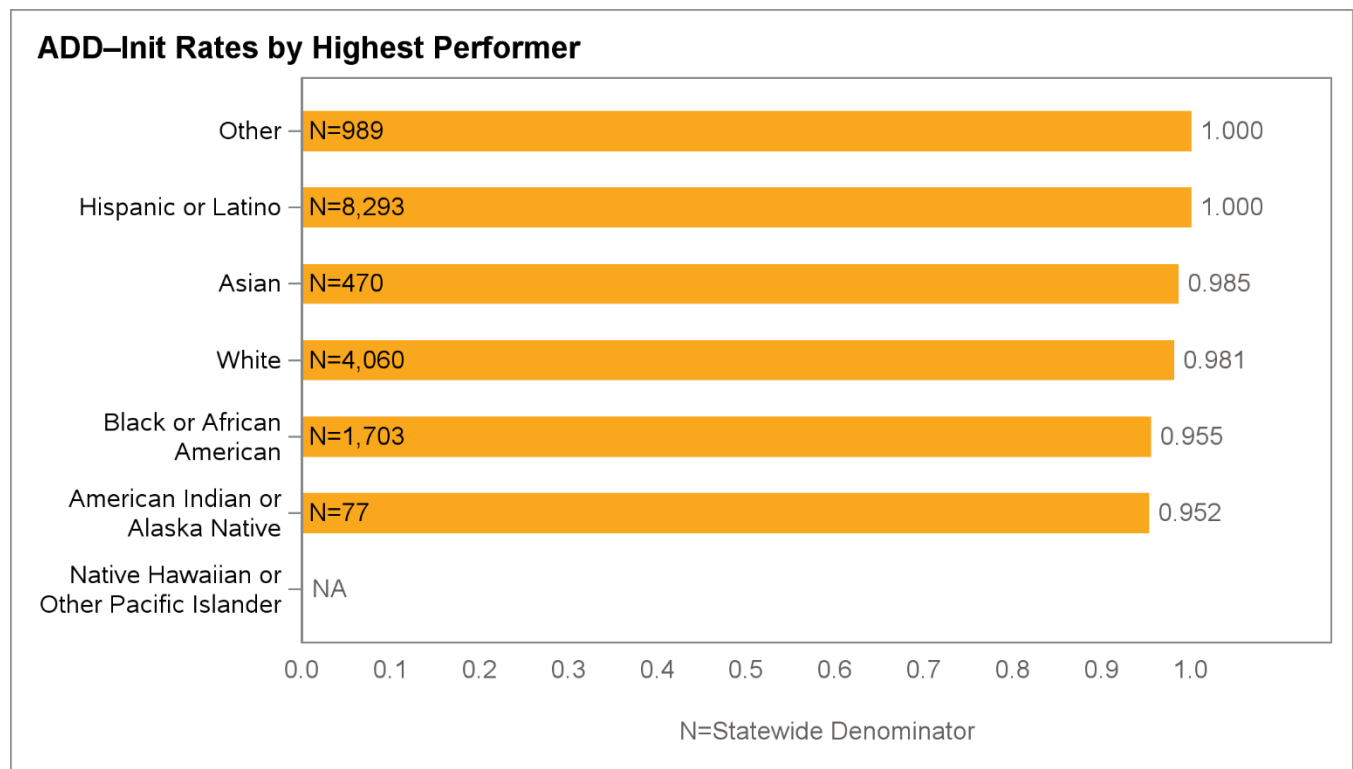


Figure A.43—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD–C&M) by Highest Performing Group

Note: The highest performing group (i.e., the Other group) had a rate of 53.2 percent.

The rate ratio for the Unknown/Missing group was 1.031 (N=266).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

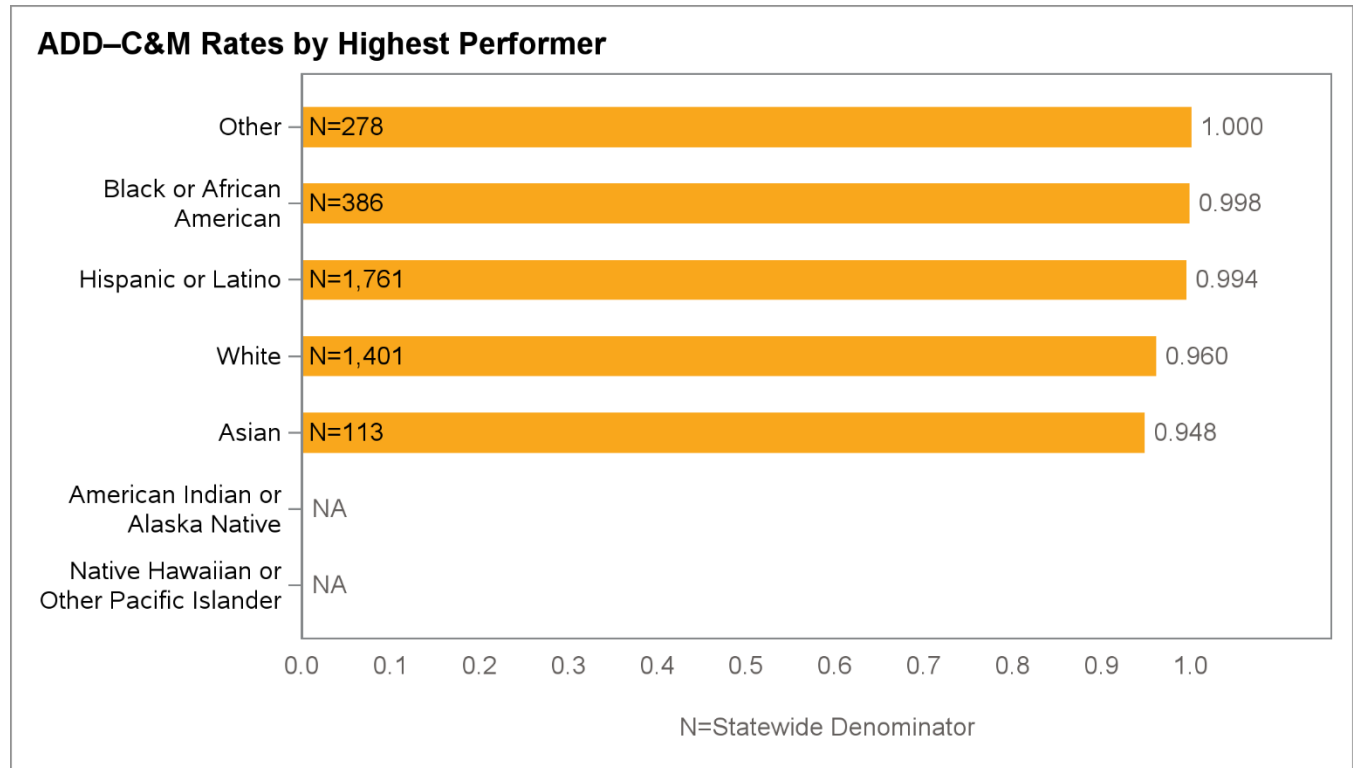


Figure A.44—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM–B) by Highest Performing Group

Note: The highest performing group (i.e., the Hispanic or Latino group) had a rate of 64.0 percent.

The rate ratio for the Unknown/Missing group was 0.851 (N=663).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

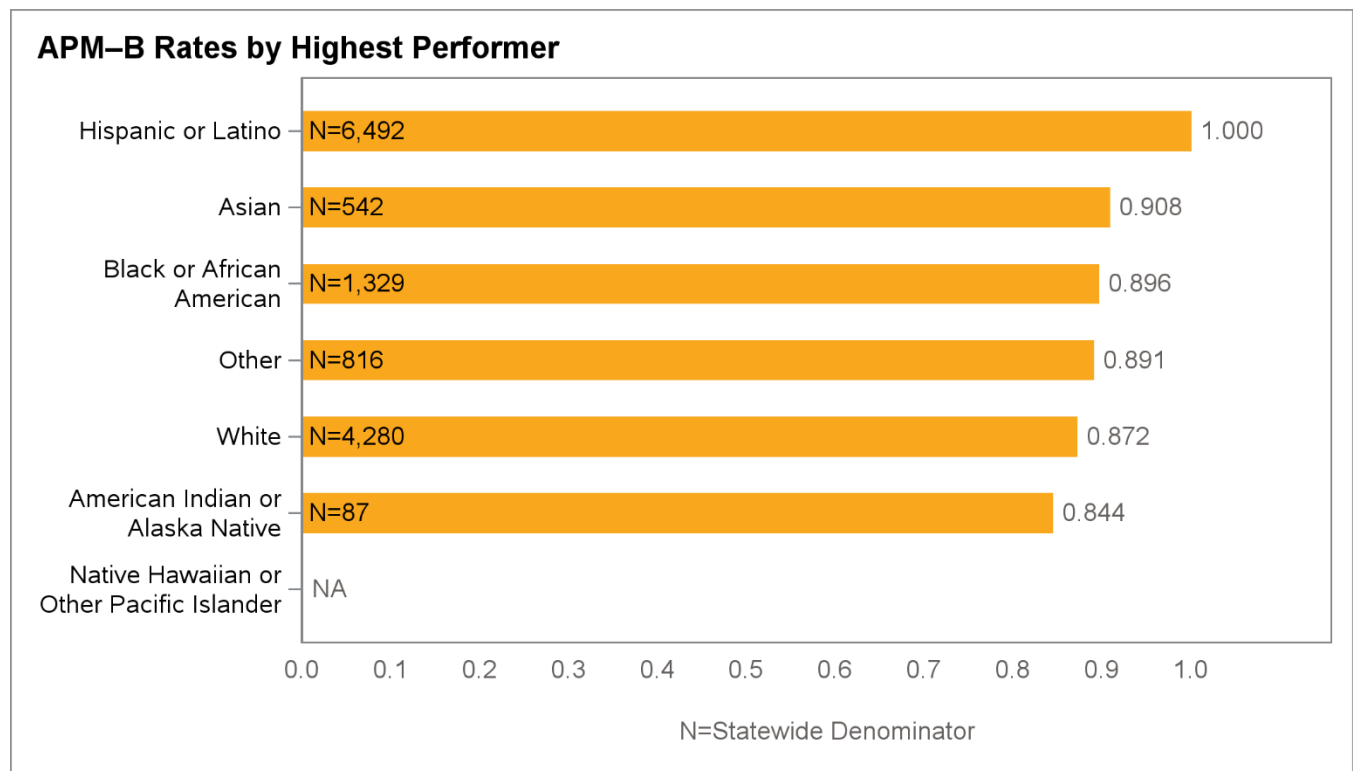


Figure A.45—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (APM–C) by Highest Performing Group

Note: The highest performing group (i.e., the Hispanic or Latino group) had a rate of 44.3 percent.

The rate ratio for the Unknown/Missing group was 0.818 (N=663).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

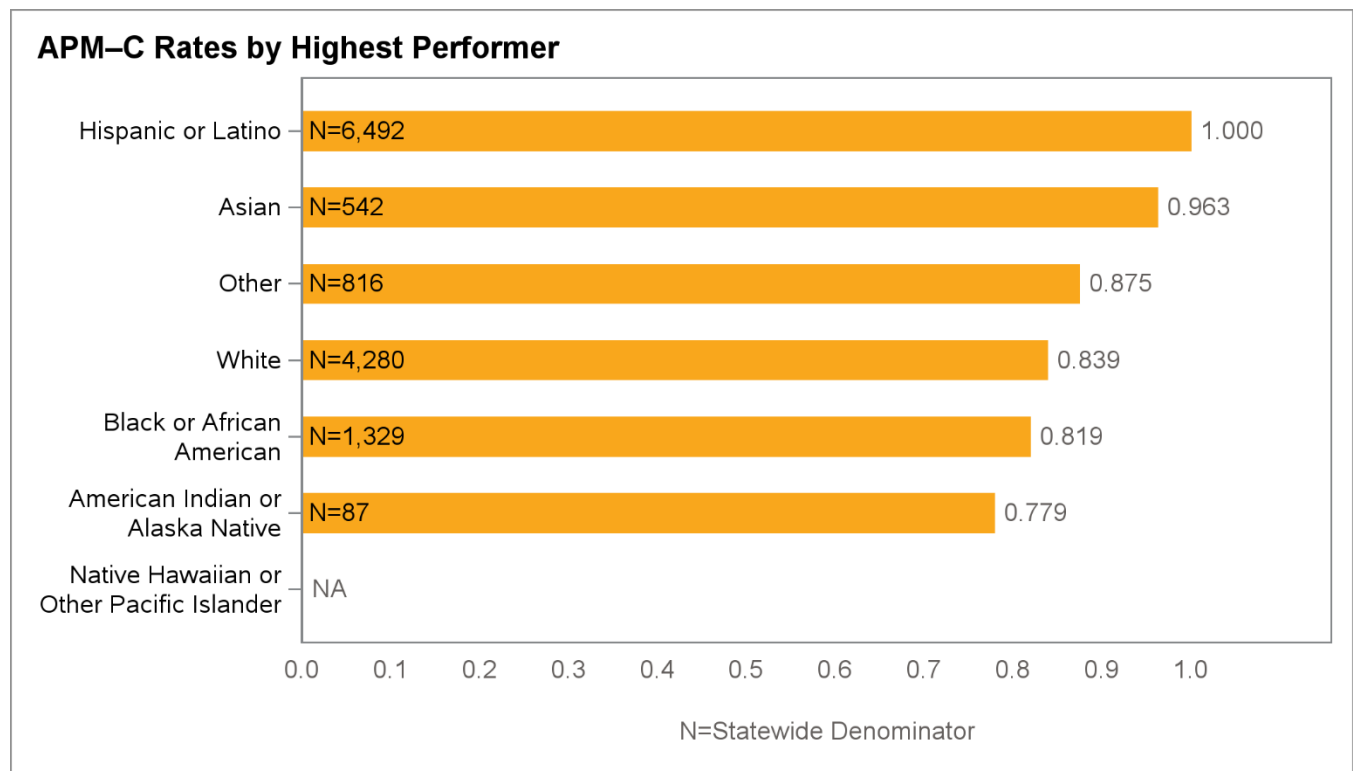


Figure A.46—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM-BC) by Highest Performing Group

Note: The highest performing group (i.e., the Hispanic or Latino group) had a rate of 43.1 percent.

The rate ratio for the Unknown/Missing group was 0.826 (N=663).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

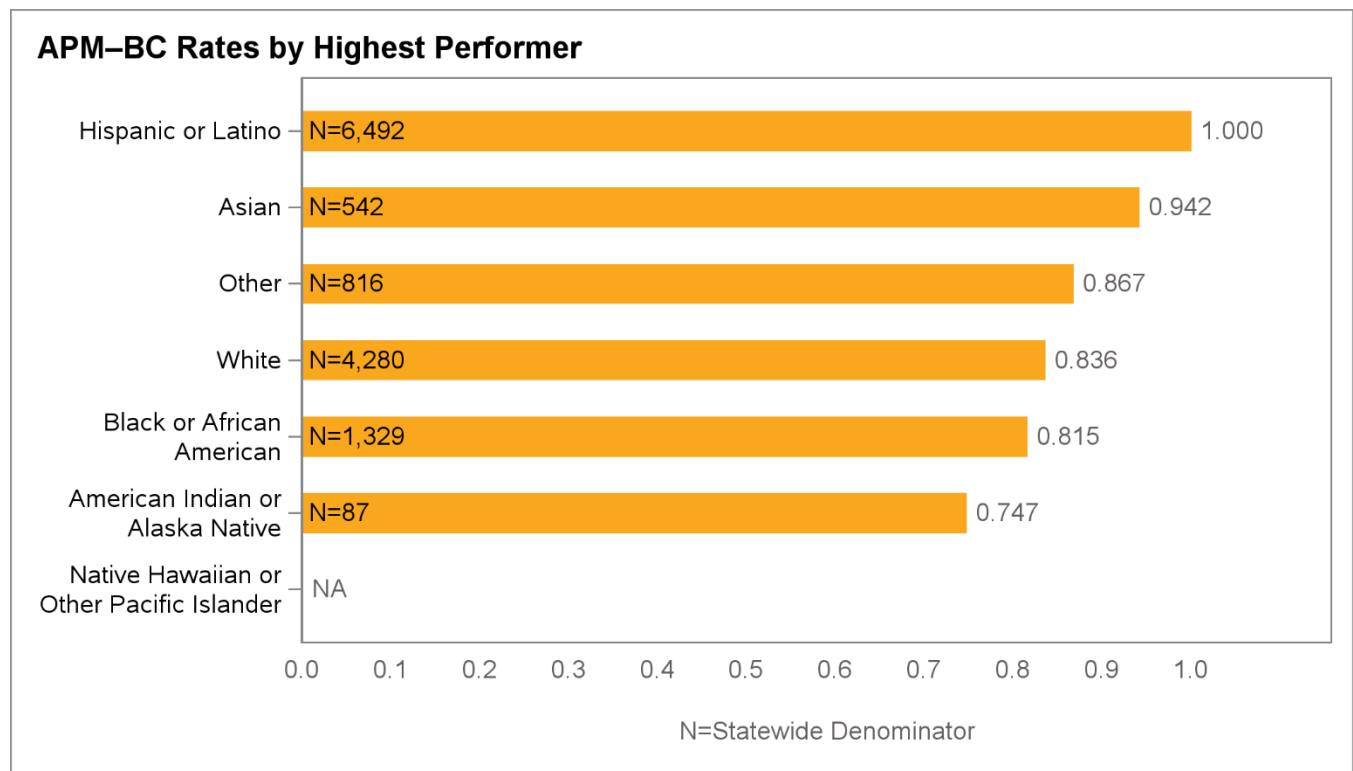
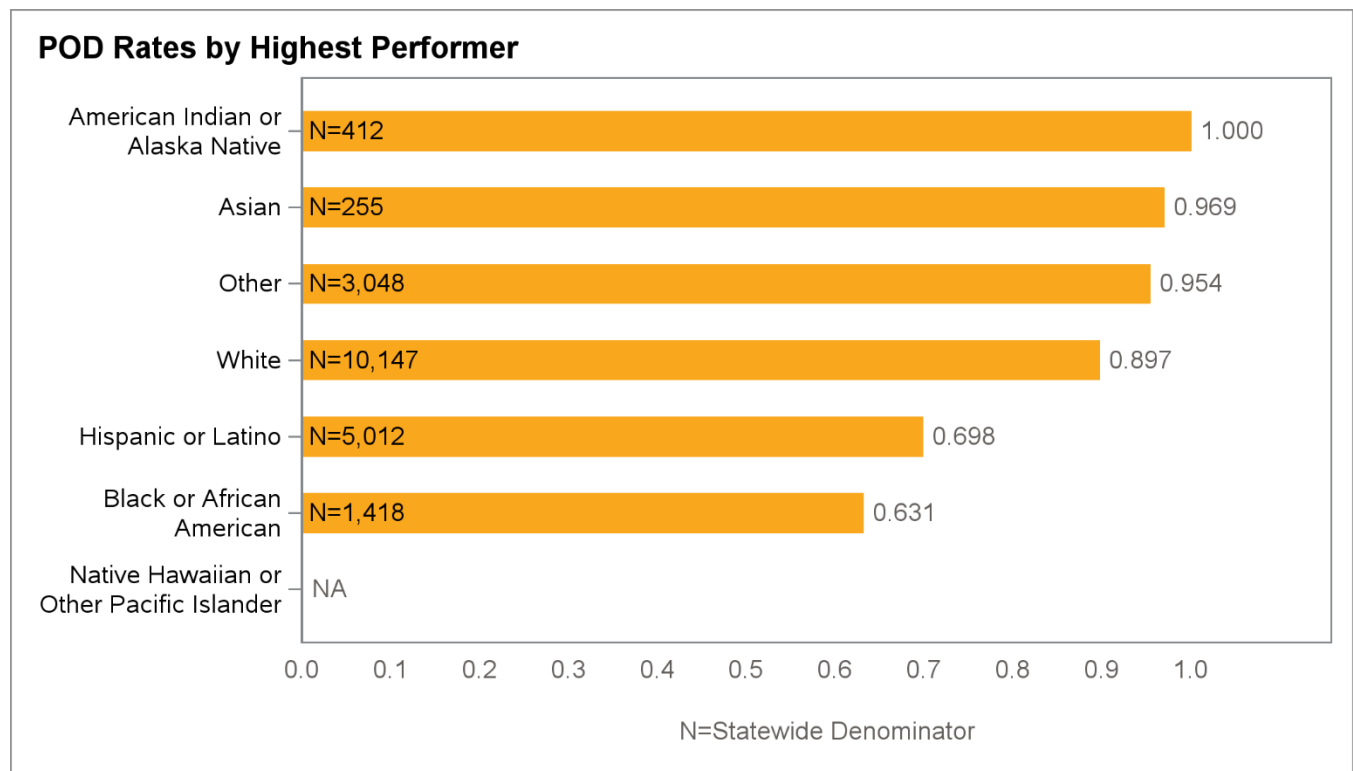


Figure A.47—Pharmacotherapy for Opioid Use Disorder (POD) by Highest Performing Group

Note: The highest performing group (i.e., the American Indian or Alaska Native group) had a rate of 25.5 percent.

The rate ratio for the Unknown/Missing group was 1.033 (N=729).

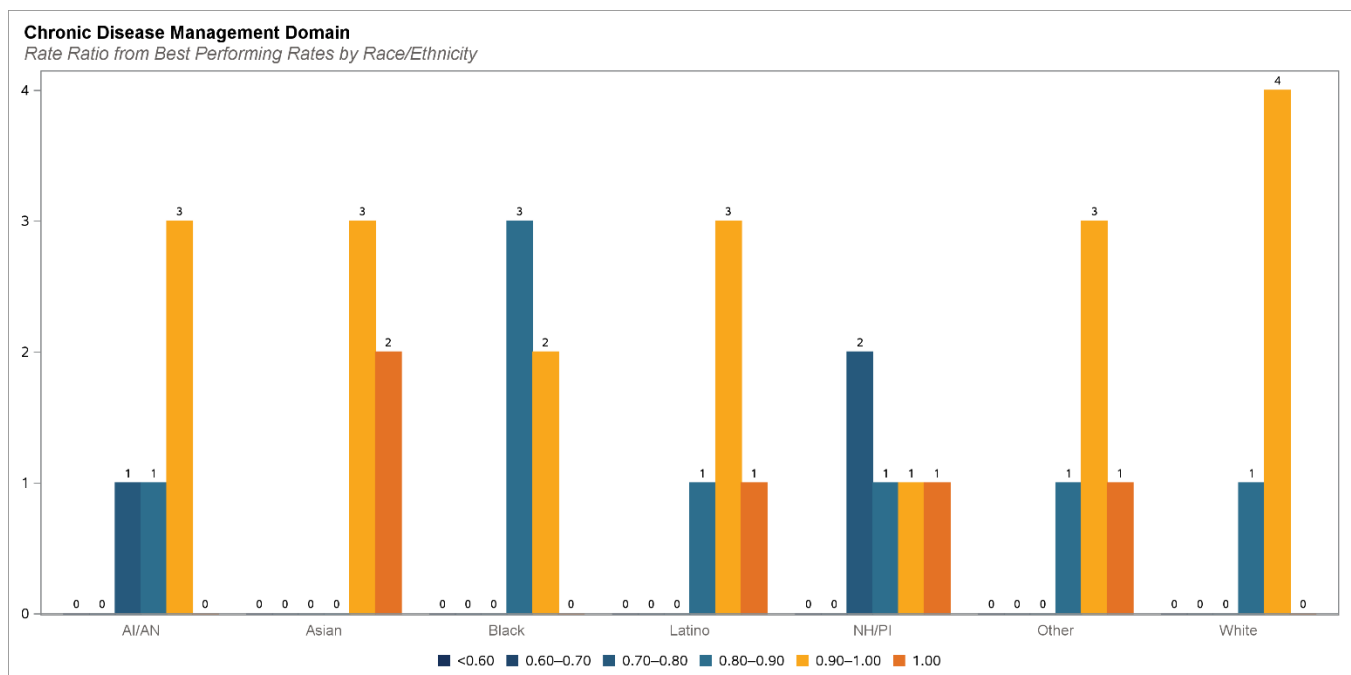
NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).



Highest Performing Racial/Ethnic Group: Chronic Disease Management Domain

Figure A.48—Highest Performing Group Summary: Chronic Disease Management Domain

Note: Within the figure, the following racial/ethnic groups have been shortened: American Indian or Alaska Native (AI/AN), Black or African American (Black), Hispanic or Latino (Latino), and Native Hawaiian or Other Pacific Islander (NH/PI).



- ◆ The Asian racial/ethnic group had the highest performing rate for two of five (40.0 percent) indicators in the Chronic Disease Management domain, with the three remaining indicator rates at 90 percent or more of the rates for the highest performing group.
- ◆ The following racial/ethnic groups did not have the highest performing rate for any indicators in the Chronic Disease Management domain:
 - American Indian or Alaska Native
 - Black or African American
 - White
- ◆ None of the racial/ethnic groups had any indicators in the Chronic Disease Management domain that was below 70 percent of the rate for the highest performing group.

- ◆ The following racial/ethnic groups had at least one indicator rate in the Chronic Disease Management domain that was at 90 percent or more of the rates for the highest performing group:
 - American Indian or Alaska Native (three rates)
 - Asian (five rates)
 - Black or African American (two rates)
 - Hispanic or Latino (four rates)
 - Native Hawaiian or Other Pacific Islander (two rates)
 - Other (four rates)
 - White (four rates)
- ◆ For the *Plan All-Cause Readmissions—Observed Readmission Rate—Total* indicator, all racial/ethnic groups had rates above 90 percent of the rate for the highest performing group (i.e., the Native Hawaiian or Other Pacific Islander group).

Figure A.49—Adults’ Access to Preventive/Ambulatory Health Services—Total (AAP) by Highest Performing Group

Note: The highest performing group (i.e., the Other group) had a rate of 66.6 percent. The rate ratio for the Unknown/Missing group was 0.923 (N=236,916).

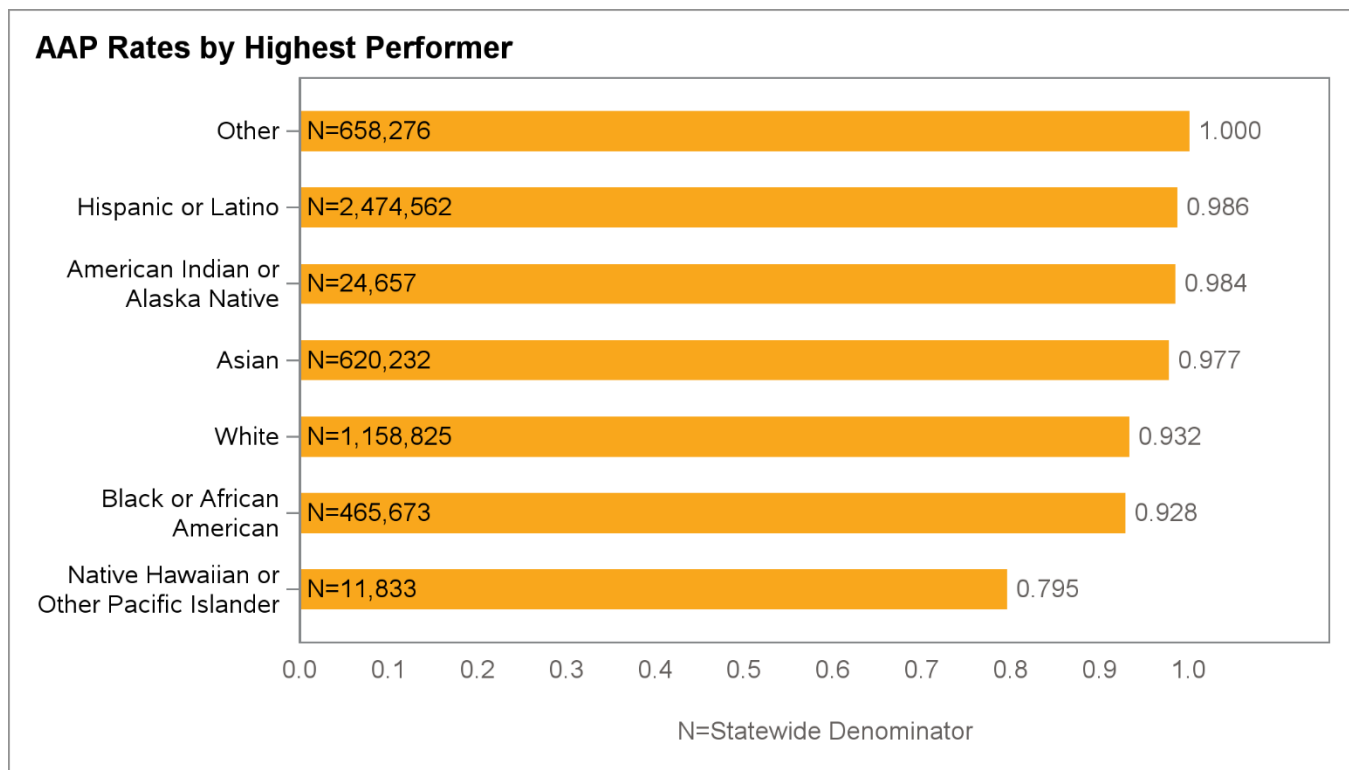


Figure A.50—Asthma Medication Ratio—Total (AMR) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 73.6 percent. The rate ratio for the Unknown/Missing group was 0.924 (N=3,606).

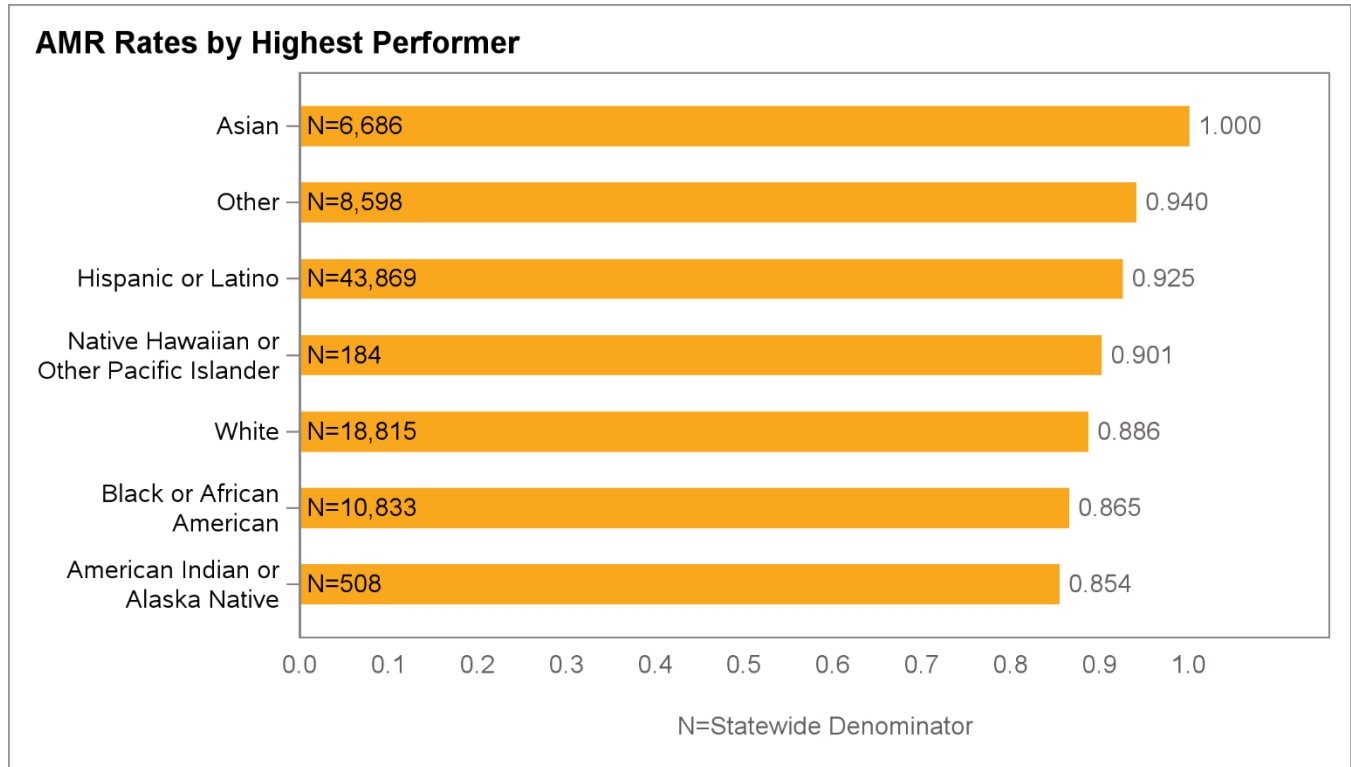


Figure A.51—Controlling High Blood Pressure—Total (CBP) by Highest Performing Group

Note: The highest performing group (i.e., the Hispanic or Latino group) had a rate of 63.9 percent.

The rate ratio for the Unknown/Missing group was 0.959 (N=848).

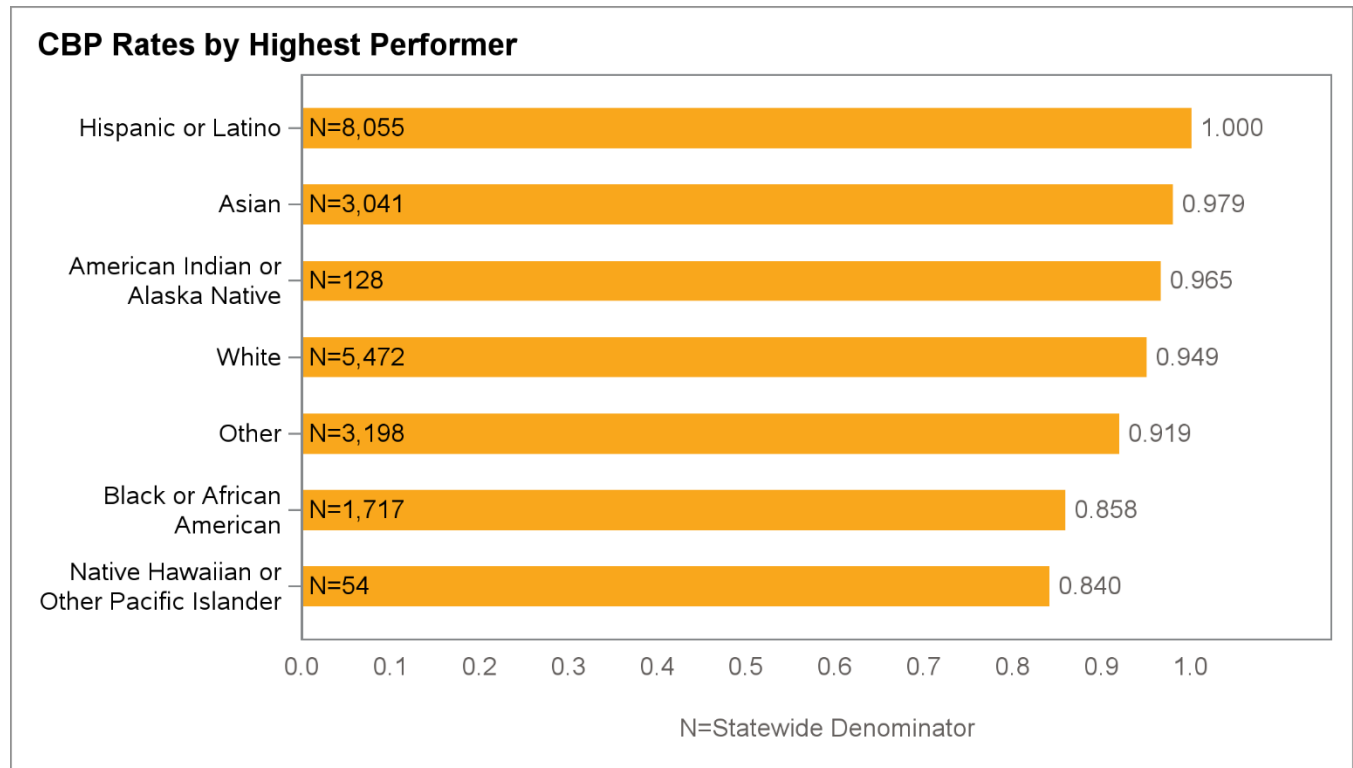


Figure A.52—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9) by Highest Performing Group

Note: The highest performing group (i.e., the Asian group) had a rate of 28.7 percent. The rate ratio for the Unknown/Missing group was 0.890 (N=872).

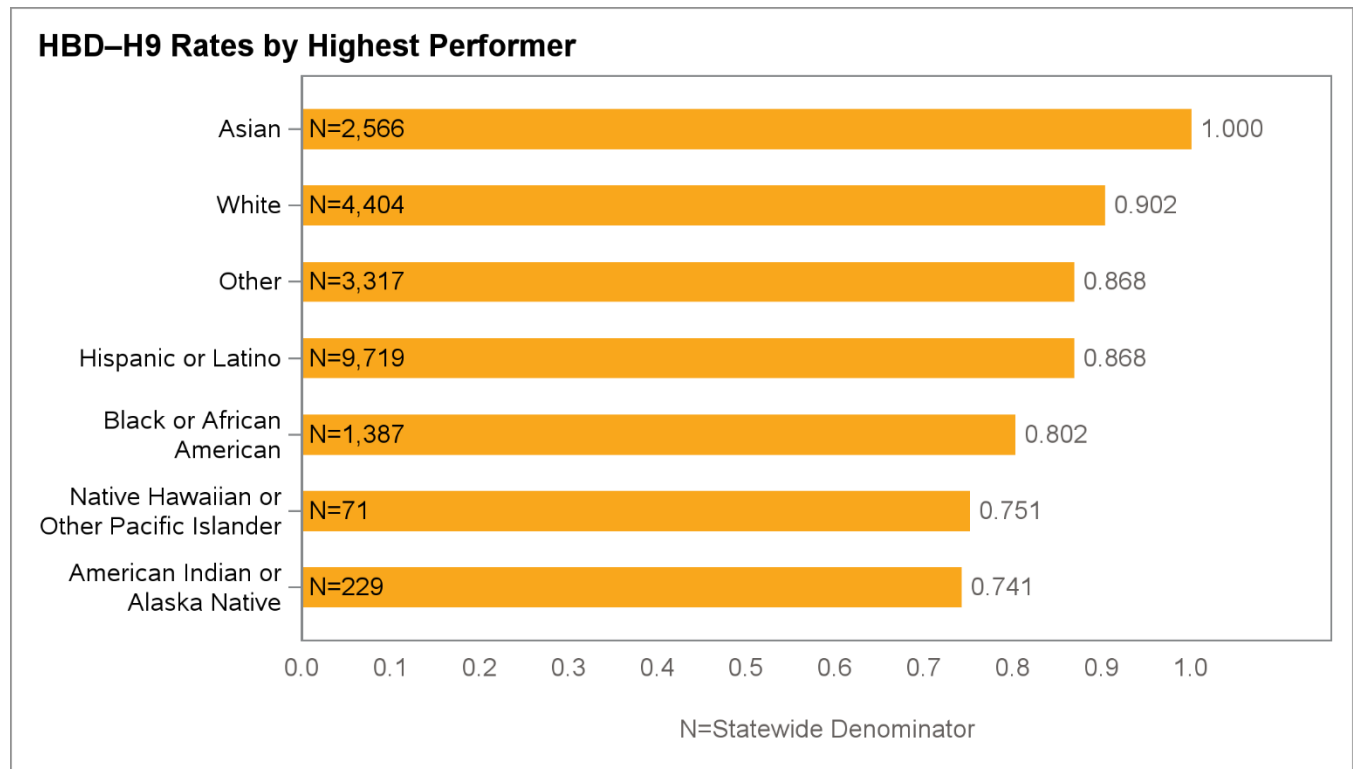
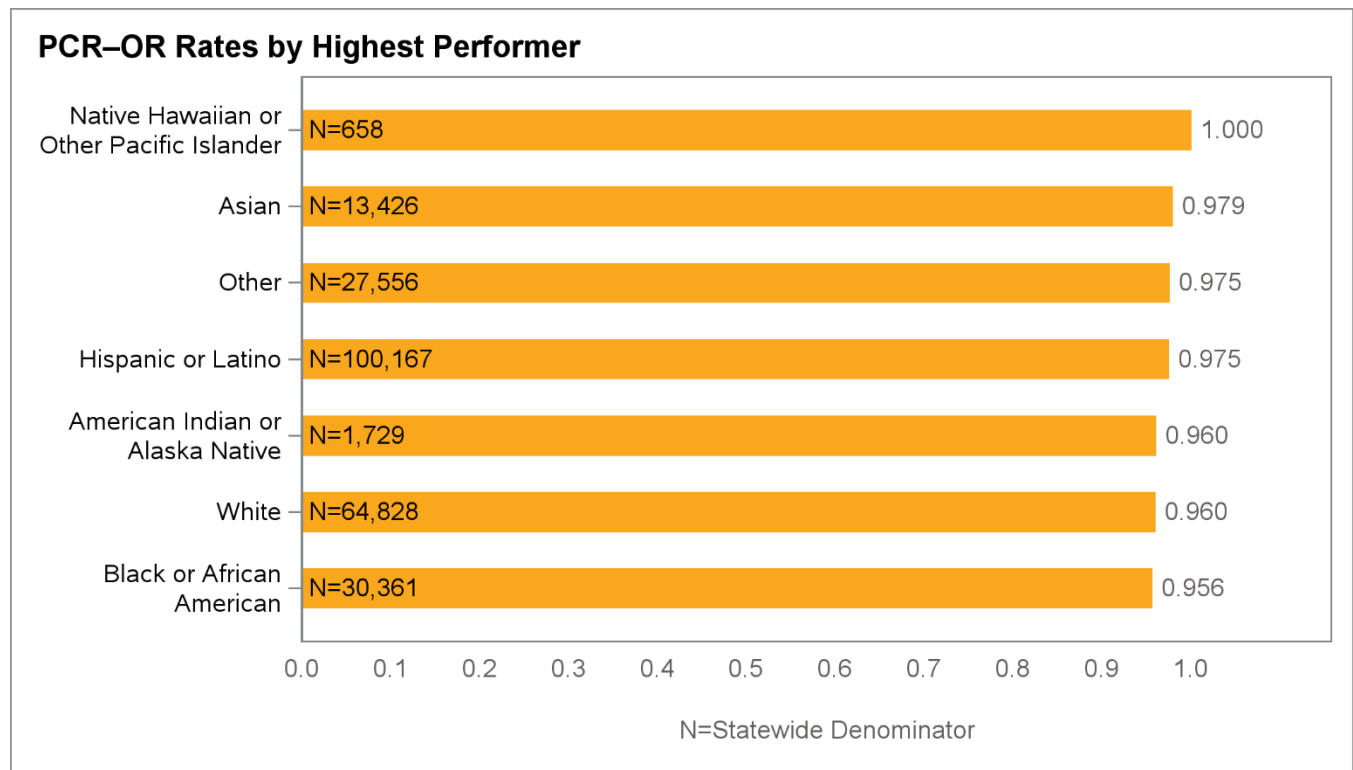


Figure A.53—Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR) by Highest Performing Group

Note: The highest performing group (i.e., the Native Hawaiian or Other Pacific Islander group) had a rate of 6.1 percent.

The rate ratio for the Unknown/Missing group was 0.967 (N=8,637).



Appendix B. Healthy Places Index Analysis

Appendix B presents graphics for each of the nine key MCAS indicators that DHCS selected for the healthy places index (HPI) analysis, stratified by race/ethnicity and HPI quartile. HSAG combined the HPI score and percentile to the patient-level detail file based on member ZIP Code using the HPI 3.0 Master File from the Public Health Alliance of Southern California website which contains data regarding the demographic composition of various communities, stratified by ZIP Code (e.g., average household income, education level, supermarket availability).¹⁵ For more information about combining the patient-level detail file and HPI data, please refer to the “Combining Data” heading in Appendix D. Methodology.

Based on the HPI percentile identified for each ZIP Code, each member was placed into a quartile range (i.e., HPI percentile values below the 25th percentile were placed into quartile 1, values at or above the 25th but below the 50th percentile were placed into quartile 2, values at or above the 50th but below the 75th percentile were placed into quartile 3, and values at or above the 75th percentile were placed into quartile 4). HSAG then calculated rates by summing the numerators and denominators for all members within a racial/ethnic group-HPI quartile combination. The nine key MCAS indicators that DHCS selected for the HPI analysis were:

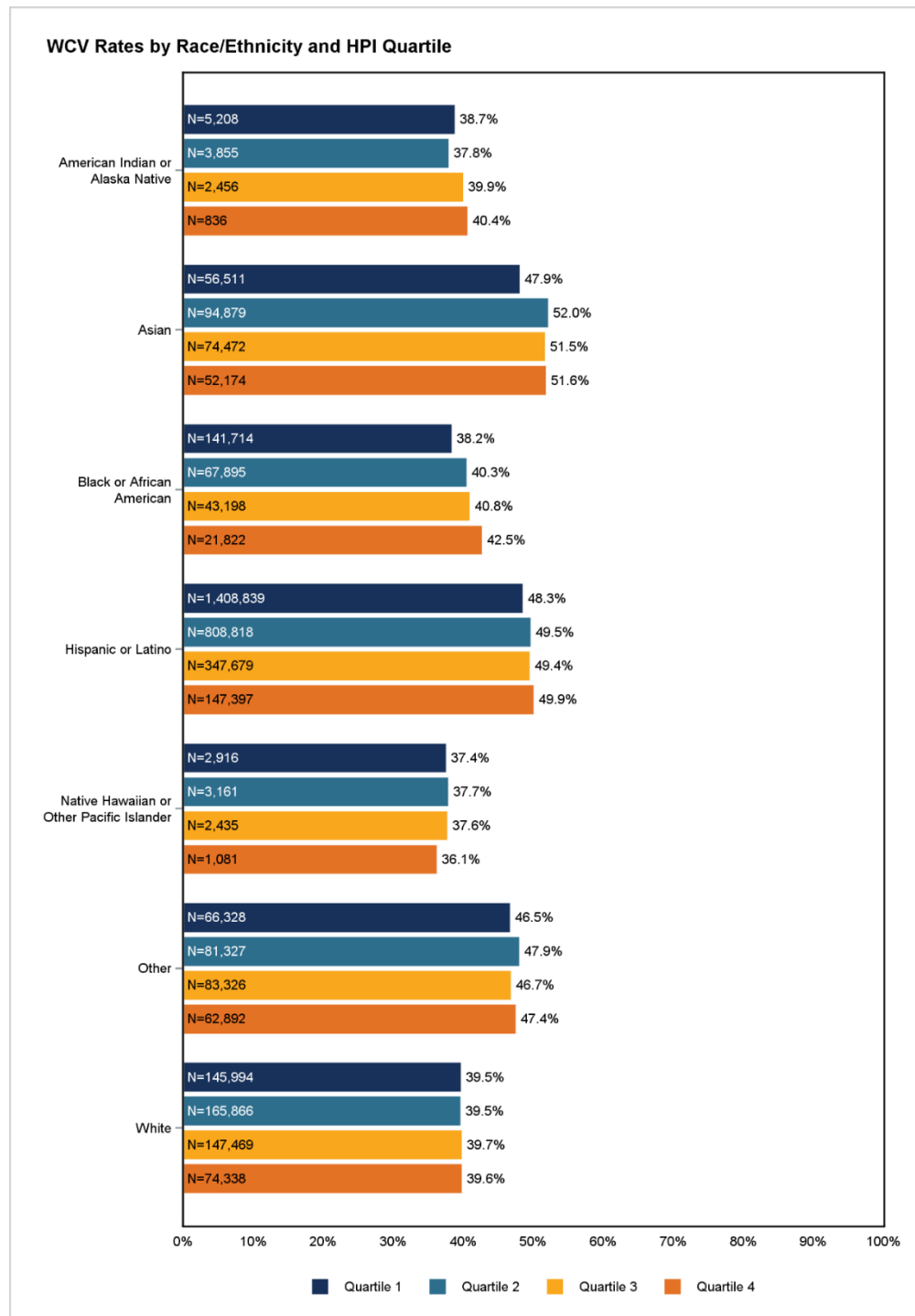
- ◆ *Child and Adolescent Well-Care Visits—Total*
- ◆ *Childhood Immunization Status—Combination 10*
- ◆ *Controlling High Blood Pressure—Total*
- ◆ *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)*
- ◆ *Immunizations for Adolescents—Combination 2*
- ◆ *Prenatal and Postpartum Care—Postpartum Care*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- ◆ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- ◆ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

Figure B.1 through Figure B.9 display the HPI analysis results for the nine key MCAS indicators listed above.

¹⁵ Public Health Alliance of Southern California. The California Healthy Places Index. Available at: <https://www.healthyplacesindex.org/>. Accessed on: Jan 31, 2024.

Figure B.1—Child and Adolescent Well-Care Visits—Total (WCV) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).



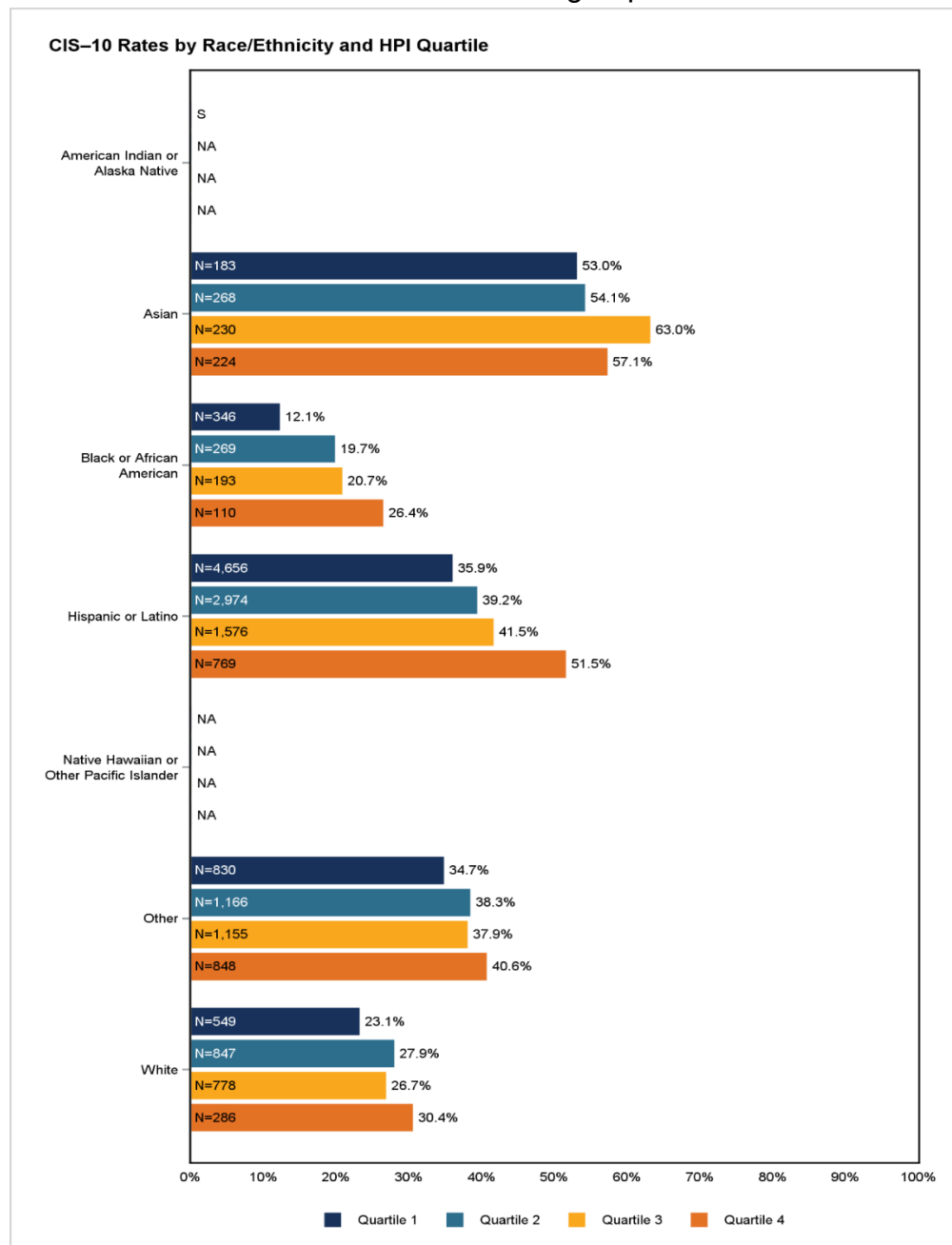
- ◆ For five of seven (71.4 percent) racial/ethnic groups (Asian, Black or African American, Hispanic or Latino, Other, and White), indicator rates were lowest for members living in HPI quartile 1 ZIP Codes. Conversely, for three of seven (42.9 percent) racial/ethnic groups (American Indian or Alaska Native, Black or African American, and Hispanic or Latino), indicator rates were highest for members living in HPI quartile 4 ZIP Codes.
- ◆ No rates were above or below each racial/ethnic group's respective overall indicator rate by more than a 10 percent relative difference.

Figure B.2—Childhood Immunization Status—Combination 10 (CIS–10) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).

S indicates fewer than 11 cases exist in the numerator for the racial/ethnic group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

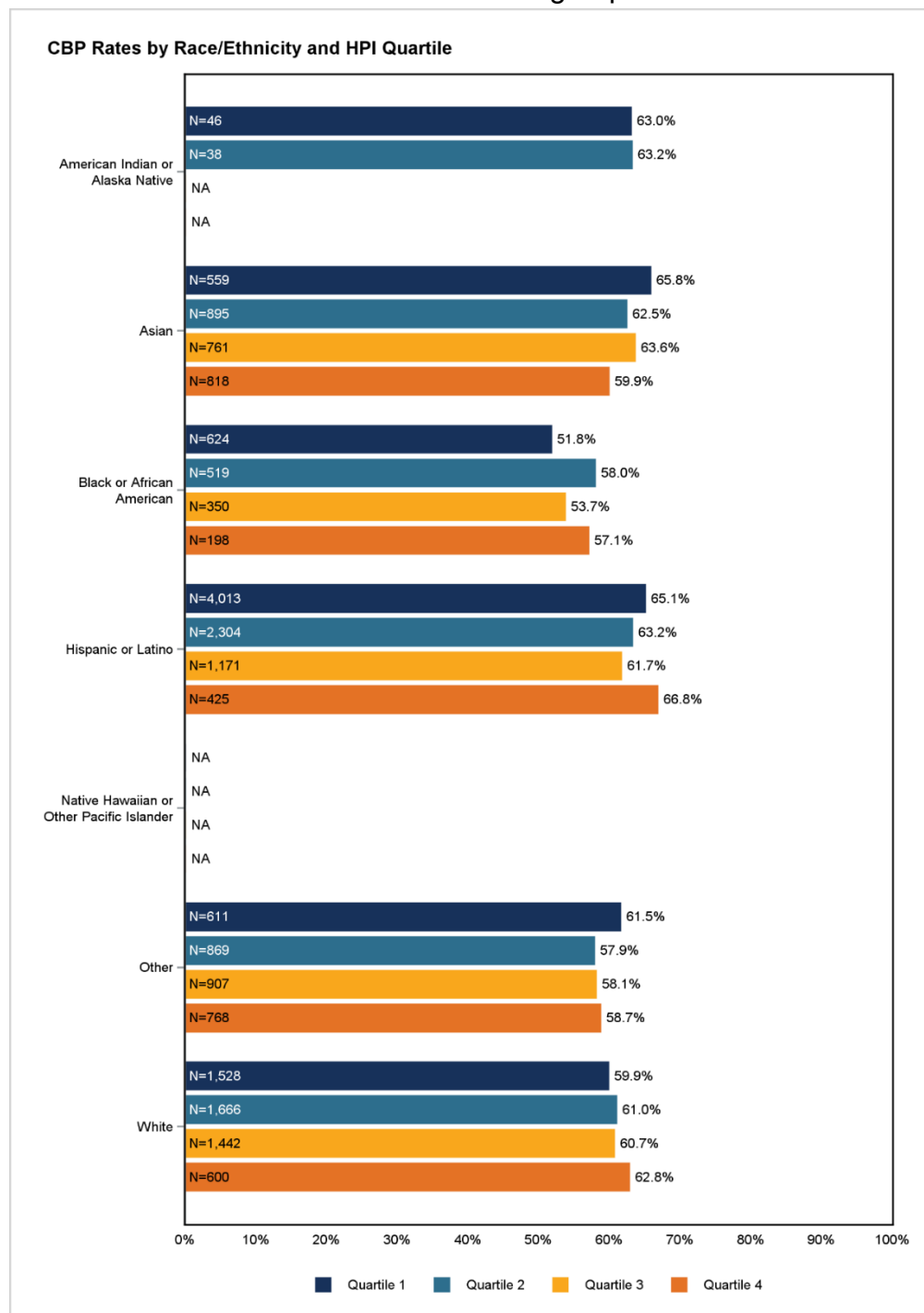


- ◆ For all racial/ethnic groups with reportable rates, indicator rates were lowest for members living in HPI quartile 1 ZIP Codes. Conversely, for four of five (80.0 percent) racial/ethnic groups with reportable rates (Black or African American, Hispanic or Latino, Other, and White), indicator rates were highest for members living in HPI quartile 4 ZIP Codes.
- ◆ The following racial/ethnic group-HPI Quartile combination rates were above their respective statewide rate by at least a 10 percent relative difference:
 - Black or African American—Quartiles 2, 3, and 4
 - Hispanic or Latino—Quartile 4
 - White—Quartile 4
- ◆ For the Black or African American racial/ethnic group, the indicator rate for members living in HPI quartile 1 ZIP Codes was lower than the overall Black or African American indicator rate by more than a 45 percent relative difference.

Figure B.3—Controlling High Blood Pressure—Total (CBP) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

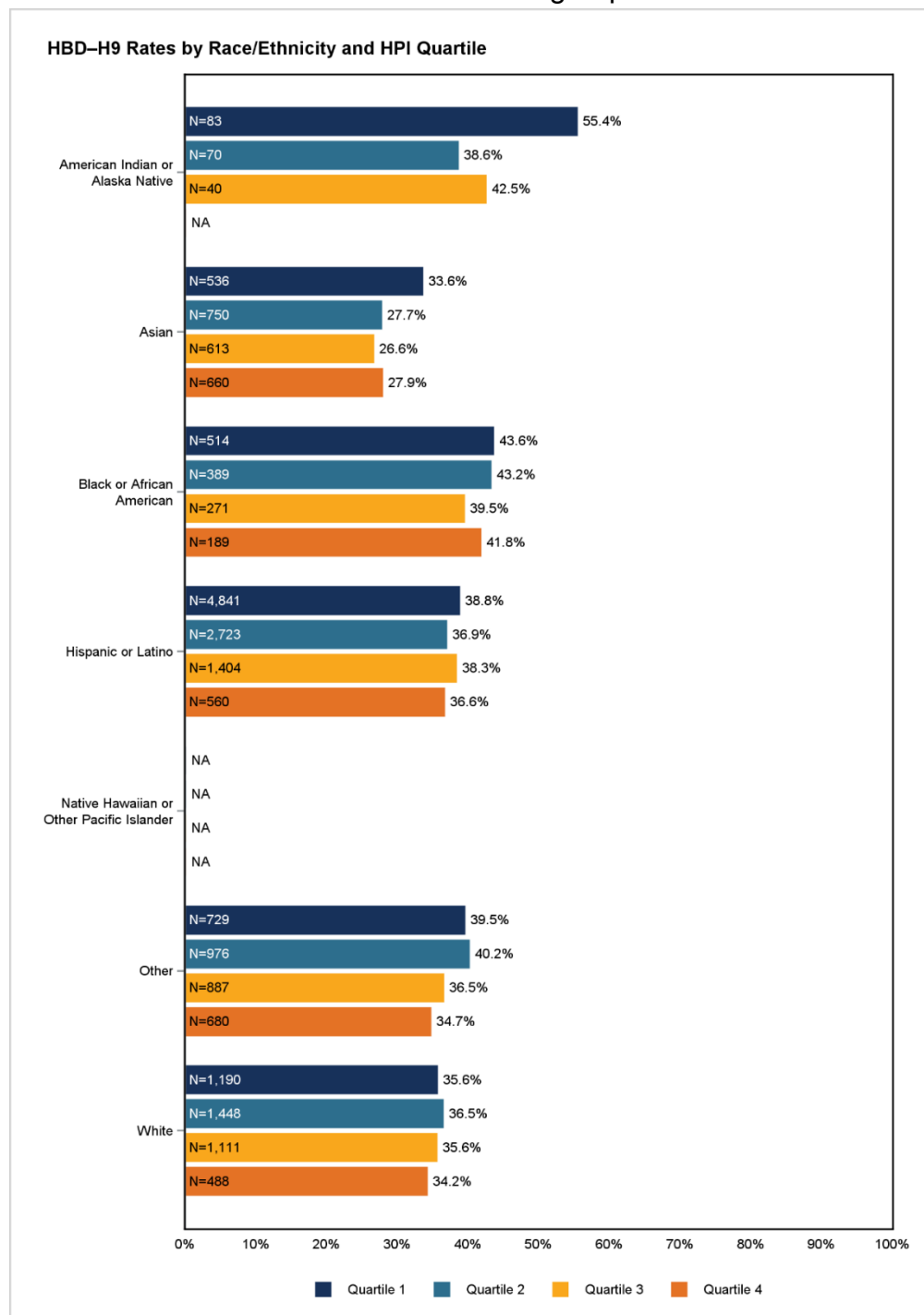


- ◆ For three of six (50.0 percent) racial/ethnic groups with reportable rates (American Indian or Alaska Native, Black or African American, and White), indicator rates were lowest for members living in HPI quartile 1 ZIP Codes. Conversely, for two of five (40.0 percent) racial/ethnic groups with reportable rates (Hispanic or Latino and White), indicator rates were highest for members living in HPI quartile 4 ZIP Codes.
- ◆ No rates were above or below each racial/ethnic group's respective overall indicator rate by more than a 10 percent relative difference.

Figure B.4—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).



- ◆ For four of six (66.7 percent) racial/ethnic groups with reportable rates (American Indian or Alaska Native, Asian, Black or African American, and Hispanic or Latino), indicator rates were highest (i.e., worst) for members living in HPI quartile 1 ZIP Codes. Conversely, for three of five (60.0 percent) racial/ethnic groups with reportable rates (Hispanic or Latino, Other, and White), indicator rates were lowest (i.e., best) for members living in HPI quartile 4 ZIP Codes.
- ◆ The following racial/ethnic group-HPI Quartile combination rates were above their respective statewide rate by at least a 10 percent relative difference:
 - American Indian or Alaska Native—Quartile 1
 - Asian—Quartile 1
- ◆ The following racial/ethnic group-HPI Quartile combination rates were below their respective statewide rate by at least a 10 percent relative difference:
 - American Indian or Alaska Native—Quartiles 2 and 3

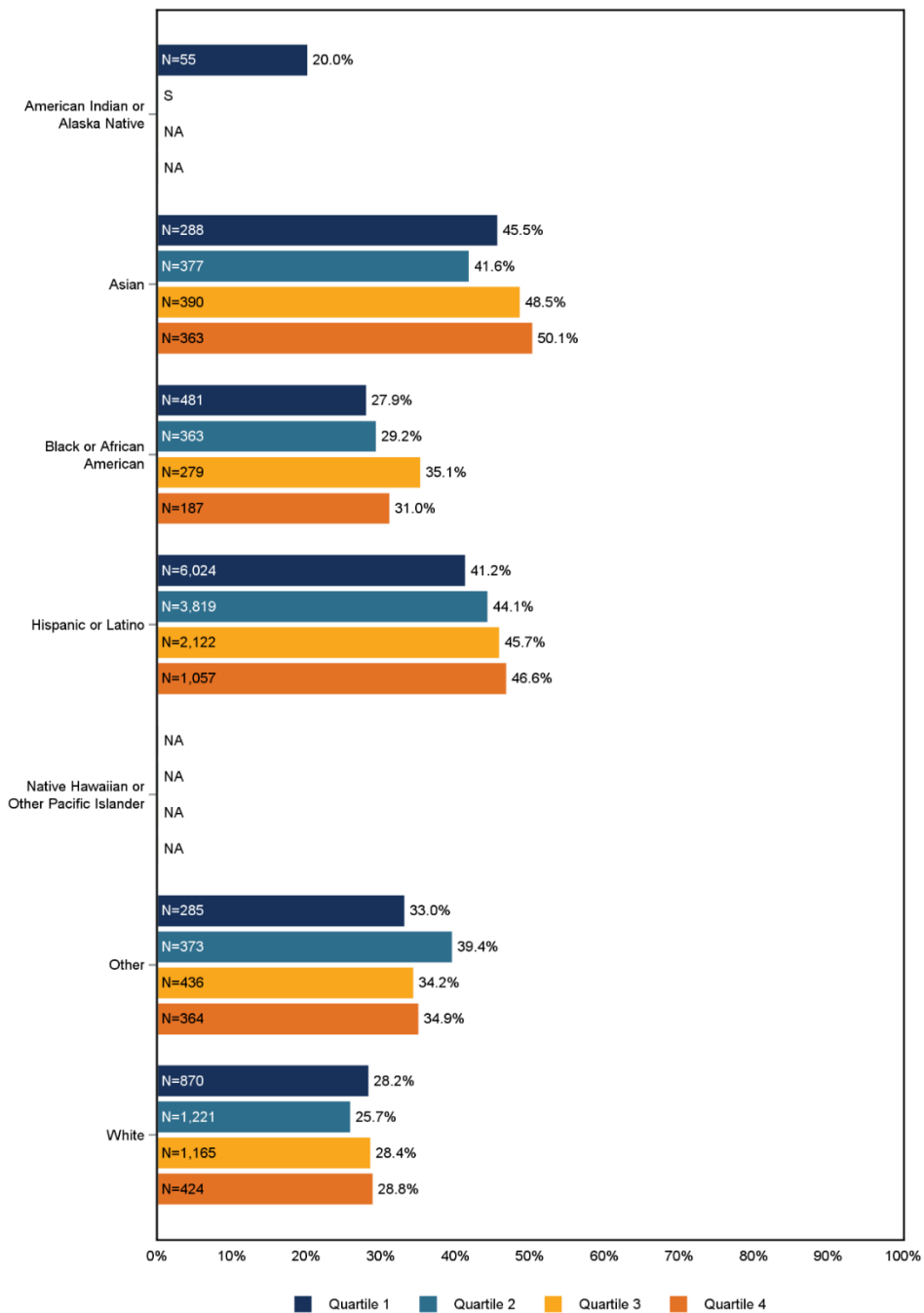
Figure B.5—Immunizations for Adolescents—Combination 2 (IMA–2) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).

S indicates fewer than 11 cases exist in the numerator for the racial/ethnic group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

IMA-2 Rates by Race/Ethnicity and HPI Quartile

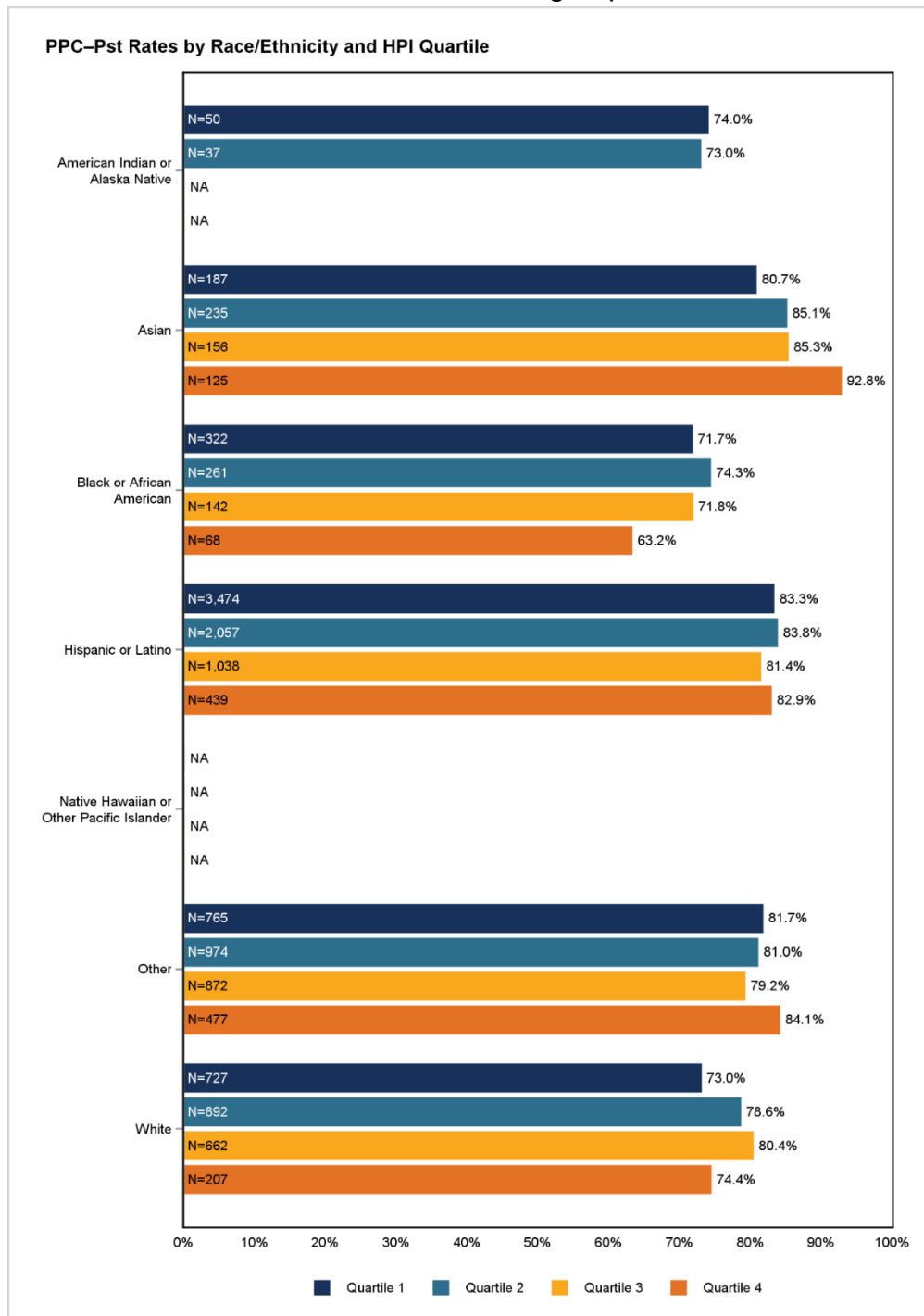


- ◆ Rates for three of five (60.0 percent) racial/ethnic groups with reportable rates (Black or African American, Hispanic or Latino, and Other), indicator rates were lowest for members living in HPI quartile 1 ZIP Codes. Conversely, rates for three or five (60.0 percent) racial/ethnic groups with reportable rates (Asian, Hispanic or Latino, and White), indicator rates were highest for members living in HPI quartile 4 ZIP Codes.
- ◆ The following racial/ethnic group-HPI Quartile combination rates were above their respective statewide rate by at least a 10 percent relative difference:
 - Black or African American—Quartile 3
 - Other—Quartile 2
- ◆ The following racial/ethnic group-HPI Quartile combination rates were below their respective statewide rate by at least a 10 percent relative difference:
 - American Indian or Alaska Native—Quartile 1
 - Asian—Quartile 2

Figure B.6—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

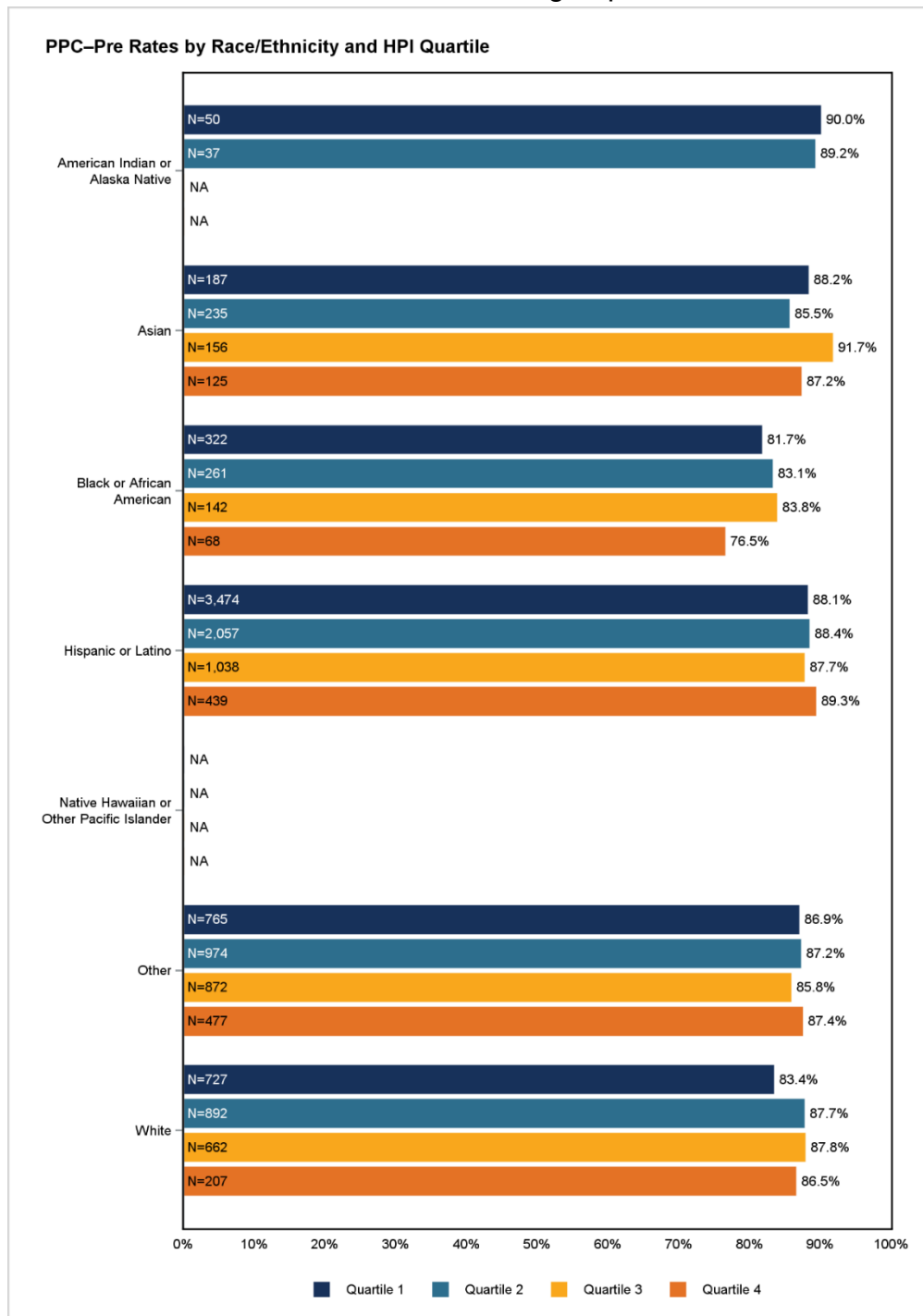


- ◆ For two of six (33.3 percent) racial/ethnic groups with reportable rates (Asian and White), indicator rates were lowest for members living in HPI quartile 1 ZIP Codes. Conversely, for two of five (40.0 percent) racial/ethnic groups with reportable rates (Asian and Other), indicator rates were highest for members living in HPI quartile 4 ZIP Codes.
- ◆ For the Black or African American racial/ethnic group, the indicator rate for members living in HPI quartile 4 ZIP Codes was lower than the overall Black or African American indicator rate by more than a 10 percent relative difference.

Figure B.7—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).



- ◆ For one of six (16.7 percent) racial/ethnic groups with reportable rates (White), the indicator rate was lowest for members living in HPI quartile 1 ZIP Codes. Conversely, for two of five (40.0 percent) racial/ethnic groups with reportable rates (Hispanic or Latino and Other), indicator rates were highest for members living in HPI quartile 4 ZIP Codes.
- ◆ No rates were above or below each racial/ethnic group's respective overall indicator rate by more than a 10 percent relative difference.

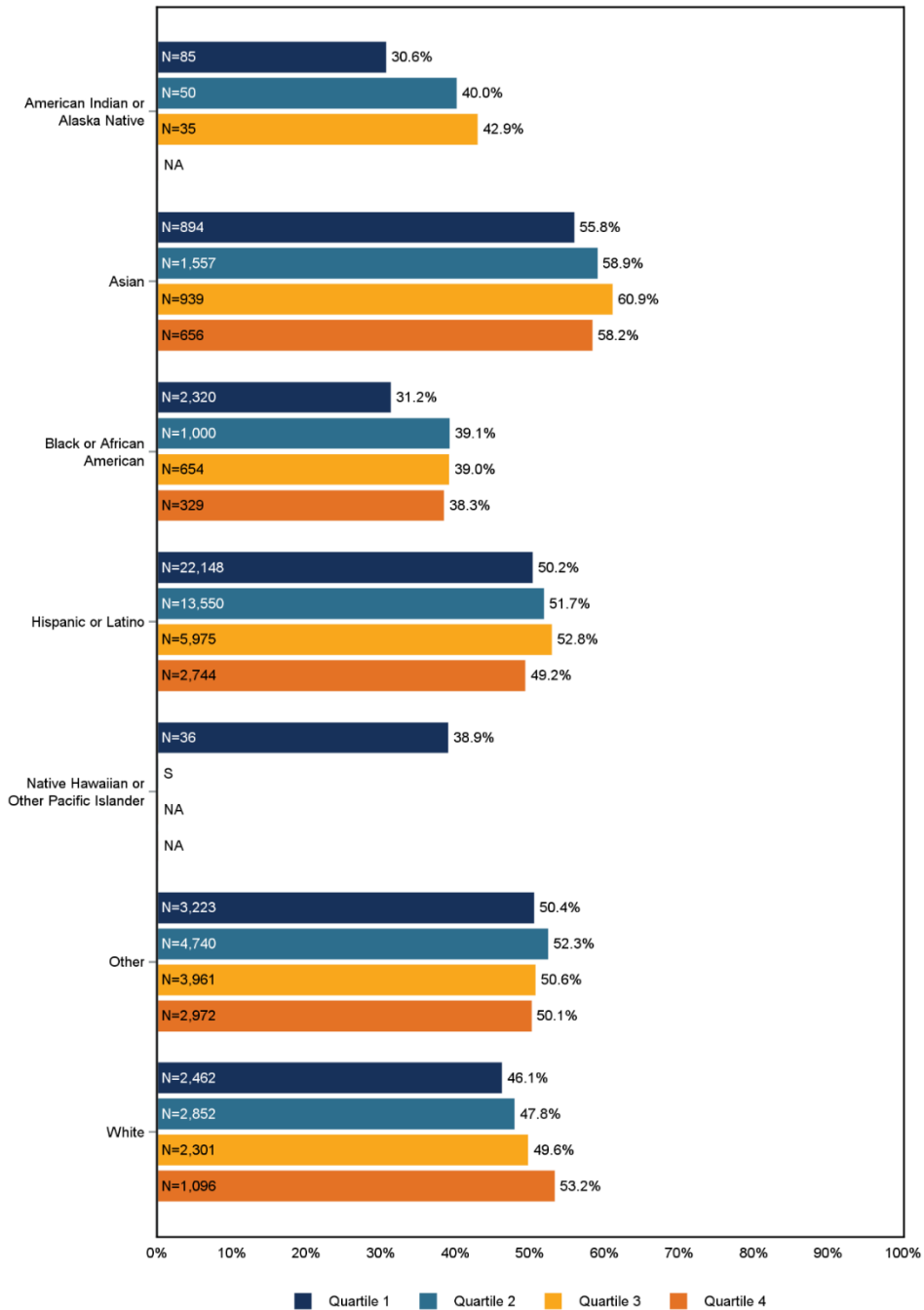
Figure B.8—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).

S indicates fewer than 11 cases exist in the numerator for the racial/ethnic group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

W30-6+ Rates by Race/Ethnicity and HPI Quartile

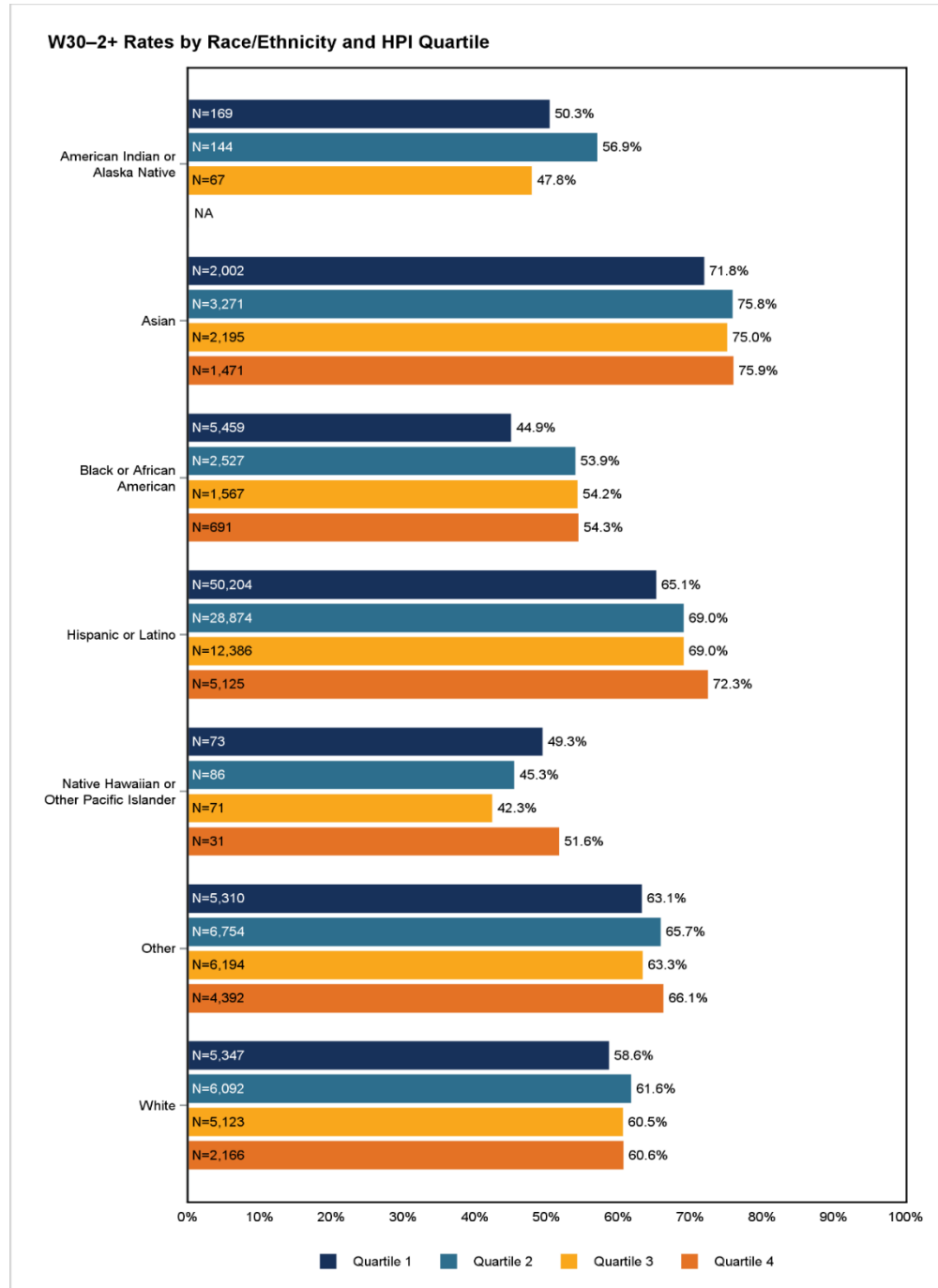


- ◆ For four of six (66.7 percent) racial/ethnic groups with reportable rates (American Indian or Alaska Native, Asian, Black or African American, and White), indicator rates were lowest for members living in HPI quartile 1 ZIP Codes. Conversely, for one of five (20.0 percent) racial/ethnic groups with reportable rates (White), indicator rates were highest for members living in HPI quartile 4.
- ◆ The following racial/ethnic group-HPI Quartile combination rates were above their respective statewide rate by at least a 10 percent relative difference:
 - American Indian or Alaska Native—Quartiles 2 and 3
 - Black or African American—Quartiles 2 and 3
- ◆ The following racial/ethnic group-HPI Quartile combination rates were below their respective statewide rate by at least a 10 percent relative difference:
 - American Indian or Alaska Native—Quartile 1
 - Black or African American—Quartile 1

Figure B.9—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+) by Race/Ethnicity and HPI Quartile

Note: A higher HPI quartile represents healthier community conditions (i.e., ZIP Codes in quartile 1 have the least healthy community conditions; ZIP Codes in quartile 4 have the healthiest community conditions).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).



- ◆ For five of seven (71.4 percent) racial/ethnic groups (Asian, Black or African American, Hispanic or Latino, Other, and White), indicator rates were lowest for members living in HPI quartile 1 ZIP Codes. Conversely, for five of six (83.3 percent) racial/ethnic groups with reportable rates (Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Other), indicator rates were highest for members living in HPI quartile 4 ZIP Codes.
- ◆ The following racial/ethnic group-HPI Quartile combination rates were above their respective statewide rate by at least a 10 percent relative difference:
 - Black or African American—Quartiles 2, 3, and 4
 - Native Hawaiian or Other Pacific Islander—Quartile 4
- ◆ For the American Indian or Alaska Native racial/ethnic group, the indicator rate for members living in HPI quartile 3 ZIP Codes was lower than the overall American Indian or Alaska Native indicator rate by more than a 10 percent relative difference.

Appendix C. Demographic Stratification Results

Appendix C displays graphics for all MCAS indicators that display measurement year 2021 and 2022 rates stratified by race/ethnicity, primary language, gender, age, and SPD populations, as applicable. The minimum performance level/median state performance rate, high performance level, and statewide aggregate are displayed on all graphics, where applicable. Please note, all stratified rates are presented in Appendix C regardless of whether they were considered key findings and included in the Findings section of the report. The appendix is organized by domain and indicator. Figure C.1 through Figure C.215 display all demographic stratification results.

Children's Health Domain

Figure C.1 through Figure C.45 display the demographic stratification results for the Children's Health Domain.

Child and Adolescent Well-Care Visits—Total (WCV)

The *Child and Adolescent Well-Care Visits—Total (WCV)* indicator measures the percentage of children ages 3 to 21 years who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner.

Figure C.1—Child and Adolescent Well-Care Visits—Total (WCV) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 49.1 percent (N=182,090) and 48.7 percent (N=211,890), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 45.3 percent and 62.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 47.5 percent.

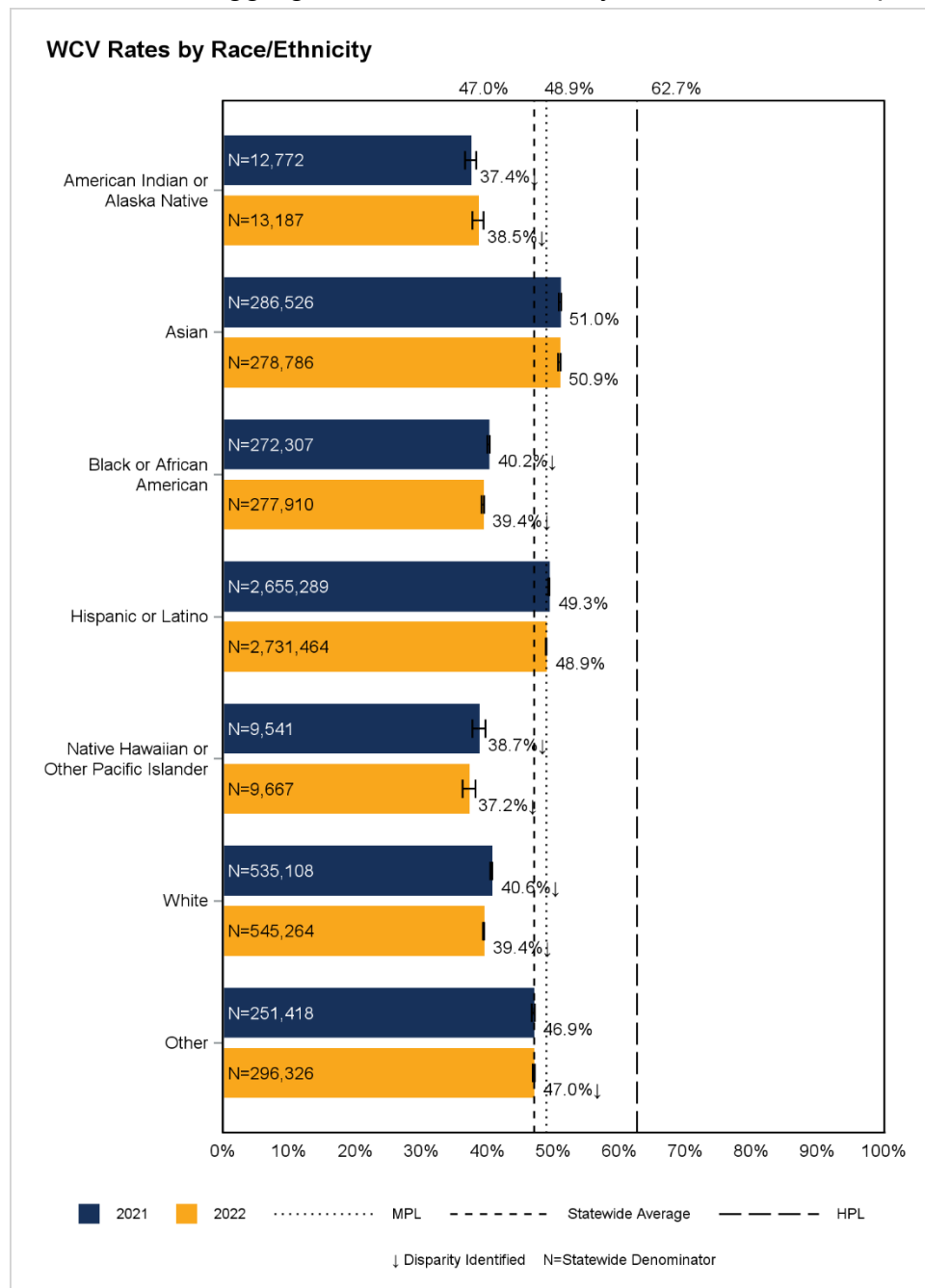


Figure C.2—Child and Adolescent Well-Care Visits—Total (WCV) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 35.0 percent (N=2,250) and 36.0 percent (N=3,099), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 45.3 percent and 62.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 47.5 percent.

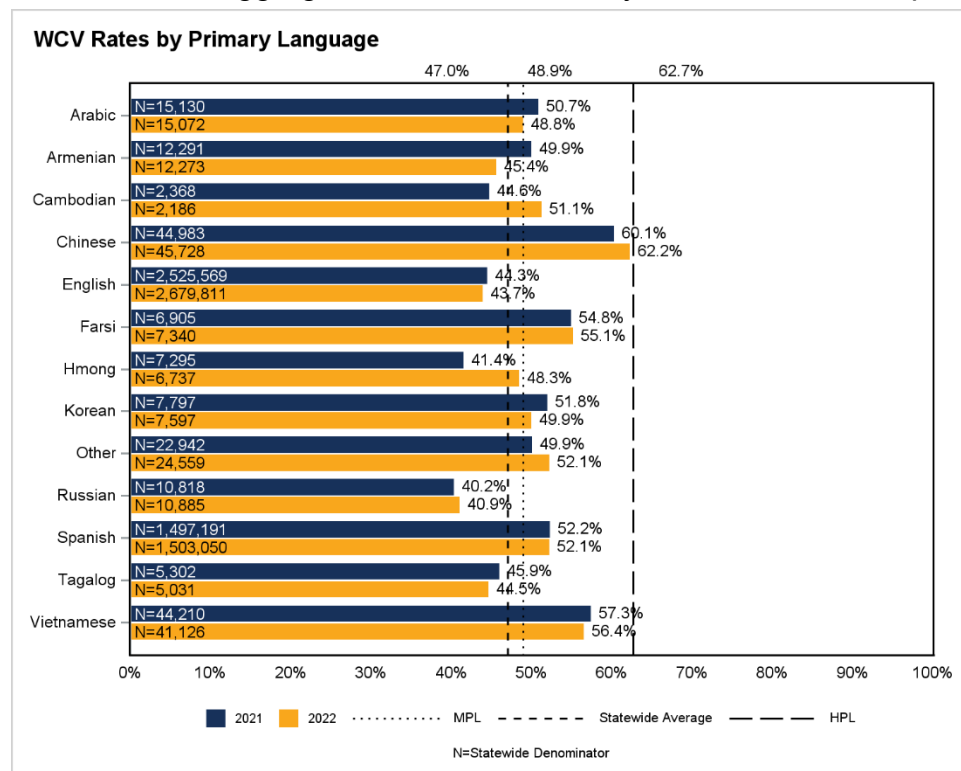


Figure C.3—Child and Adolescent Well-Care Visits—Total (WCV) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 45.3 percent and 62.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 47.5 percent.

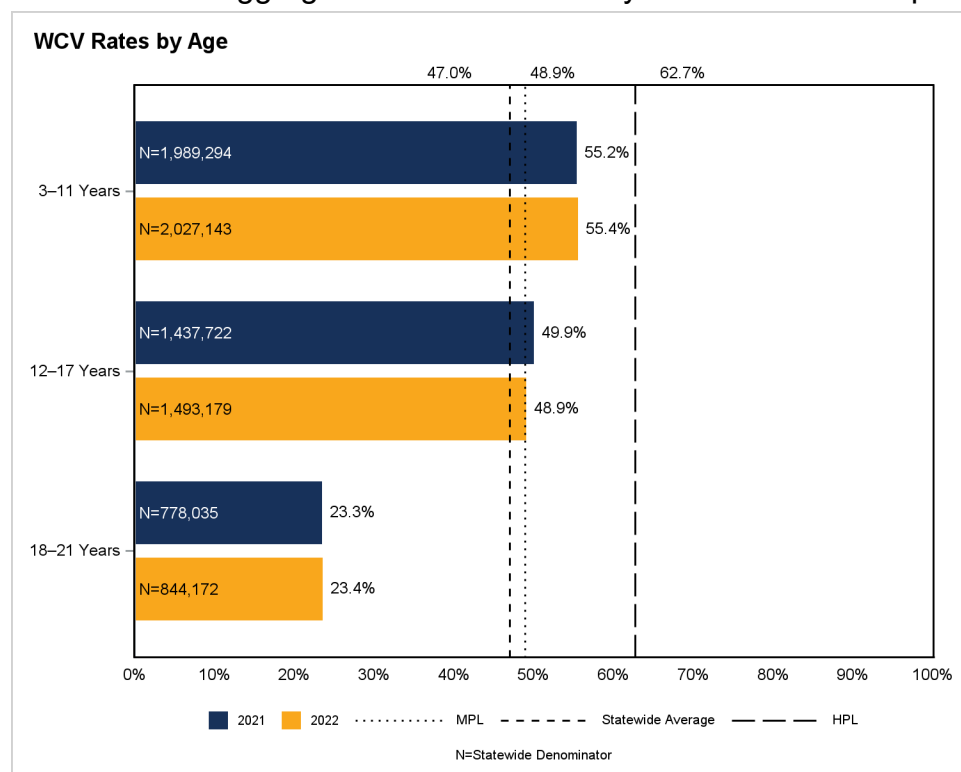


Figure C.4—Child and Adolescent Well-Care Visits—Total (WCV) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 48.1 percent (N=857) and 47.4 percent (N=1,585), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 45.3 percent and 62.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 47.5 percent.

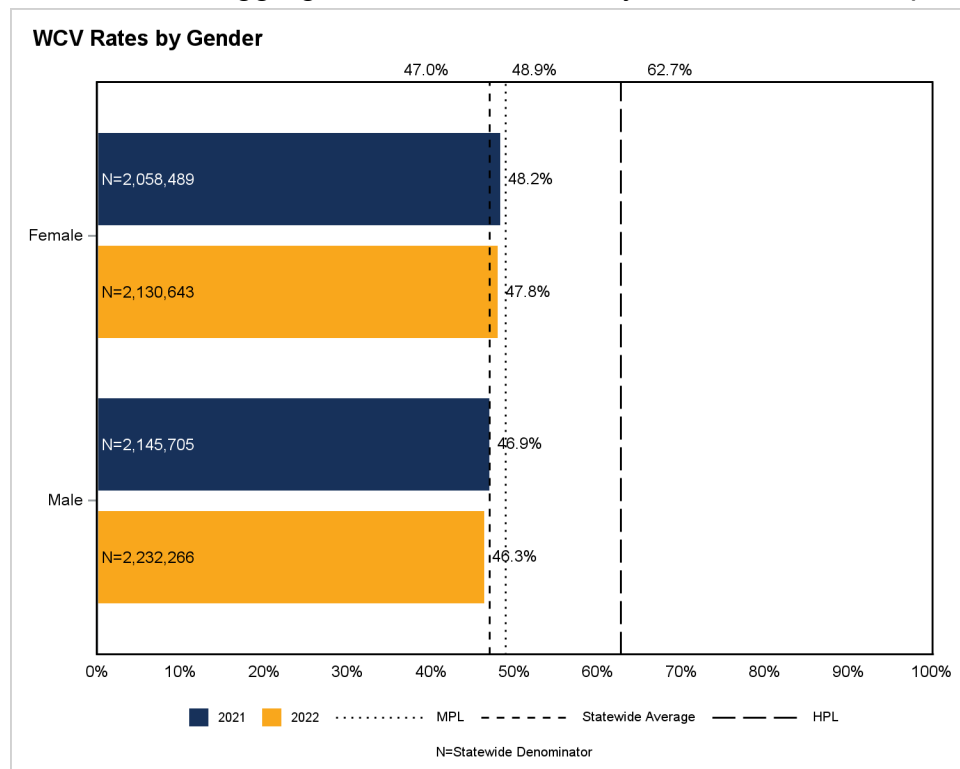
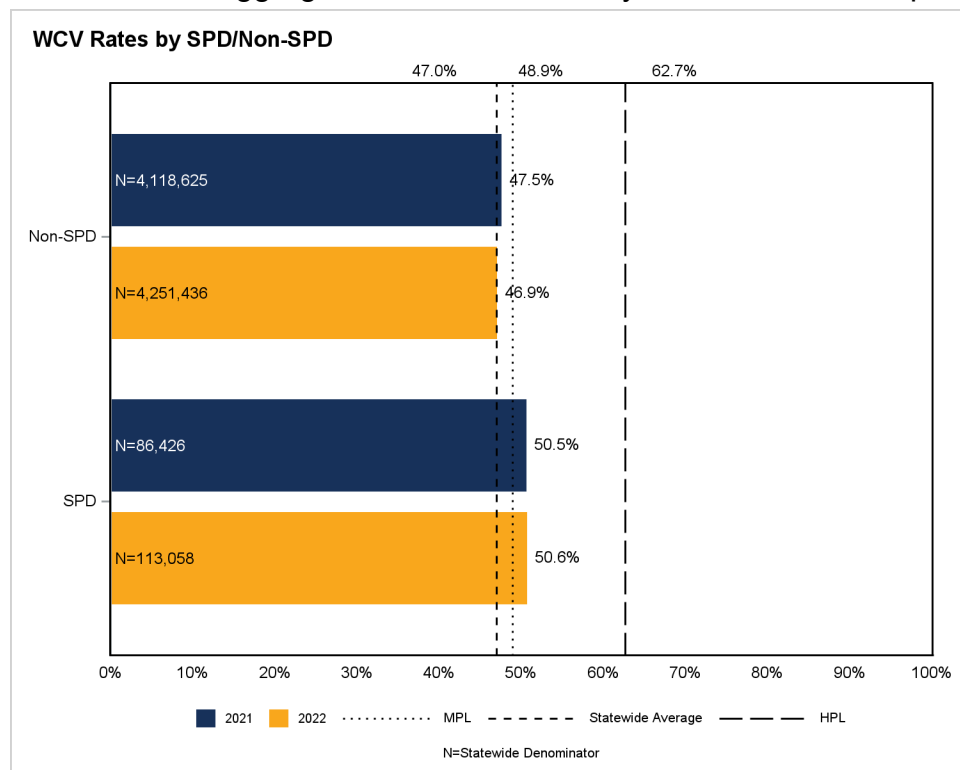


Figure C.5—Child and Adolescent Well-Care Visits—Total (WCV) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 45.3 percent and 62.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 47.5 percent.

**Childhood Immunization Status—Combination 10 (CIS-10)**

The *Childhood Immunization Status—Combination 10 (CIS-10)* indicator measures the percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis; three polio; one measles, mumps, and rubella; three haemophilus influenza type B; three hepatitis B; one chicken pox; four pneumococcal conjugate; one hepatitis A; two or three rotavirus; and two influenza vaccines by their second birthday.

Figure C.6—Childhood Immunization Status—Combination 10 (CIS-10) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 31.1 percent (N=3,236) and 27.2 percent (N=3,539), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.2 percent and 53.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 37.8 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

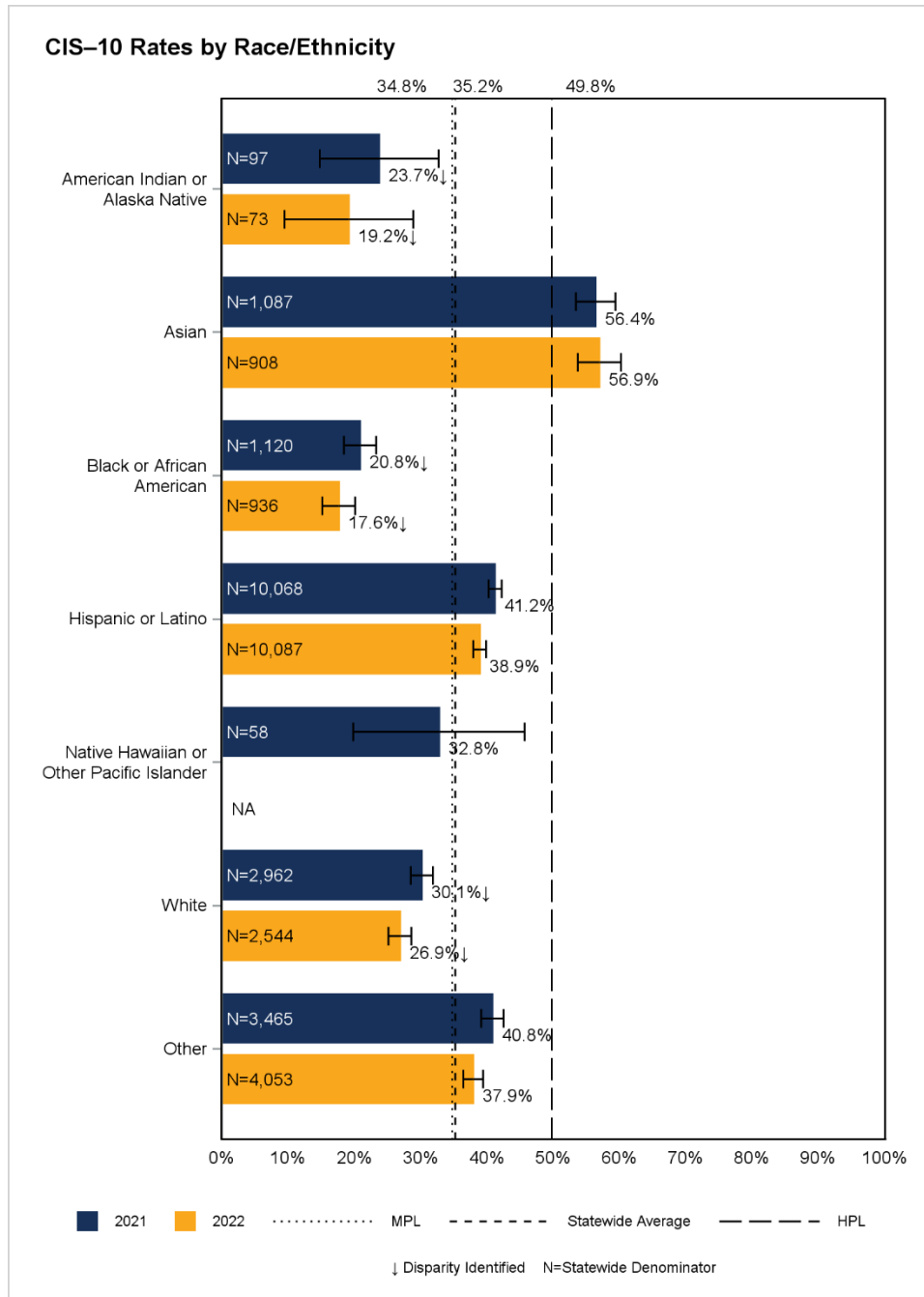


Figure C.7—Childhood Immunization Status—Combination 10 (CIS–10) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.2 percent and 53.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 37.8 percent.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

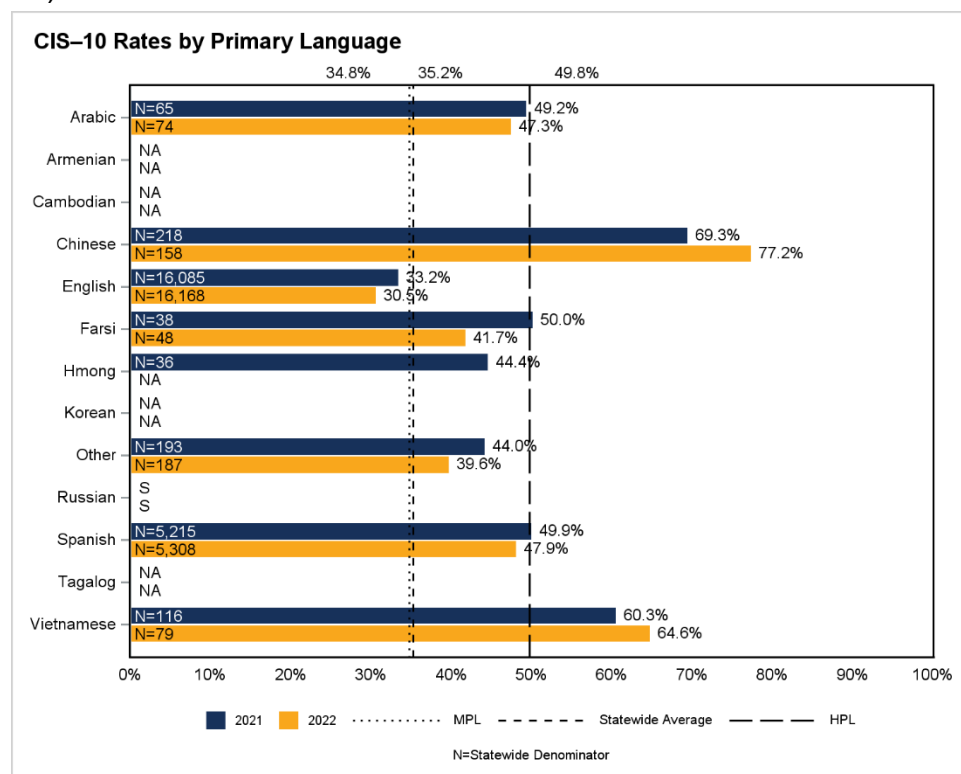


Figure C.8—Childhood Immunization Status—Combination 10 (CIS–10) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.2 percent and 53.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 37.8 percent.

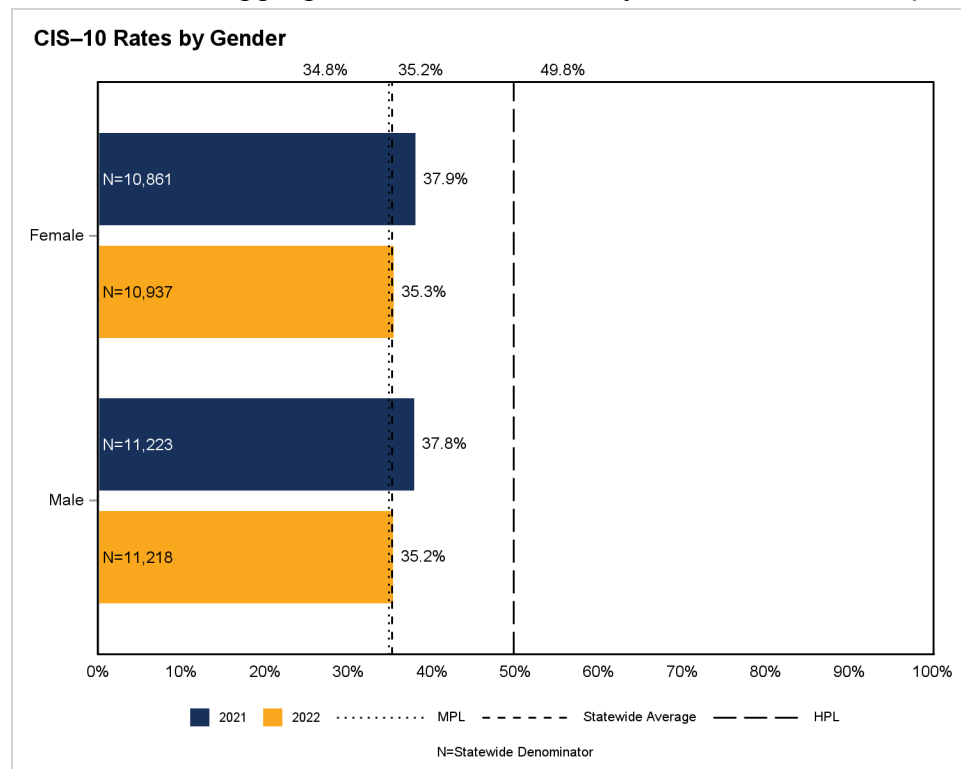
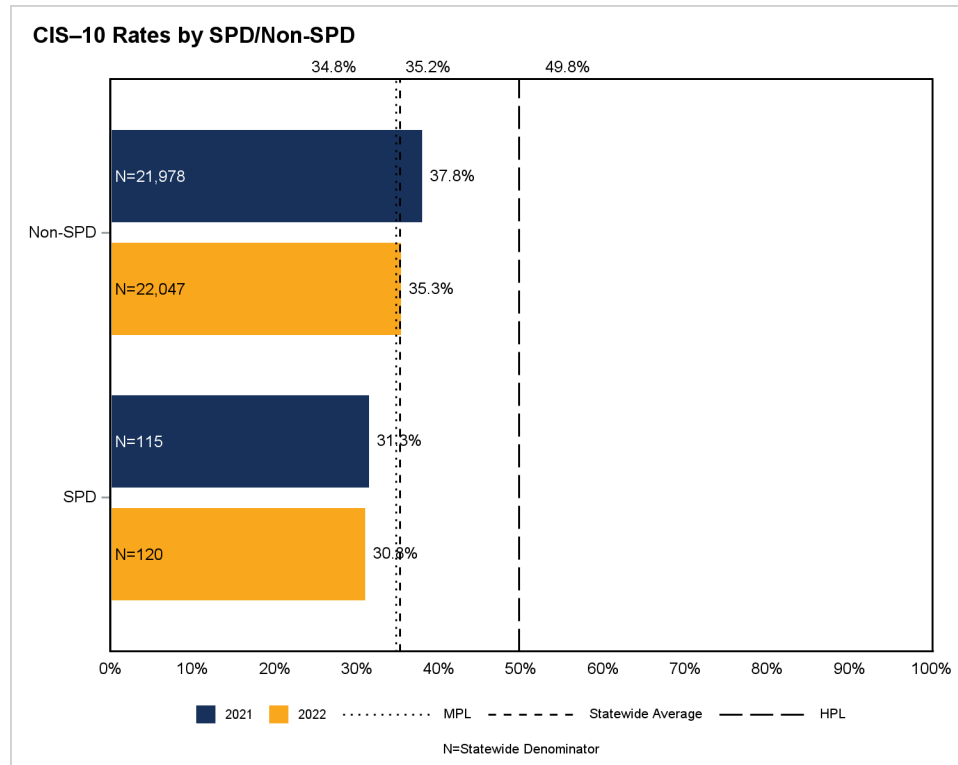


Figure C.9—Childhood Immunization Status—Combination 10 (CIS–10) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.2 percent and 53.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 37.8 percent.



Developmental Screening in the First Three Years of Life—Total (DEV)

The *Developmental Screening in the First Three Years of Life—Total (DEV)* indicator measures the percentage of children who were screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on the child's first, second, or third birthday. Due to inconsistent reporting of EHR data by MCPs, differences in rates may be impacted by data completeness.

Figure C.10—Developmental Screening in the First Three Years of Life—Total (DEV) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 24.9 percent (N=60,590) and 29.9 percent (N=65,084), respectively

The median state performance rate represents the 50th percentile.

The median state performance rate for measurement year 2021 was 35.6 percent.

The statewide aggregate for measurement year 2021 was 28.8 percent.

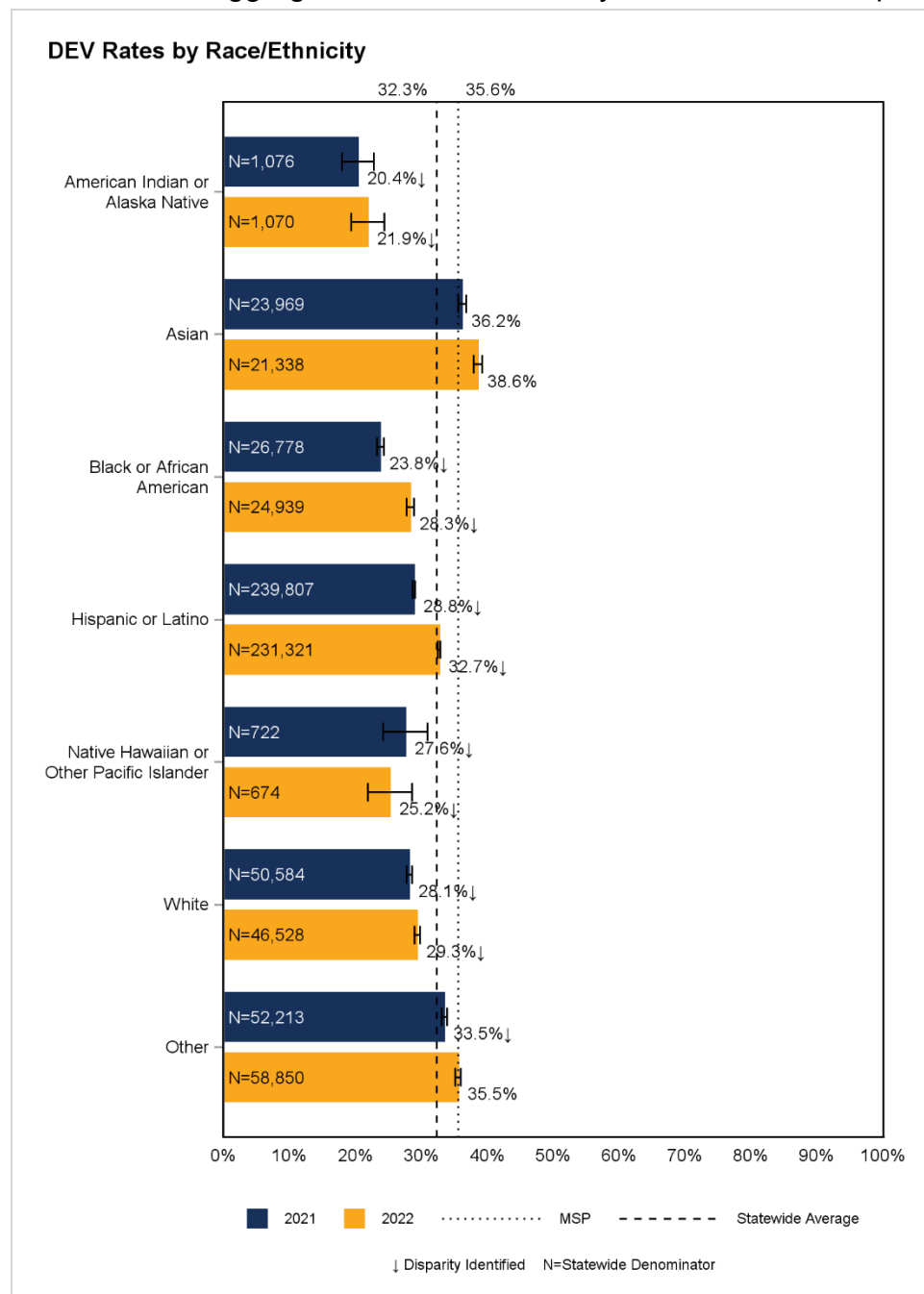


Figure C.11—Developmental Screening in the First Three Years of Life—Total (DEV) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 21.5 percent (N=460) and 30.9 percent (N=560), respectively

The median state performance rate represents the 50th percentile.

The median state performance rate for measurement year 2021 was 35.6 percent.

The statewide aggregate for measurement year 2021 was 28.8 percent.

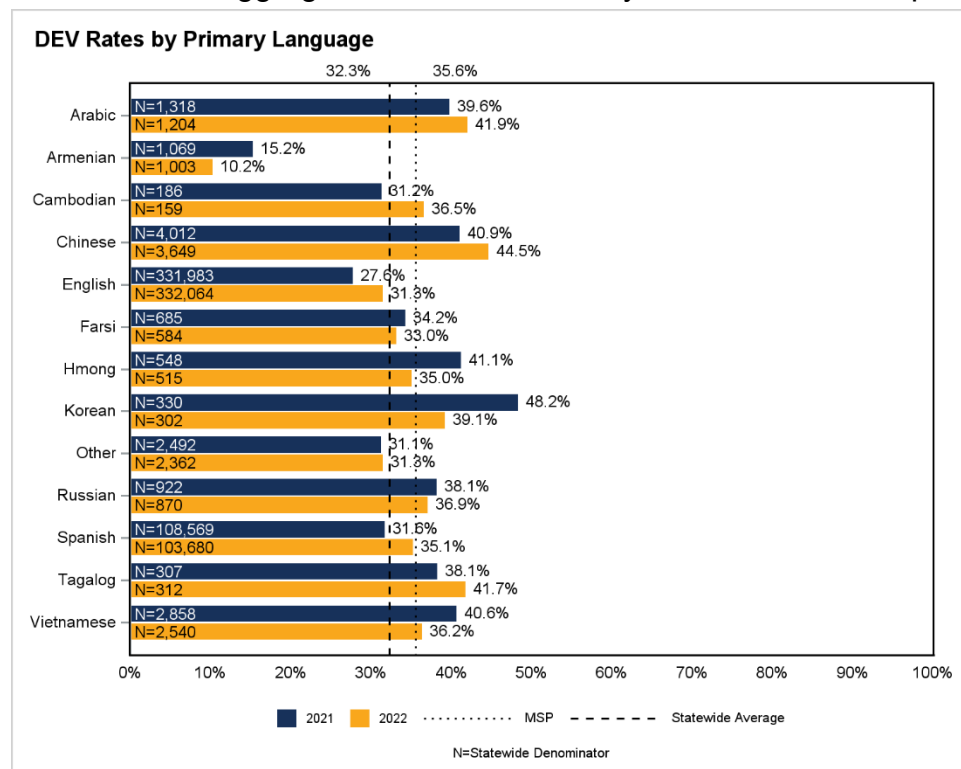


Figure C.12—Developmental Screening in the First Three Years of Life—Total (DEV) Rates by Age

Note: The median state performance rate represents the 50th percentile.

The median state performance rate for measurement year 2021 was 35.6 percent.

The statewide aggregate for measurement year 2021 was 28.8 percent.

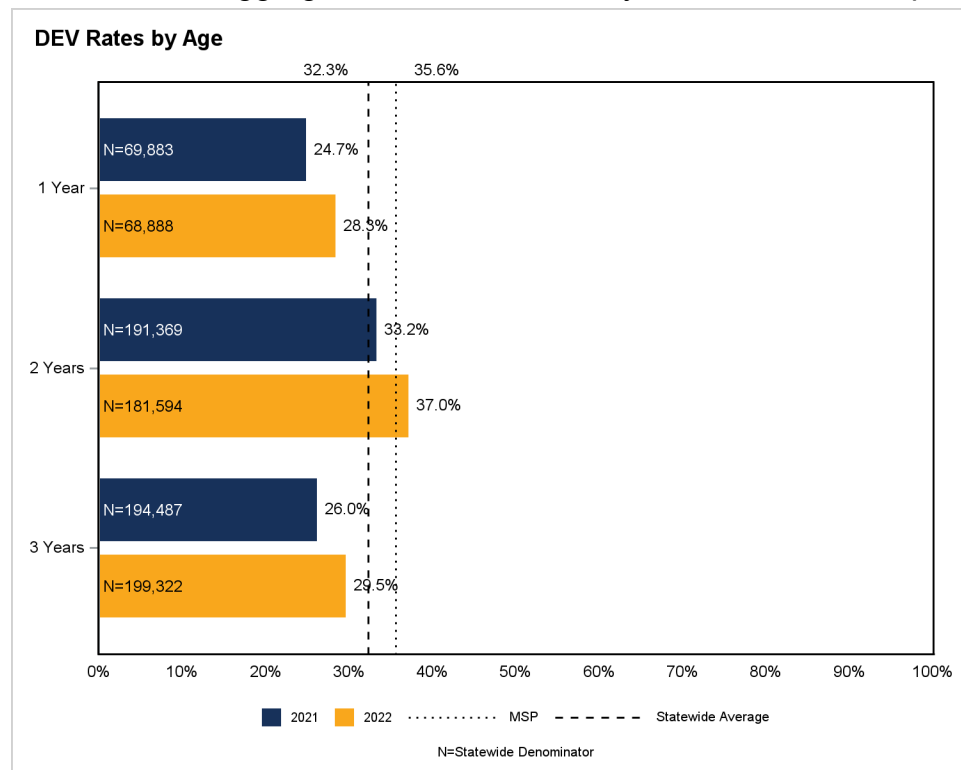


Figure C.13—Developmental Screening in the First Three Years of Life—Total (DEV) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 19.9 percent (N=297) and 35.6 percent (N=410), respectively

The median state performance rate represents the 50th percentile.

The median state performance rate for measurement year 2021 was 35.6 percent.

The statewide aggregate for measurement year 2021 was 28.8 percent.

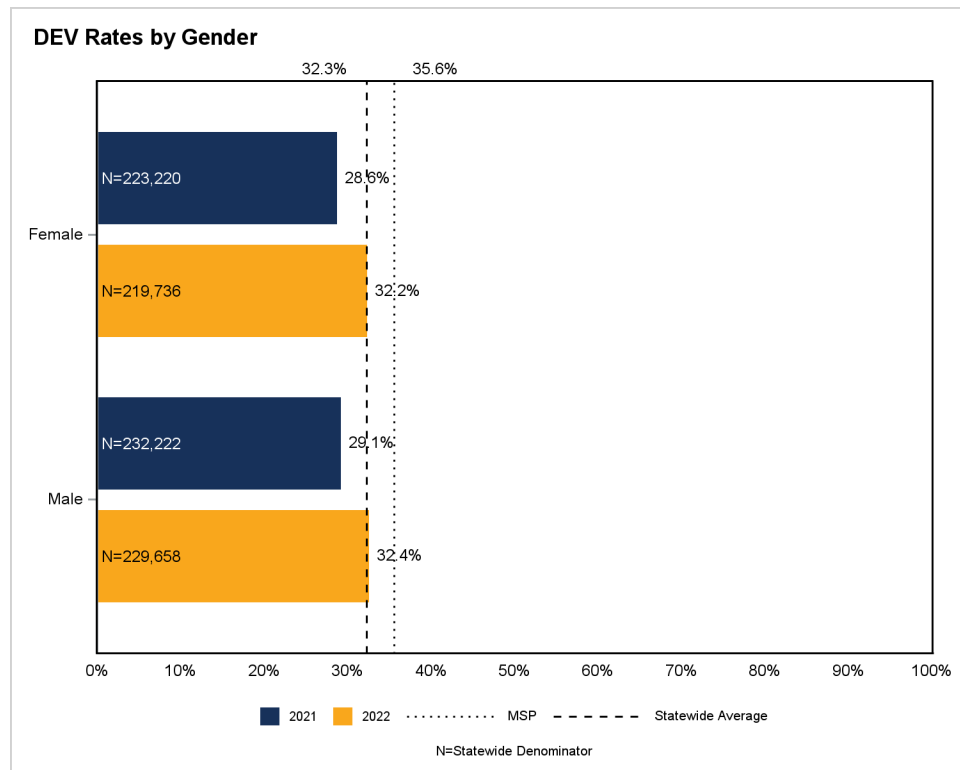
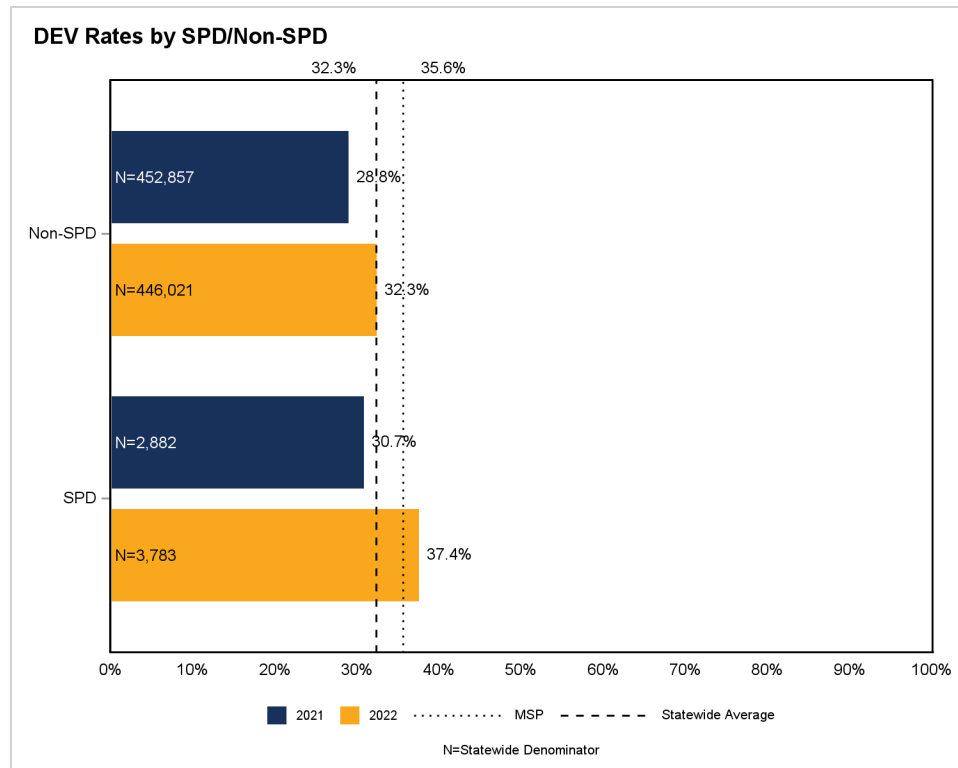


Figure C.14—Developmental Screening in the First Three Years of Life—Total (DEV) Rates by SPD/Non-SPD

Note: The median state performance rate represents the 50th percentile.
The minimum performance level for measurement year 2021 was 35.6 percent.
The statewide aggregate for measurement year 2021 was 28.8 percent.



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 vaccine; and have completed the HPV vaccine series by their 13th birthday.

Figure C.15—Immunizations for Adolescents—Combination 2 (IMA-2) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 29.3 percent (N=485), and 27.8 percent (N=586), respectively.
The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.
The minimum performance level and high performance level for measurement year 2021 were 36.7 percent and 50.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.0 percent.

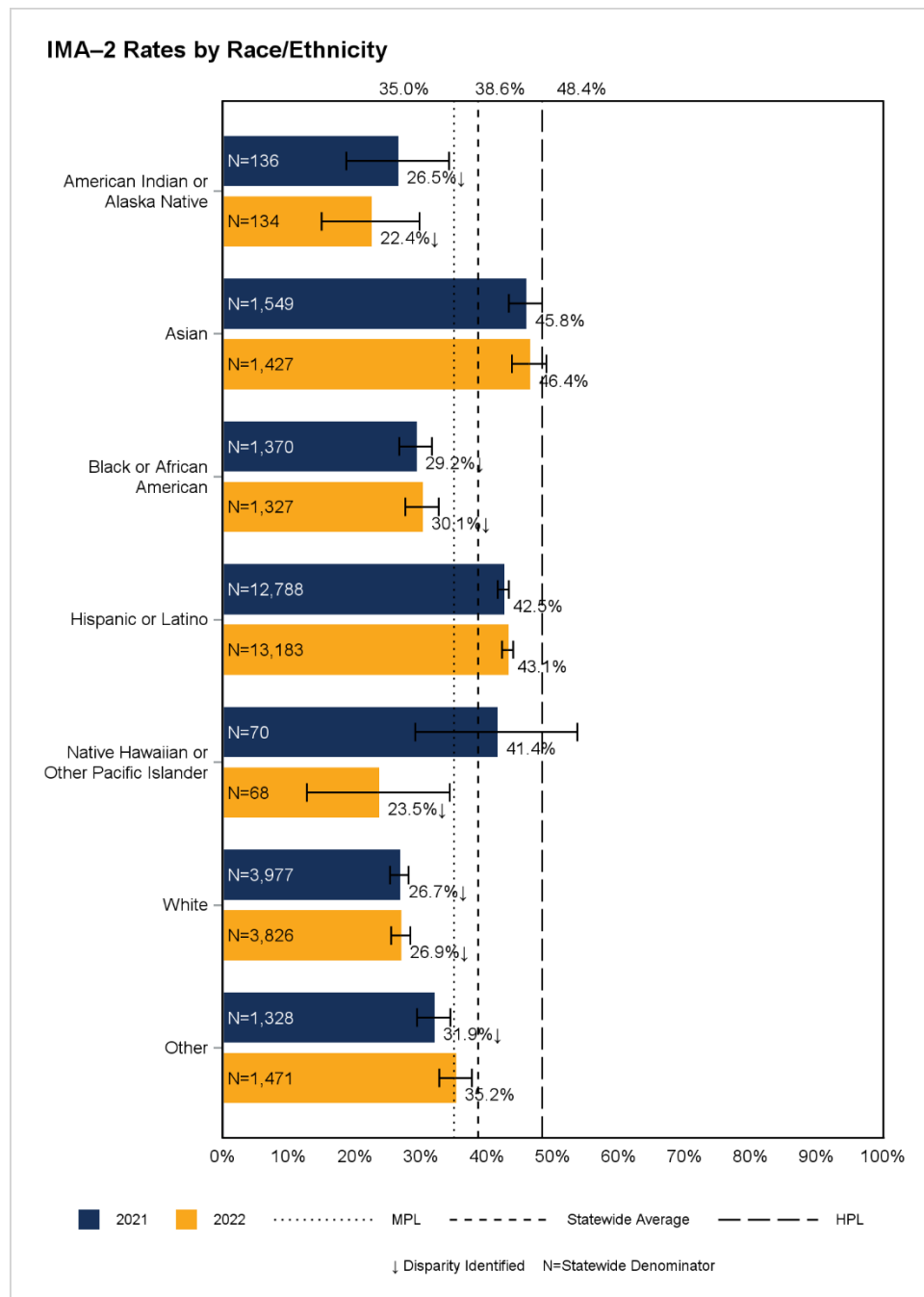


Figure C.16—Immunizations for Adolescents—Combination 2 (IMA-2) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 36.7 percent and 50.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.0 percent.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

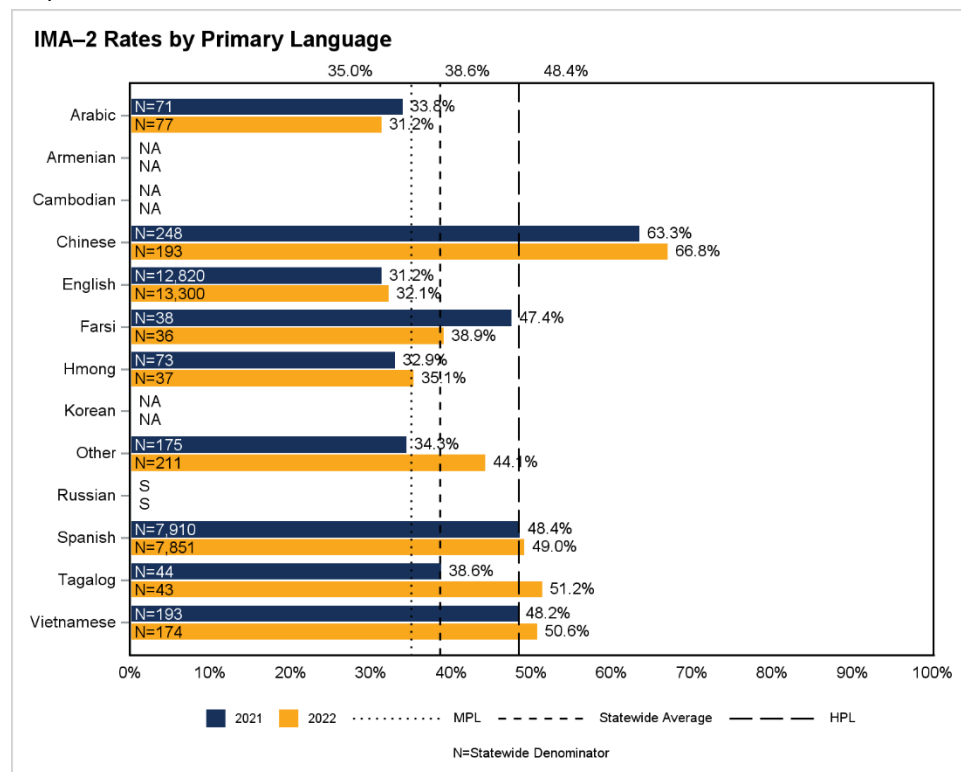


Figure C.17—Immunizations for Adolescents—Combination 2 (IMA-2) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 36.7 percent and 50.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.0 percent.

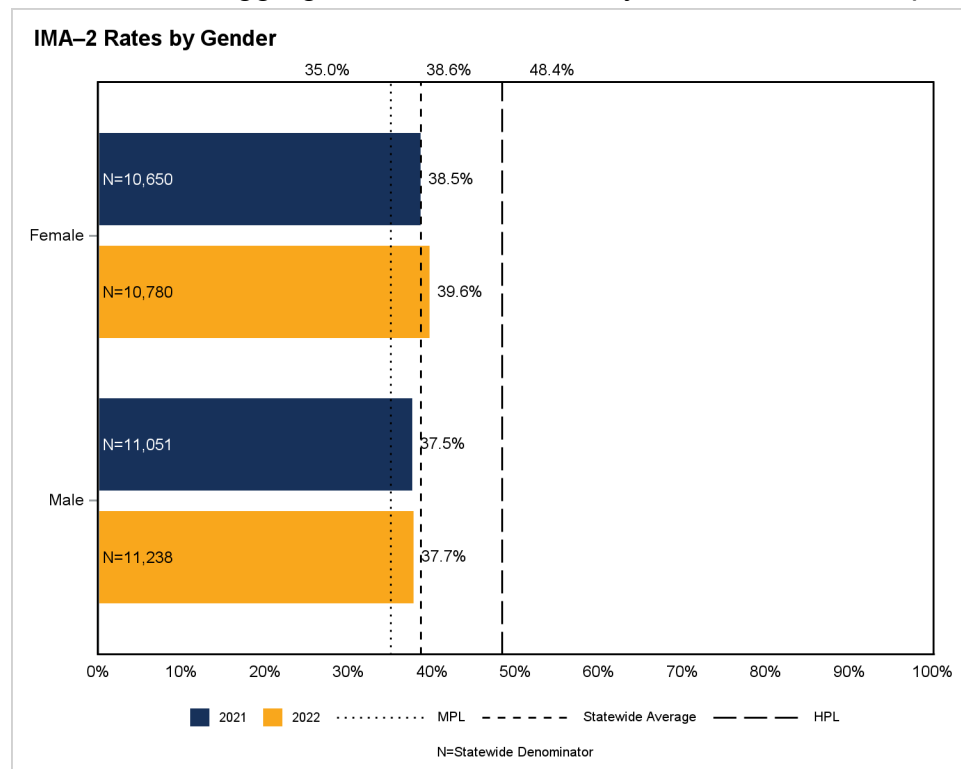
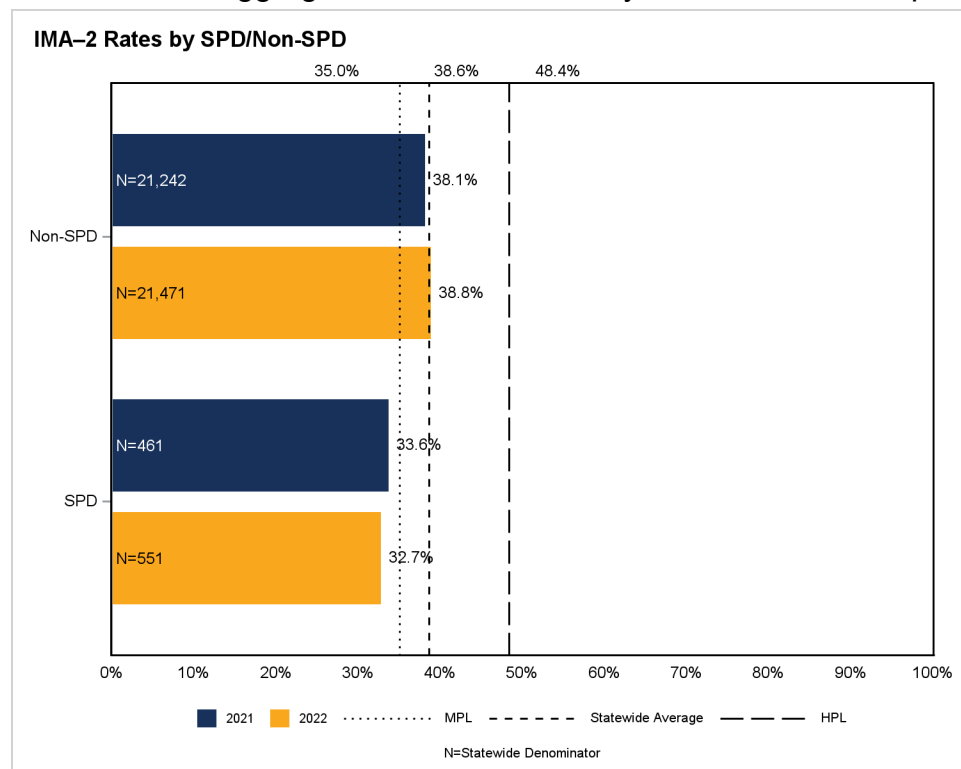


Figure C.18—Immunizations for Adolescents—Combination 2 (IMA-2) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 36.7 percent and 50.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.0 percent.



Lead Screening in Children (LSC)

The *Lead Screening in Children (LSC)* indicator measures the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Figure C.19—Lead Screening in Children (LSC) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 46.7 percent (N=3,561).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

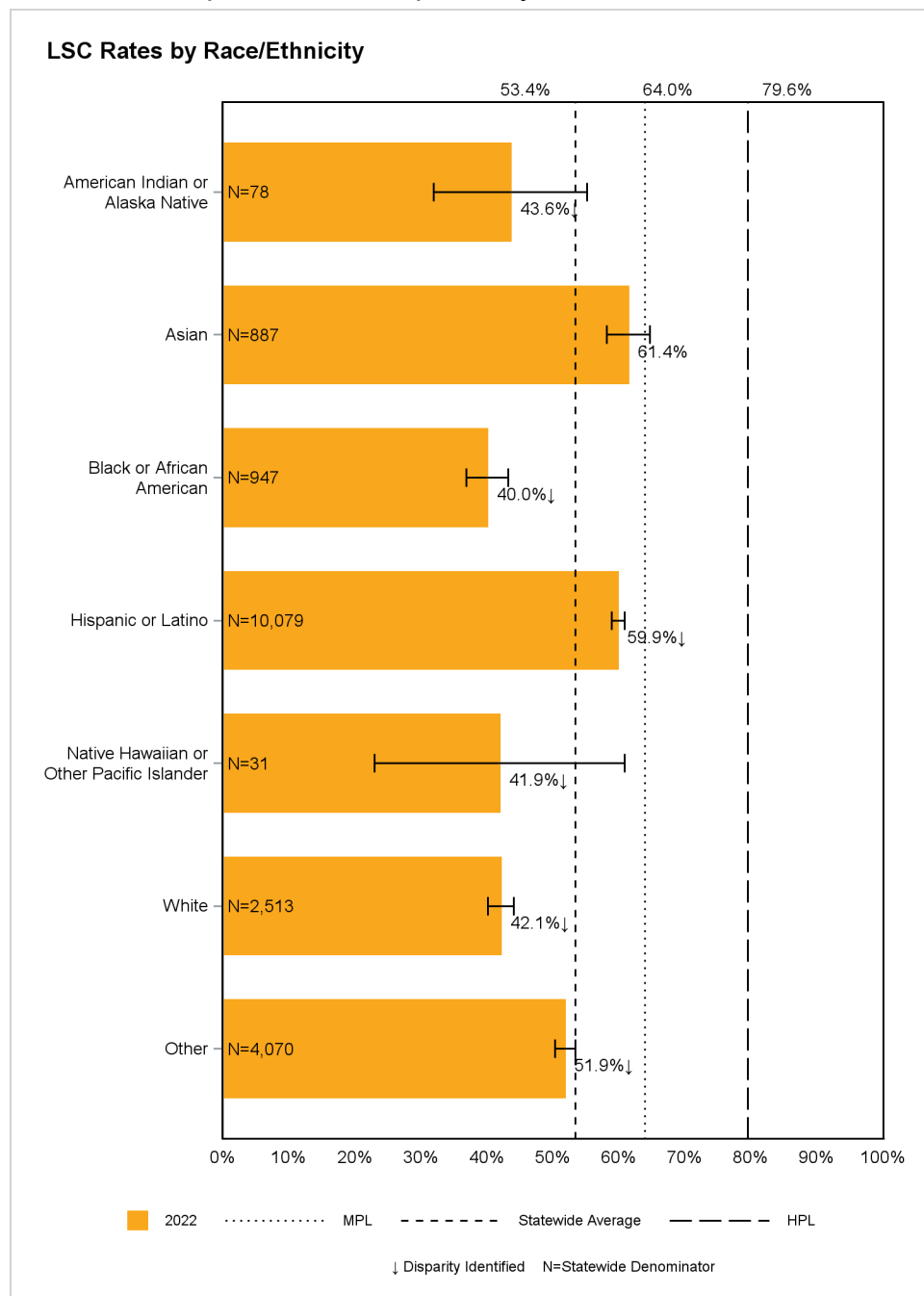


Figure C.20—Lead Screening in Children (LSC) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group suppressed due to a small denominator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

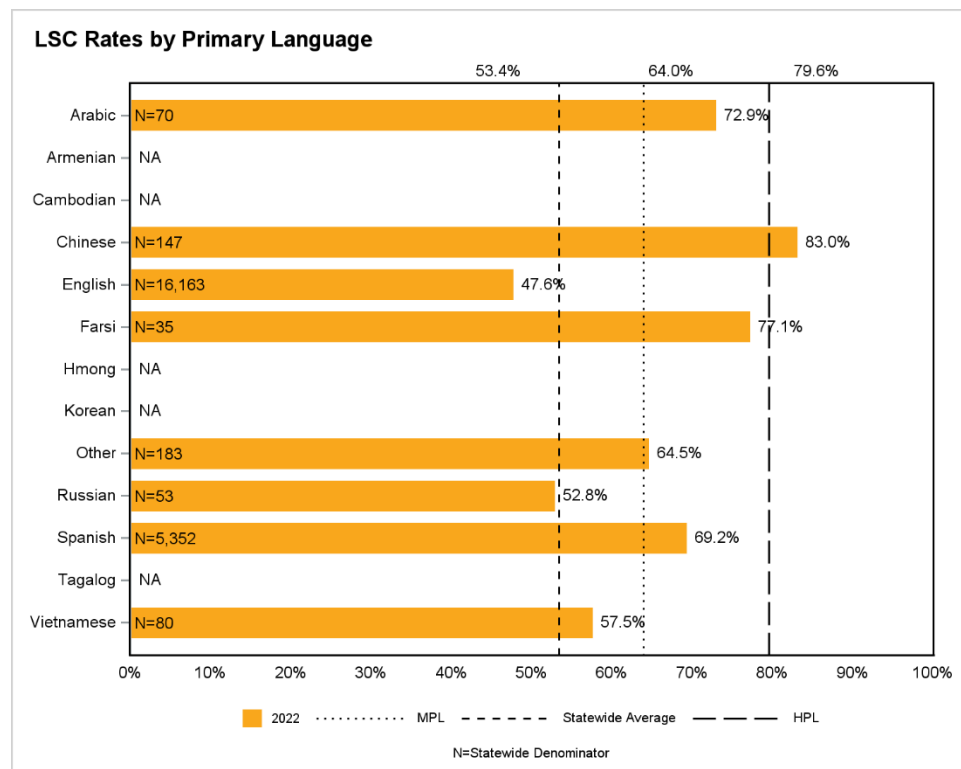


Figure C.21—Lead Screening in Children (LSC) Rates by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group suppressed due to a small denominator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

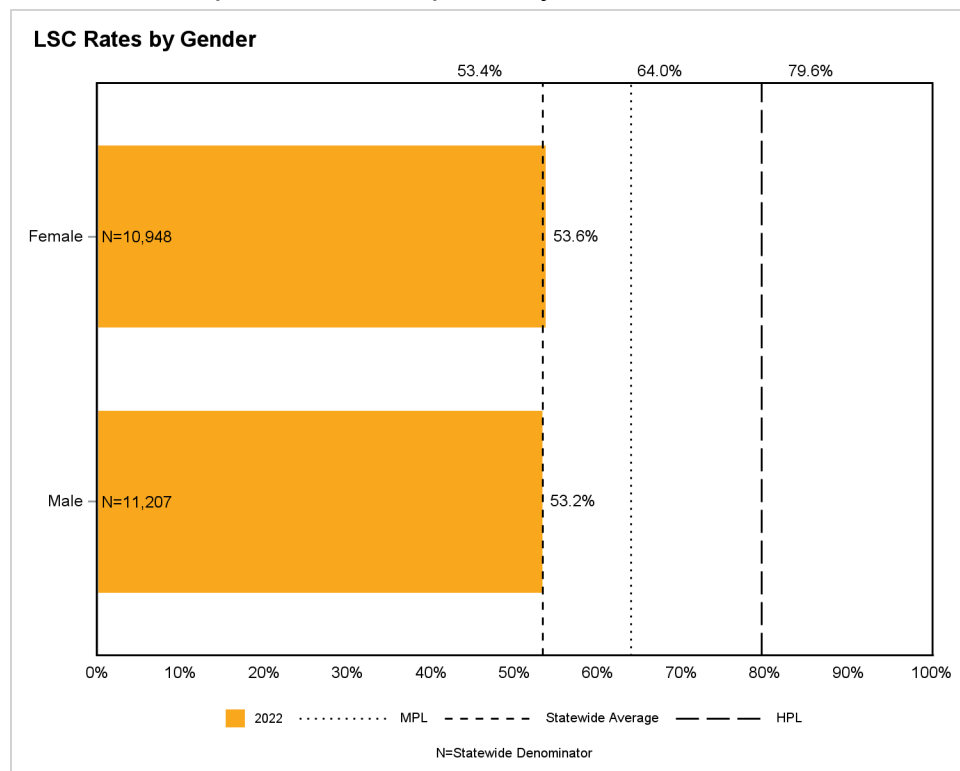
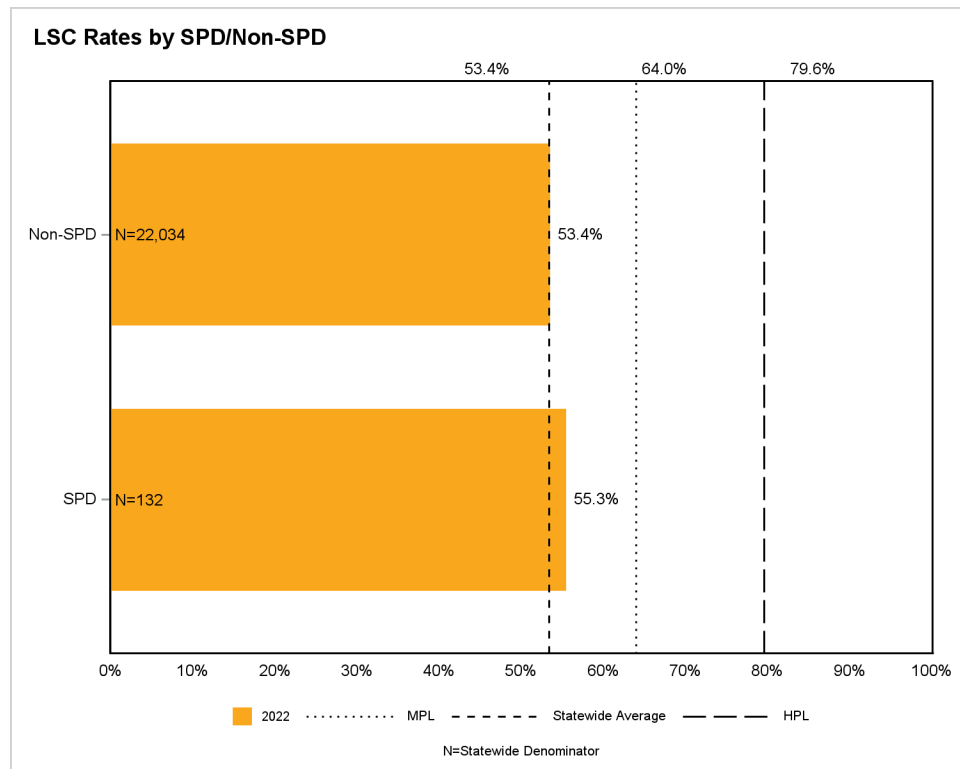


Figure C.22—Lead Screening in Children (LSC) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.



Topical Fluoride for Children—Dental Services—Total (TFL-DS)

The *Topical Fluoride for Children—Dental Services—Total (TFL-DS)* indicator measures the percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as dental services within the measurement year.

Figure C.23—Topical Fluoride for Children—Dental Services—Total (TFL-DS) by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 8.7 percent (N=263,801).

The following are the measurement year 2022 denominator sizes for select racial/ethnic groups: American Indian or Alaska Native (13,461), Black or African American (285,474), Native Hawaiian or Other Pacific Islander (9,769), and White (557,747).

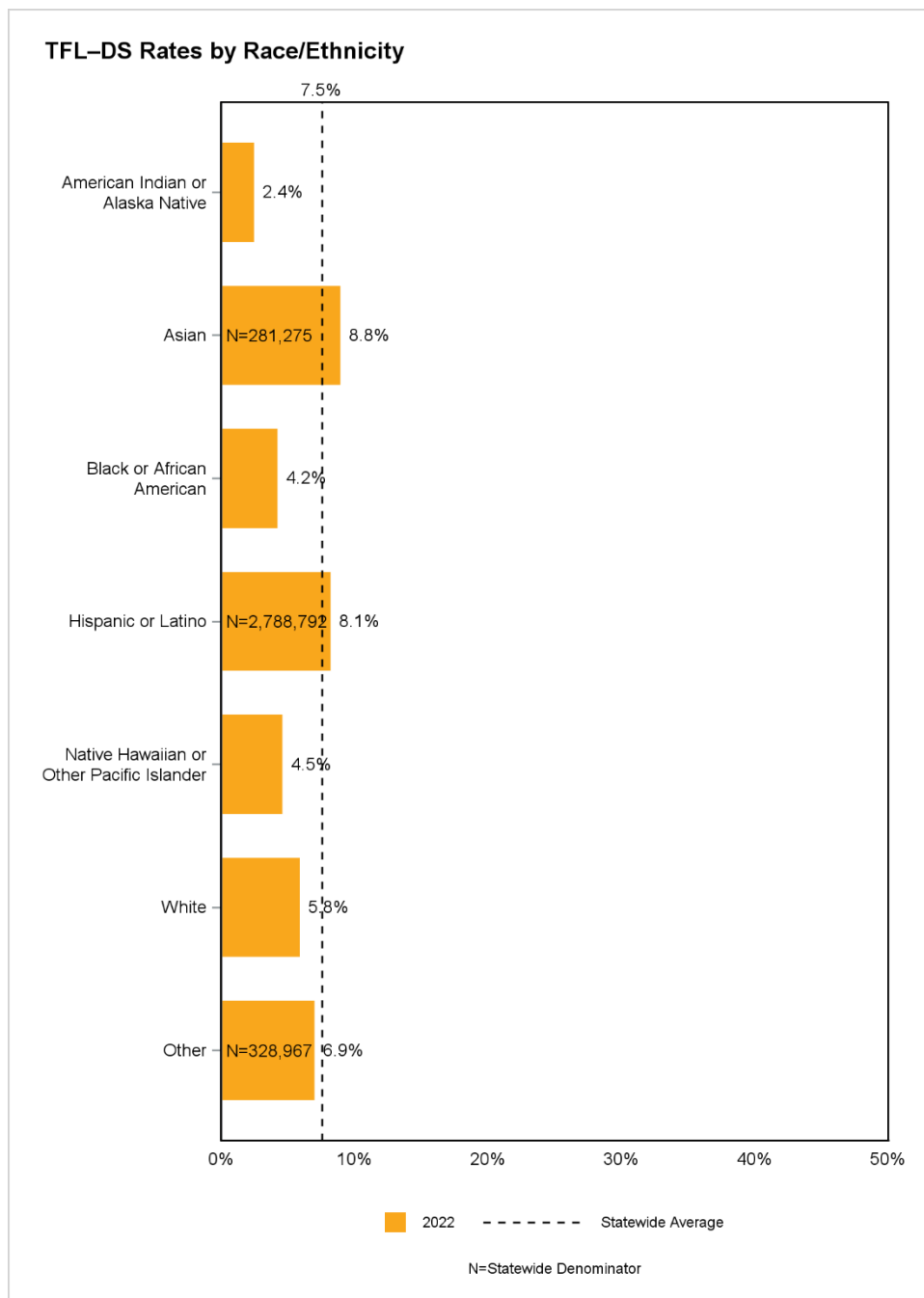


Figure C.24—Topical Fluoride for Children—Dental Services—Total (TFL-DS) by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was 3.3 percent (N=3,364).

The measurement year 2022 denominator size for the Armenian primary language group was 12,612.

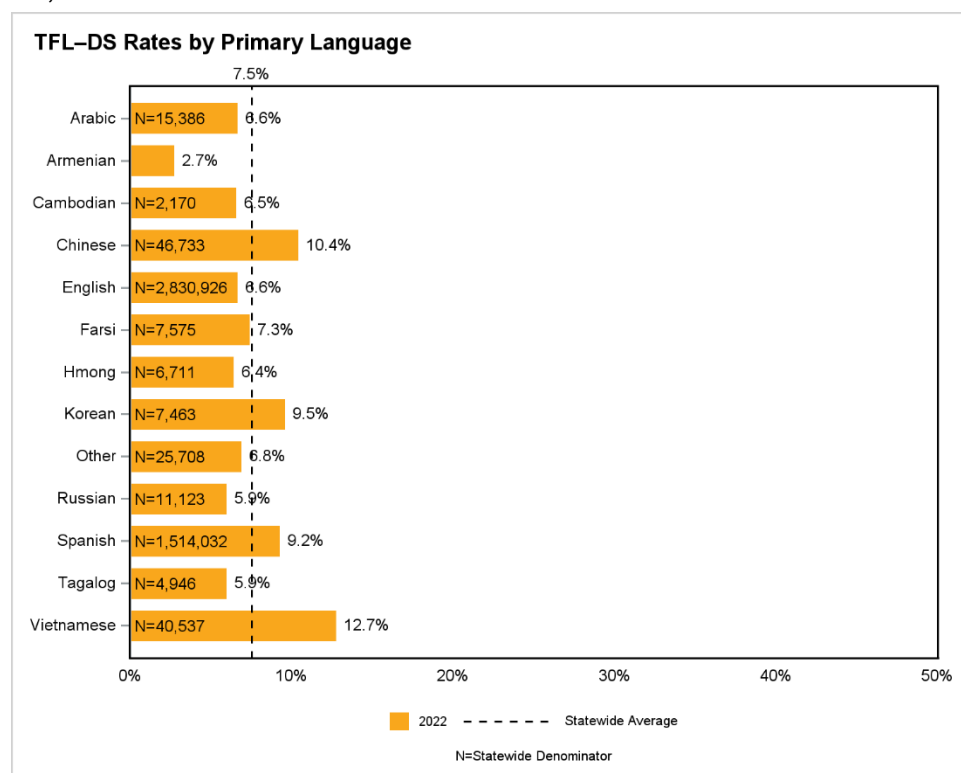


Figure C.25—Topical Fluoride for Children—Dental Services—Total (TFL-DS) by Age

Note: The following are the measurement year 2022 denominator sizes for select age groups: 1–2 Years (342,810), 15–18 Years (984,077), and 19–20 Years (425,862).

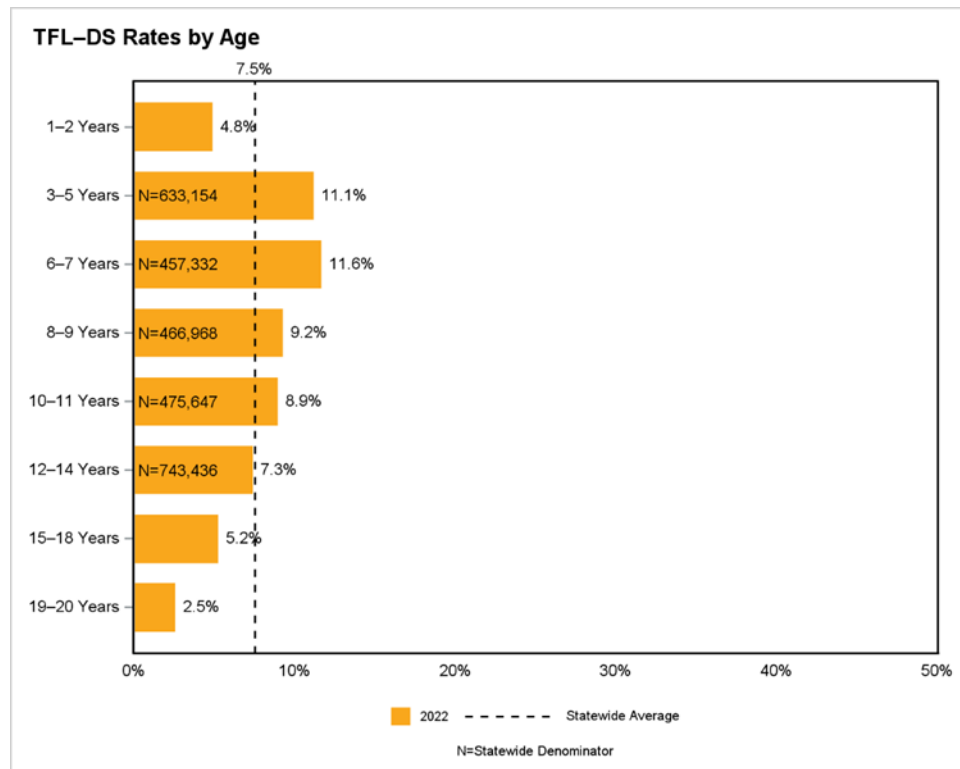


Figure C.26—Topical Fluoride for Children—Dental Services—Total (TFL-DS) by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group was 4.2 percent (N=1,815).

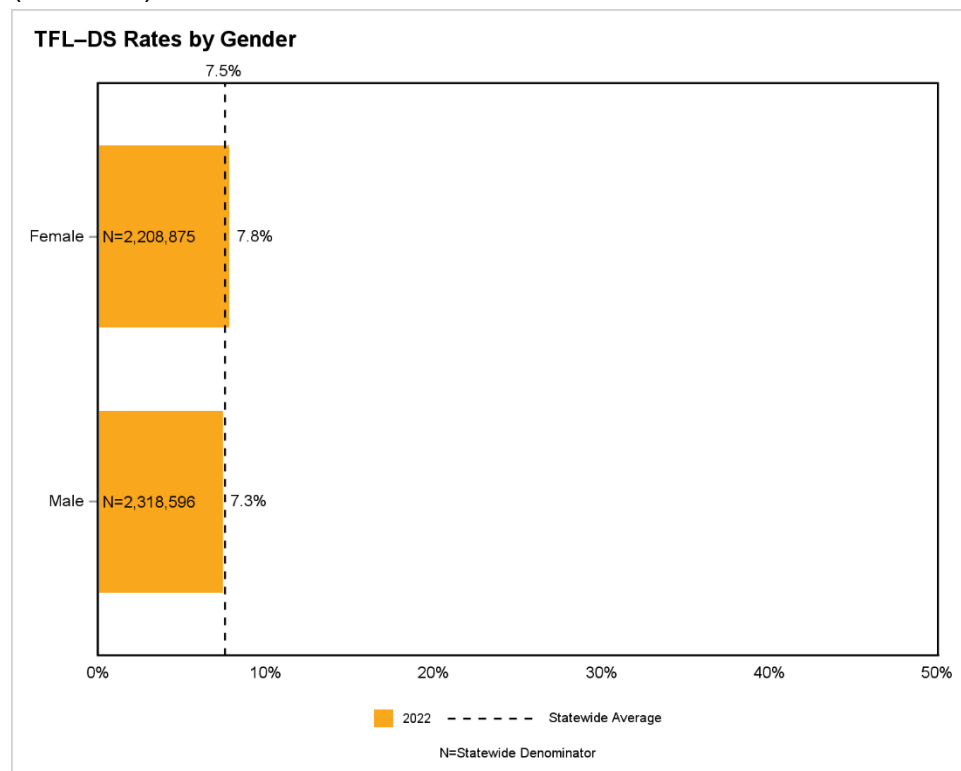
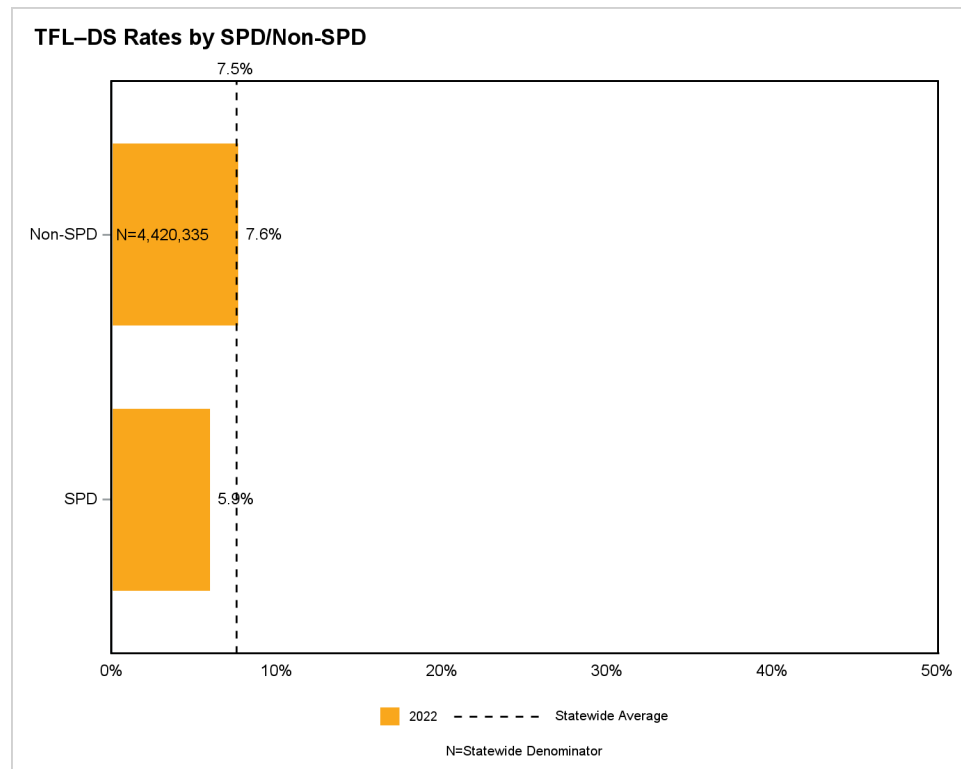


Figure C.27—Topical Fluoride for Children—Dental Services—Total (TFL-DS) by SPD/Non-SPD

Note: The measurement year 2022 denominator size for the SPD group is 108,951.



Topical Fluoride for Children—Oral Health Services—Total (TFL-OH)

The *Topical Fluoride for Children—Oral Health Services—Total (TFL-OH)* indicator measures the percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as oral health services within the measurement year.

Figure C.28—Topical Fluoride for Children—Oral Health Services—Total (TFL–OH) by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 1.2 percent (N=263,801).

The following are the measurement year 2022 denominator sizes for select racial/ethnic groups: American Indian or Alaska Native (13,461), Asian (281,275), Black or African American (285,474), Hispanic or Latino (2,788,792), Native Hawaiian or Other Pacific Islander (9,769), Other (328,967), and White (557,747).

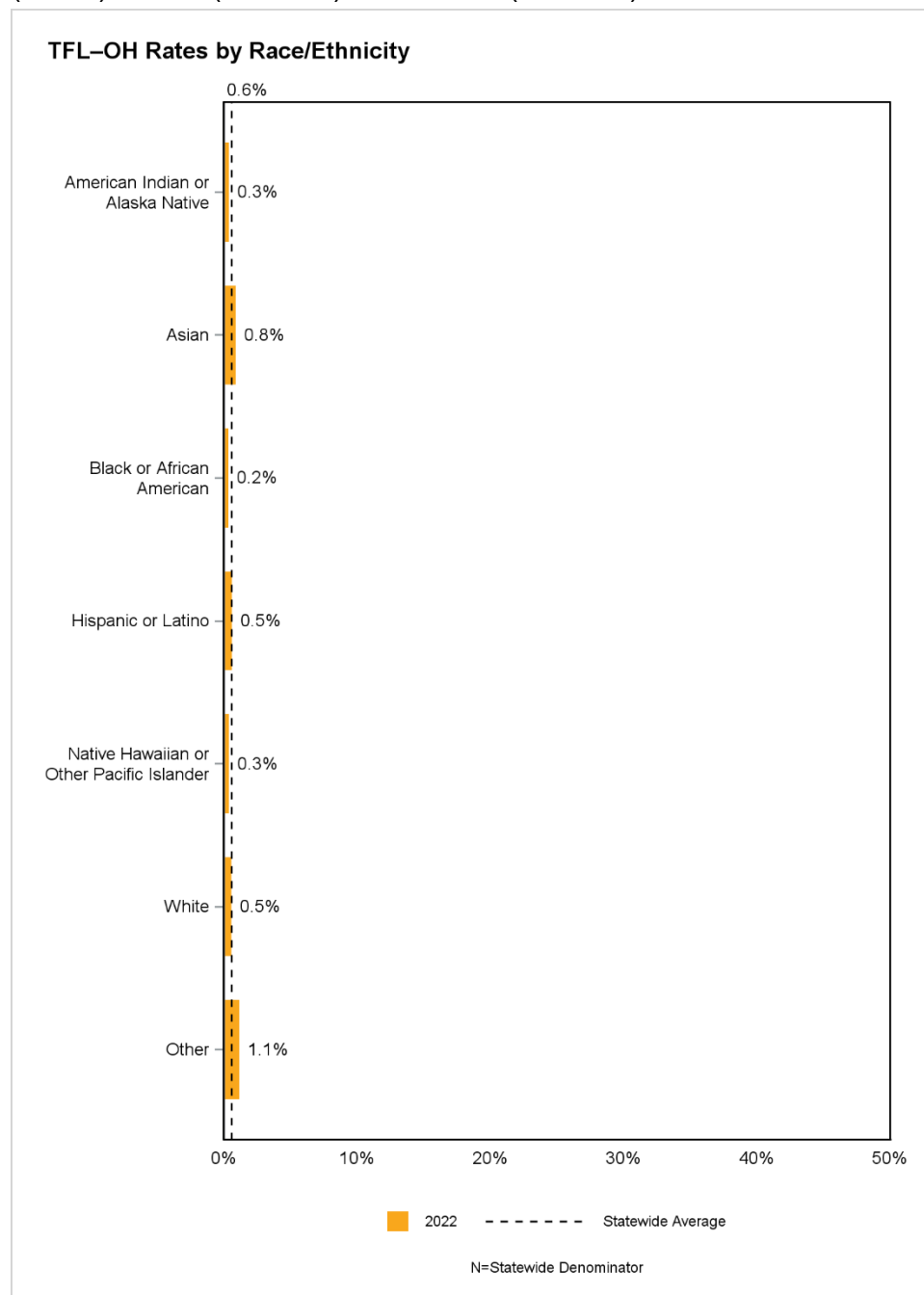


Figure C.29—Topical Fluoride for Children—Oral Health Services—Total (TFL–OH) by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was 1.0 percent (N=3,364).

The following are the measurement year 2022 denominator sizes for select primary language groups: Arabic (15,386), Armenian (12,612), Cambodian (2,170), Chinese (46,733), English (2,830,926), Farsi (7,575), Hmong (6,711), Korean (7,463), Other (25,708), Russian (11,123), Spanish (1,514,032), Tagalog (4,946), and Vietnamese (40,537).

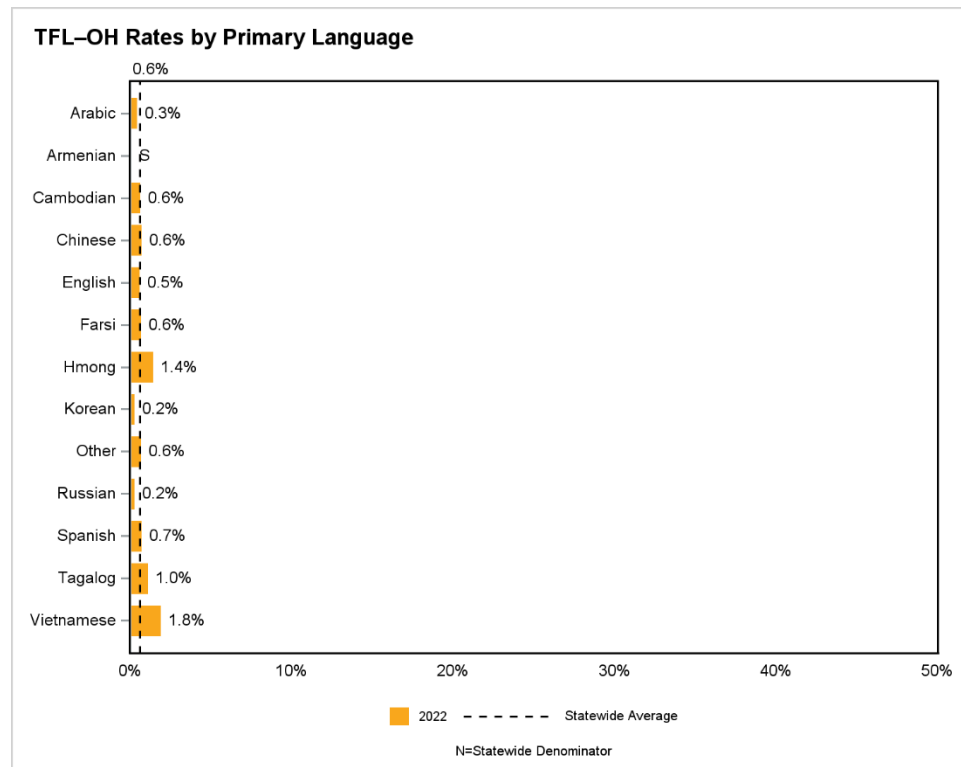


Figure C.30—Topical Fluoride for Children—Oral Health—Total (TFL–OH) by Age

Note: The following are the measurement year 2022 denominator sizes for select age language groups: 1–2 Years (342,810), 3–5 Years (633,154), 6–7 Years (457,332), 8–9 Years (466,968), 10–11 Years (475,647), 12–14 Years (743,436), 15–18 Years (984,077), and 19–20 Years (425,862).

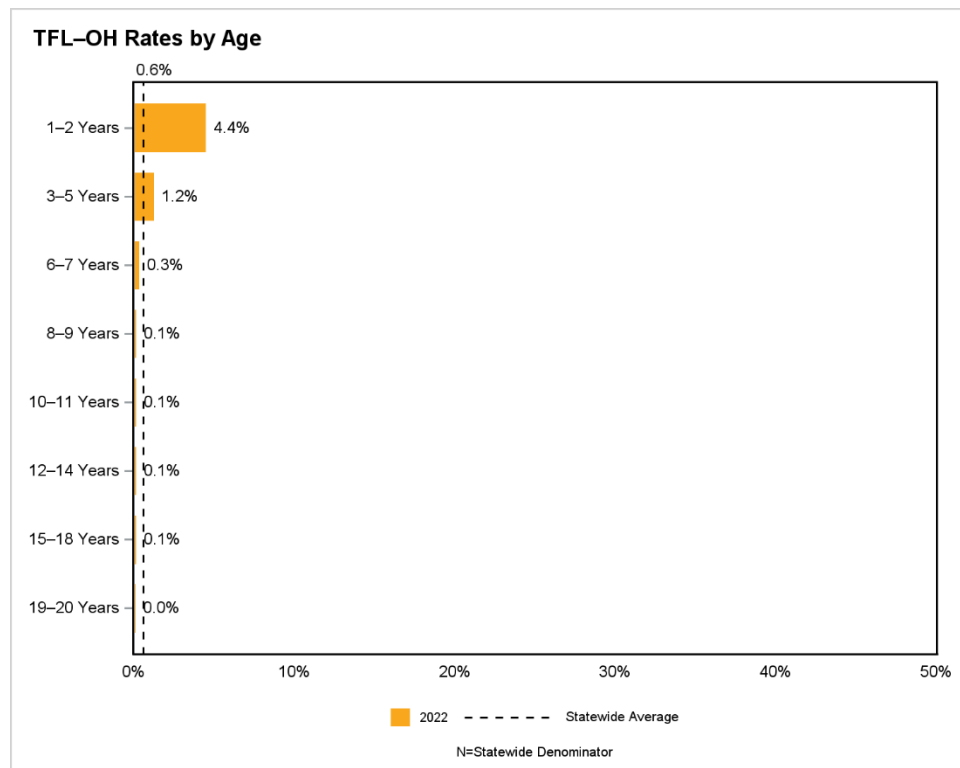


Figure C.31—Topical Fluoride for Children—Oral Health—Total (TFL–OH) by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group was 1.8 percent (N=1,815).

The following are the measurement year 2022 denominator sizes for select gender groups: Female (2,208,875) and Male (2,318,596).

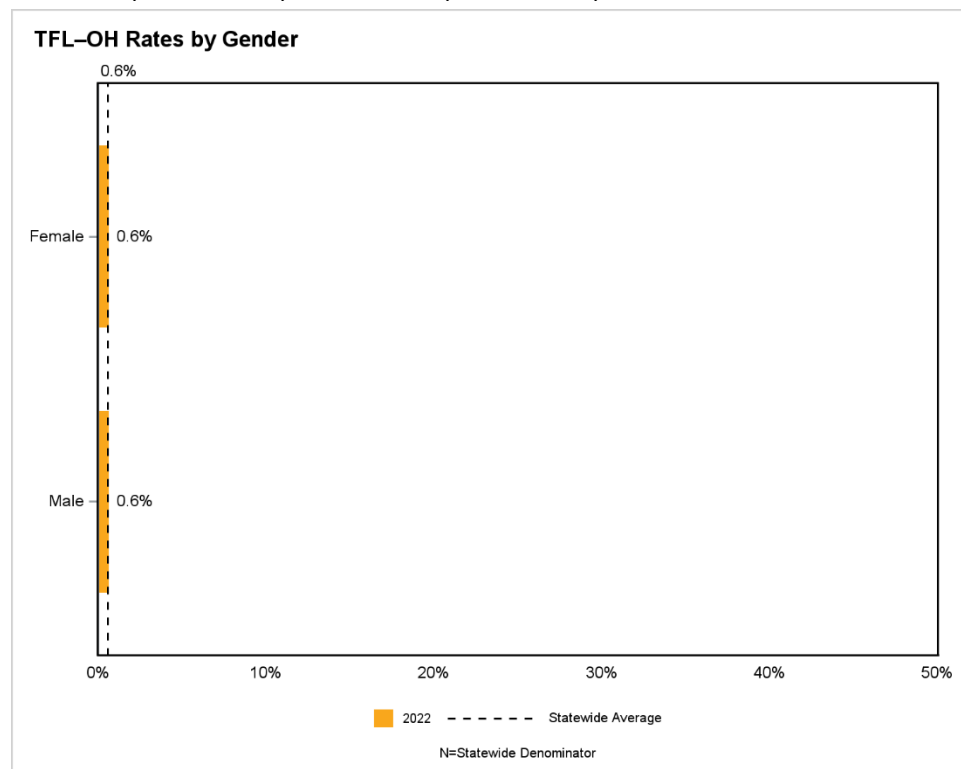
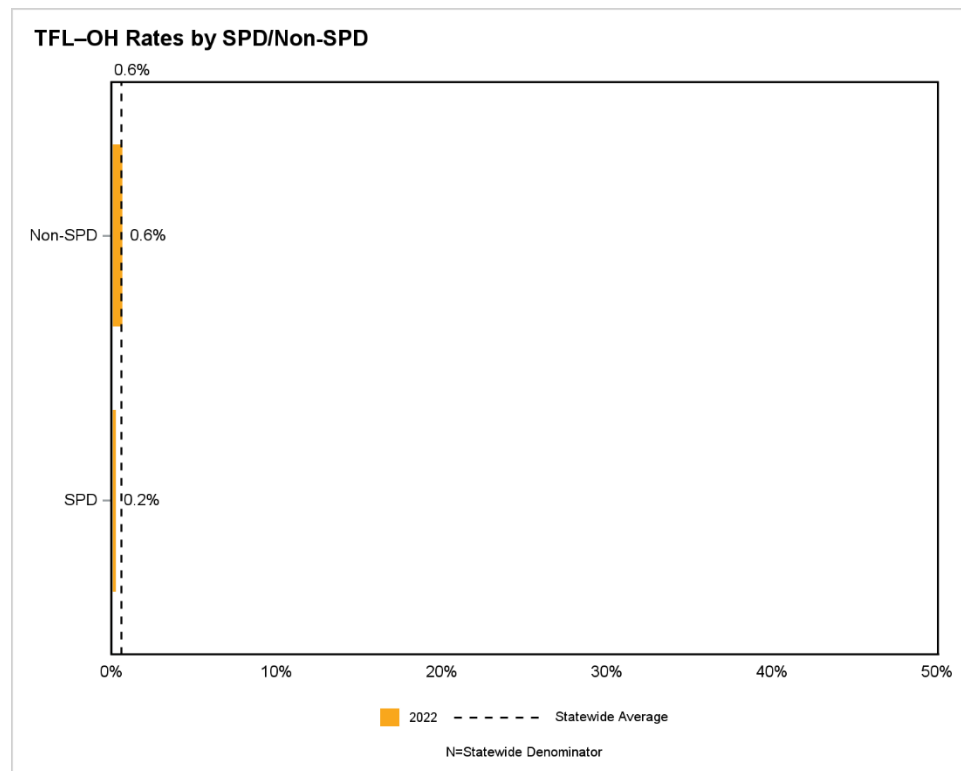


Figure C.32—Topical Fluoride for Children—Dental Services—Total (TFL–OH) by SPD/Non-SPD

Note: The following are the measurement year 2022 denominator sizes for select SPD/Non-SPD groups: Non-SPD (4,420,335) and SPD (108,951).



Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL–DO)

The *Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL–DO)* indicator measures the percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as dental or oral health services within the measurement year.

Figure C.33—Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL–DO) by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 12.7 percent (N=263,801).

The following are the measurement year 2022 denominator sizes for select racial/ethnic groups: American Indian or Alaska Native (13,461), Black or African American (285,474), and Native Hawaiian or Other Pacific Islander (9,769).

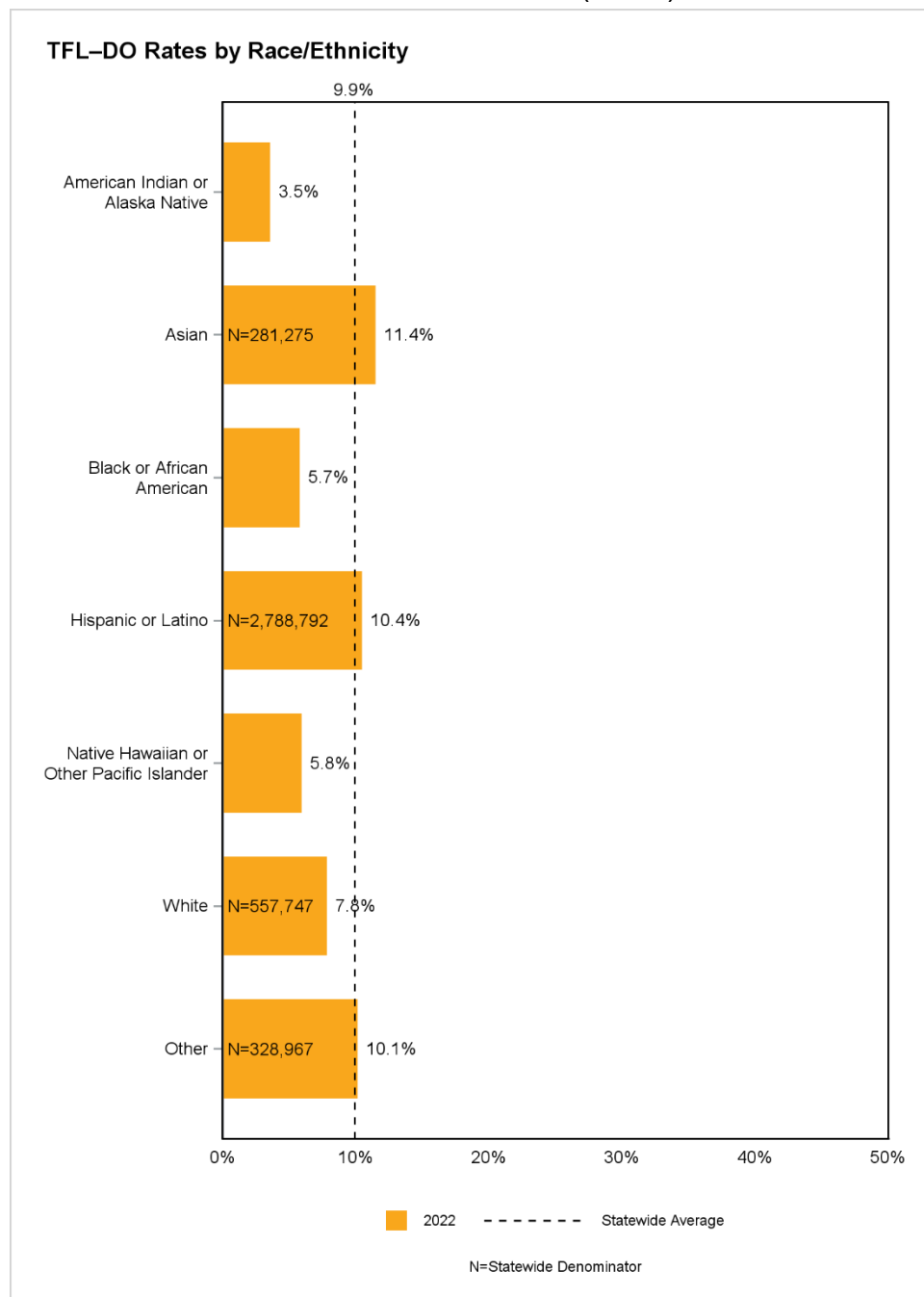


Figure C.34—Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL–DO) by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was 5.6 percent (N=3,364).

The measurement year 2022 denominator size for the Armenian primary language group was 12,612.

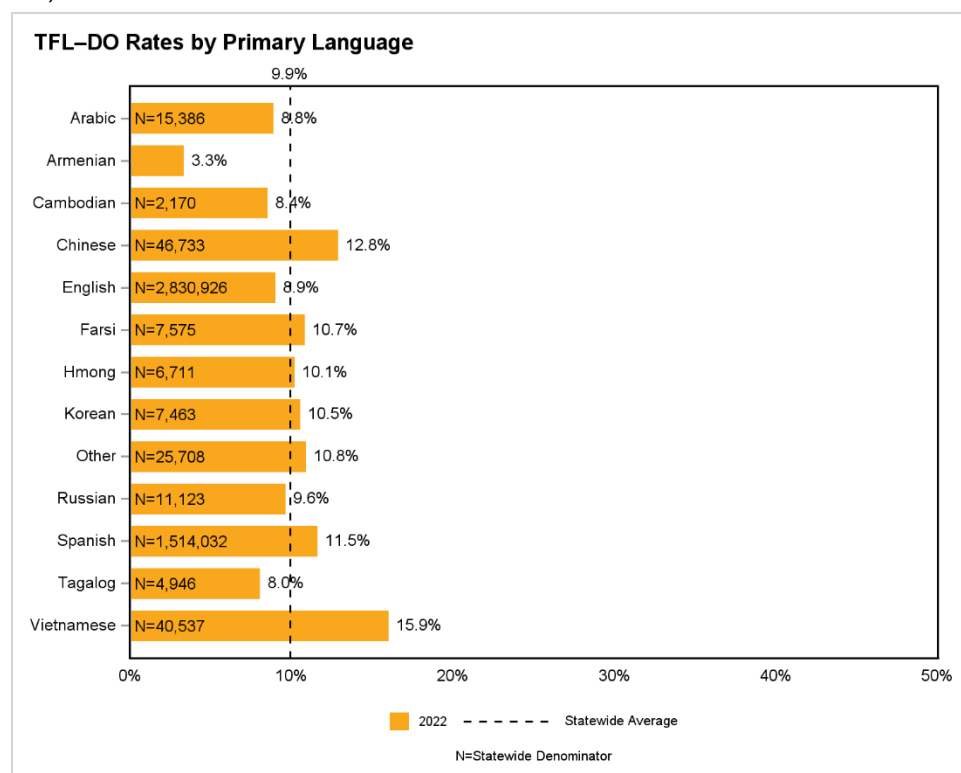


Figure C.35—Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL–DO) by Age

Note: The following are the measurement year 2022 denominator sizes for select age language groups: 15–18 Years (984,077) and 19–20 Years (425,862).

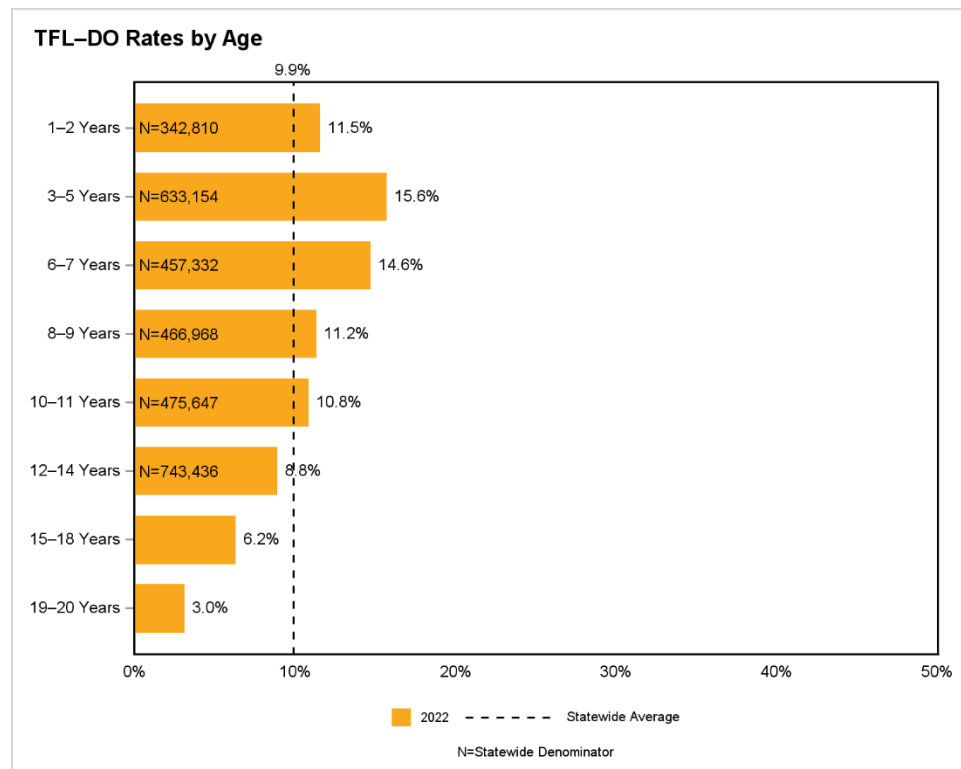


Figure C.36—Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL–DO) by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group was 7.7 percent (N=1,815).

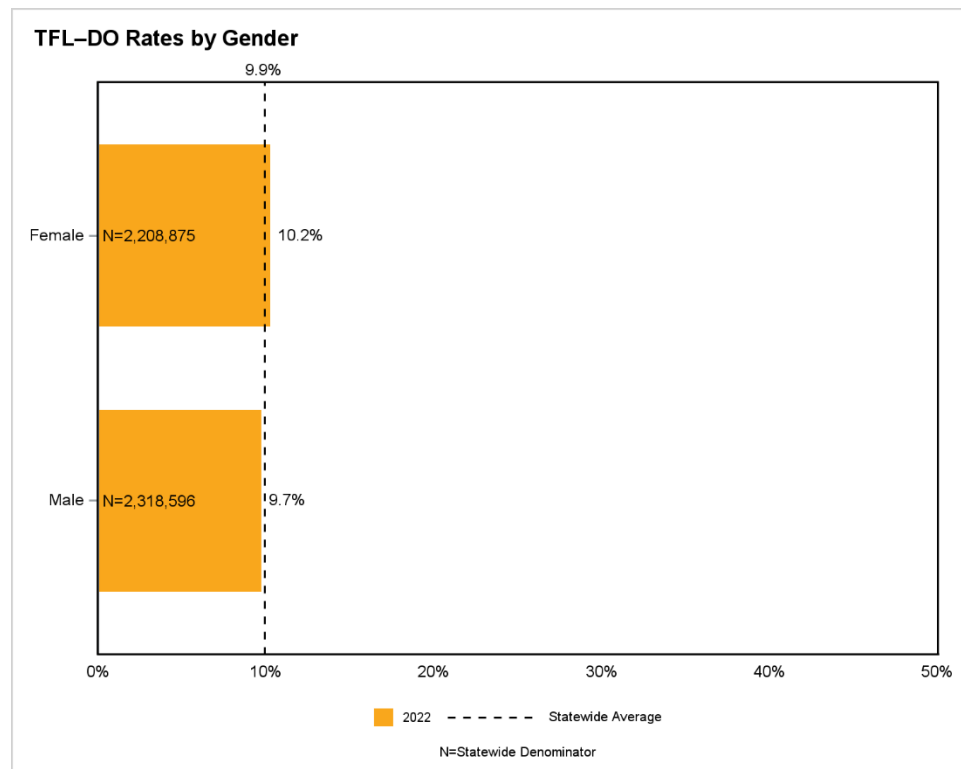
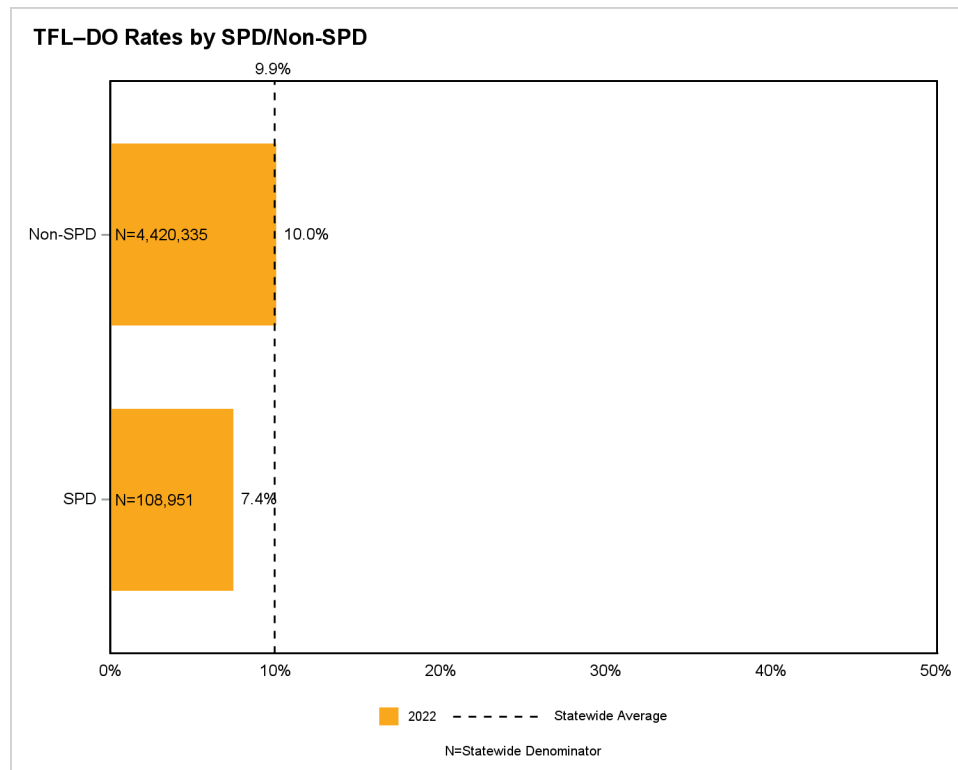


Figure C.37—Topical Fluoride for Children—Dental or Oral Health Services—Total (TFL–DO) by SPD/Non-SPD



Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+)* indicator measures the percentage of children who turned 15 months old during the measurement year who received six or more well-child visits with a PCP.

Figure C.38—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 36.6 percent (N=15,652) and 47.5 percent (N=16,328), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 68.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 40.2 percent.

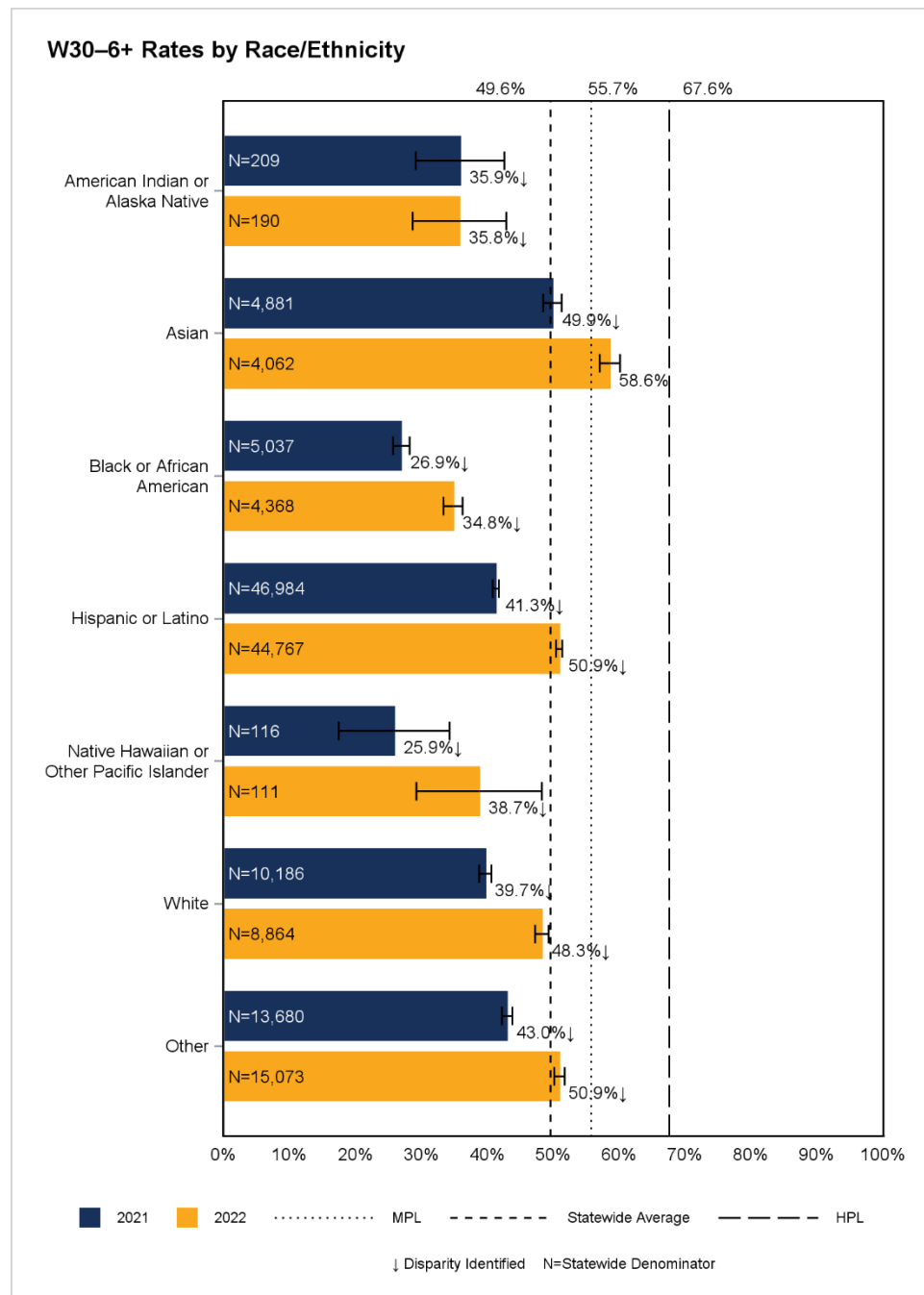


Figure C.39—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 32.4 percent (N=105) and 37.8 percent (N=225), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 68.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 40.2 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

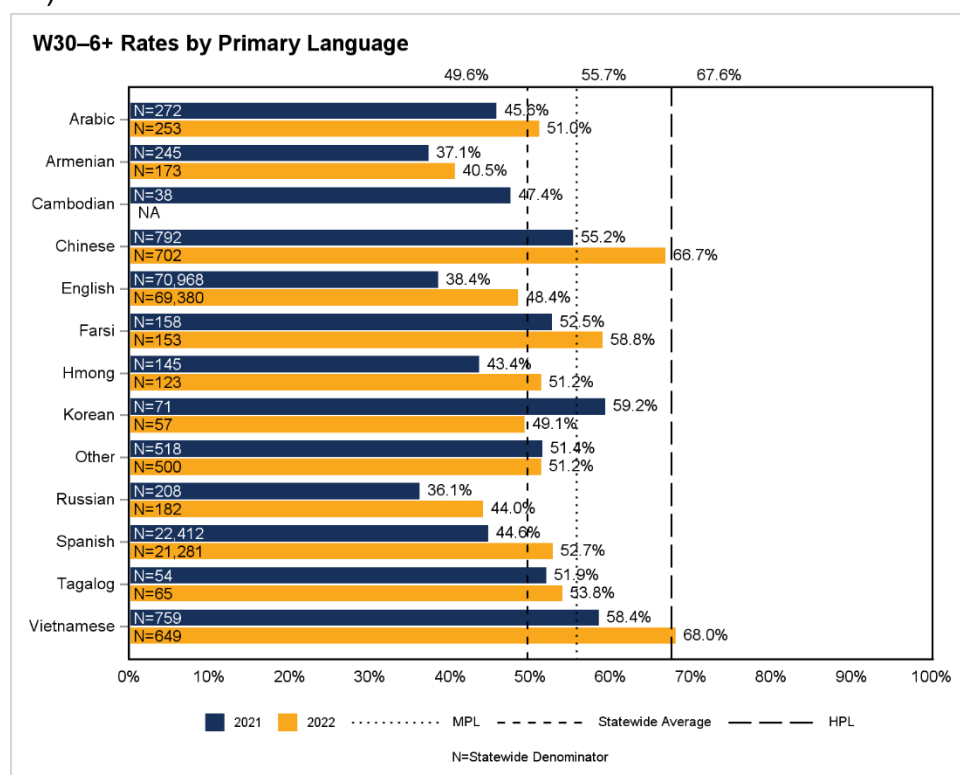


Figure C.40—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 34.2 percent (N=79) and 37.6 percent (N=210), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 68.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 40.2 percent.

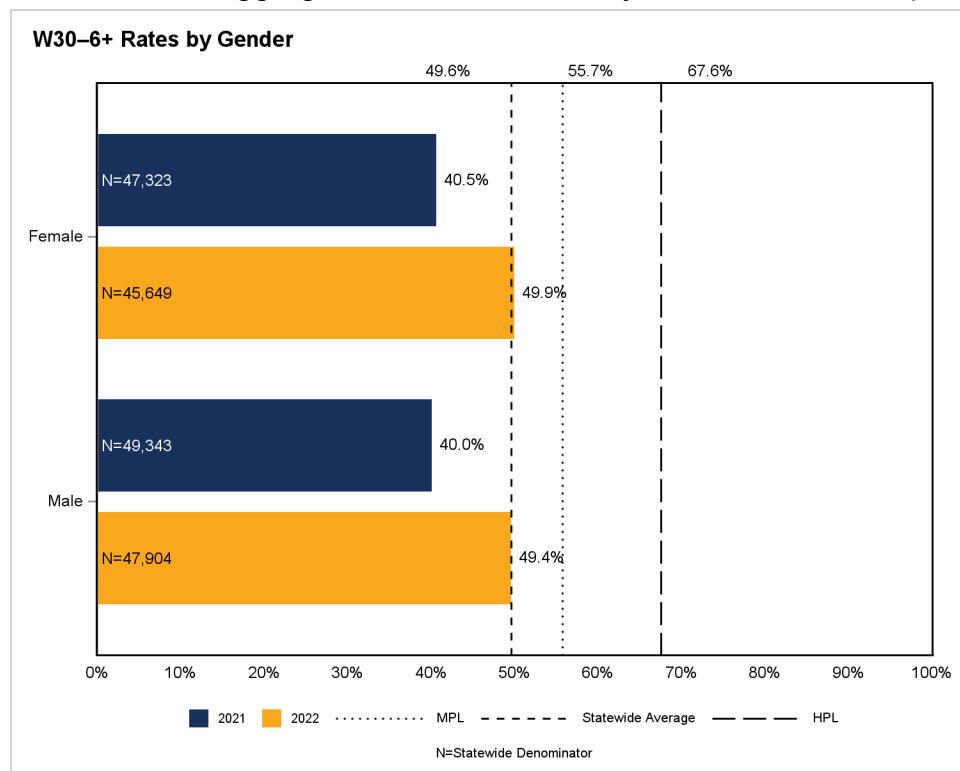
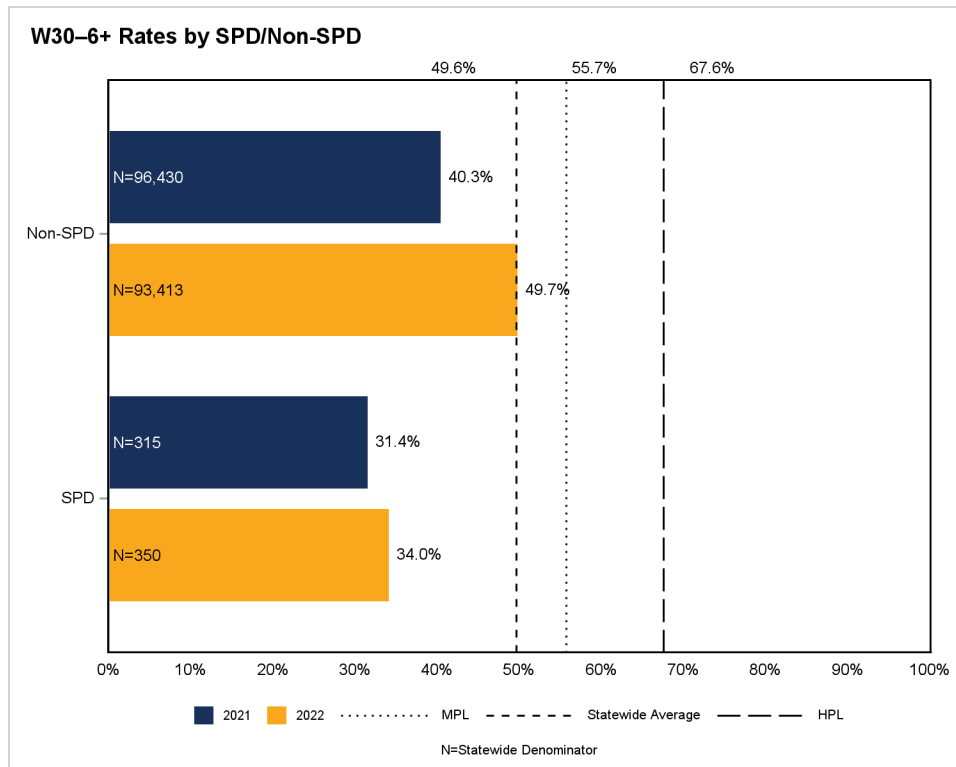


Figure C.41—Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 68.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 40.2 percent.



Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)

The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)* indicator measures the percentage of children who turned 30 months old during the measurement year who received two or more well-child visits with a PCP.

Figure C.42—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 55.0 percent (N=24,062) and 60.0 percent (N=25,447), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 70.7 percent and 82.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 60.3 percent.

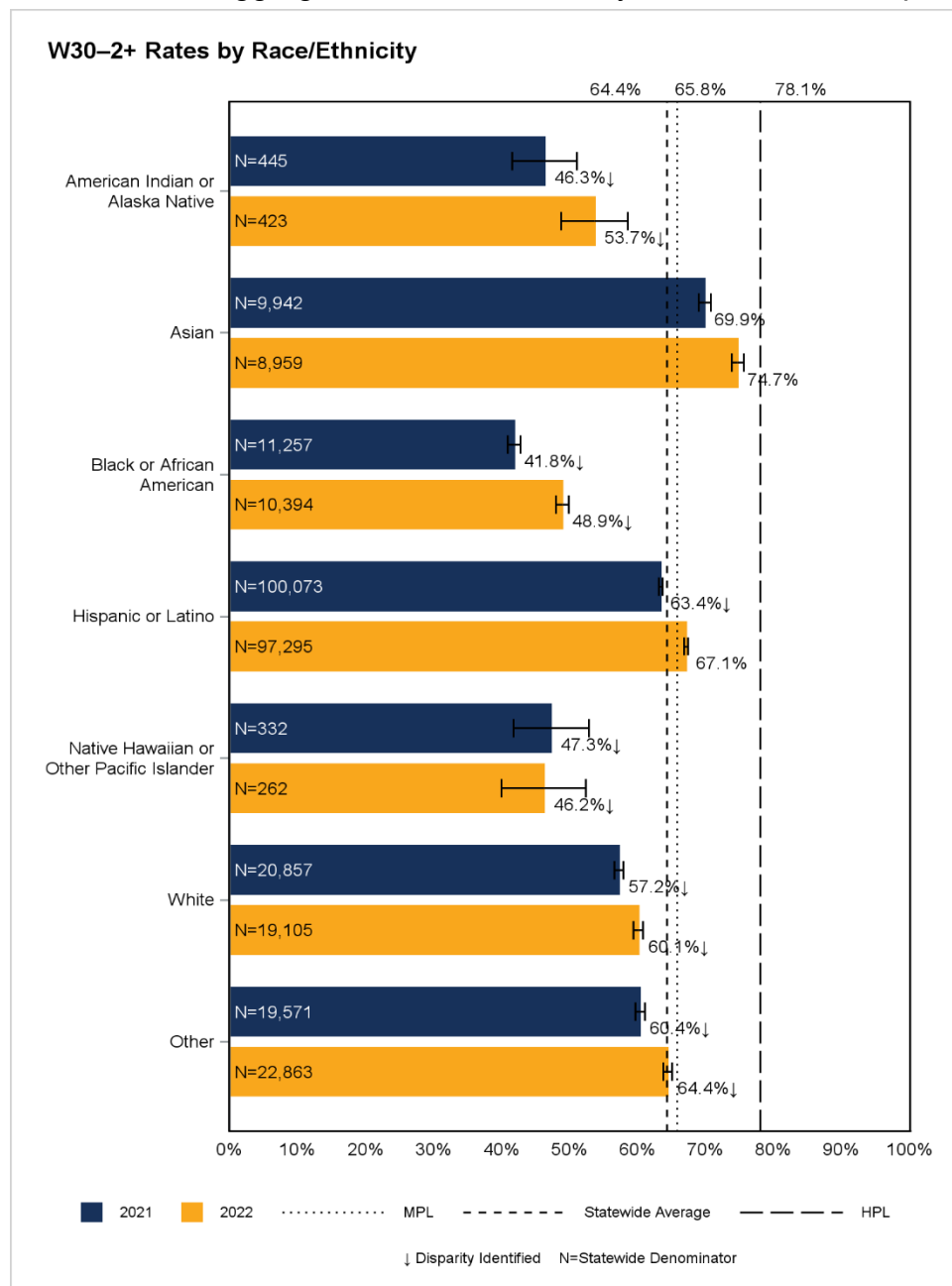


Figure C.43—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 42.7 percent (N=178) and 61.3 percent (N=204), respectively

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 70.7 percent and 82.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 60.3 percent.

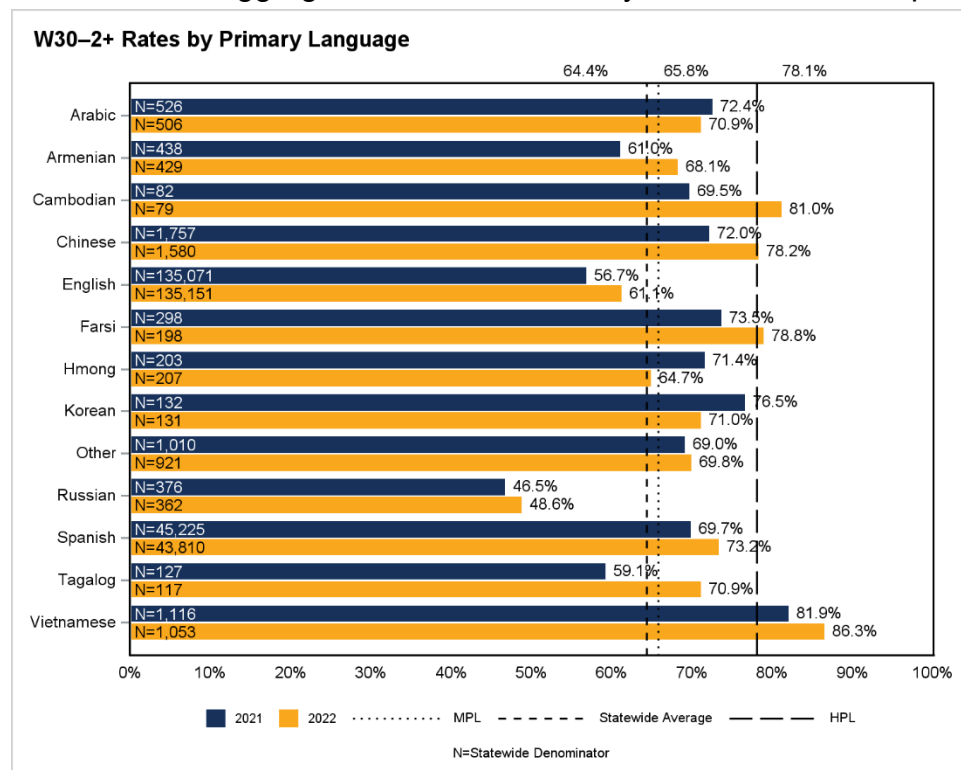


Figure C.44—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 45.5 percent (N=99) and 66.2 percent (N=142), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 70.7 percent and 82.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 60.3 percent.

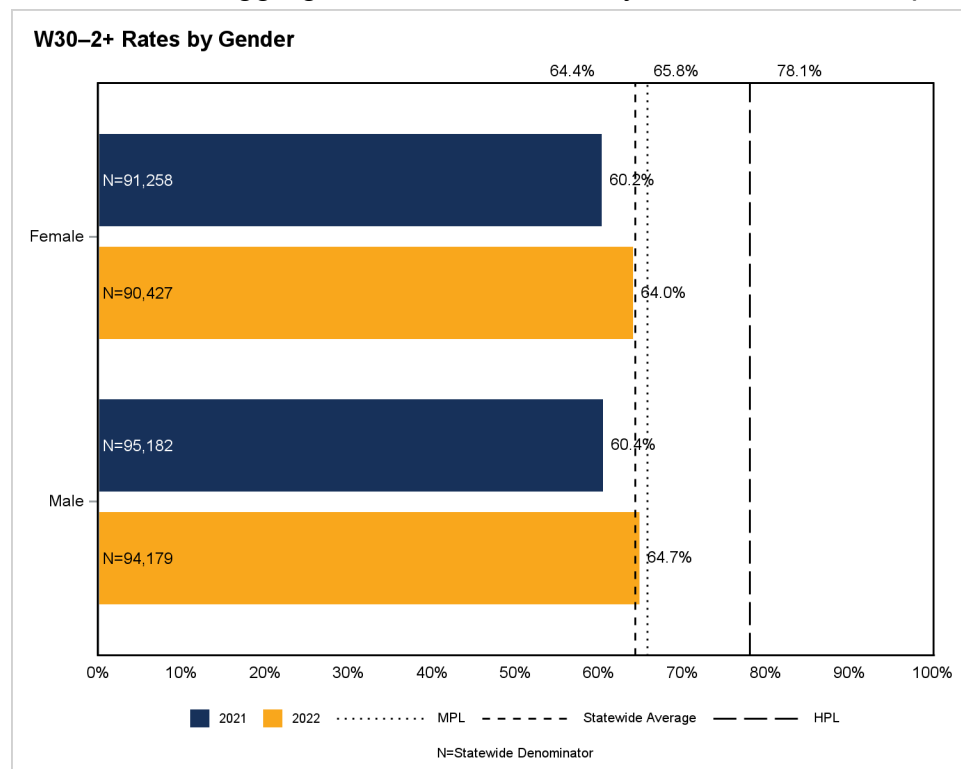
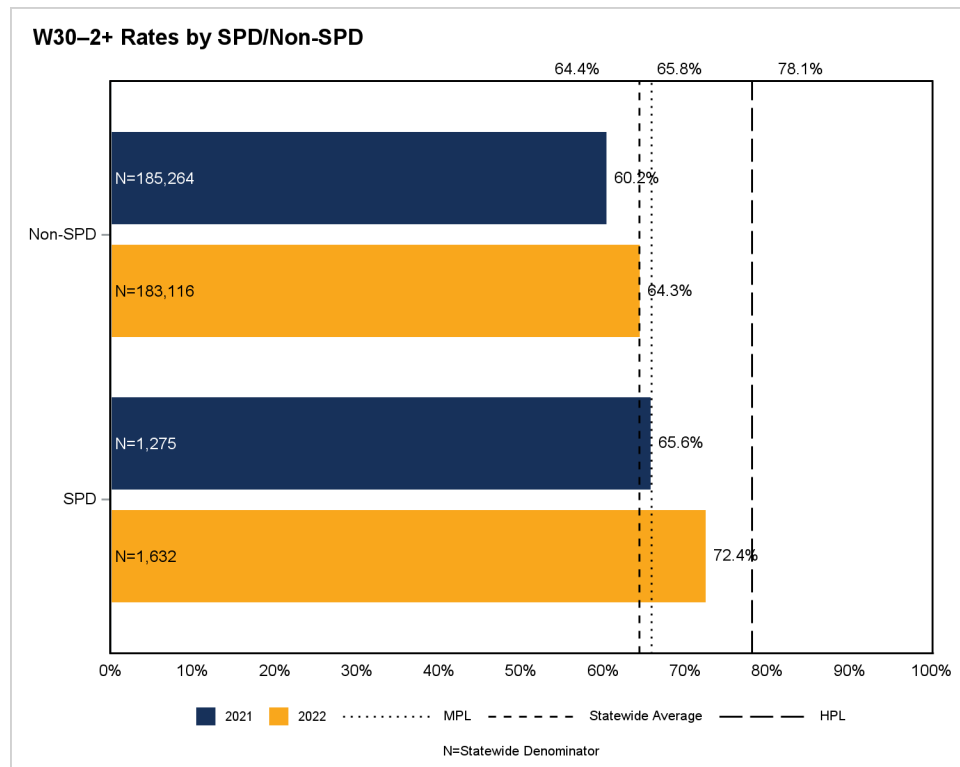


Figure C.45—Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 70.7 percent and 82.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 60.3 percent.



Reproductive Health Domain

Figure C.46 through Figure C.89 display the demographic stratification results for the Reproductive Health Domain.

Chlamydia Screening in Women—Total (CHL)

The *Chlamydia Screening in Women—Total (CHL)* indicator measures the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Figure C.46—Chlamydia Screening in Women—Total (CHL) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 59.2 percent (N=8,017) and 60.0 percent (N=9,279), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 66.2 percent, respectively.

The statewide aggregate for measurement year 2021 was 63.6 percent.

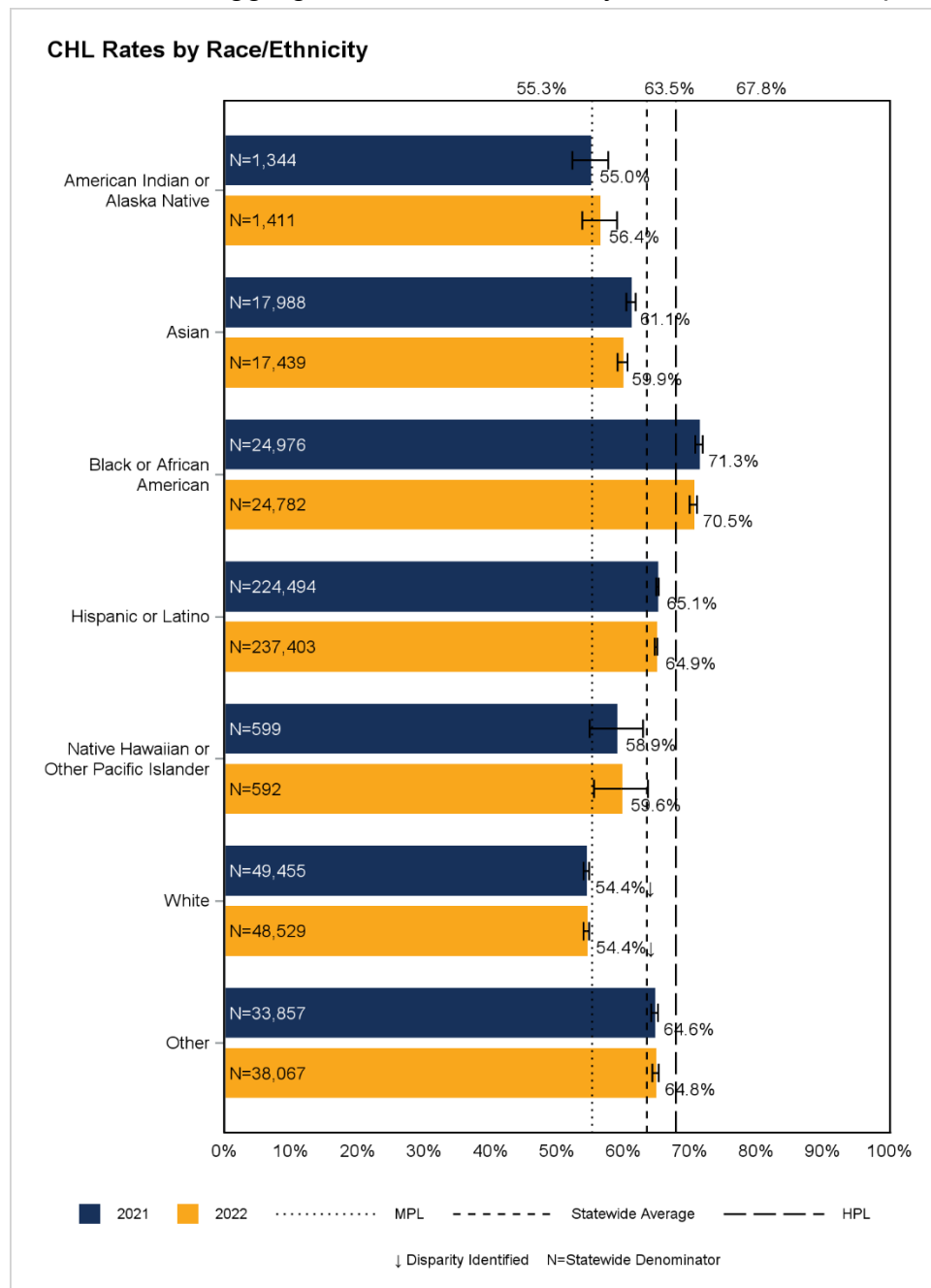


Figure C.47—Chlamydia Screening in Women—Total (CHL) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 52.0 percent (N=77) and 51.3 percent (N=78), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 66.2 percent, respectively.

The statewide aggregate for measurement year 2021 63.6 percent.

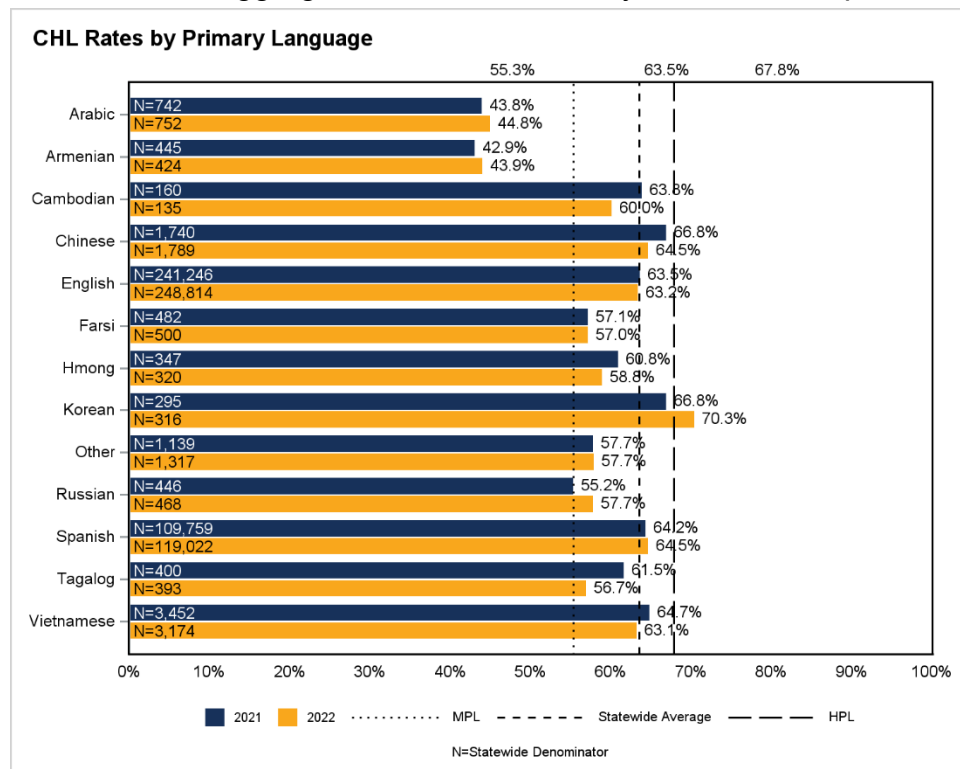


Figure C.48—Chlamydia Screening in Women—Total (CHL) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 66.2 percent, respectively.

The statewide aggregate for measurement year 2021 was 63.6 percent.

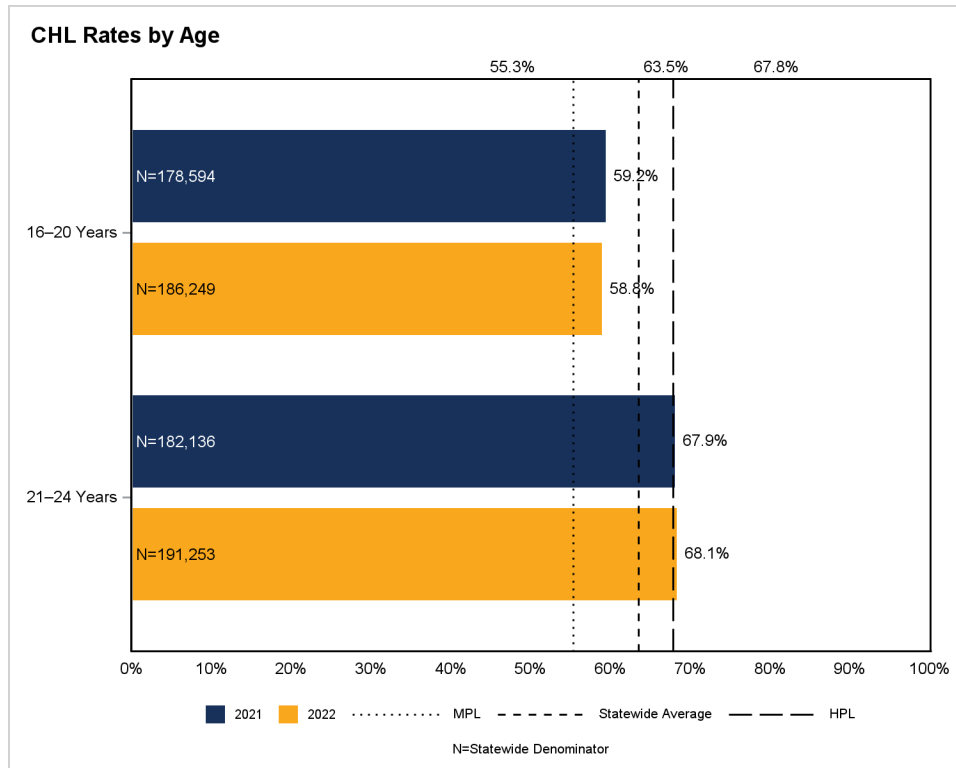
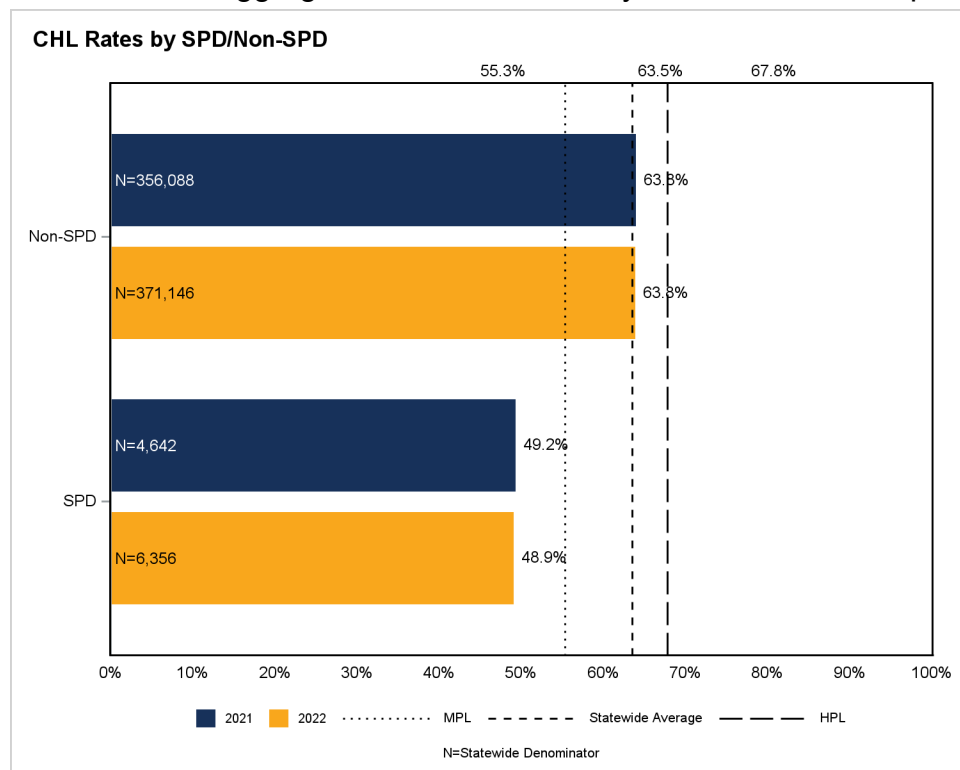


Figure C.49—Chlamydia Screening in Women—Total (CHL) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 54.9 percent and 66.2 percent, respectively.

The statewide aggregate for measurement year 2021 was 63.6 percent.



Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520)

The *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520)* indicator measures the percentage of women 15 to 20 years of age at risk of unintended pregnancy who were provided a most effective or moderately effective method of contraception.

Figure C.50—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 13.8 percent (N=13,422) and 12.9 percent (N=15,524), respectively.

The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 30.0 percent.

The statewide aggregate for measurement year 2021 was 13.9 percent.

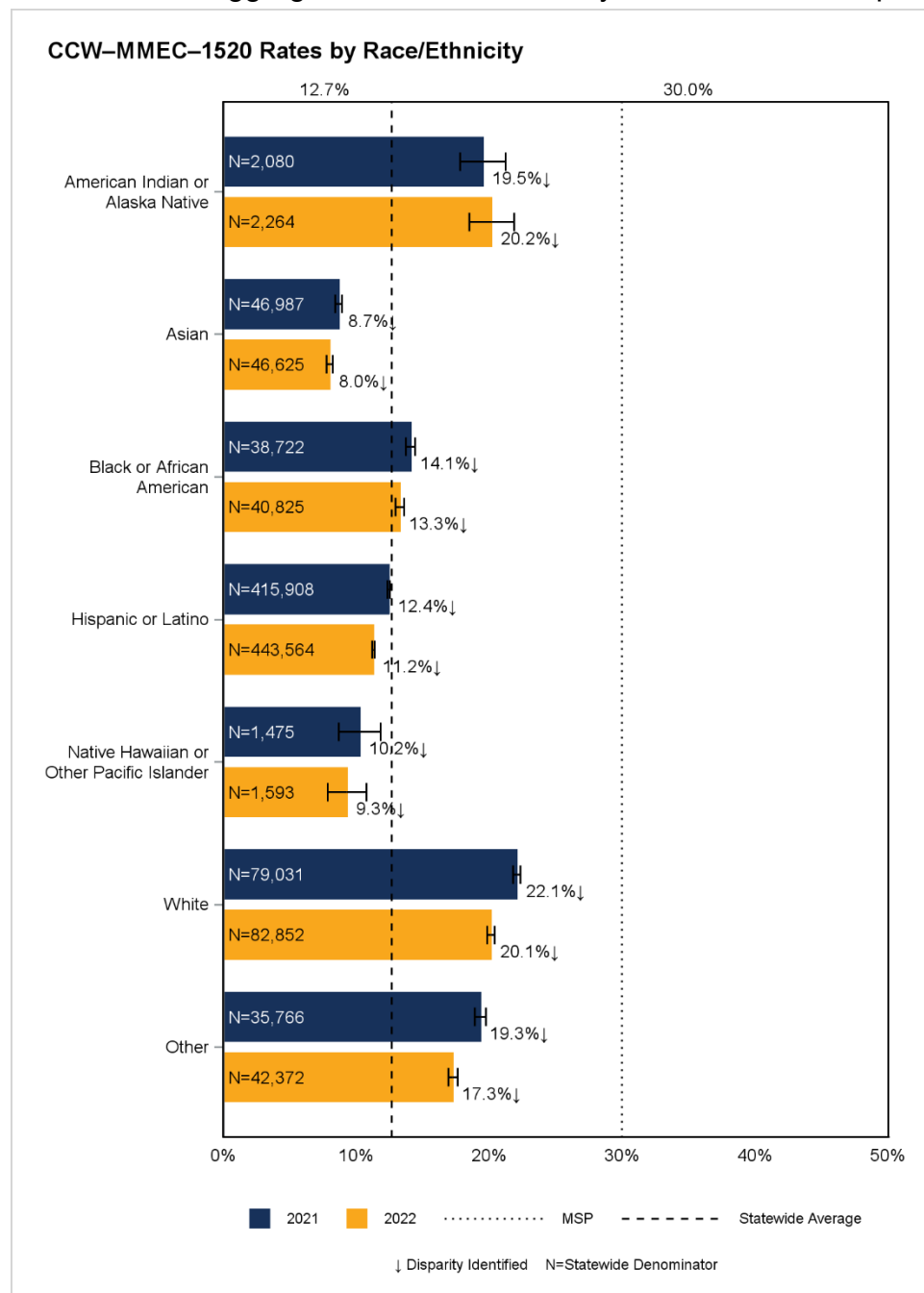


Figure C.51—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 7.7 percent (N=156) and 6.6 percent (N=197), respectively.

The measurement year 2021 denominator size for the Armenian primary language group was 1,757.

The following are the measurement year 2022 denominator sizes for select primary language groups: Armenian (1,762) and Korean (1,525).

The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 30.0 percent.

The statewide aggregate for measurement year 2021 was 13.9 percent.

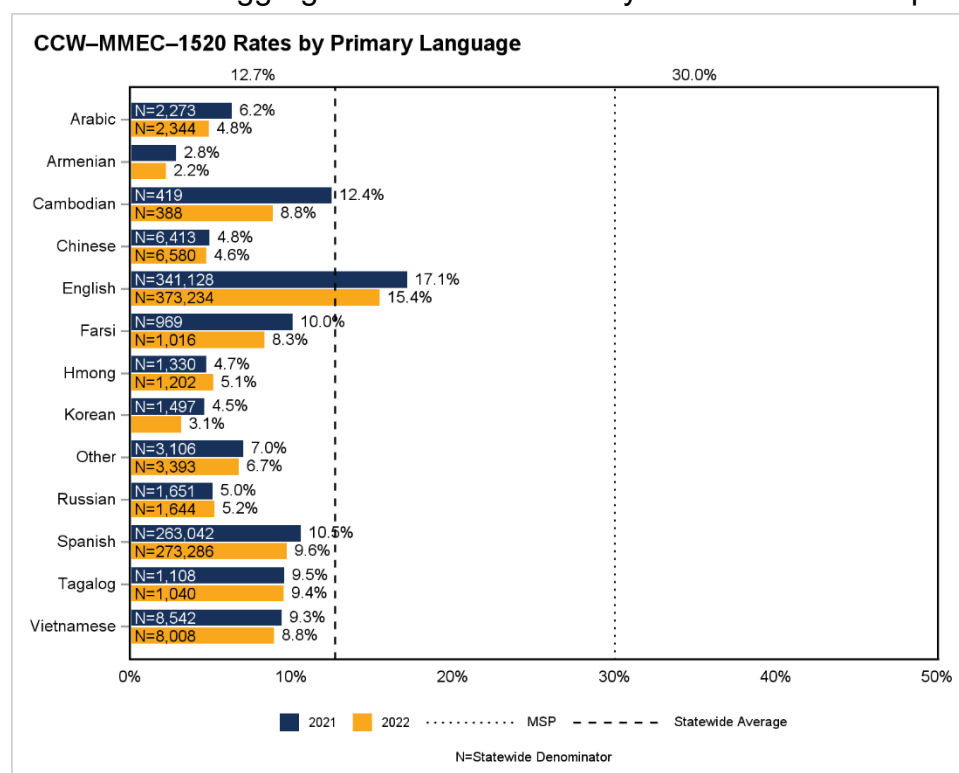
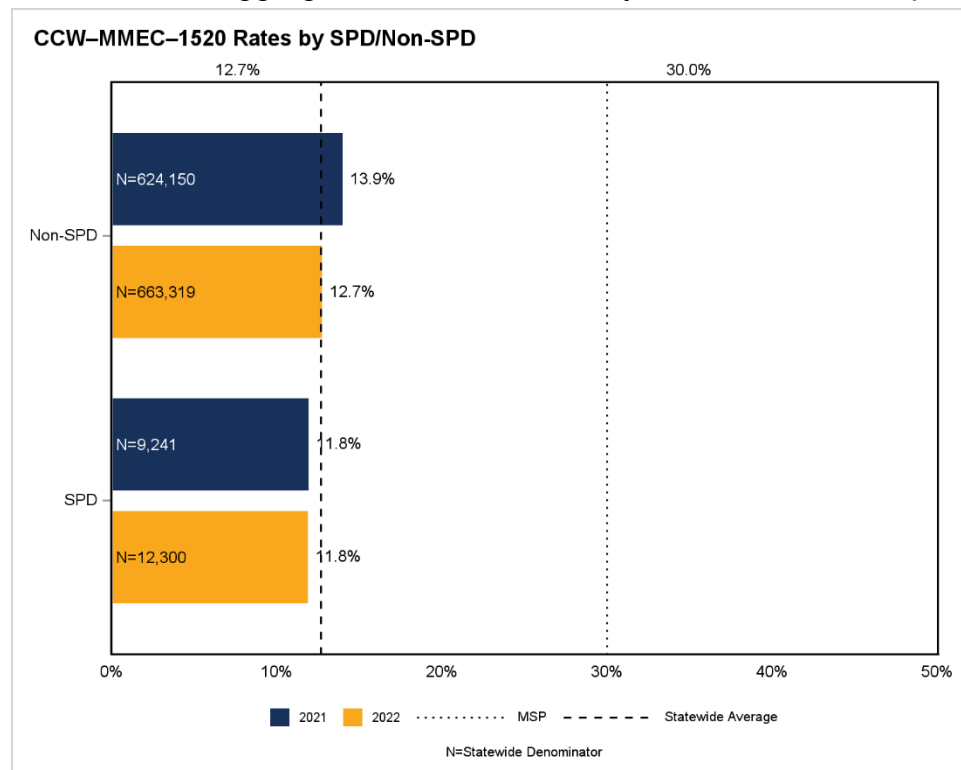


Figure C.52—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520) Rates by SPD/Non-SPD

Note: The median state performance rate represents the 50th percentile.

The median state performance rate for measurement year 2021 was 30.0 percent.

The statewide aggregate for measurement year 2021 was 13.9 percent.



Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144)

The *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144)* indicator measures the percentage of women 21 to 44 years of age at risk of unintended pregnancy who were provided a most effective or moderately effective method of contraception.

Figure C.53—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 21.2 percent (N=54,544) and 19.2 percent (N=66,448), respectively.

The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 24.5 percent.

The statewide aggregate for measurement year 2021 was 23.2 percent.

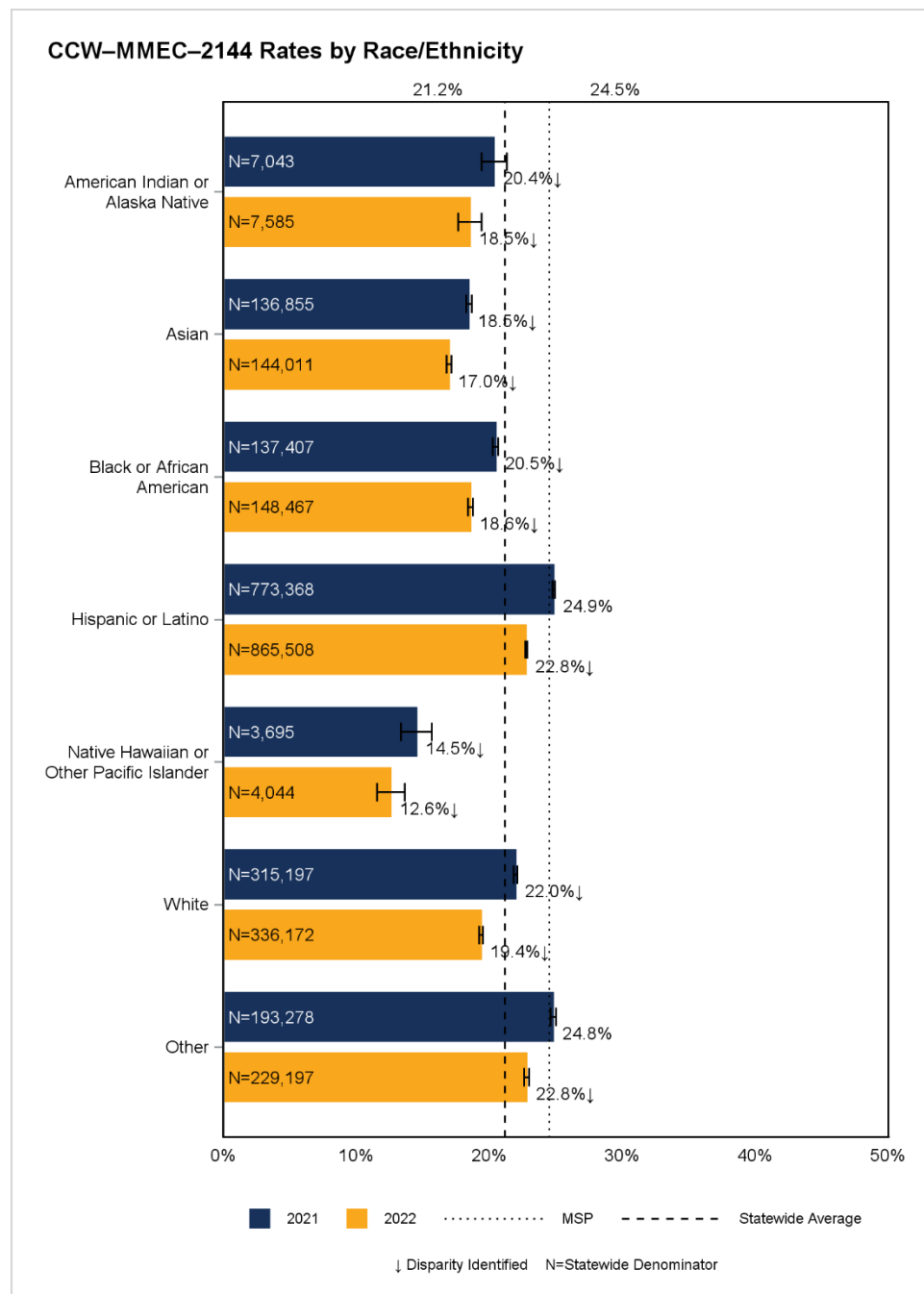


Figure C.54—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 16.7 percent (N=1,703) and 16.5 percent (N=1,543), respectively.

The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 24.5 percent.

The statewide aggregate for measurement year 2021 was 23.2 percent.

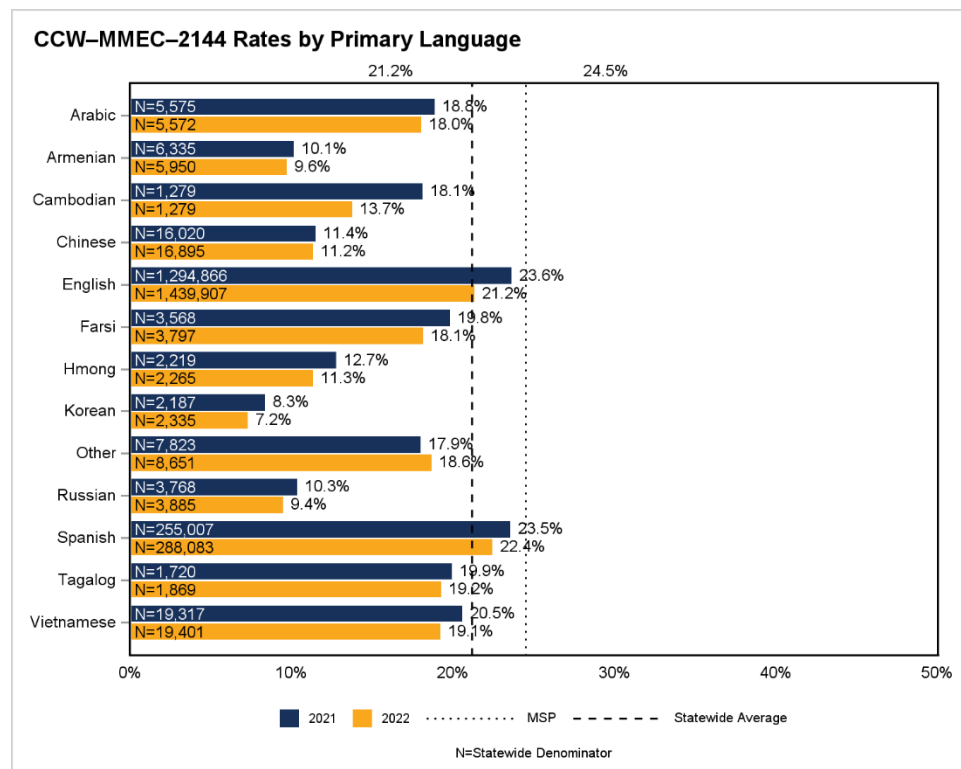
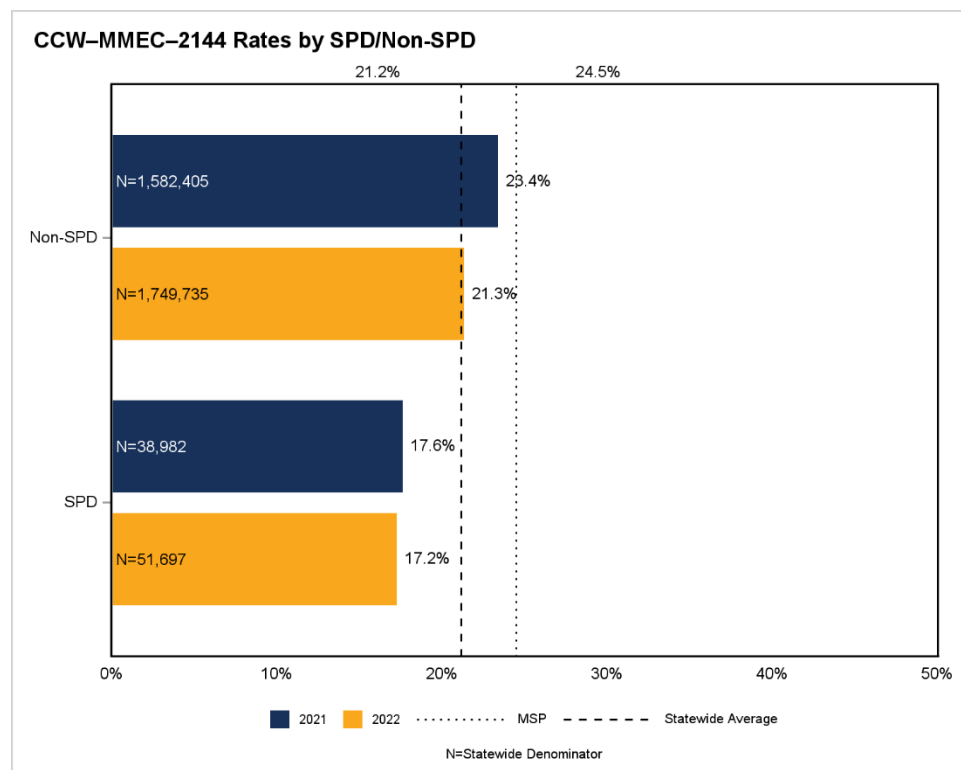


Figure C.55—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144) Rates by SPD/Non-SPD

Note: The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 24.5 percent.

The statewide aggregate for measurement year 2021 was 23.2 percent.



Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years (CCP–MMEC60–1520)

The *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15–20 Years (CCP–MMEC60–1520)* indicator measures the percentage of women 15 to 20 years of age who had a live birth who were provided a most effective or moderately effective method of contraception within 60 days of delivery.

Figure C.56—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15 to 20 Years (CCP-MMEC60-1520) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 39.2 percent (N=171) and 36.1 percent (N=194), respectively

The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 43.9 percent.

The statewide aggregate for measurement year 2021 was 35.9 percent.

S indicates fewer than 11 cases exist in the numerator for the racial/ethnic group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

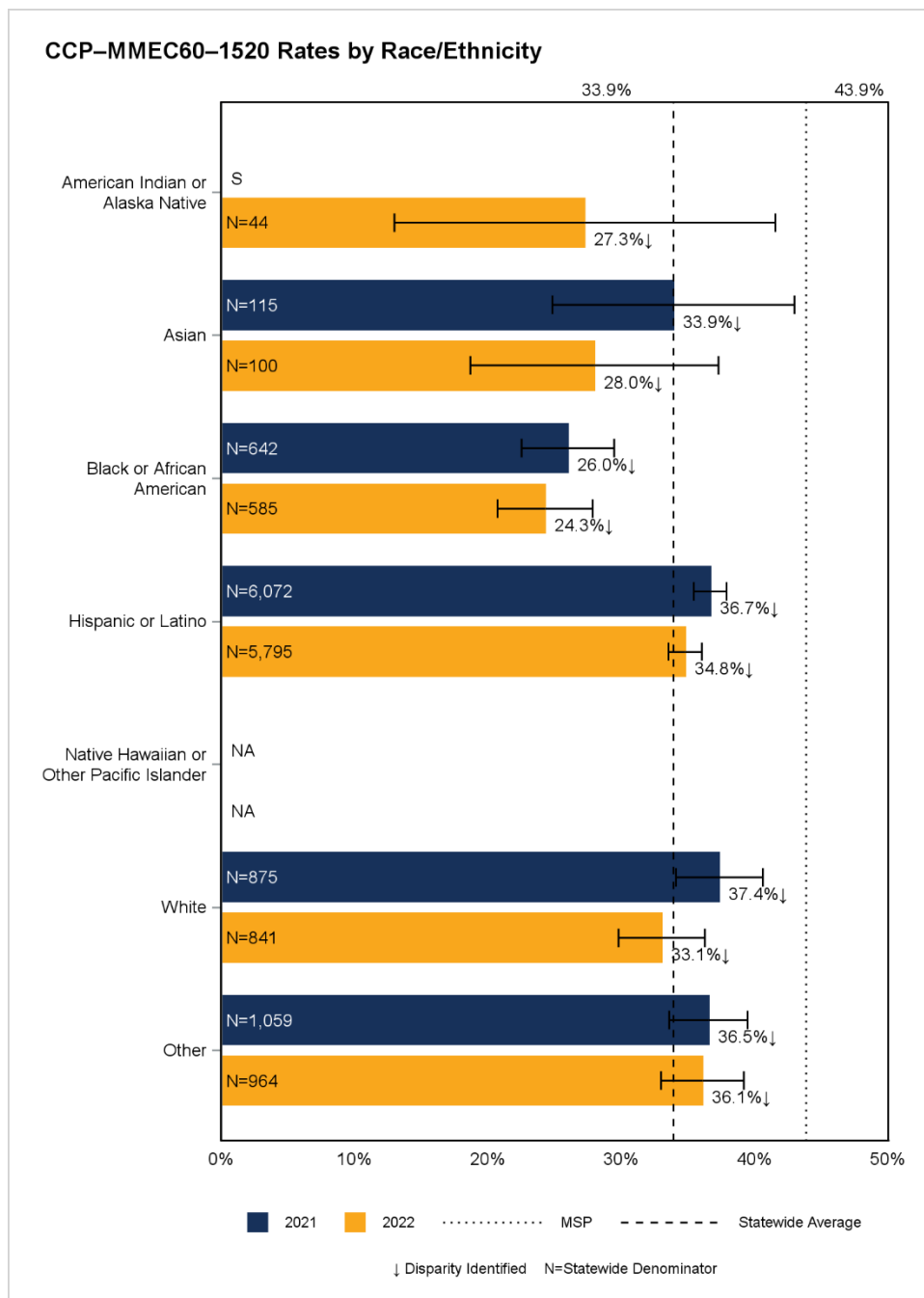


Figure C.57—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15 to 20 Years (CCP–MMEC60–1520) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 43.9 percent.

The statewide aggregate for measurement year 2021 was 35.9 percent.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

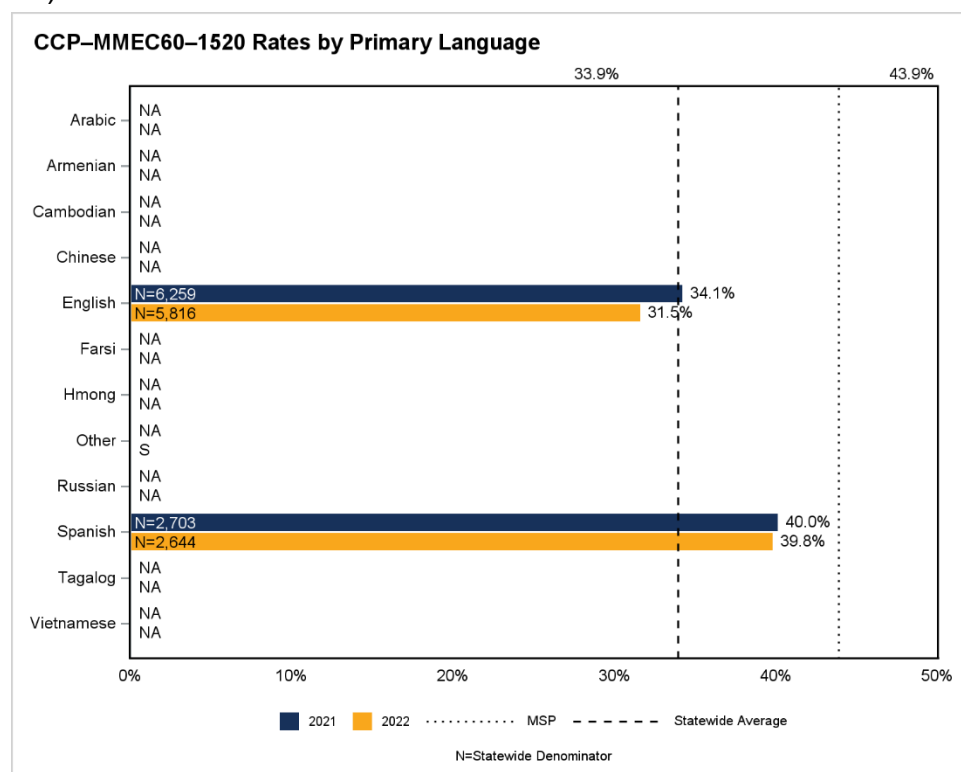
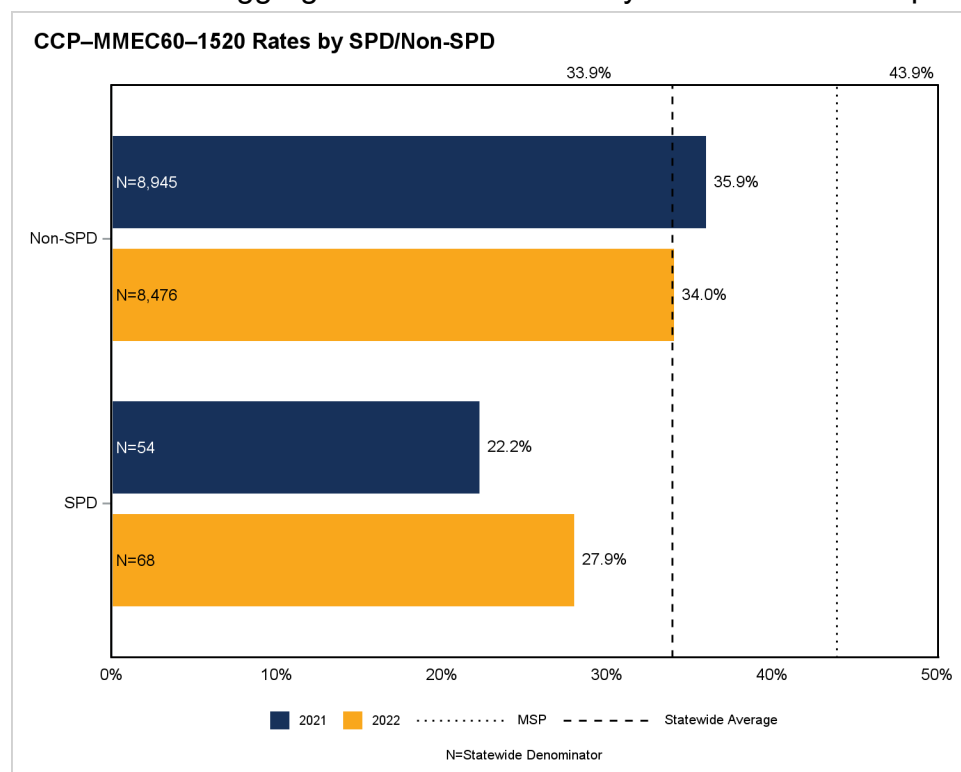


Figure C.58—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 15 to 20 Years (CCP–MMEC60–1520) Rates by SPD/Non-SPD

Note: The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 43.9 percent.

The statewide aggregate for measurement year 2021 was 35.9 percent.



Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144)

The *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144)* indicator measures the percentage of women 21 to 44 years of age who had a live birth who were provided a most effective or moderately effective method of contraception within 60 days of delivery.

Figure C.59—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 33.9 percent (N=2,944) and 32.0 percent (N=3,424), respectively.

The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 41.6 percent.

The statewide aggregate for measurement year 2021 was 35.2 percent.

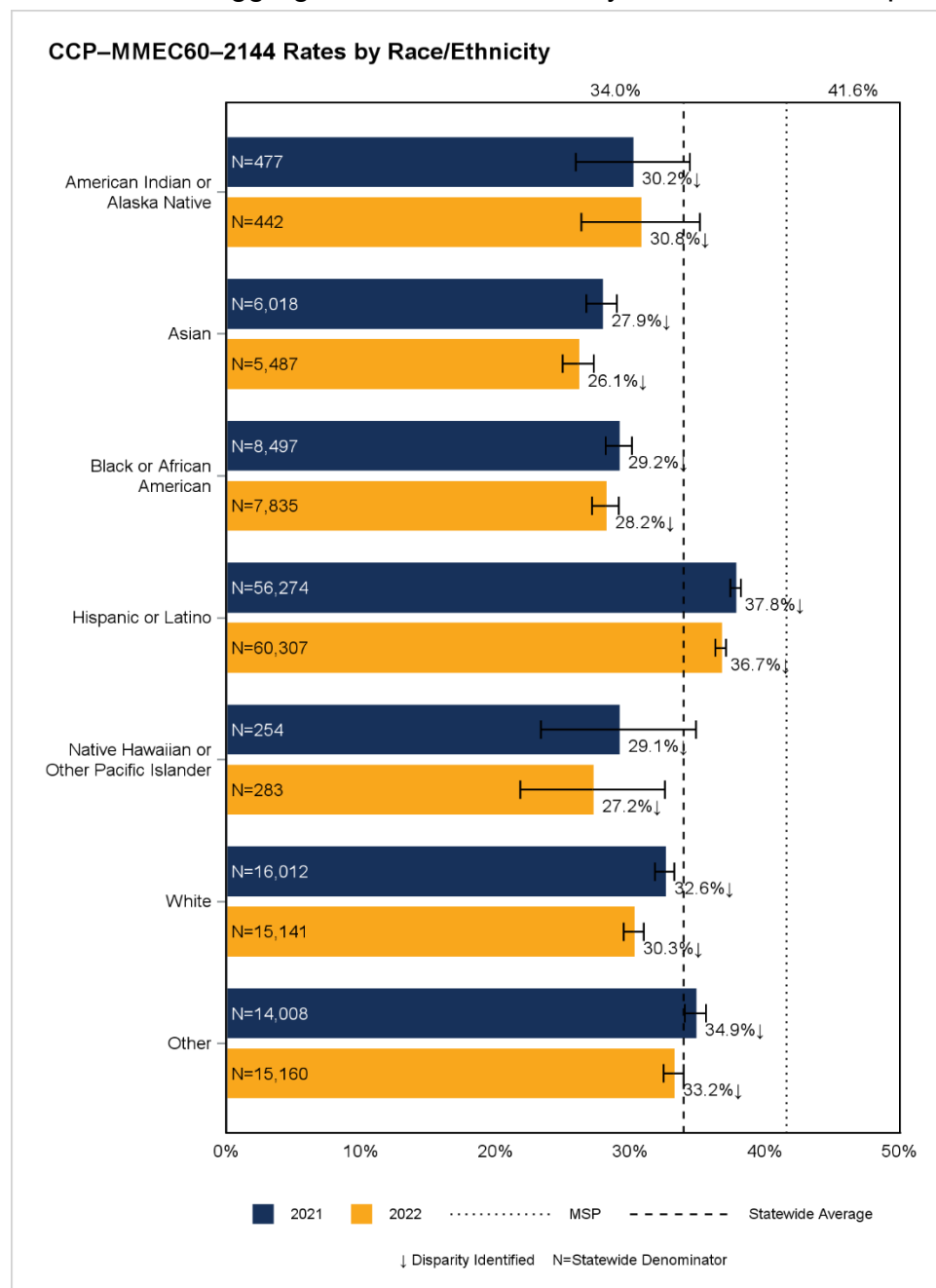


Figure C.60—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 41.6 percent.

The statewide aggregate for measurement year 2021 was 35.2.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

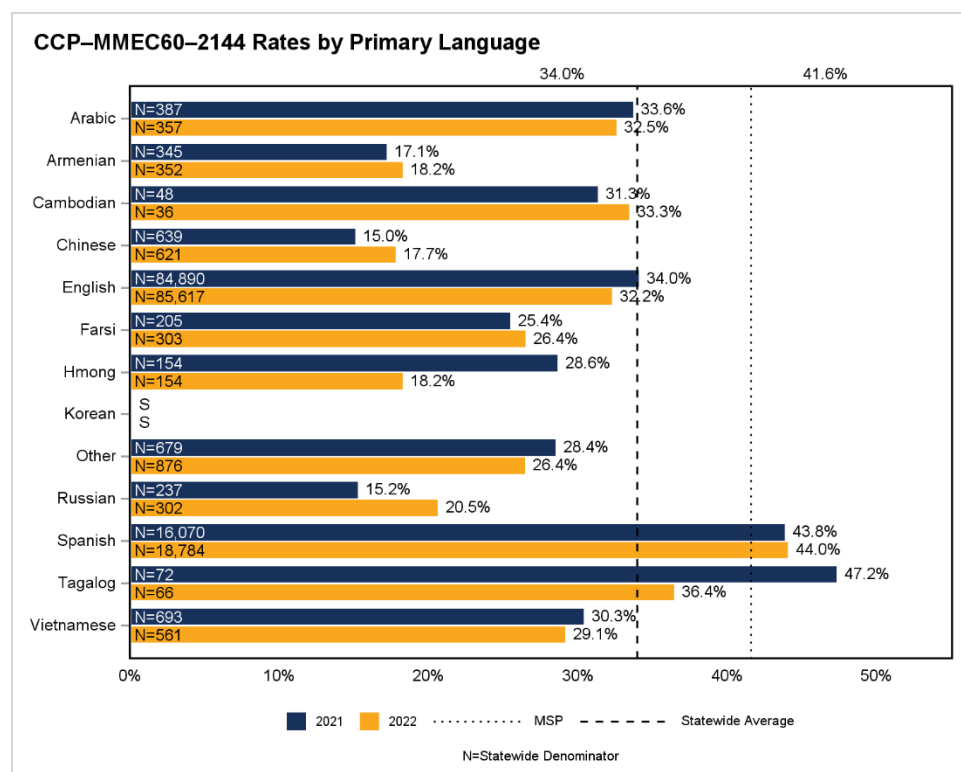
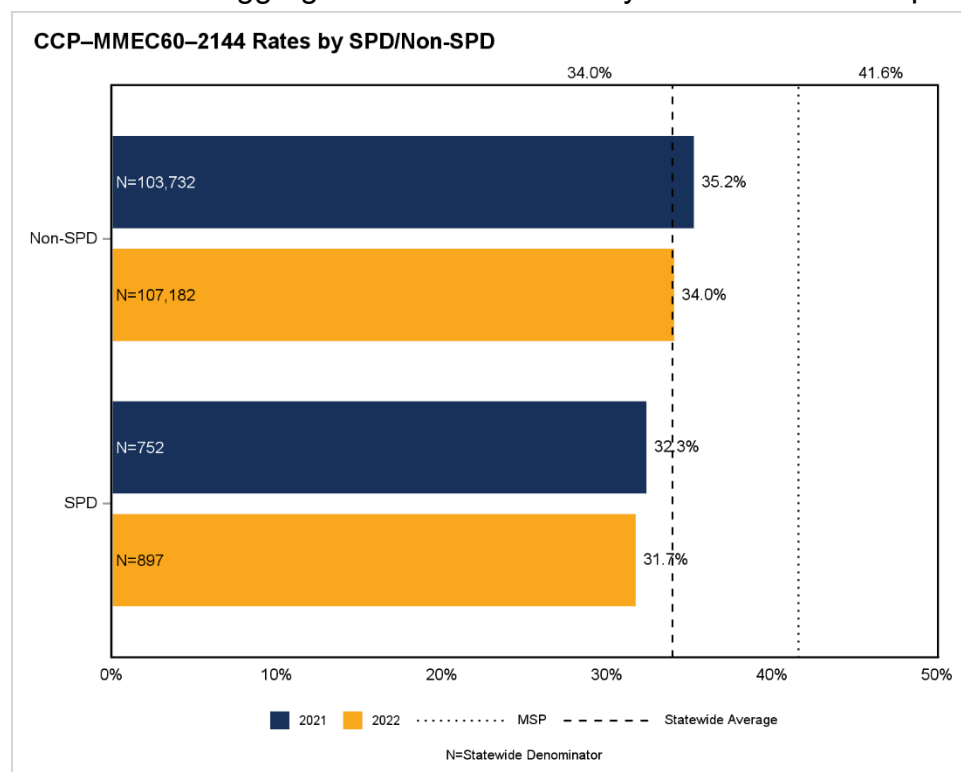


Figure C.61—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144) Rates by SPD/Non-SPD

Note: The median state performance rate represents the 50th percentile. The median state performance rate for measurement year 2021 was 41.6 percent.

The statewide aggregate for measurement year 2021 was 35.2 percent.



Postpartum Depression Screening and Follow-Up—Depression Screening (PDS–E–DS)

The *Postpartum Depression Screening and Follow-Up—Depression Screening (PDS–E–DS)* indicator measures the percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.

Figure C.62—Postpartum Depression Screening and Follow-Up—Depression Screening (PDS–E–DS) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 6.5 percent (N=4,459).

The measurement year 2022 denominator size for American Indian or Alaska Native racial/ethnic group was 594.

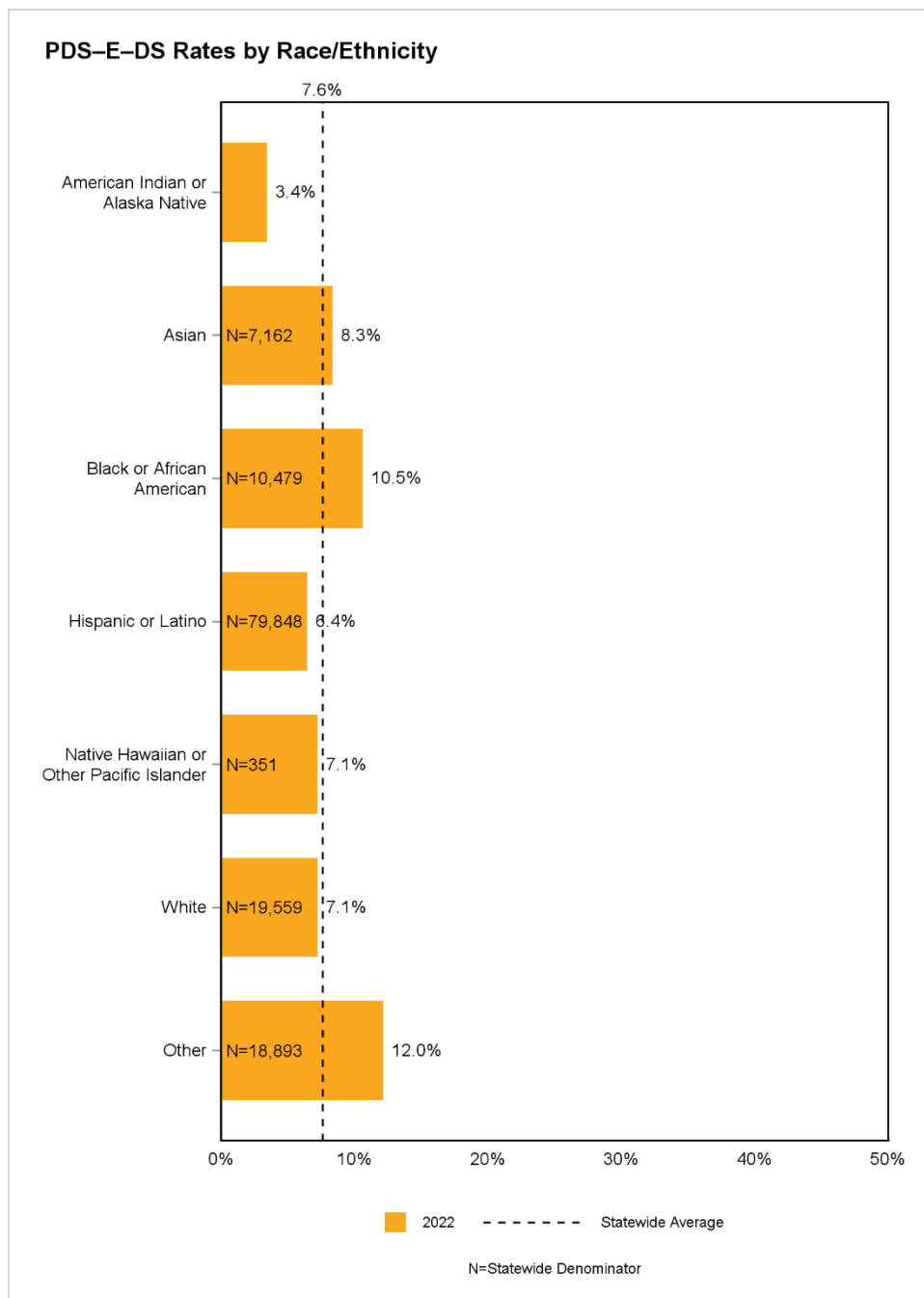


Figure C.63—Postpartum Depression Screening and Follow-Up—Depression Screening (PDS–E–DS) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.

The measurement year 2022 denominator size for the Vietnamese primary language group was 805.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

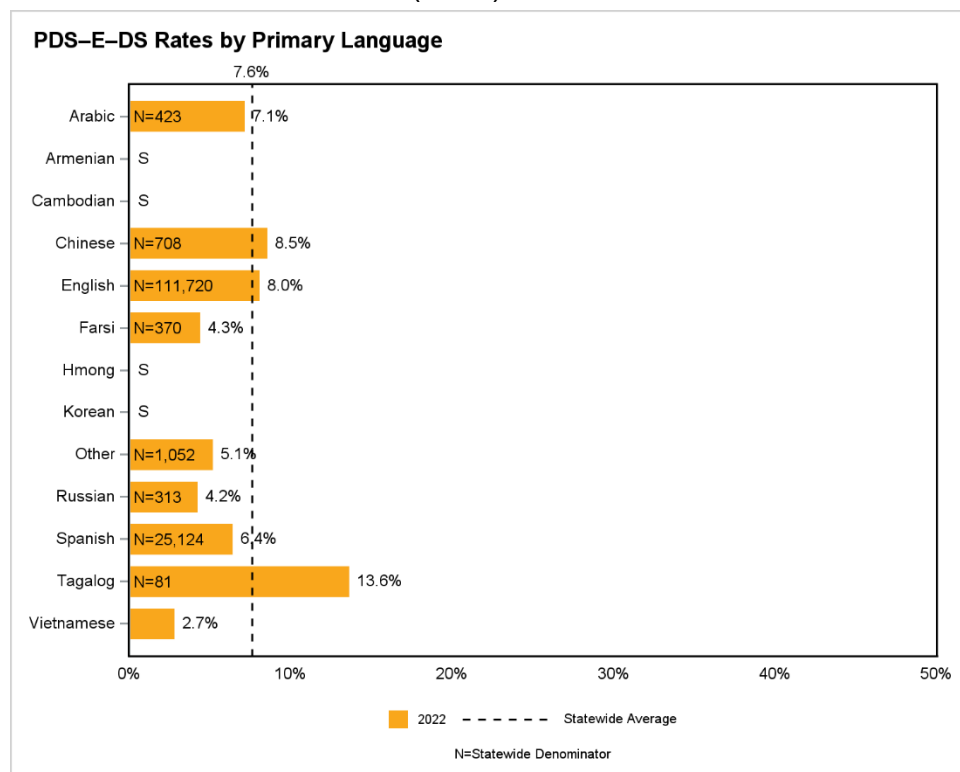


Figure C.64—Postpartum Depression Screening and Follow-Up—Depression Screening (PDS–E–DS) Rates by Age

Note: The measurement year 2022 denominator size for the 18–20 Years age group was 8,314.

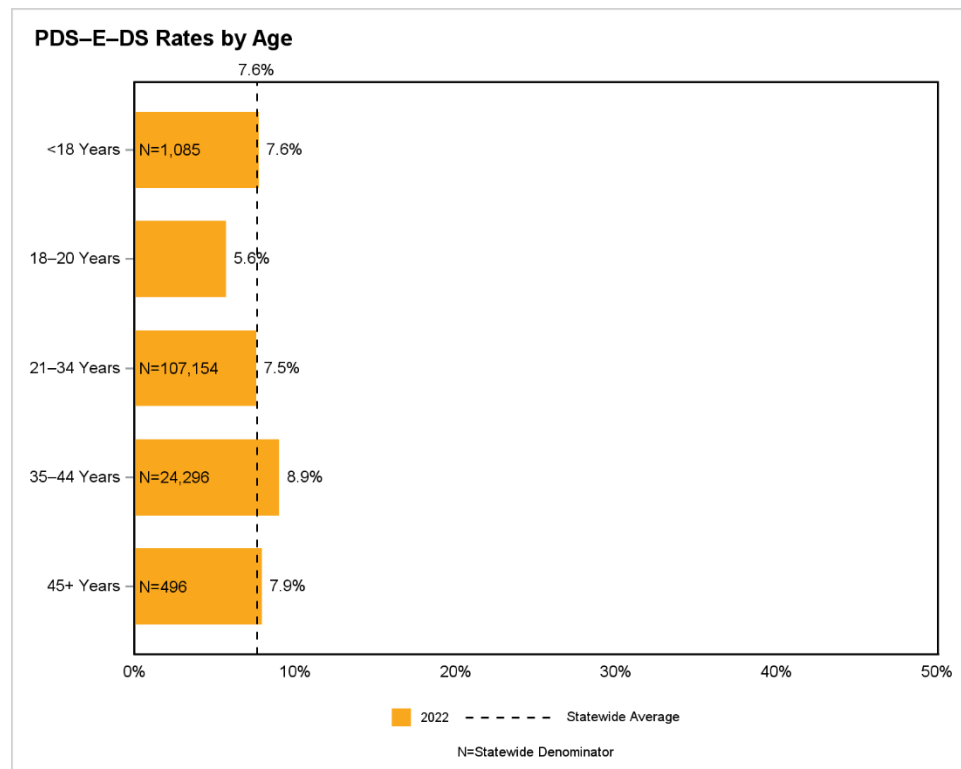
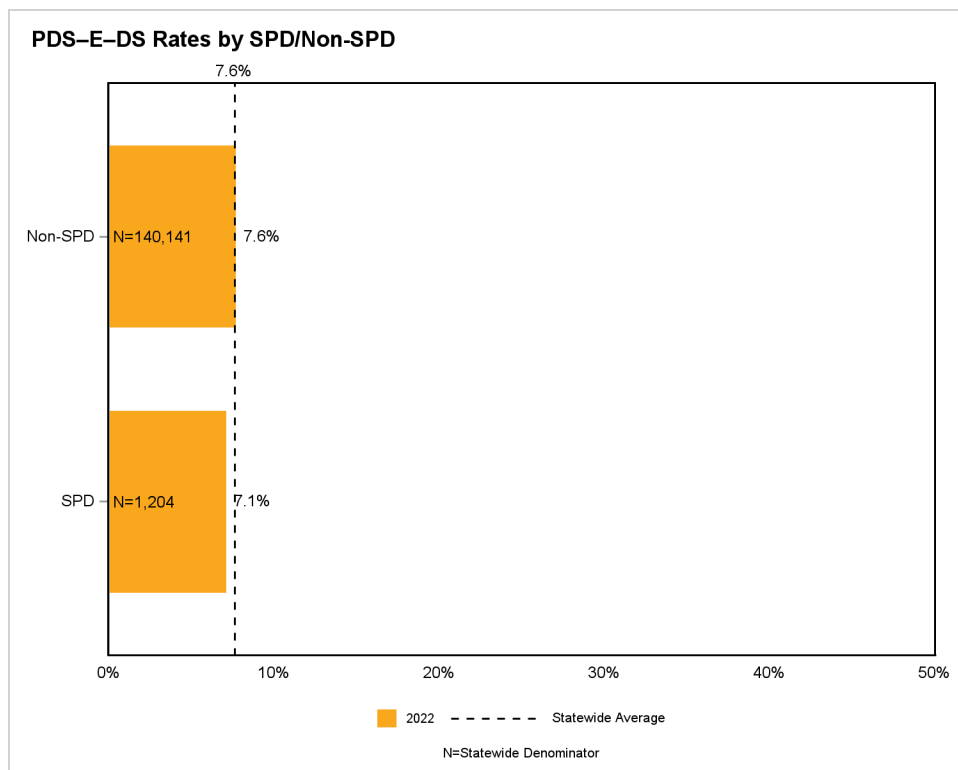


Figure C.65—Postpartum Depression and Screening and Follow-Up—Depression Screening (PDS–E–DS) Rates by SPD/Non-SPD



Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen (PDS–E–FU)

The *Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen (PDS–E–FU)* indicator measures the percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Figure C.66—Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen (PDS–E–FU) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 87.2 percent (N=39).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

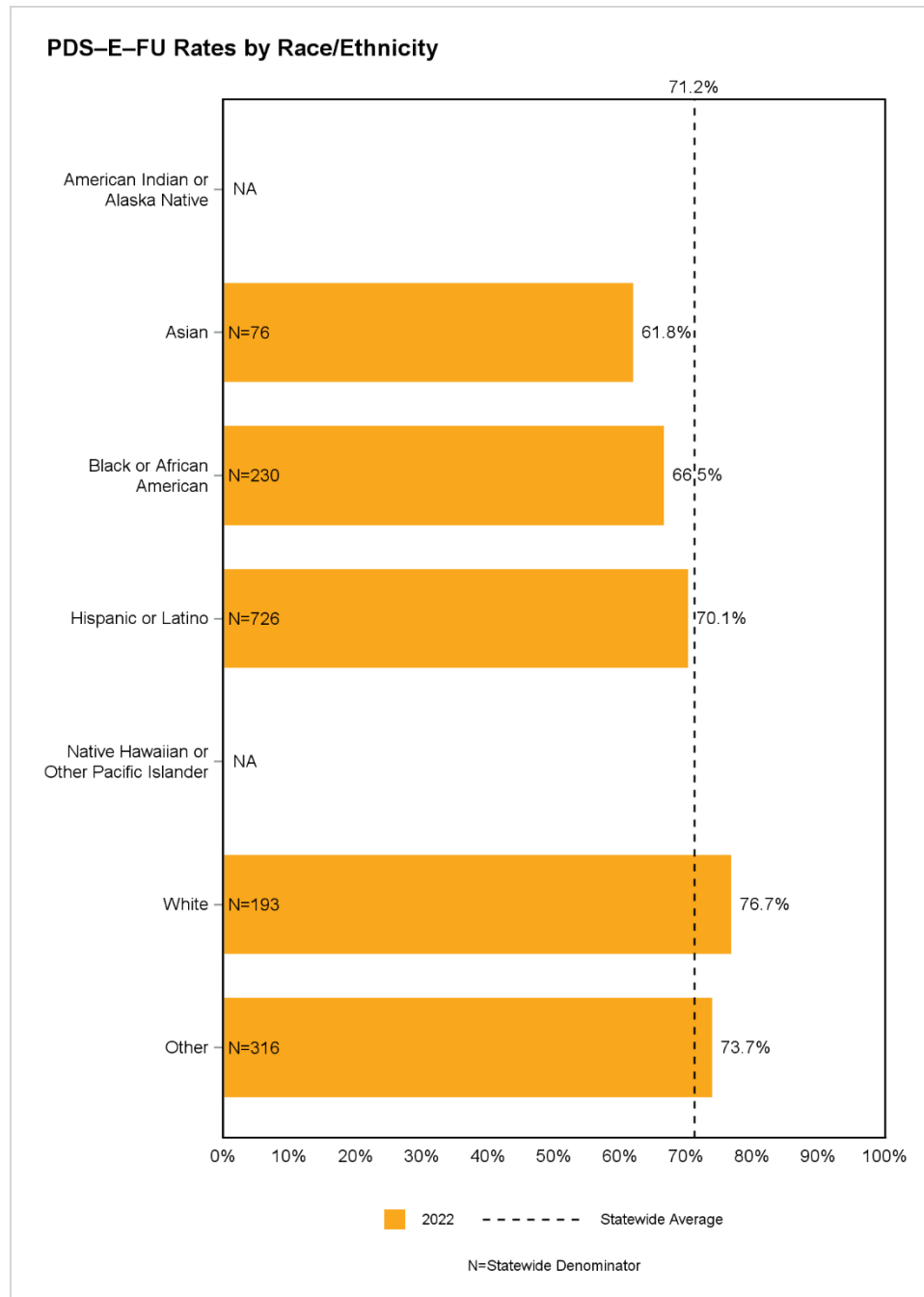


Figure C.67—Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen (PDS–E–FU) Rates by Primary Language

Note: NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

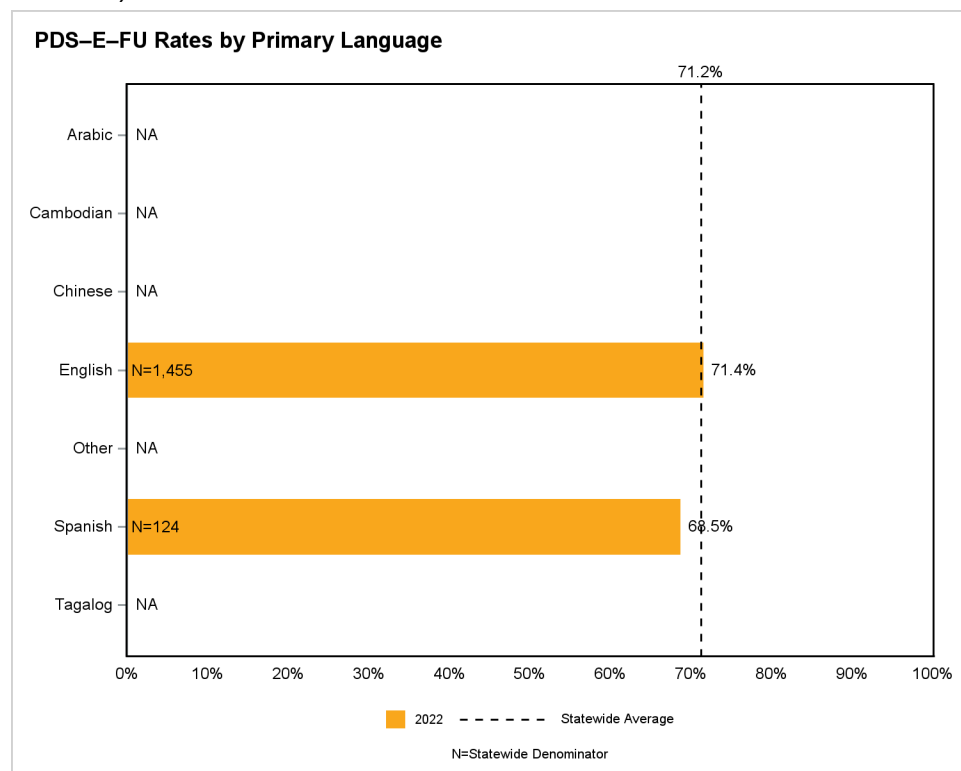


Figure C.68—Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen (PDS–E–FU) Rates by Age

Note: NA indicates the rate for the age group had a small denominator (i.e., less than 30).

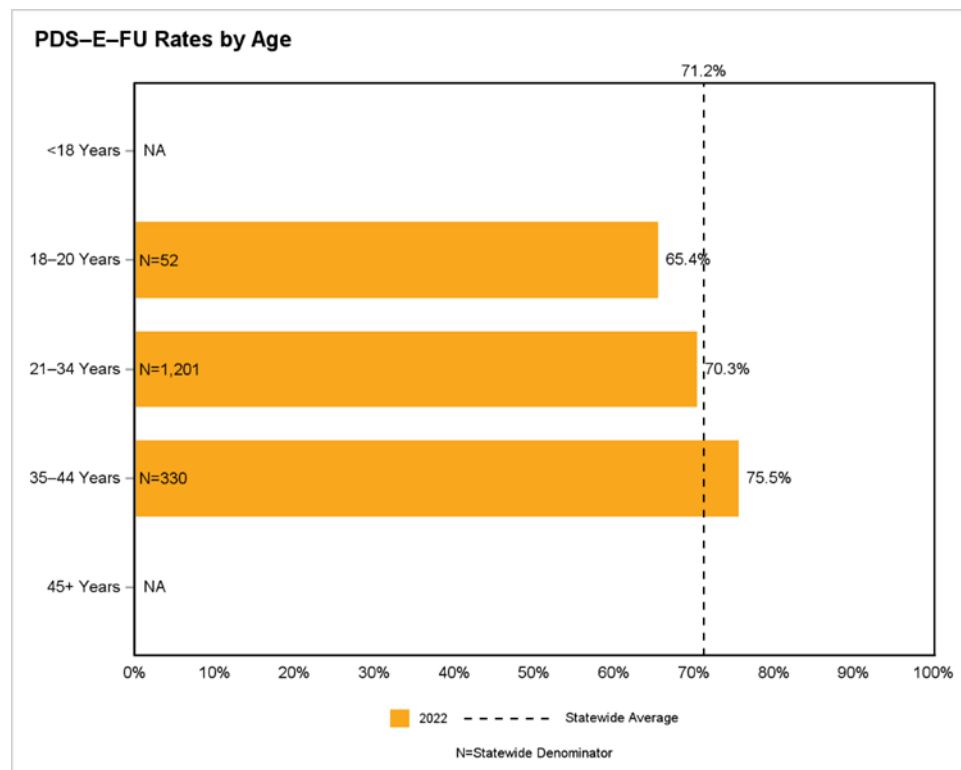
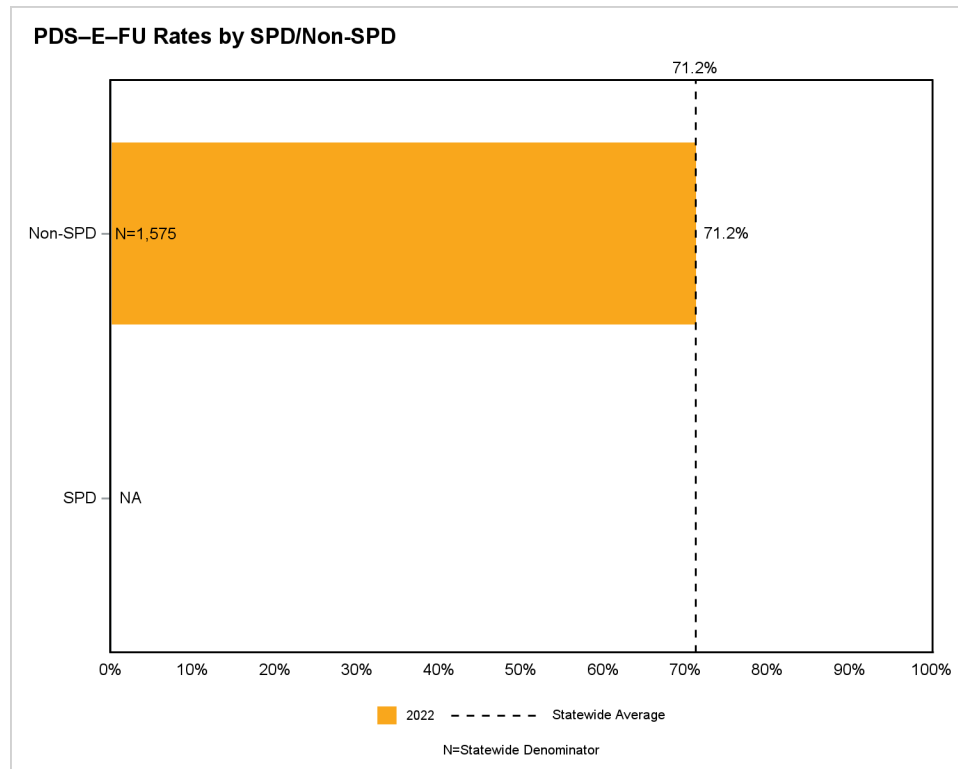


Figure C.69—Postpartum Depression Screening and Follow-Up—Follow-Up on Positive Screen (PDS–E–FU) Rates by SPD/Non-SPD

Note: NA indicates the rate for the SPD/Non-SPD group had a small denominator (i.e., less than 30).



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 7 and 84 days after delivery.

Figure C.70—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 83.6 percent (N=409) and 81.9 percent (N=419), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.4 percent and 83.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 80.8 percent.

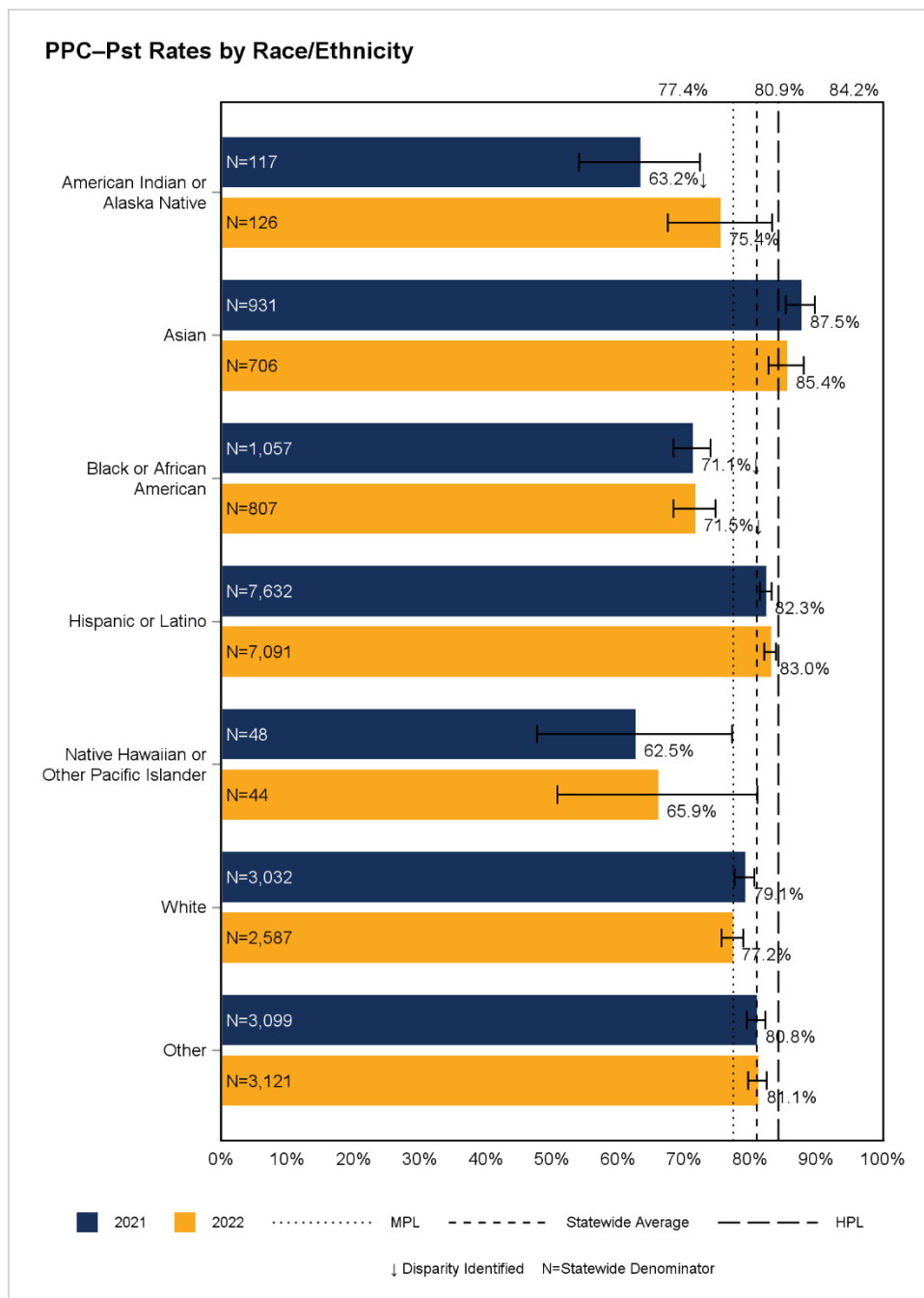


Figure C.71—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.4 percent and 83.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 80.8 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

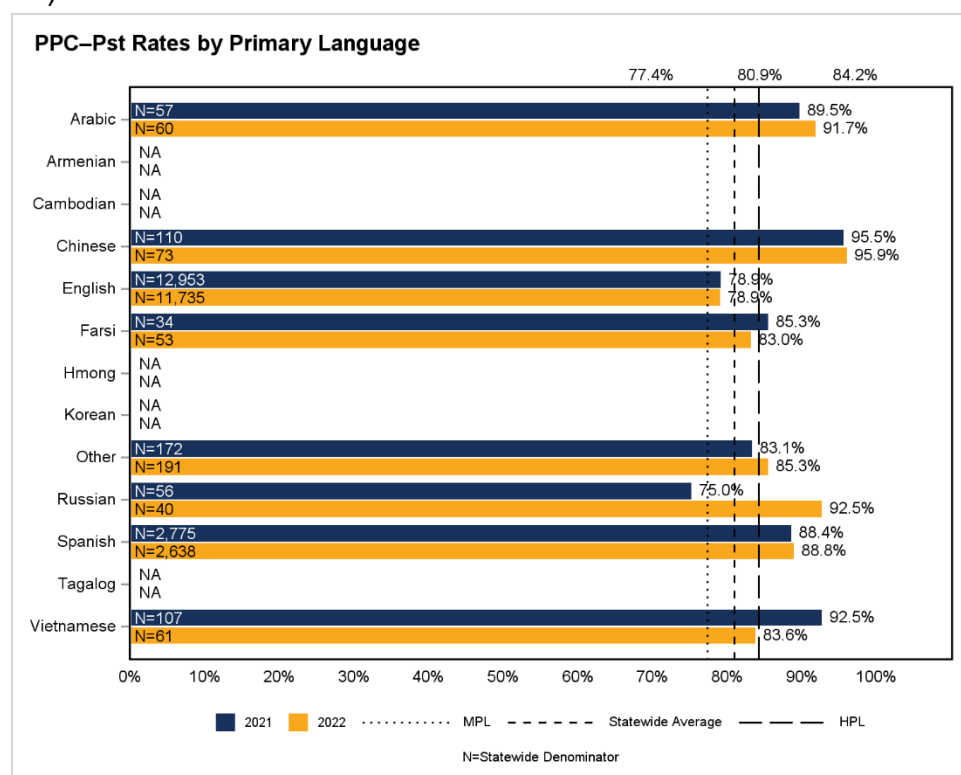


Figure C.72—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.4 percent and 83.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 80.8 percent.

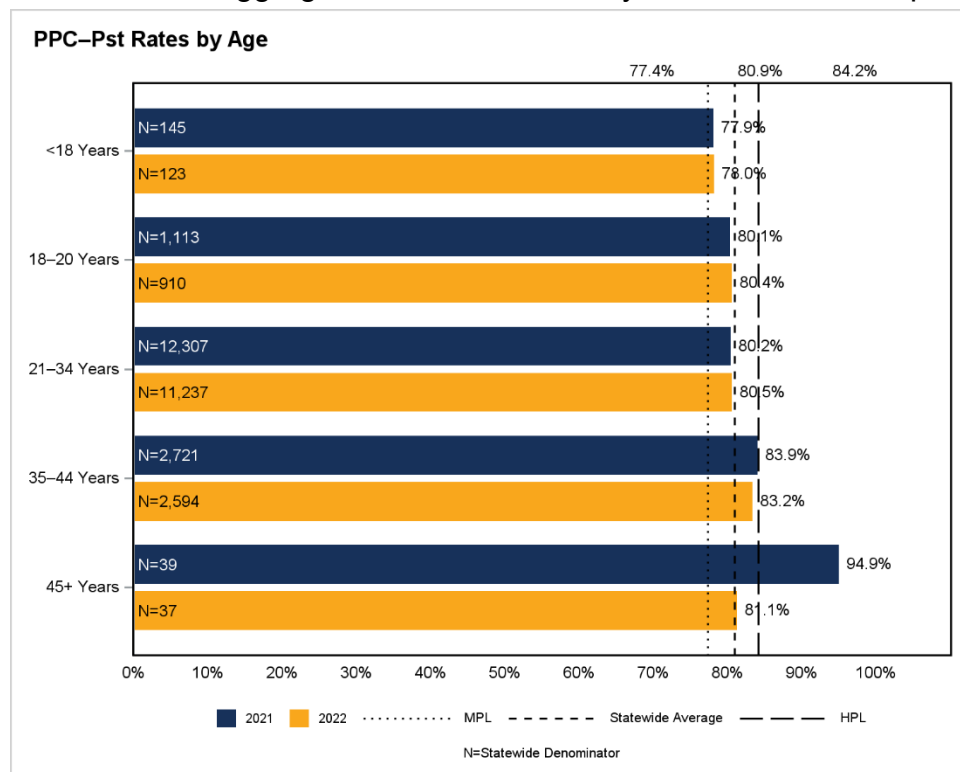
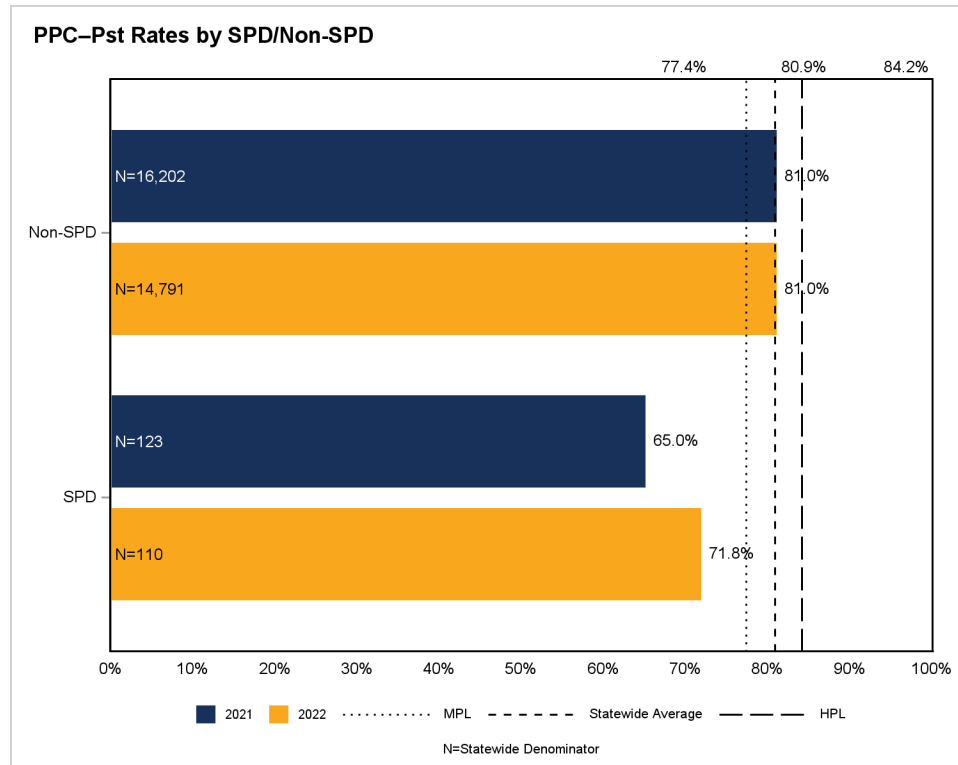


Figure C.73—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.4 percent and 83.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 80.8 percent.



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 C.74—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 89.5 percent (N=409) and 88.5 percent (N=419), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 85.9 percent and 92.2 percent, respectively.

The statewide aggregate for measurement year 2021 was 87.1 percent.

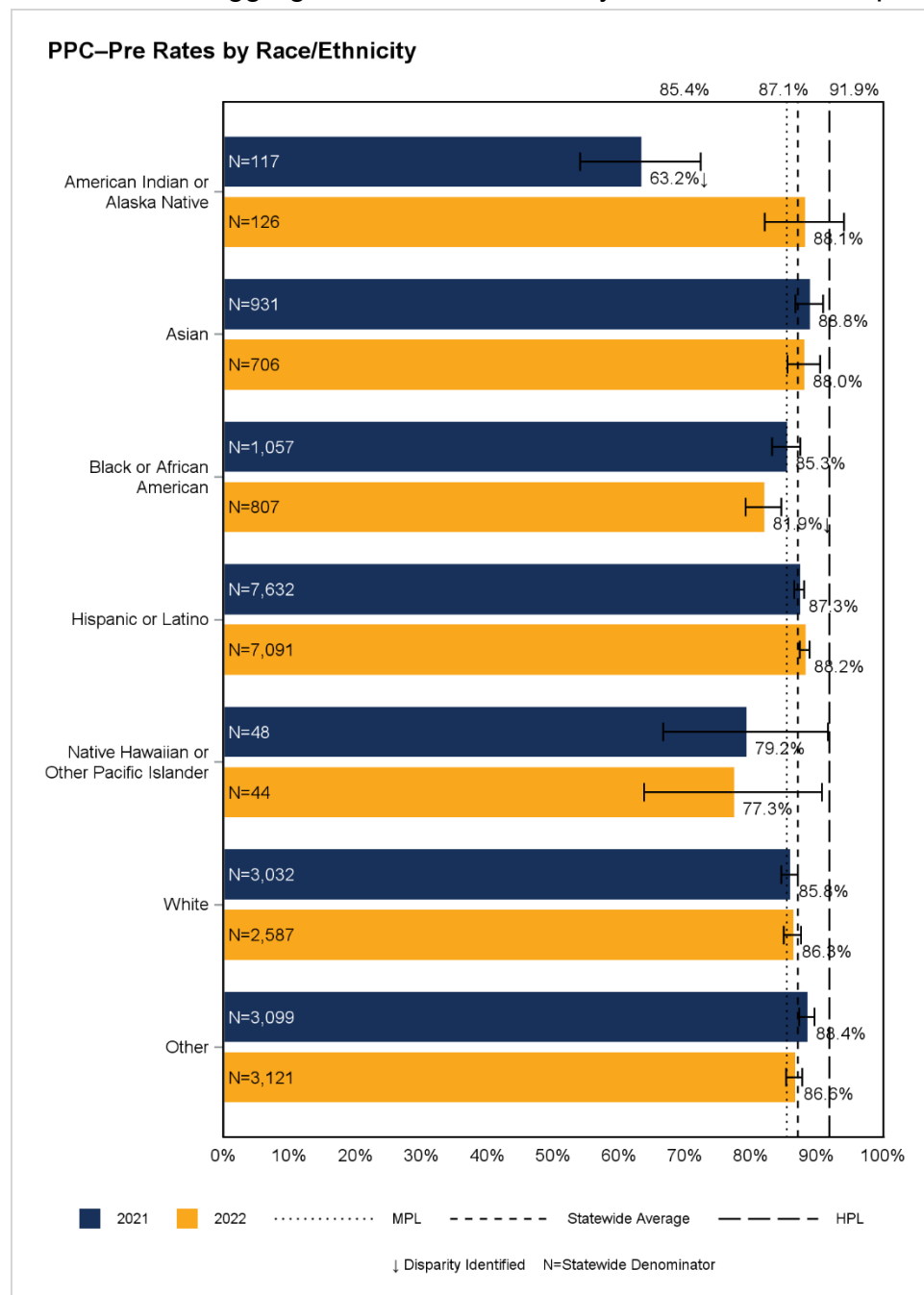


Figure C.75—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 85.9 percent and 92.2 percent, respectively.

The statewide aggregate for measurement year 2021 was 87.1 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

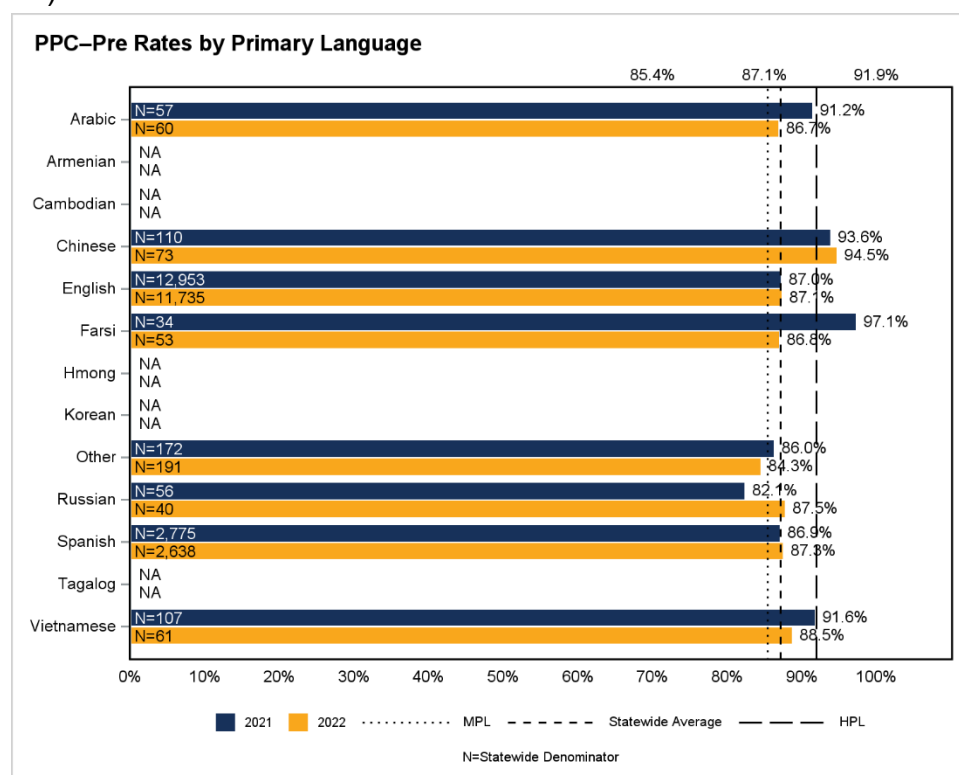


Figure C.76—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Age

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 85.9 percent and 92.2 percent, respectively.

The statewide aggregate for measurement year 2021 was 87.1 percent.

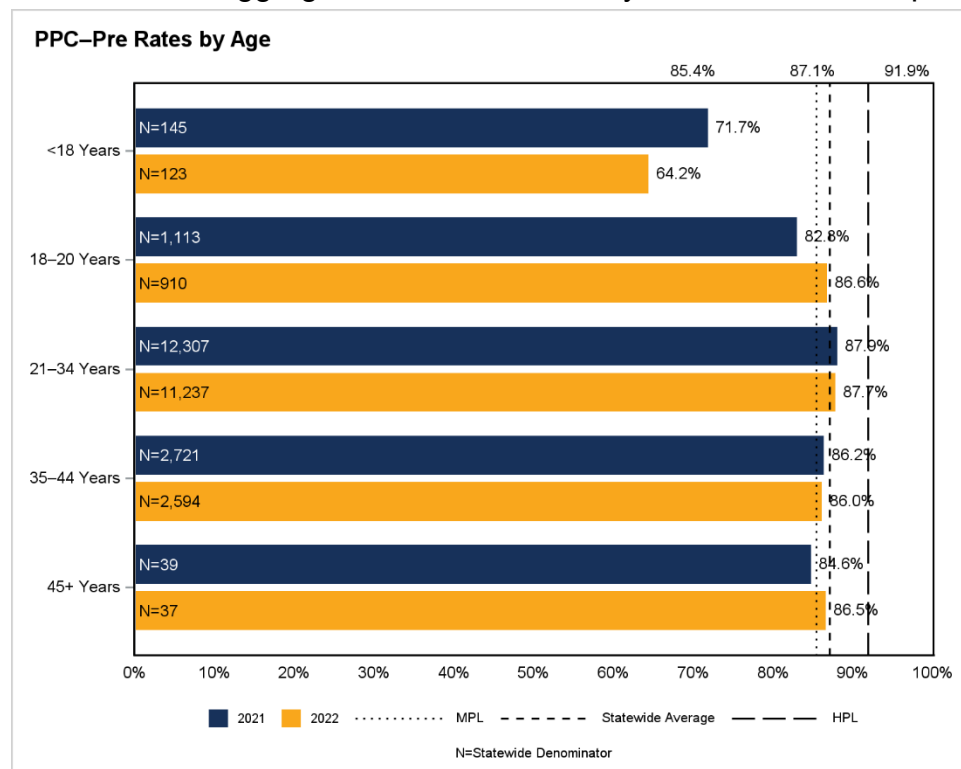
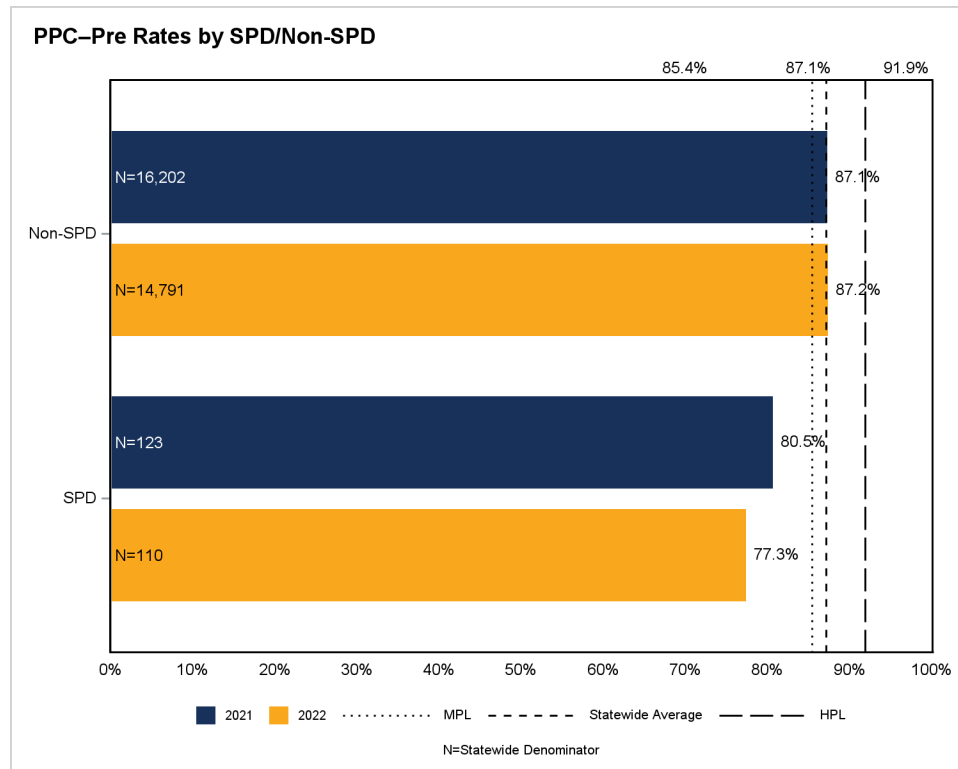


Figure C.77—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.



Prenatal Depression Screening and Follow-Up—Depression Screening (PND–E–DS)

The *Prenatal Depression Screening and Follow-Up—Depression Screening (PDS–E–DS)* indicator measures the percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.

Figure C.78—Prenatal Depression Screening and Follow-Up—Depression Screening (PND–E–DS) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 8.2 percent (N=3,505).

The measurement year 2022 denominator size for the American Indian or Alaska Native racial/ethnic group was 469.

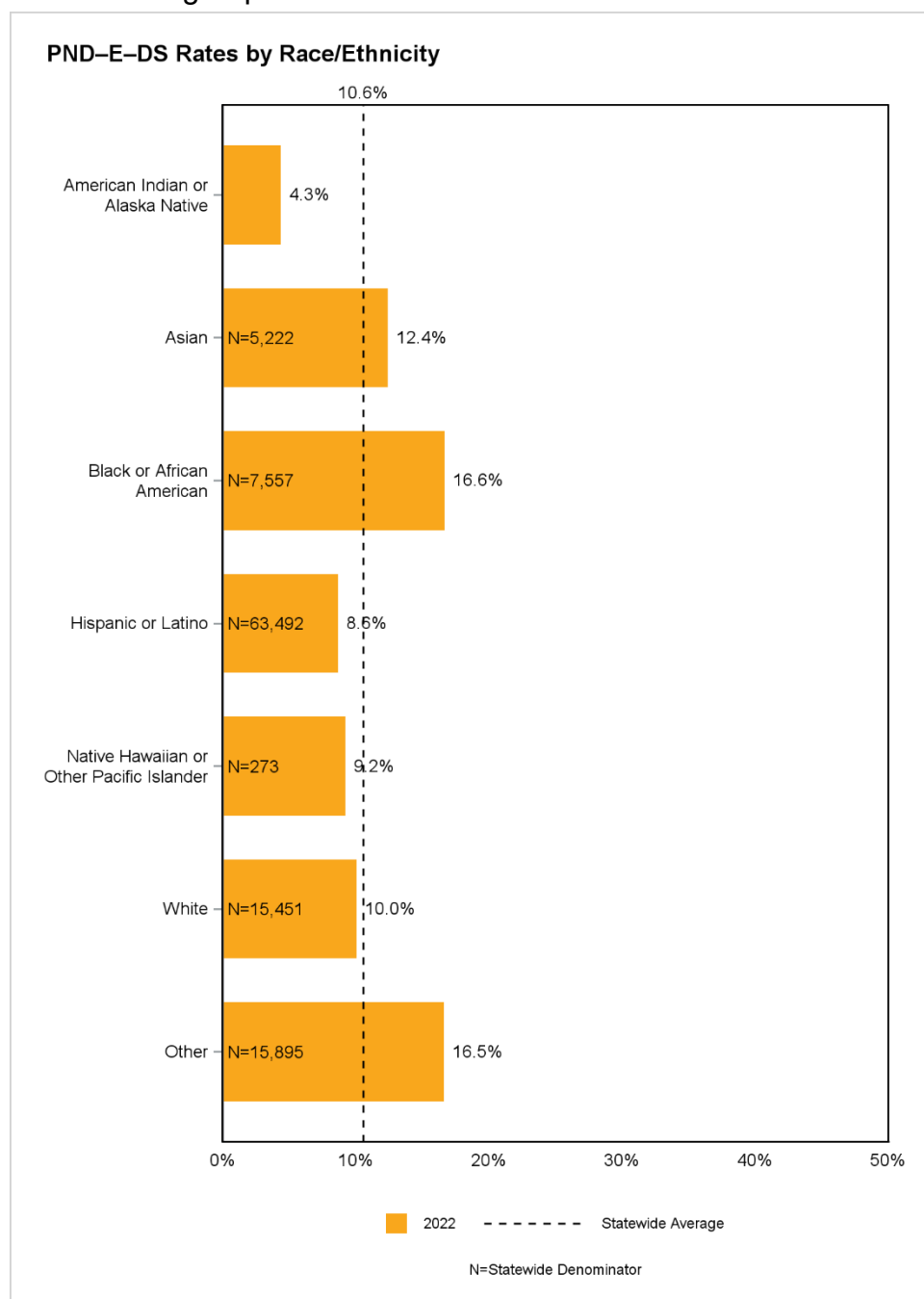


Figure C.79—Prenatal Depression Screening and Follow-Up—Depression Screening (PND–E–DS) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group were suppressed due to small denominators.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

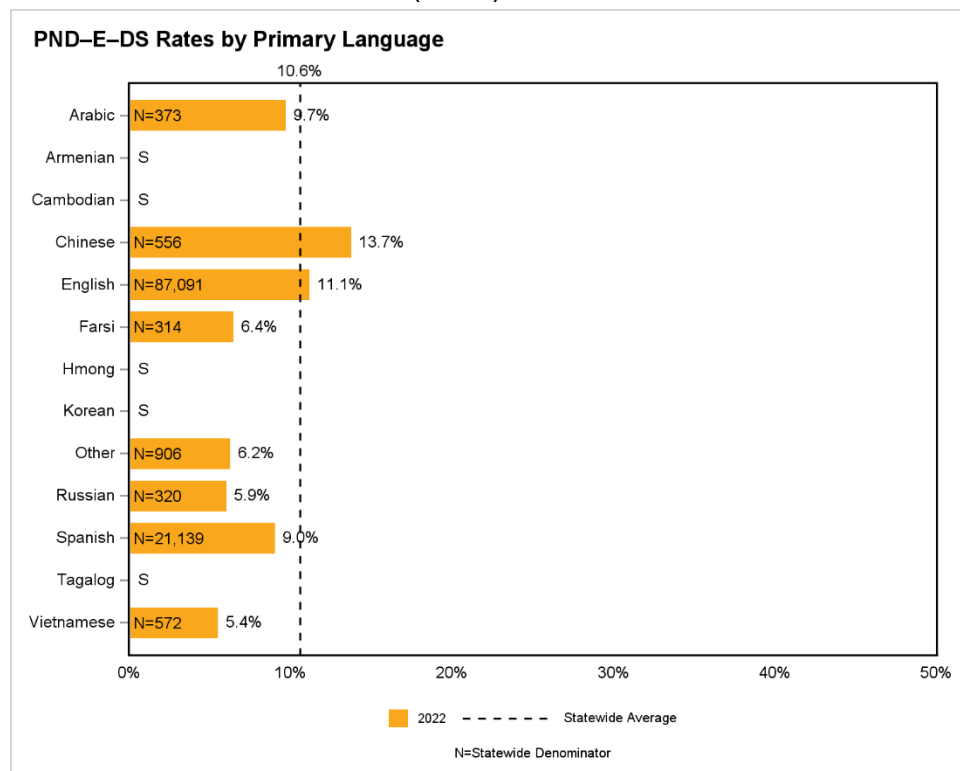


Figure C.80—Prenatal Depression Screening and Follow-Up—Depression Screening (PND–E–DS) Rates by Age

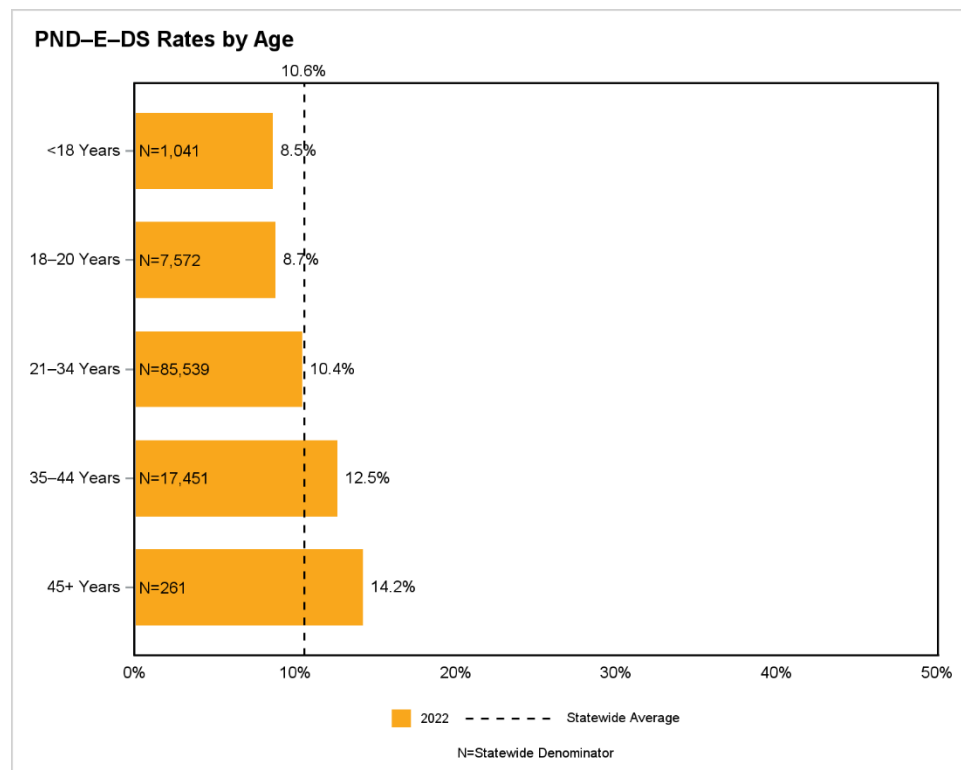
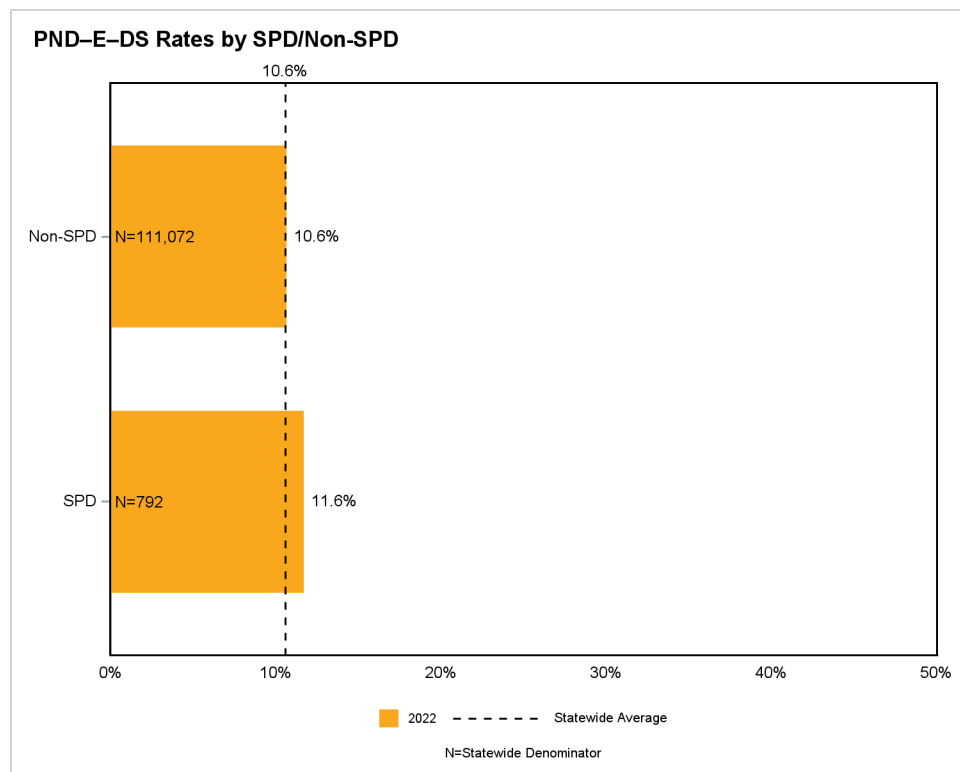


Figure C.81—Prenatal Depression Screening and Follow-Up—Depression Screening (PND-E-DS) Rates by SPD/Non-SPD



Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen (PND-E-FU)

The *Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen (PND-E-FU)* indicator measures the percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Figure C.82—Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen (PND–E–FU) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 52.3 percent (N=44).

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

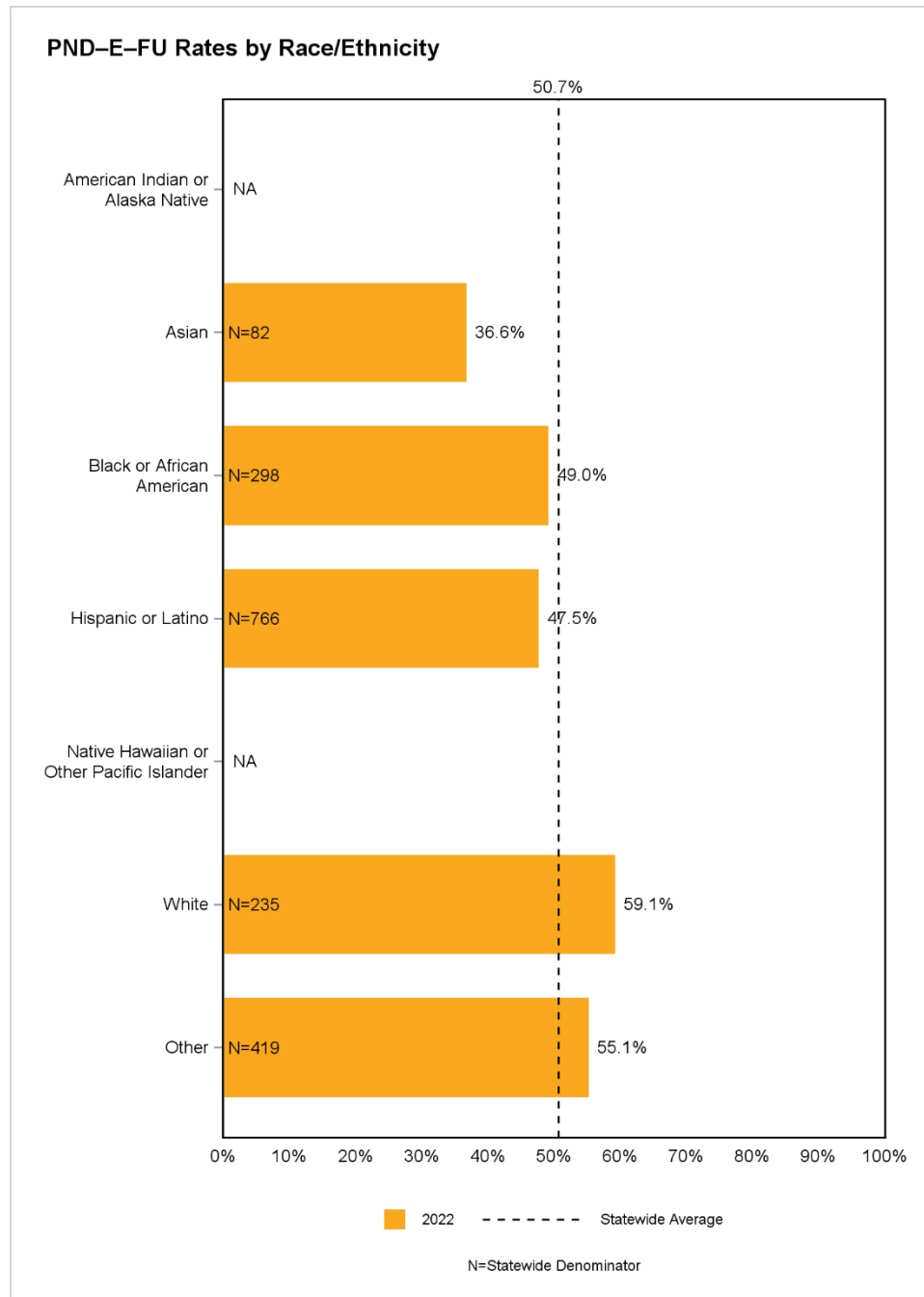


Figure C.83—Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen (PND–E–FU) Rates by Primary Language

Note: NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

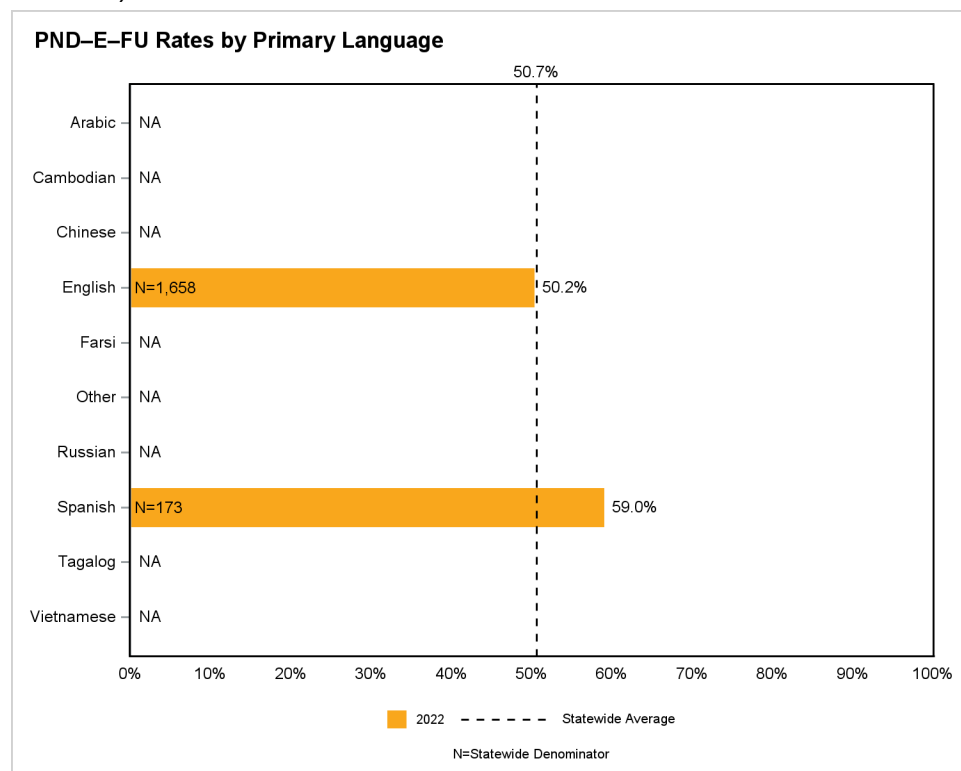


Figure C.84—Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen (PND–E–FU) Rates by Age

Note: NA indicates the rate for the age group had a small denominator (i.e., less than 30).

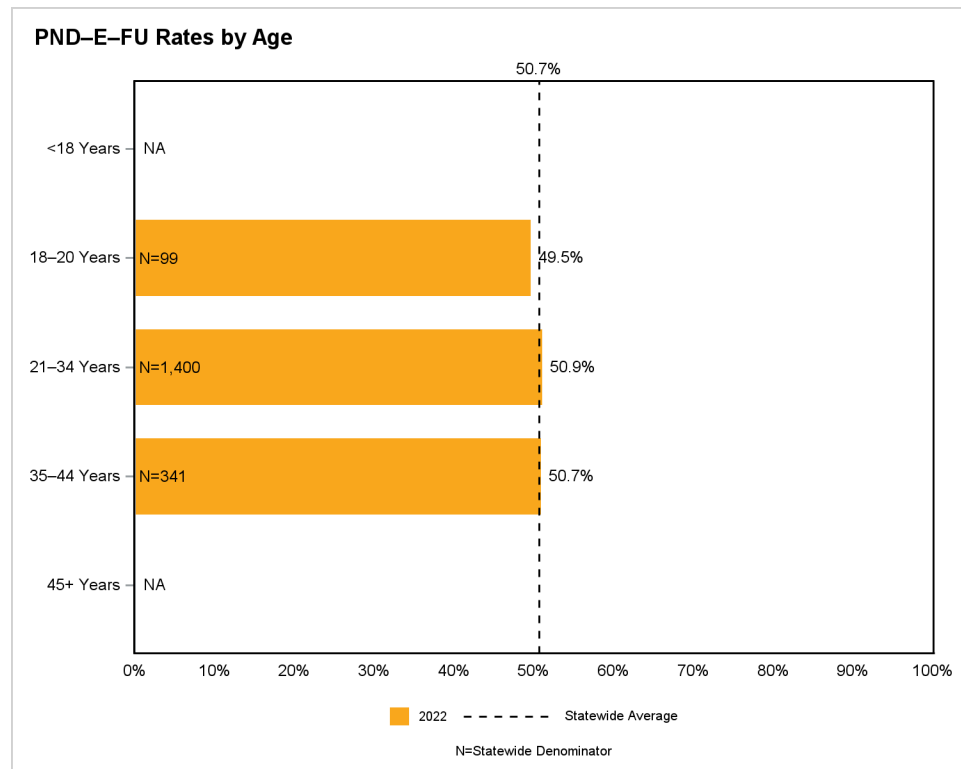
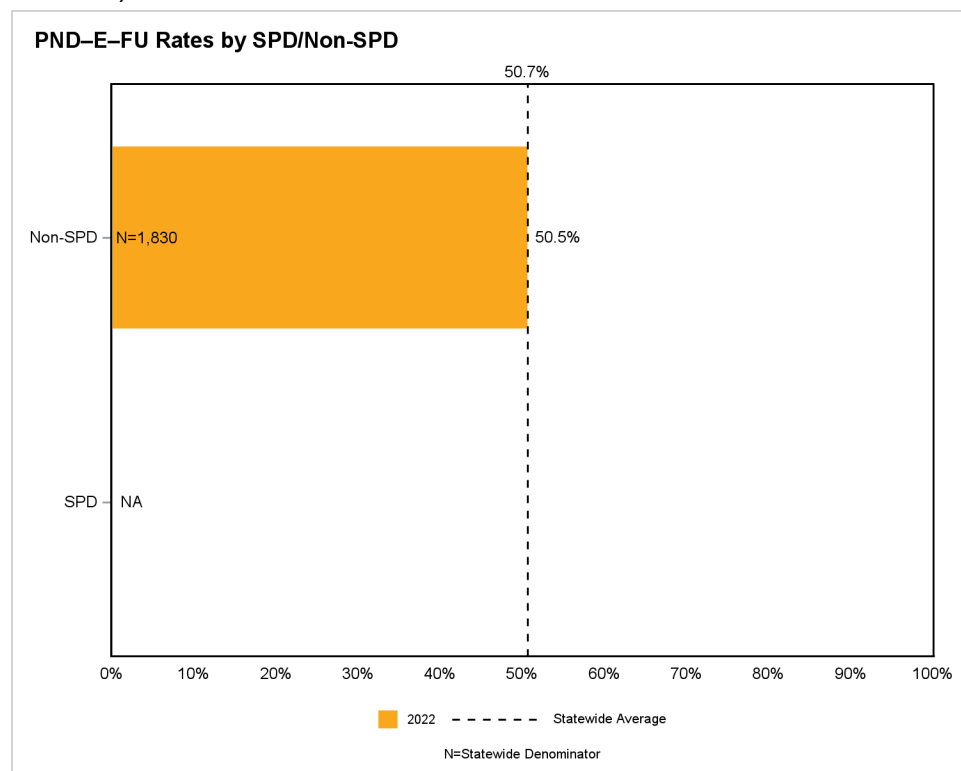


Figure C.85—Prenatal Depression Screening and Follow-Up—Follow-Up on Positive Screen (PND–E–FU) Rates by SPD/Non-SPD

Note: NA indicates the rate for the SPD/Non-SPD group had a small denominator (i.e., less than 30).



Prenatal Immunization Status—Combination (PRS–E–Combo)

The *Prenatal Immunization Status—Combination (PRS–E–Combo)* indicator measures the percentage of deliveries in the measurement year in which women received influenza and Tdap vaccinations.

Figure C.86—Prenatal Immunization Status—Combination (PRS–E–Combo) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 25.7 percent (N=3,548).

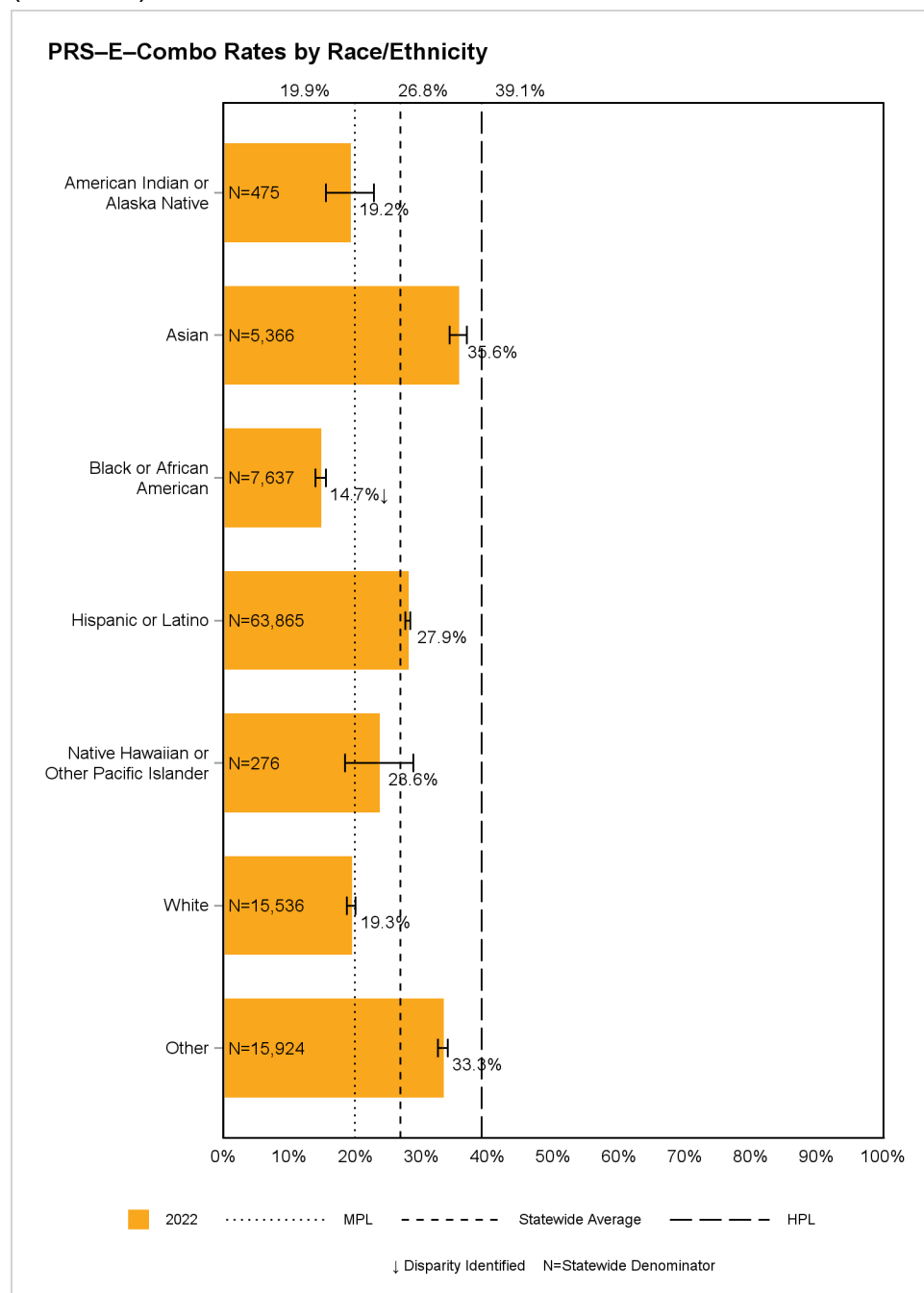


Figure C.87—Prenatal Immunization Status—Combination (PRS–E–Combo) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to small denominators.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

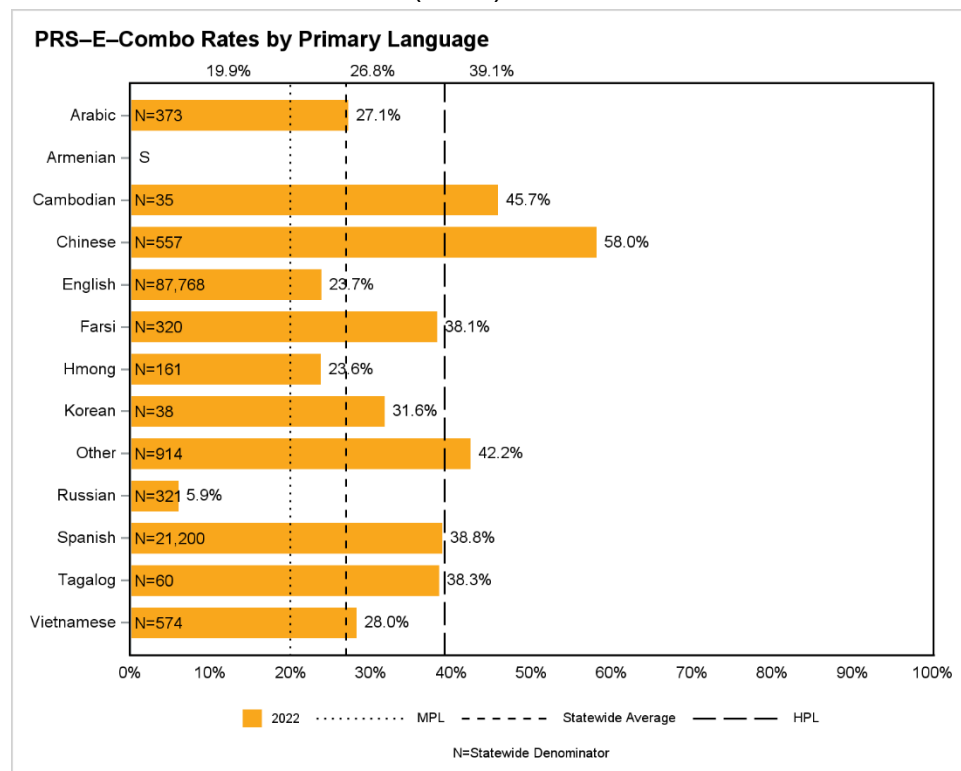


Figure C.88—Prenatal Immunization Status—Combination (PRS–E–Combo) Rates by Age

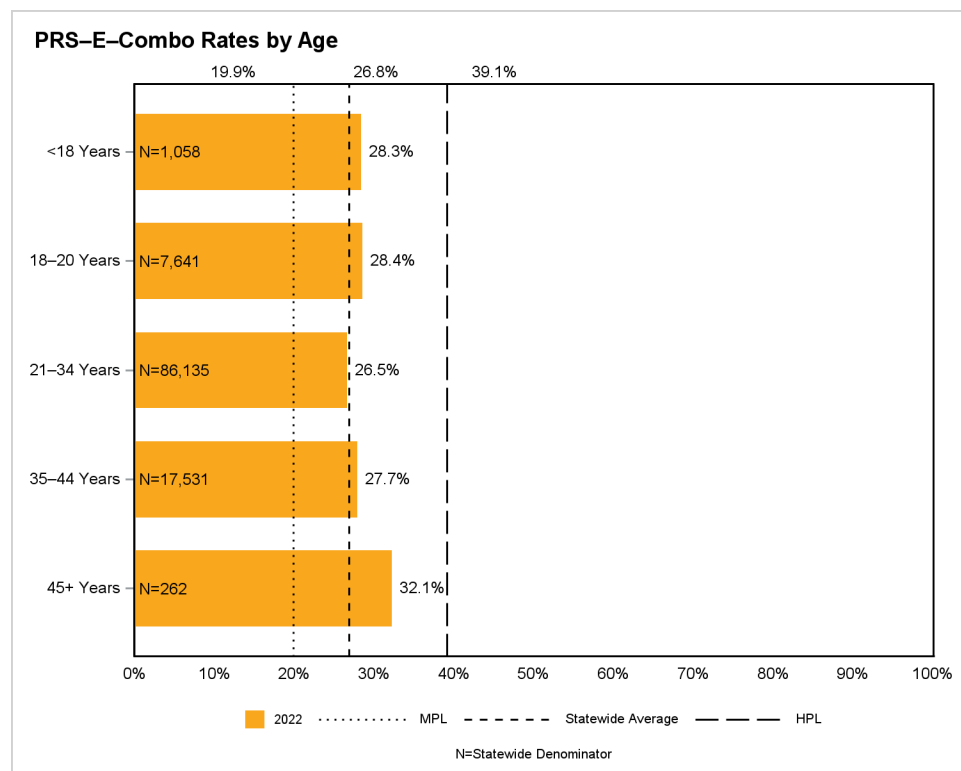
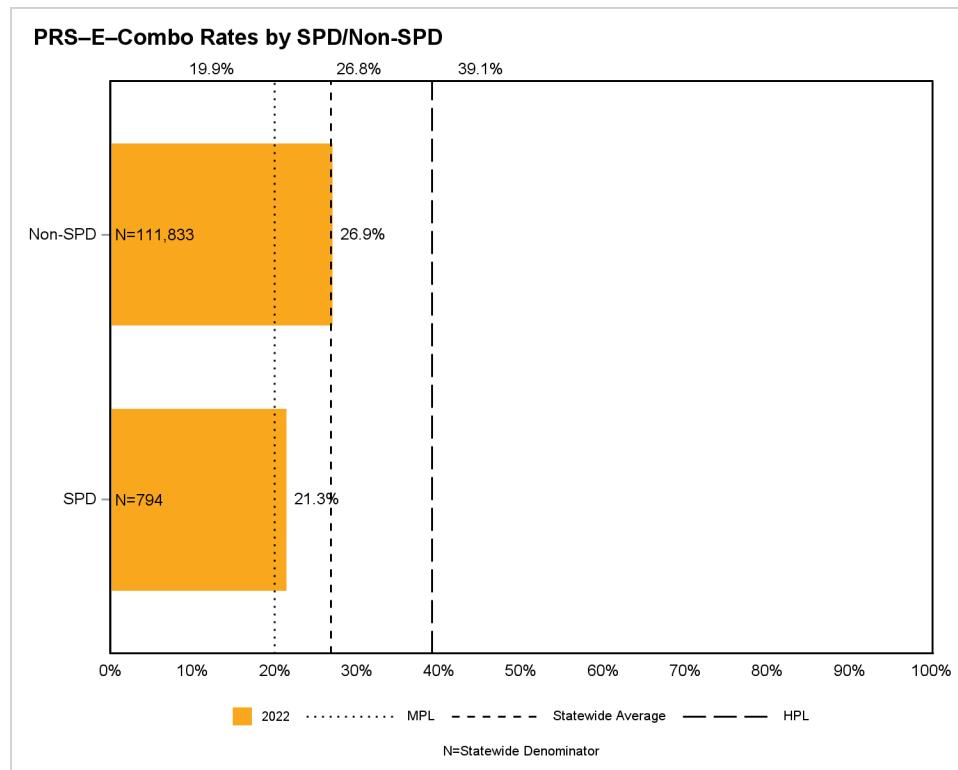


Figure C.89—Prenatal Immunization Status—Combination (PRS–E–Combo) Rates by SPD/Non-SPD



Cancer Prevention Domain

Figure C.90 through Figure C.100 display the demographic stratification results for the Cancer Prevention Domain.

Breast Cancer Screening—Total (BCS)

The *Breast Cancer Screening—Total (BCS)* indicator measures the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.

Figure C.90—Breast Cancer Screening—Total (BCS) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 49.9 percent (N=21,325) and 51.2 percent (N=24,324), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.9 percent and 63.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 54.0 percent.

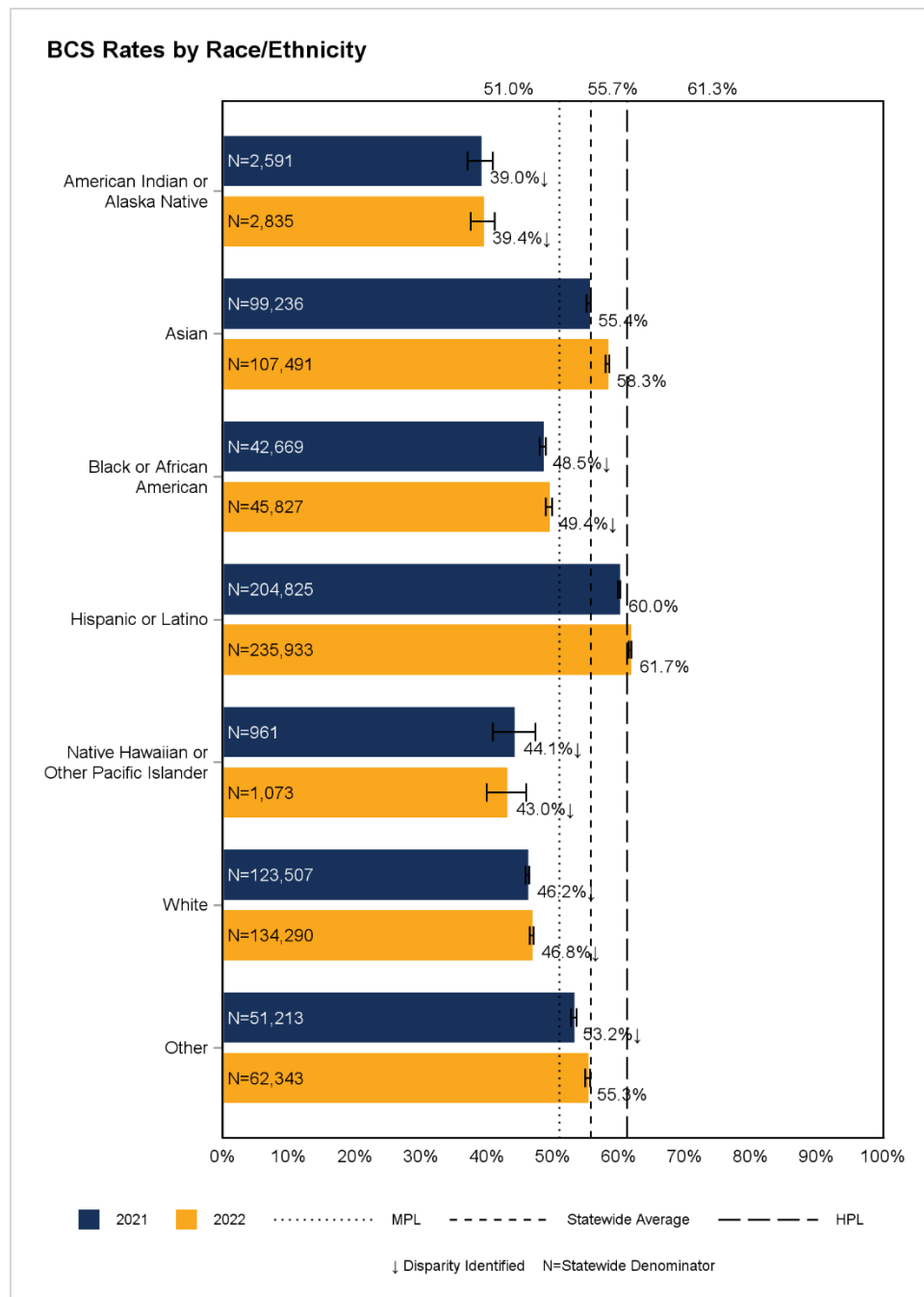


Figure C.91—Breast Cancer Screening—Total (BCS) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 37.9 percent (N=2,608) and 38.8 percent (N=2,118) respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.9 percent and 63.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 54.0 percent.

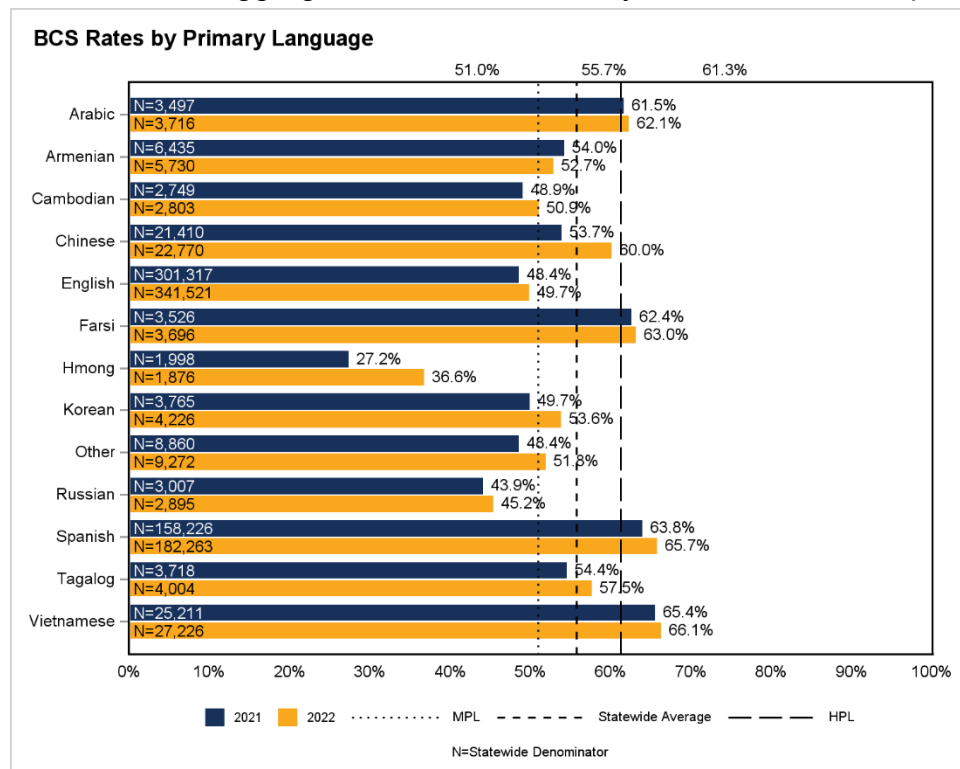


Figure C.92—Breast Cancer Screening—Total (BCS) Rates by Age

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.9 percent and 63.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 54.0 percent.

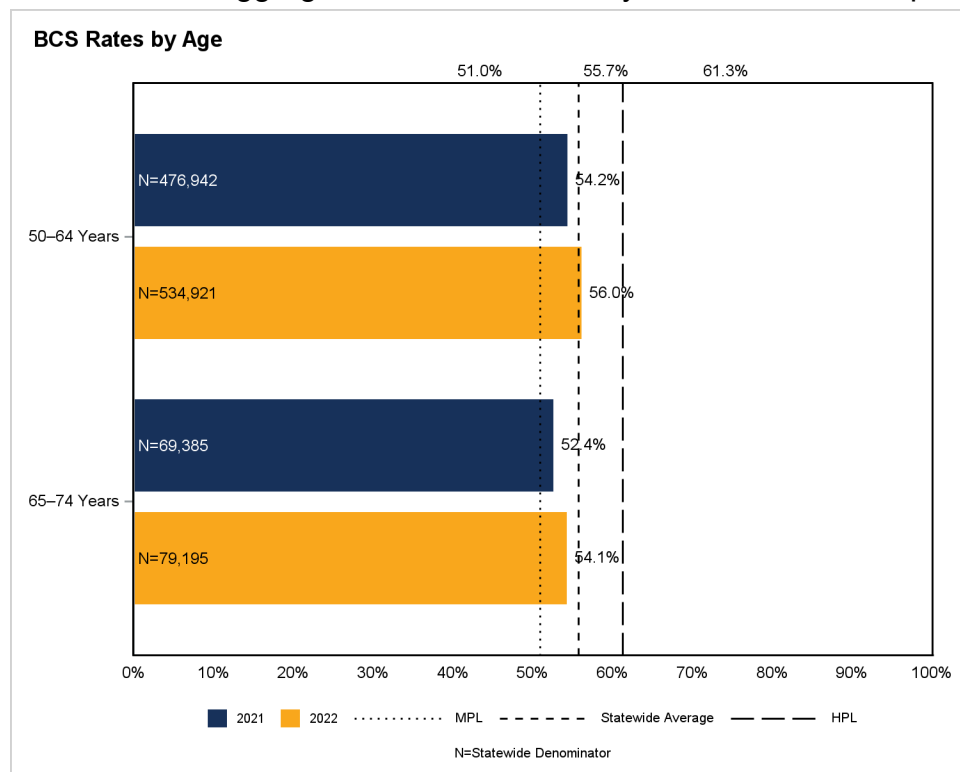
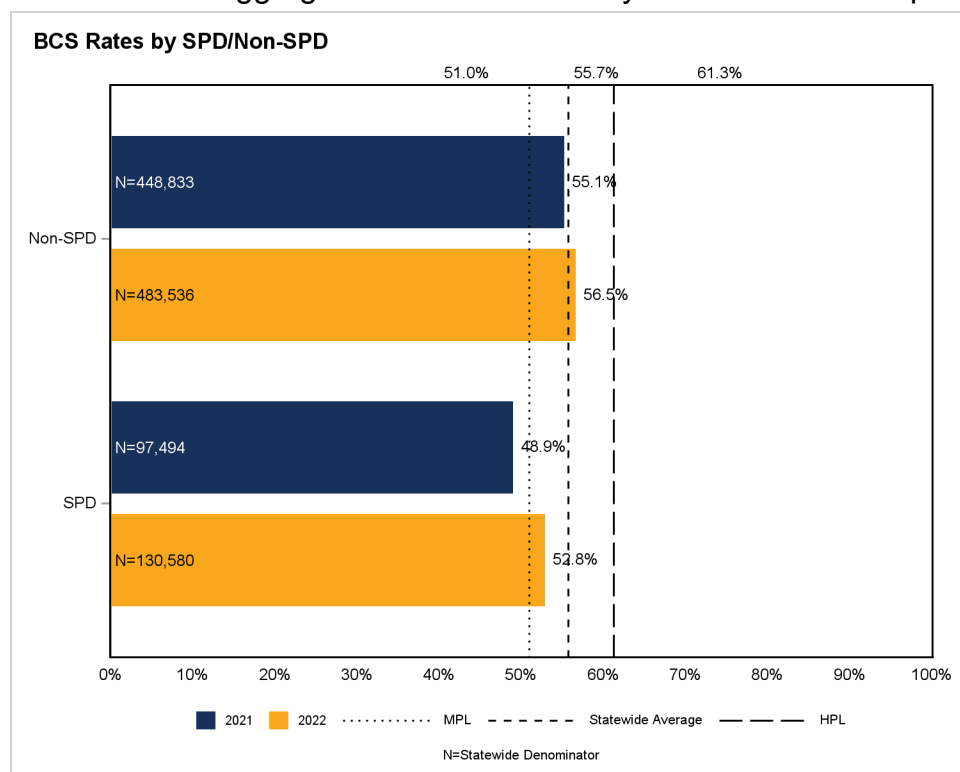


Figure C.93—Breast Cancer Screening—Total (BCS) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.9 percent and 63.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 54.0 percent.

**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 C.94—Cervical Cancer Screening (CCS) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 51.3 percent (N=729) and 48.7 percent (N=764), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 59.1 percent and 68.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 56.5 percent.

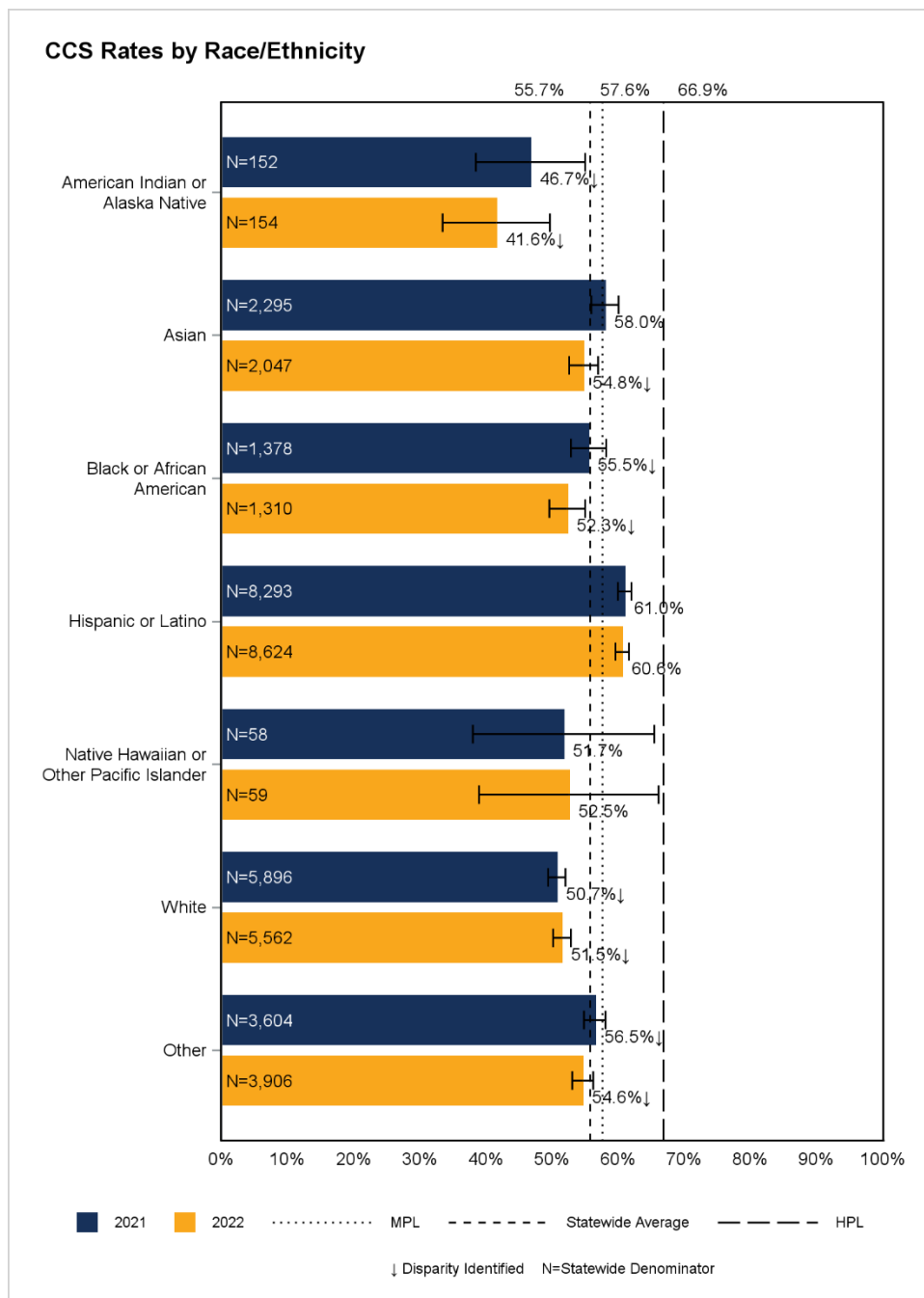


Figure C.95—Cervical Cancer Screening (CCS) Rates by Primary Language

Note: The measurement year 2021 rate for the Unknown/Missing group was 32.1 percent (N=56). The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 59.1 percent and 68.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 56.5 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

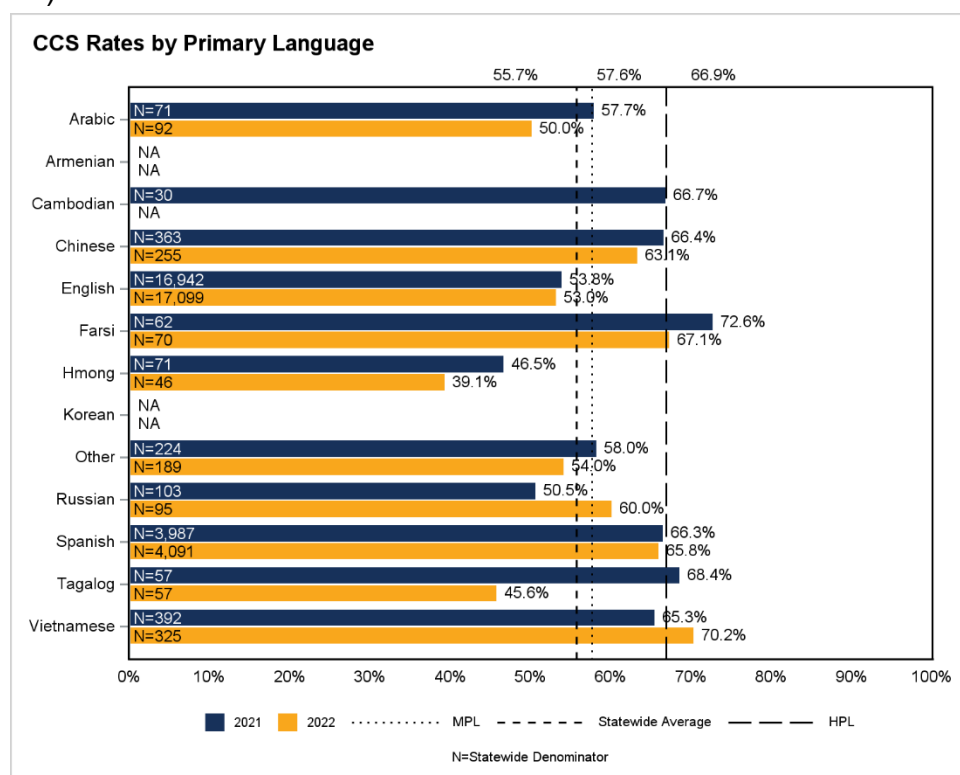
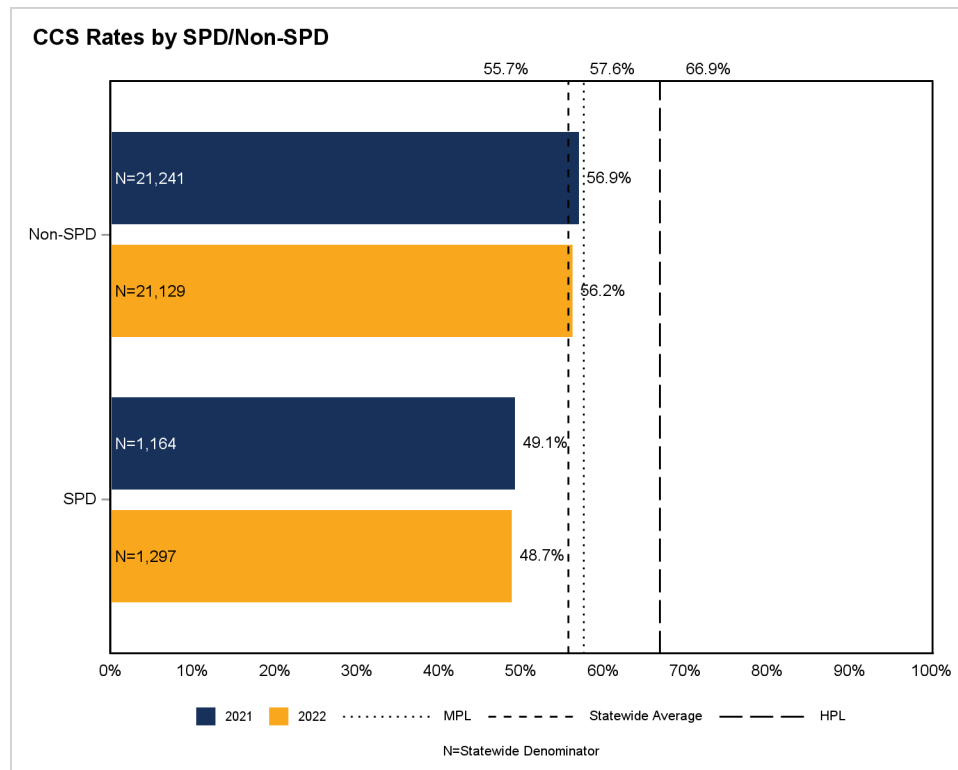


Figure C.96—Cervical Cancer Screening (CCS) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 59.1 percent and 68.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 56.5 percent.

**Colorectal Cancer Screening—Total (COL)**

The *Colorectal Cancer Screening—Total (COL)* indicator measures the percentage of members 46 to 75 years of age who had an appropriate screening for colorectal cancer.

Figure C.97—Colorectal Cancer Screening—Total (COL) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 33.9 percent (N=67,331).

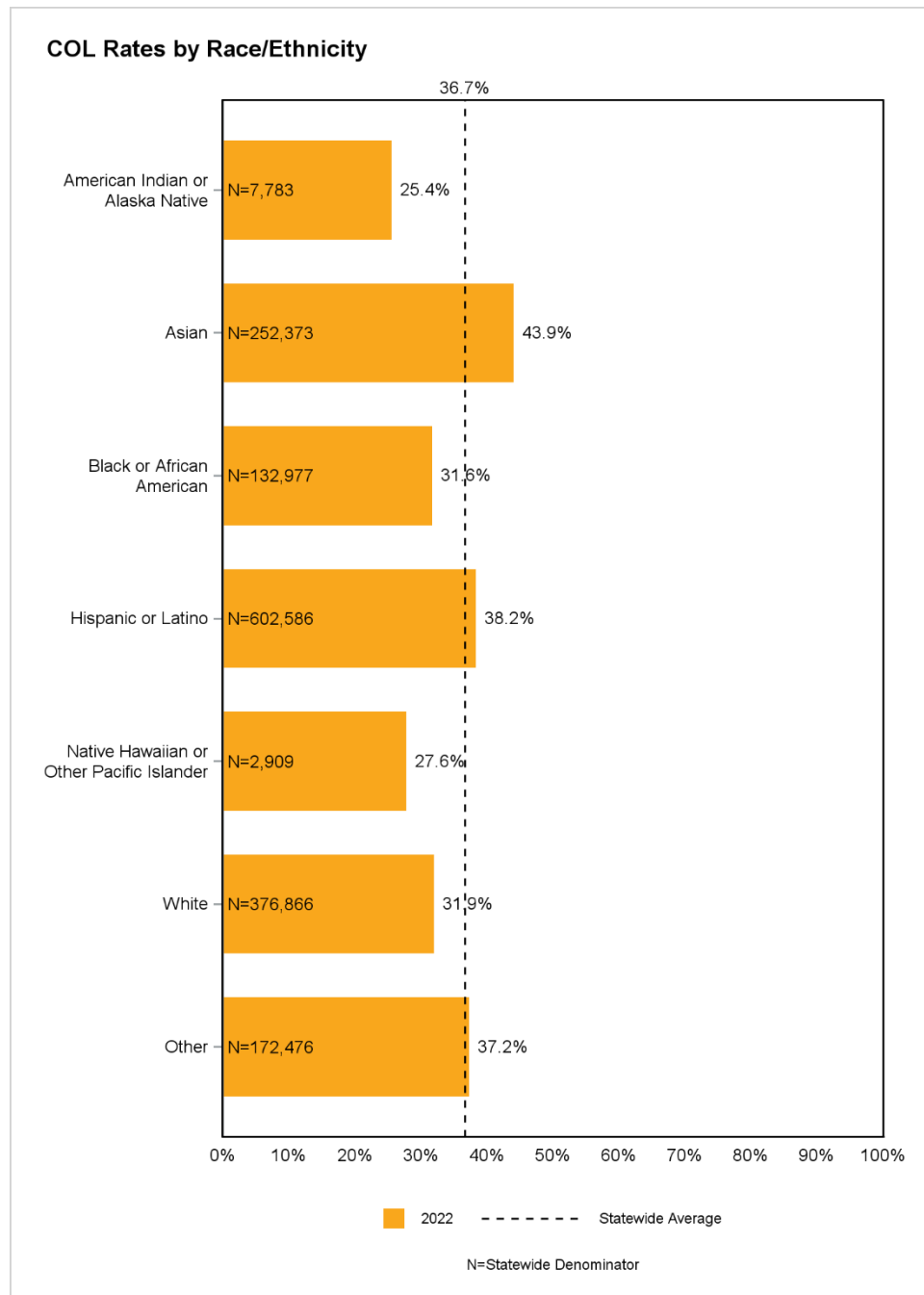


Figure C.98—Colorectal Cancer Screening—Total (COL) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was 30.7 percent (N=7,069).

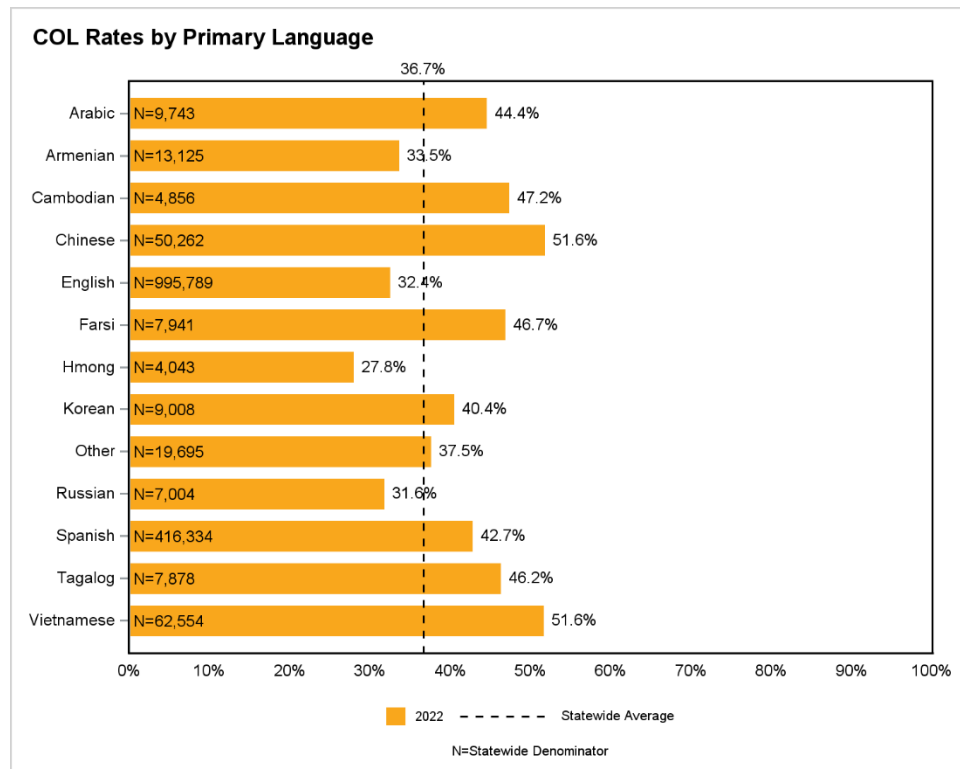


Figure C.99—Colorectal Cancer Screening—Total (COL) Rates by Age

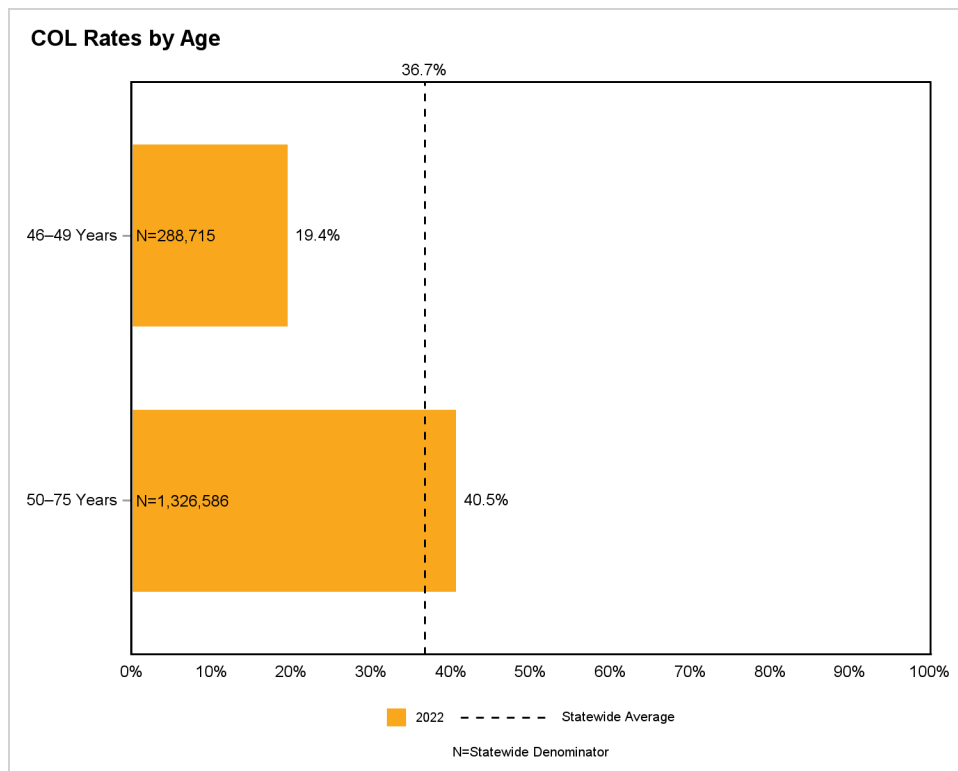
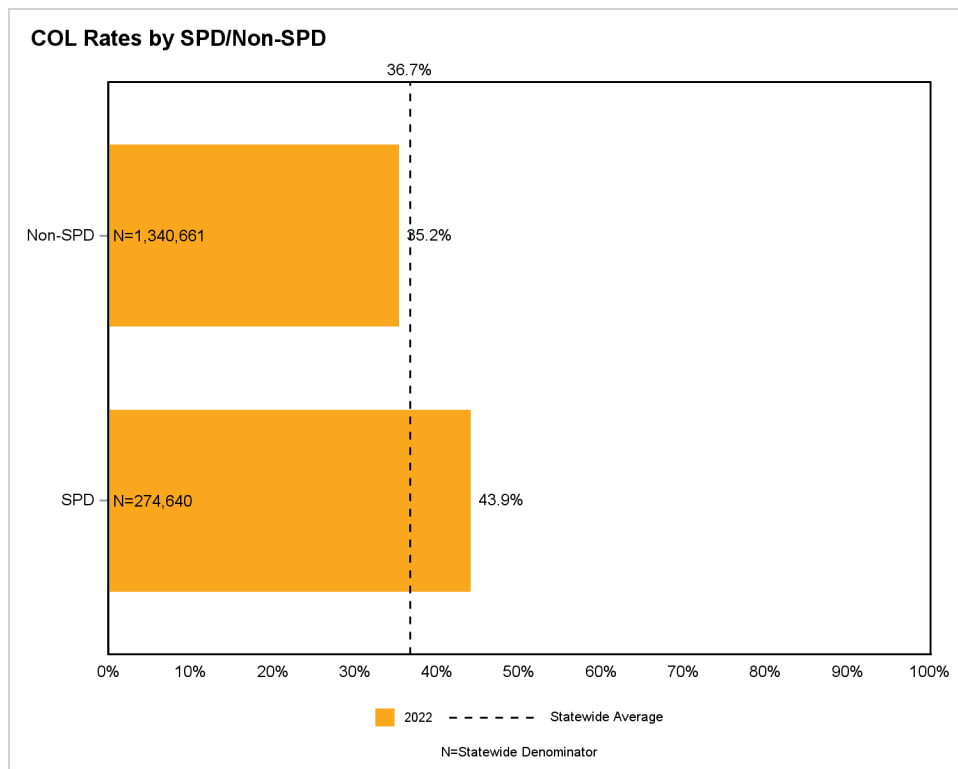


Figure C.100—Colorectal Cancer Screening—Total (COL) Rates by SPD/Non-SPD



Behavioral Health Domain

Figure C.101 through Figure C.185 display the demographic stratification results for the Behavioral Health Domain.

Antidepressant Medication Management—Effective Acute Phase Treatment—Total (AMM–Acute)

The *Antidepressant Medication Management—Effective Acute Phase Treatment—Total (AMM–Acute)* indicator measures the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days.

Figure C.101—Antidepressant Medication Management—Effective Acute Phase Treatment—Total (AMM–Acute) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 69.6 percent (N=3,706) and 69.3 percent (N=4,546), respectively

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.7 percent and 67.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.1 percent.

AMM—Acute Rates by Race/Ethnicity

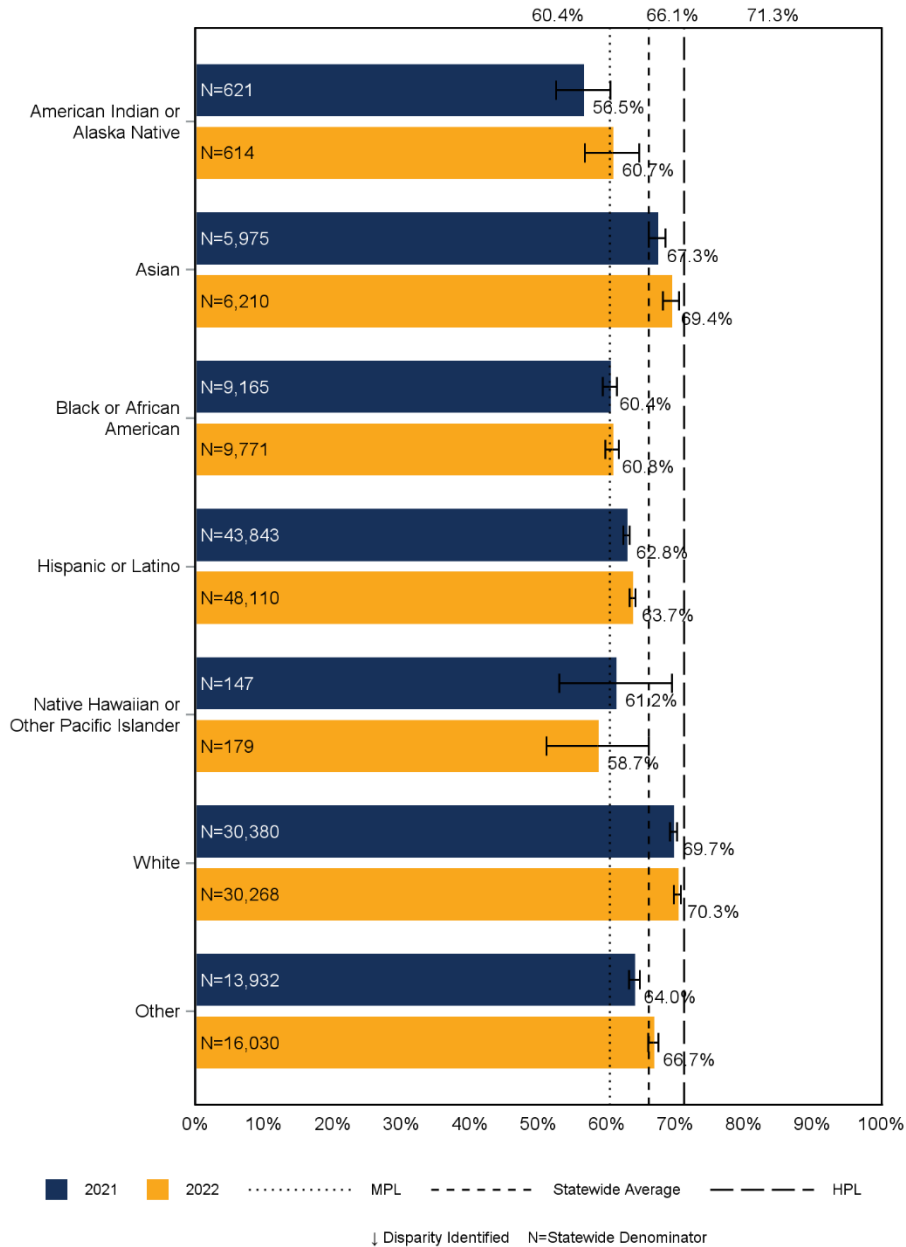


Figure C.102—Antidepressant Medication Management—Effective Acute Phase Treatment—Total (AMM–Acute) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 71.7 percent (N=145) and 63.7 percent (N=284), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.7 percent and 67.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.1 percent.

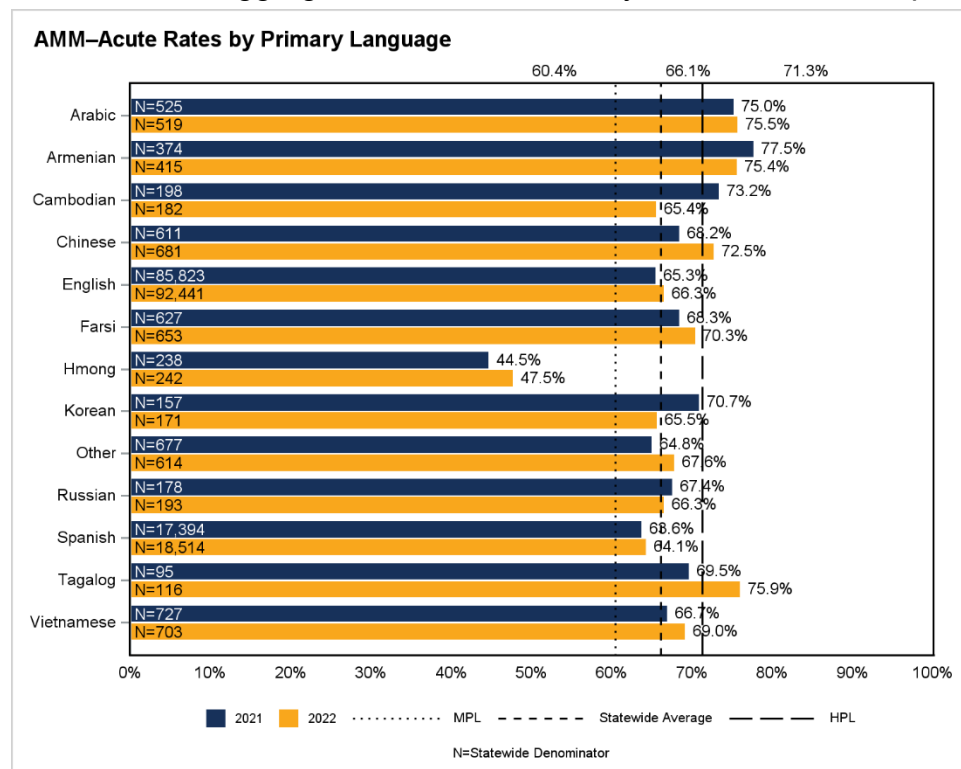


Figure C.103—Antidepressant Medication Management—Effective Acute Phase Treatment—Total (AMM–Acute) Rates by Gender

Note: The measurement year 2021 rate for the Unknown/Missing group was suppressed due to a small denominator. The measurement year 2022 rate for the Unknown/Missing group was 58.4 percent (N=173).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.7 percent and 67.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.1 percent.

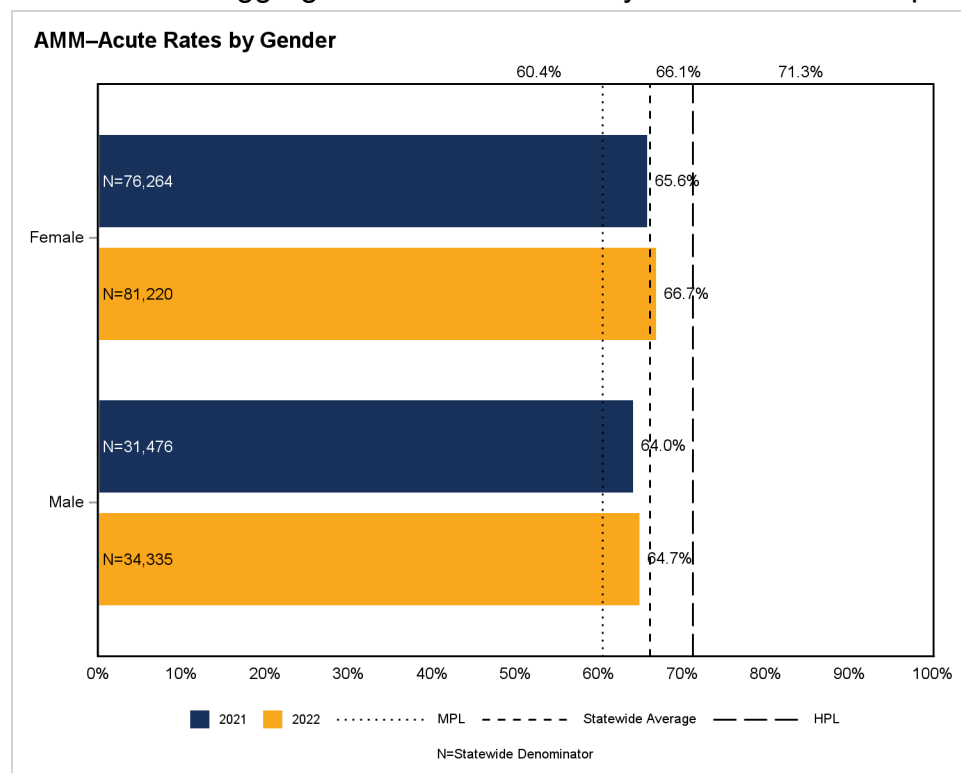
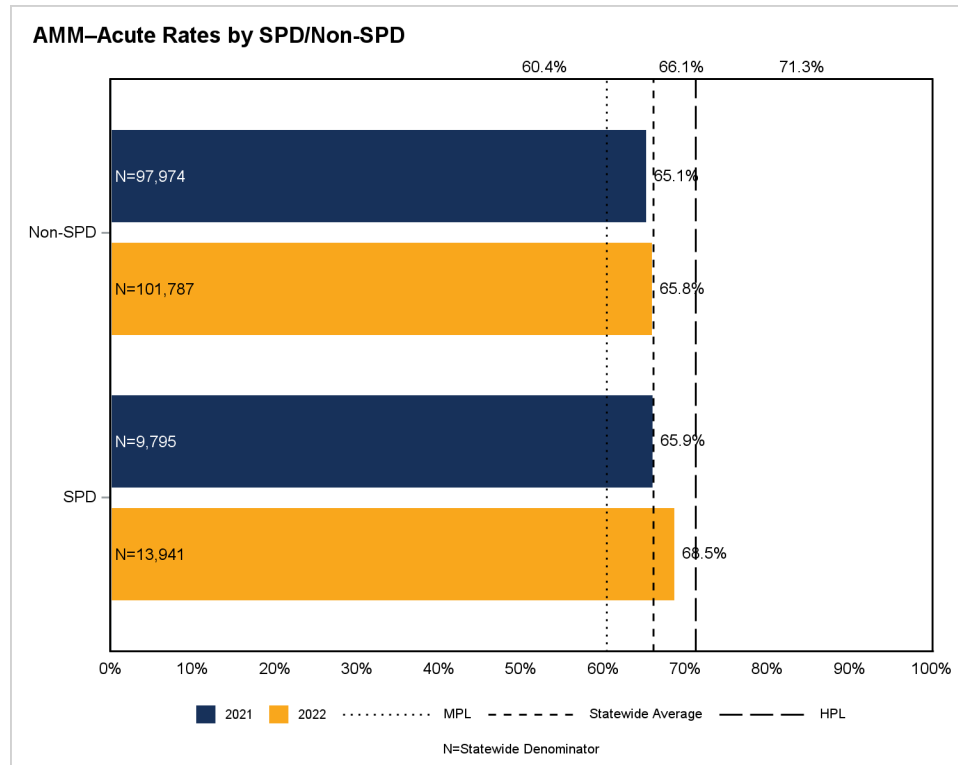


Figure C.104—Antidepressant Medication Management—Effective Acute Phase Treatment—Total (AMM–Acute) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.7 percent and 67.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.1 percent.



Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (AMM–Cont)

The *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (AMM–Cont)* indicator measures the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days.

Figure C.105—Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (AMM–Cont) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 56.0 percent (N=3,706) and 53.7 percent (N=4,546), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 40.3 percent and 52.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 48.5 percent.

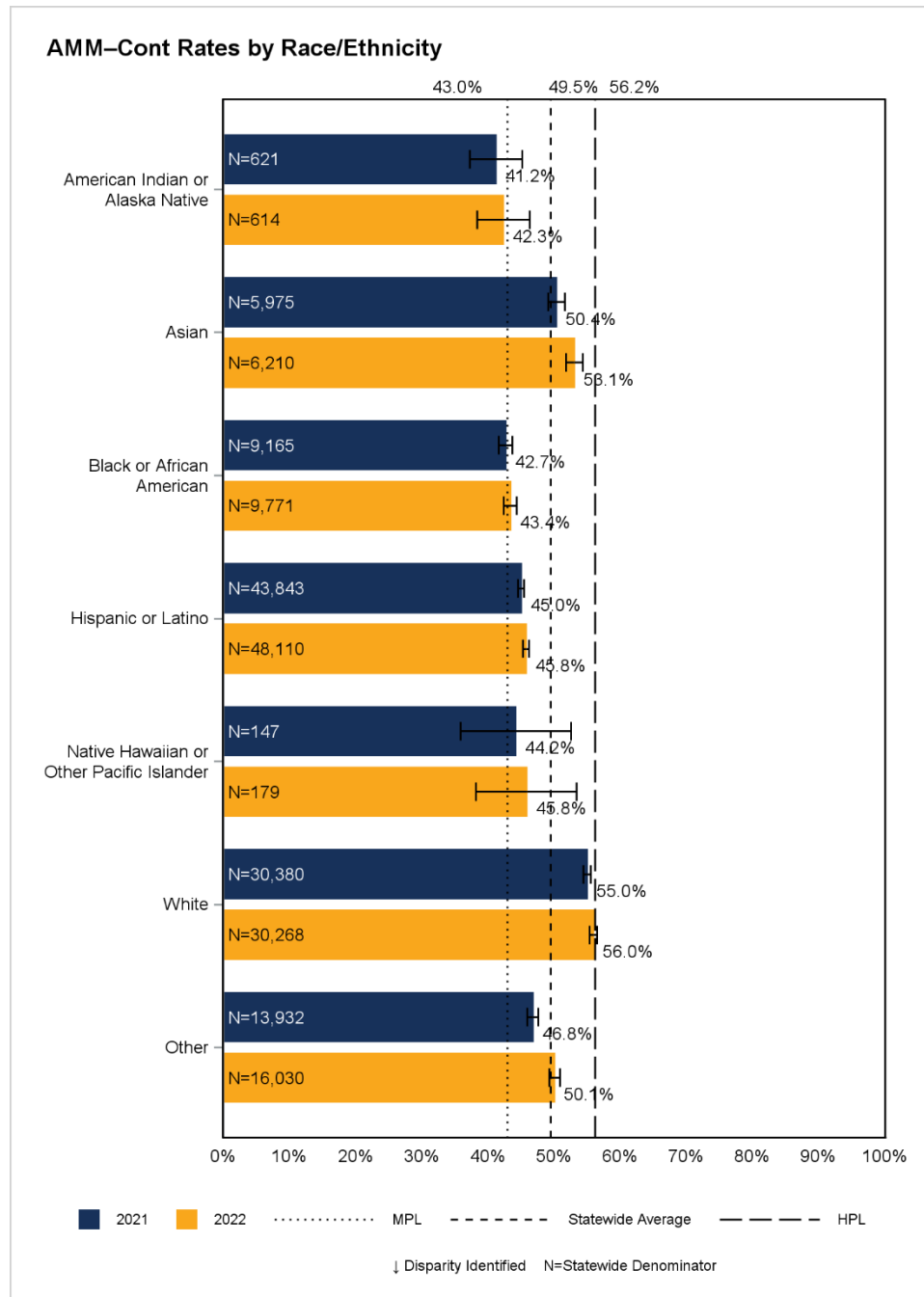


Figure C.106—Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (AMM–Cont) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 57.2 percent (N=145) and 51.4 percent (N=284), respectively

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 40.3 percent and 52.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 48.5 percent.

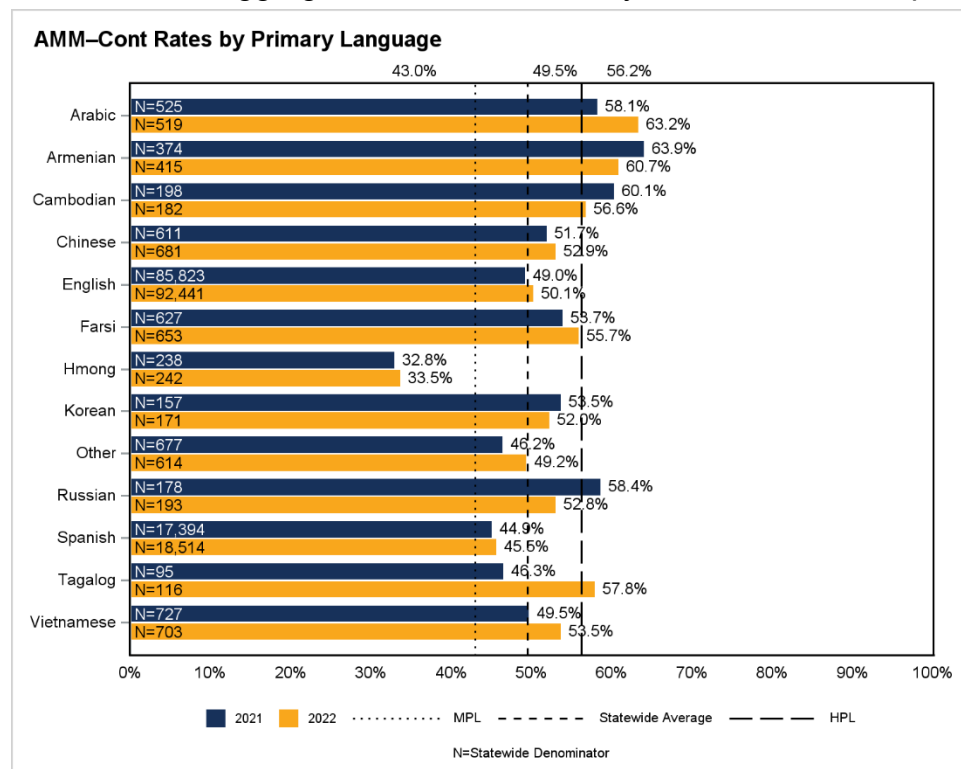


Figure C.107—Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (AMM–Cont) Rates by Gender

Note: The measurement year 2021 rate for the Unknown/Missing group was suppressed due to a small denominator. The measurement year 2022 rate for the Unknown/Missing group was 46.2 percent (N=173).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 40.3 percent and 52.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 48.5 percent.

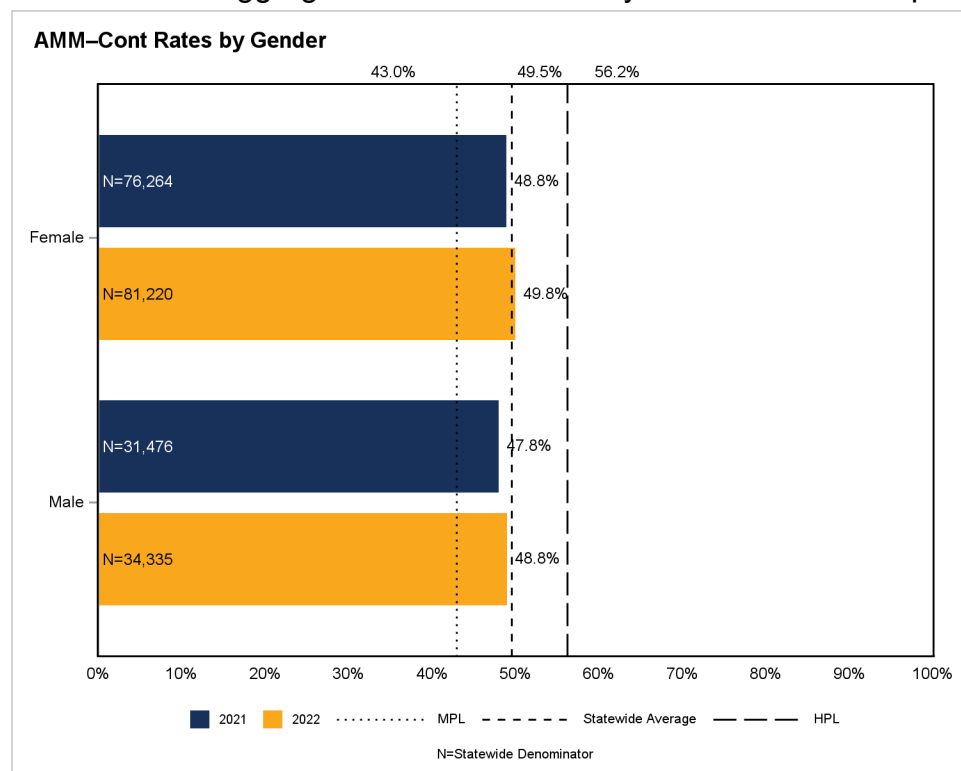
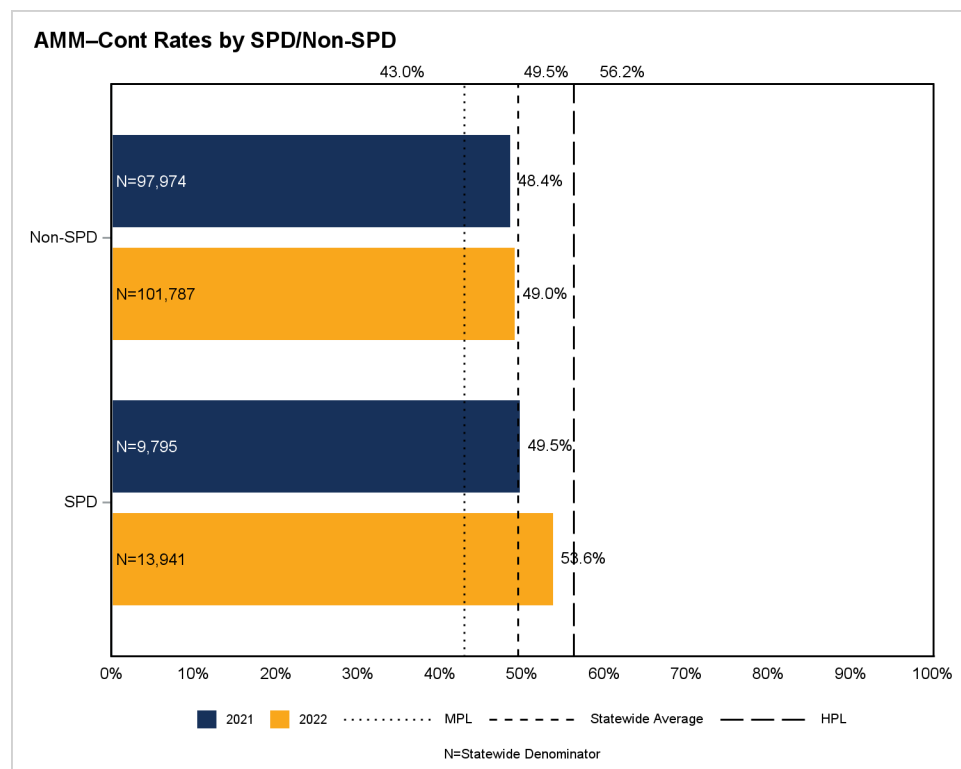


Figure C.108—Antidepressant Medication Management—Effective Continuation Phase Treatment—Total (AMM–Cont) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 40.3 percent and 52.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 48.5 percent.



Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR–E–PHQ)

The *Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR–E–PHQ)* indicator measures the percentage of members who have a follow-up PHQ-9 score documented within four to eight months after the initial elevated PHQ-9 score.

Figure C.109—Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR-E-PHQ) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 41.6 percent (N=190).

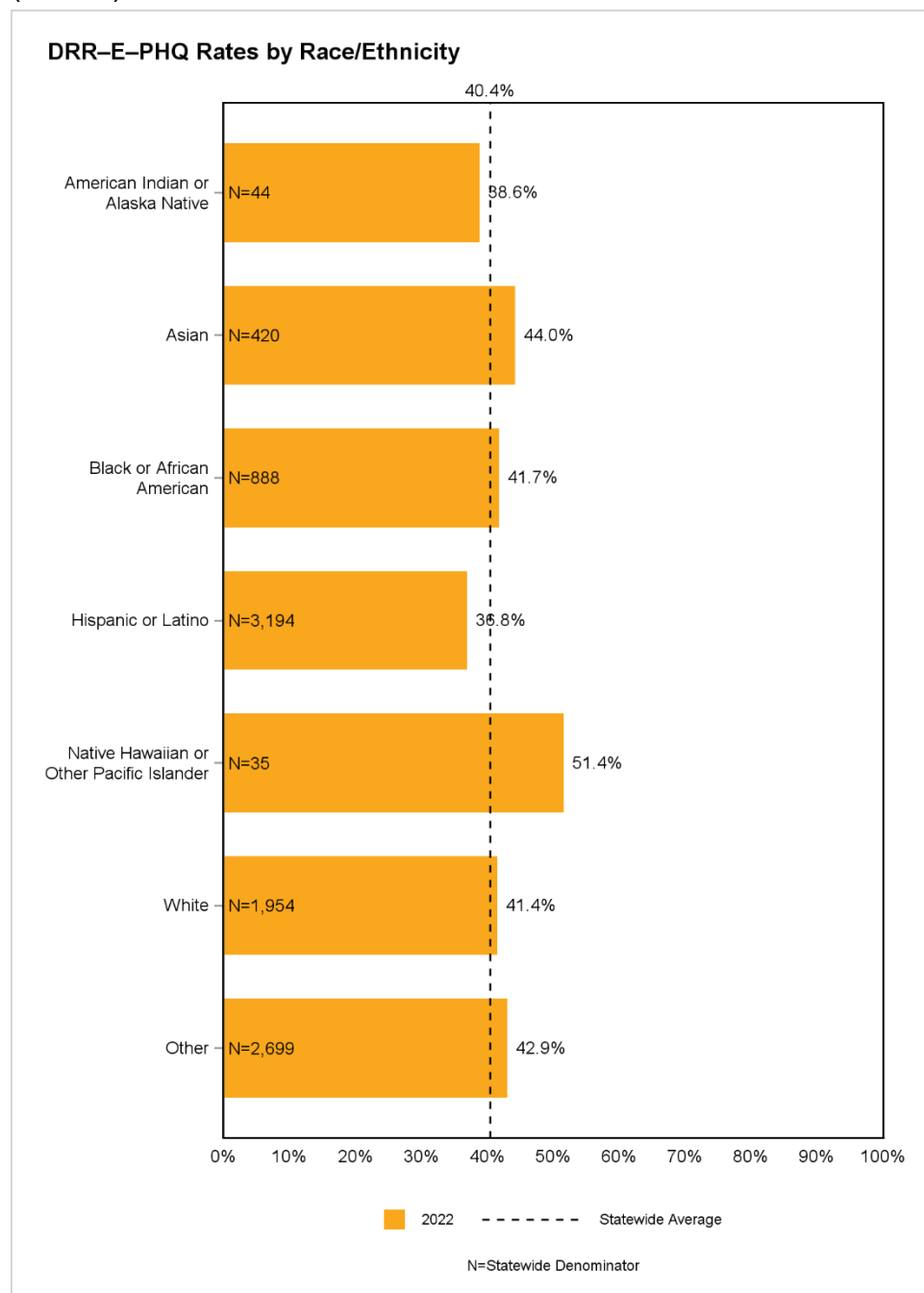


Figure C.110—Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR-E-PHQ) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was 41.3 percent (N=46).

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

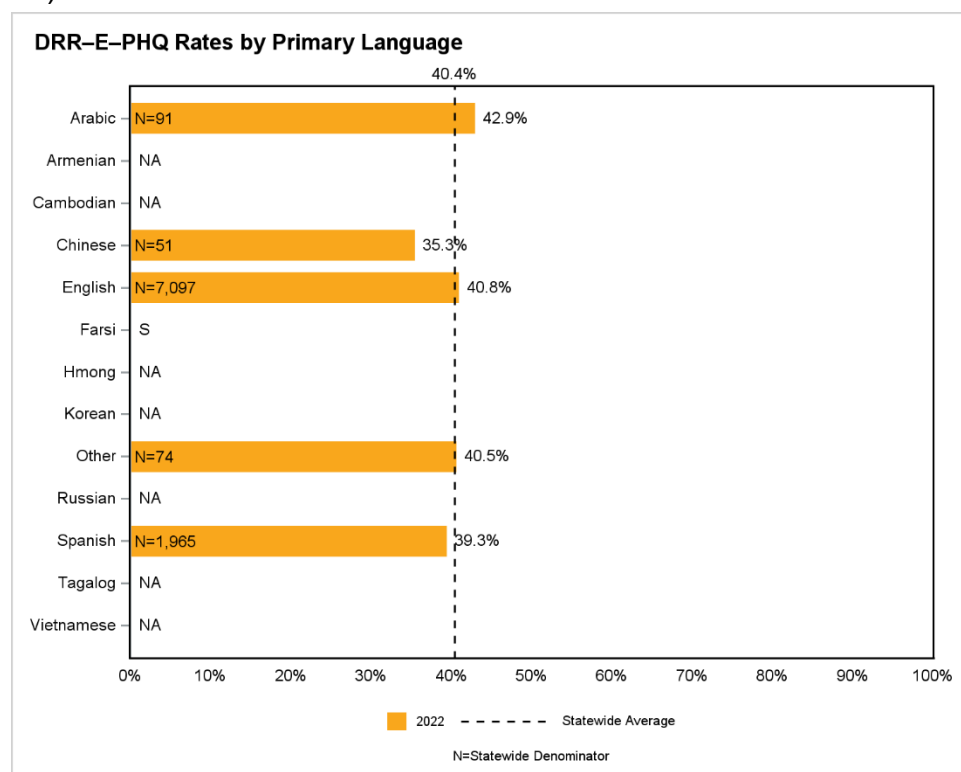


Figure C.111—Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR-E-PHQ) Rates by Age

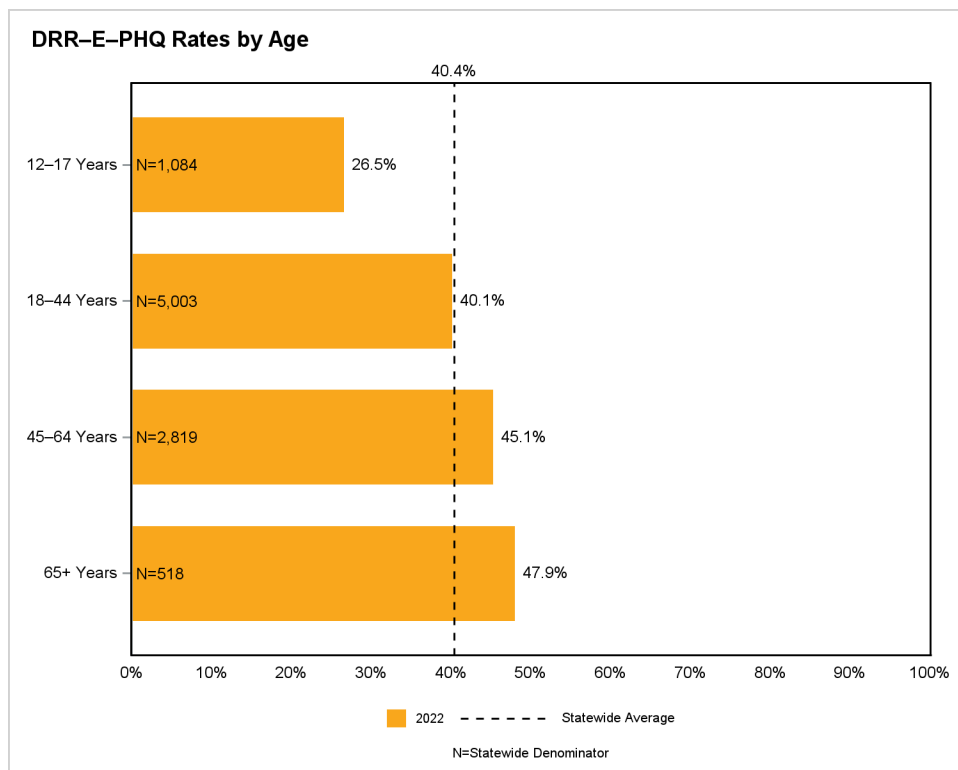


Figure C.112—Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR-E-PHQ) Rates by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group was 40.0 percent (N=40).

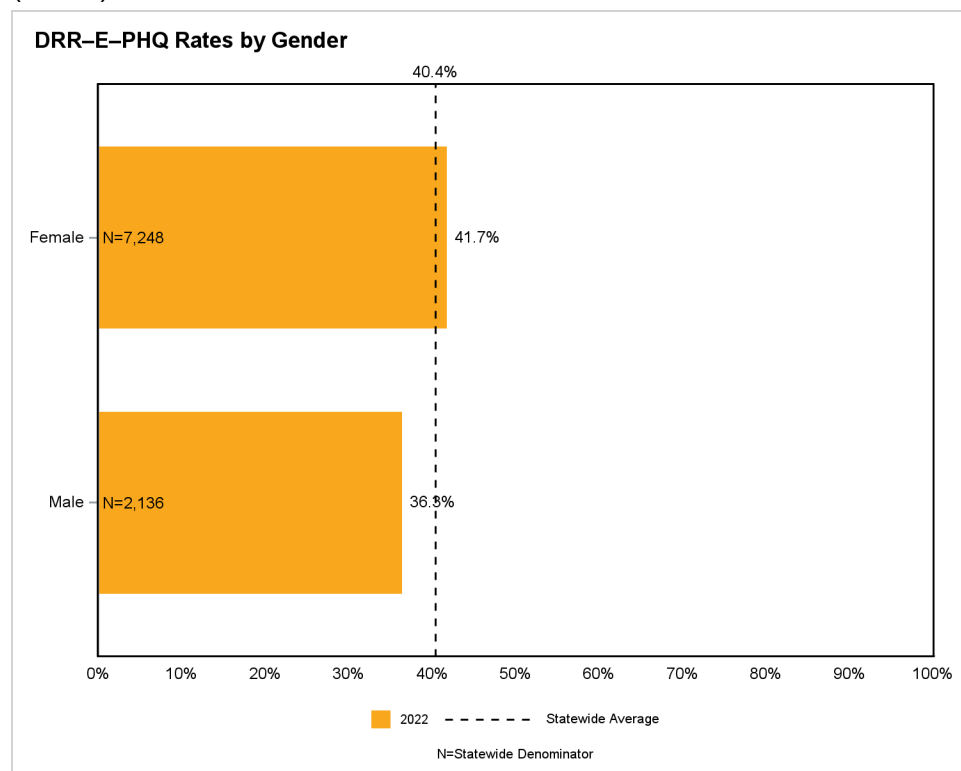
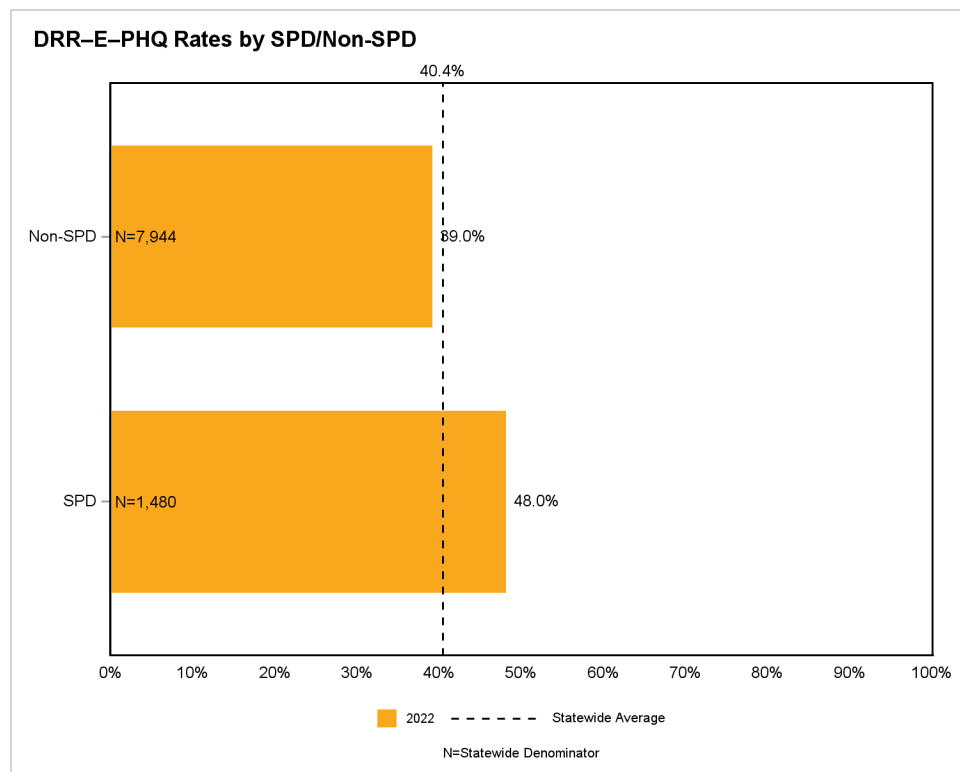


Figure C.113—Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR-E-PHQ) Rates by SPD/Non-SPD



Depression Remission or Response for Adolescents and Adults—Depression Remission—Total (DRR-E-RM)

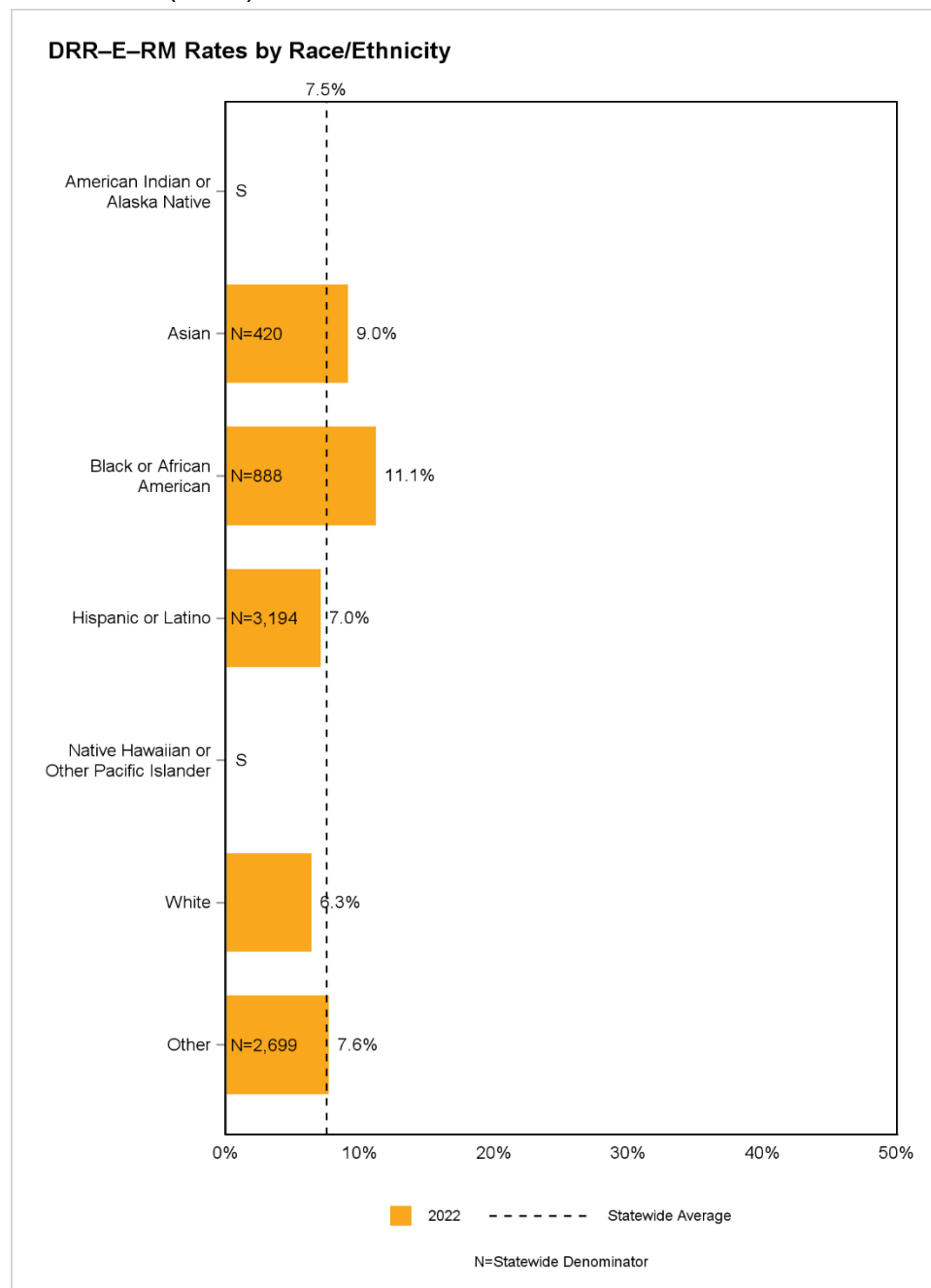
The *Depression Remission or Response for Adolescents and Adults—Depression Remission—Total (DRR-E-RM)* indicator measures the percentage of members who achieved remission within four to eight months after the initial elevated PHQ-9 score.

**Figure C.114—Depression Remission or Response for Adolescents and Adults—
Depression Remission—Total (DRR-E-RM) Rates by Race/Ethnicity**

Note: The measurement year 2022 rate for the Unknown/Missing group was 5.8 percent (N=190).

The measurement year 2022 denominator size for the White racial/ethnic group was 1,954.

S indicates fewer than 11 cases exist in the numerator for the racial/ethnic group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

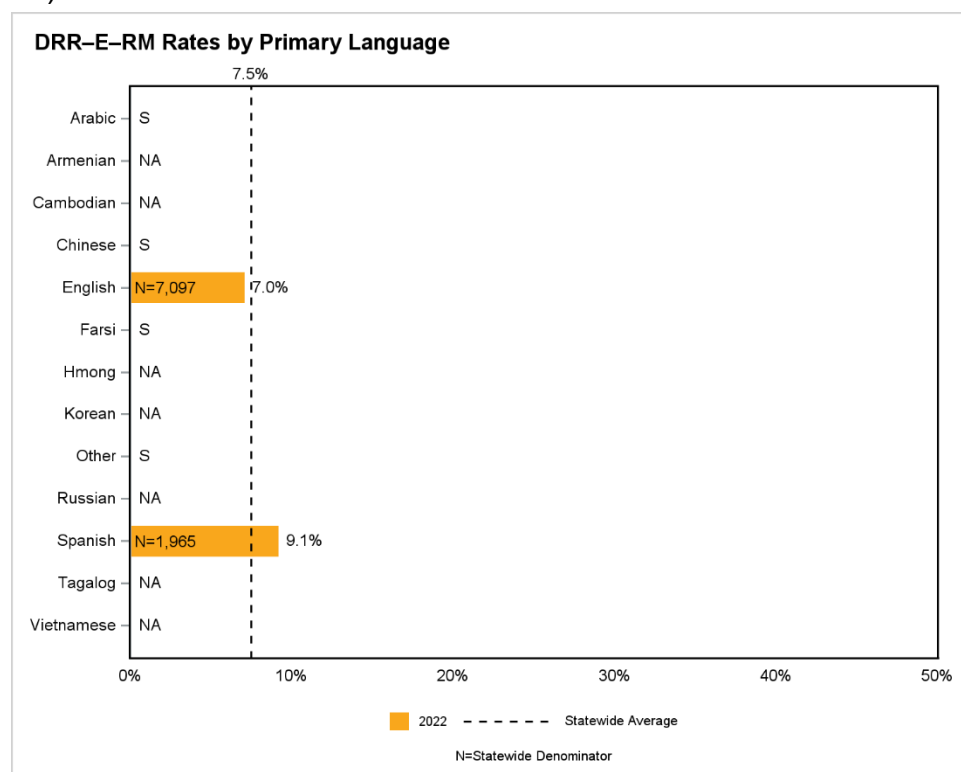


**Figure C.115—Depression Remission or Response for Adolescents and Adults—
Depression Remission—Total (DRR–E–RM) Rates by Primary Language**

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.

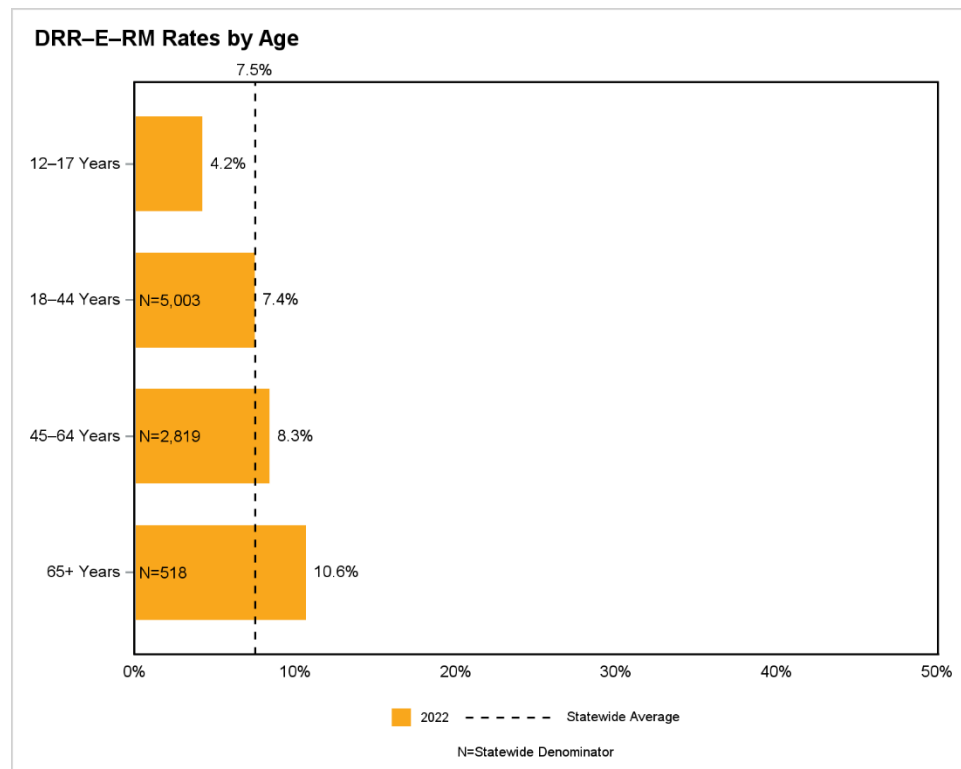
S indicates fewer than 11 cases exist in the numerator for the primary language group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).



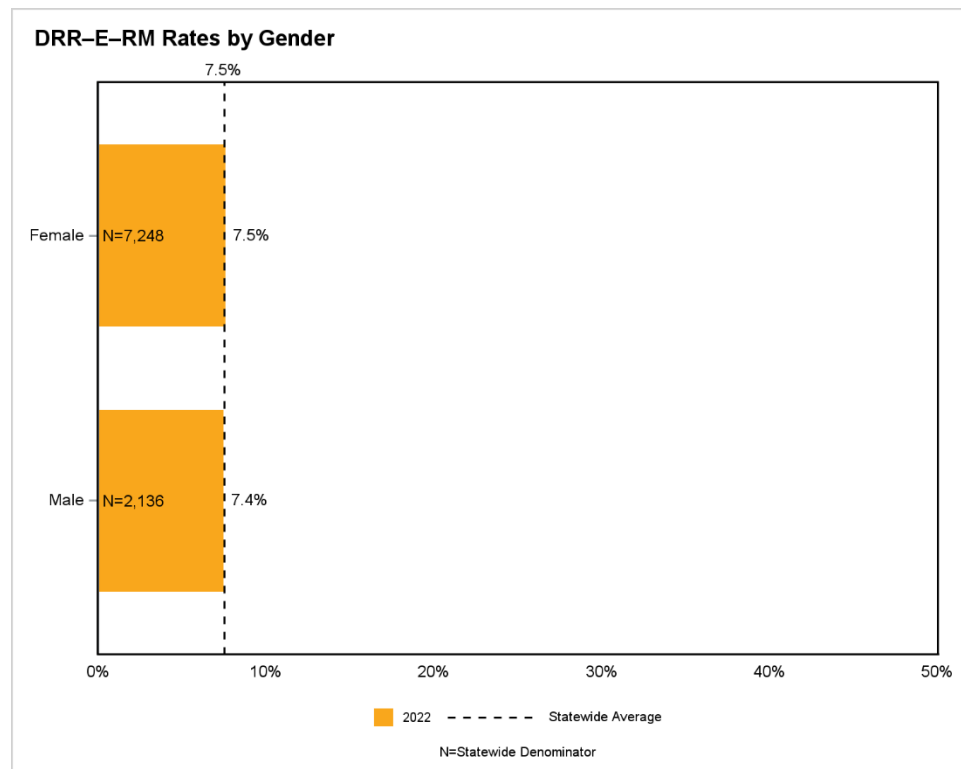
**Figure C.116—Depression Remission or Response for Adolescents and Adults—
Depression Remission—Total (DRR-E-RM) Rates by Age**

Note: The following is the measurement year 2022 denominator size for the 12–17 Years age group was 1,084.

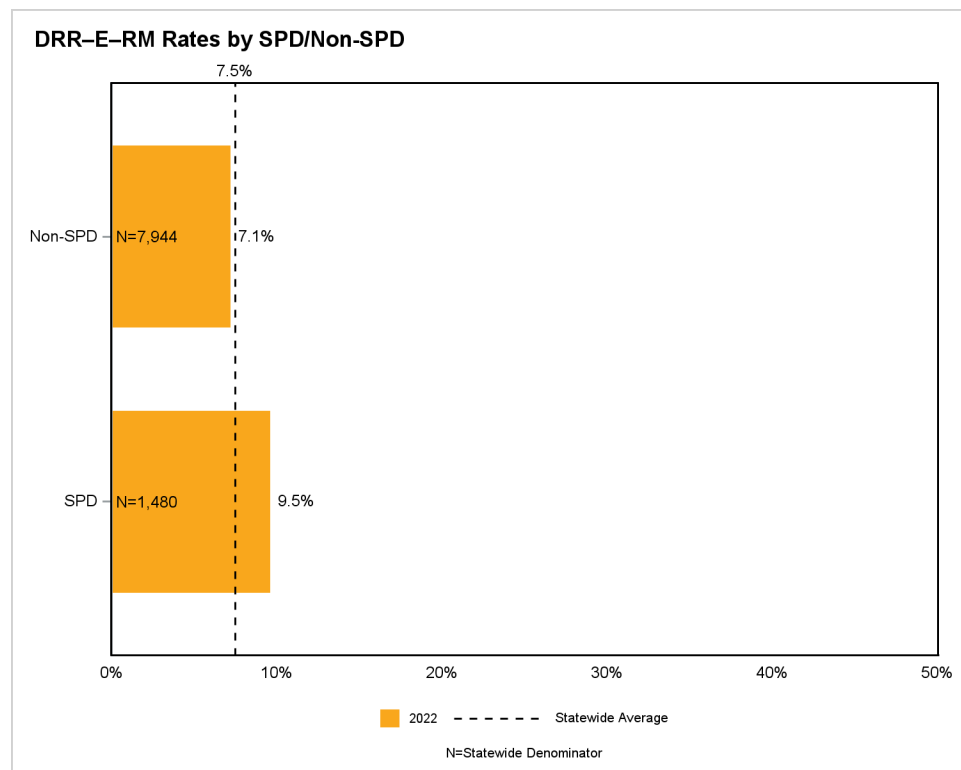


**Figure C.117—Depression Remission or Response for Adolescents and Adults—
Depression Remission—Total (DRR-E-RM) Rates by Gender**

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.



**Figure C.118—Depression Remission or Response for Adolescents and Adults—
Depression Remission—Total (DRR-E-RM) Rates by SPD/Non-SPD**



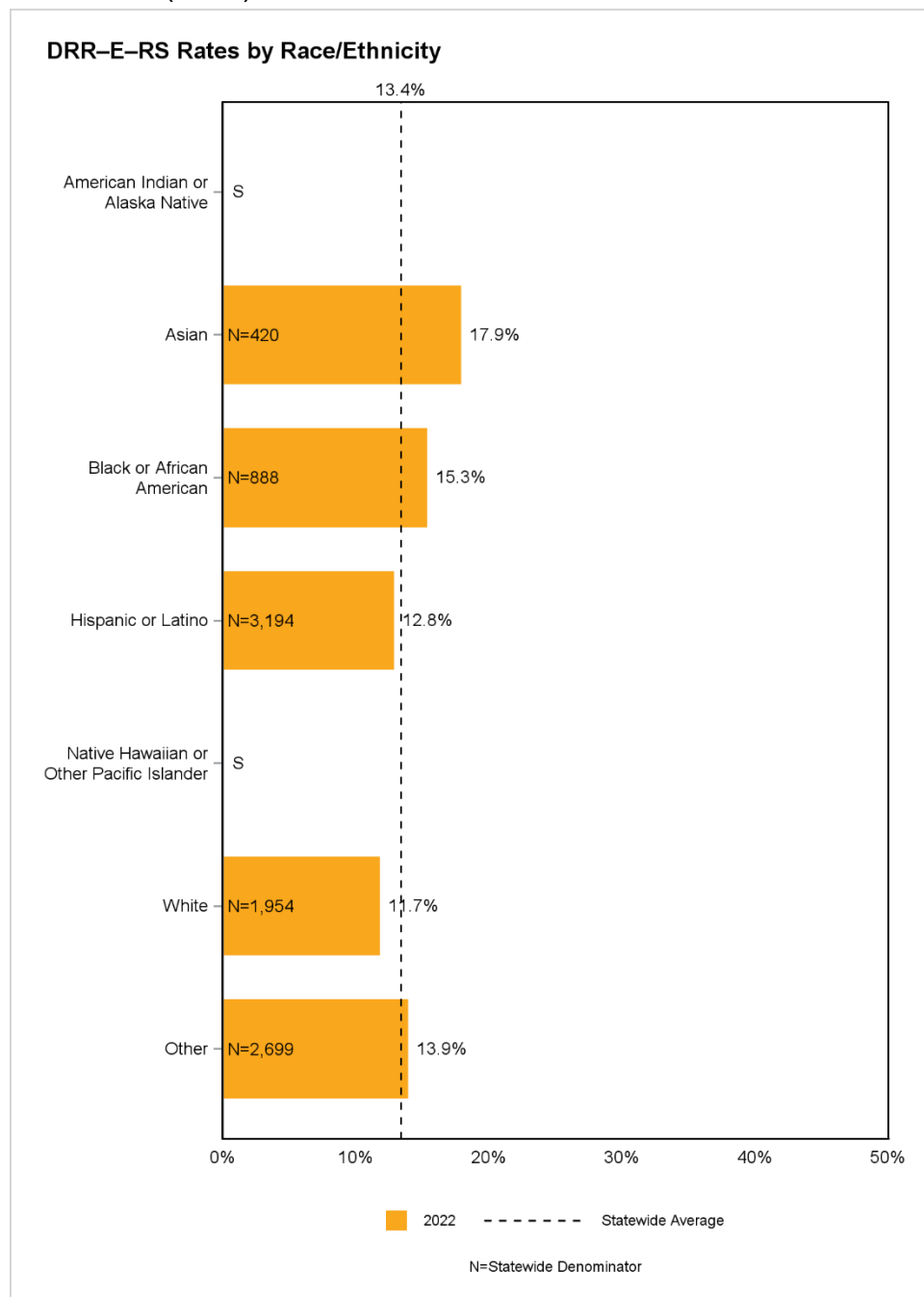
Depression Remission or Response for Adolescents and Adults—Depression Response—Total (DRR-E-RS)

The *Depression Remission or Response for Adolescents and Adults—Depression Response—Total (DRR-E-RS)* indicator measures the percentage of members who showed response within four to eight months after the initial elevated PHQ-9 score.

**Figure C.119—Depression Remission or Response for Adolescents and Adults—
Depression Response—Total (DRR–E–RS) Rates by Race/Ethnicity**

Note: The measurement year 2022 rate for the Unknown/Missing group was 15.3 percent (N=190).

S indicates fewer than 11 cases exist in the numerator for the racial/ethnic group; therefore, HSAG suppresses displaying the rate in this report to satisfy the DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

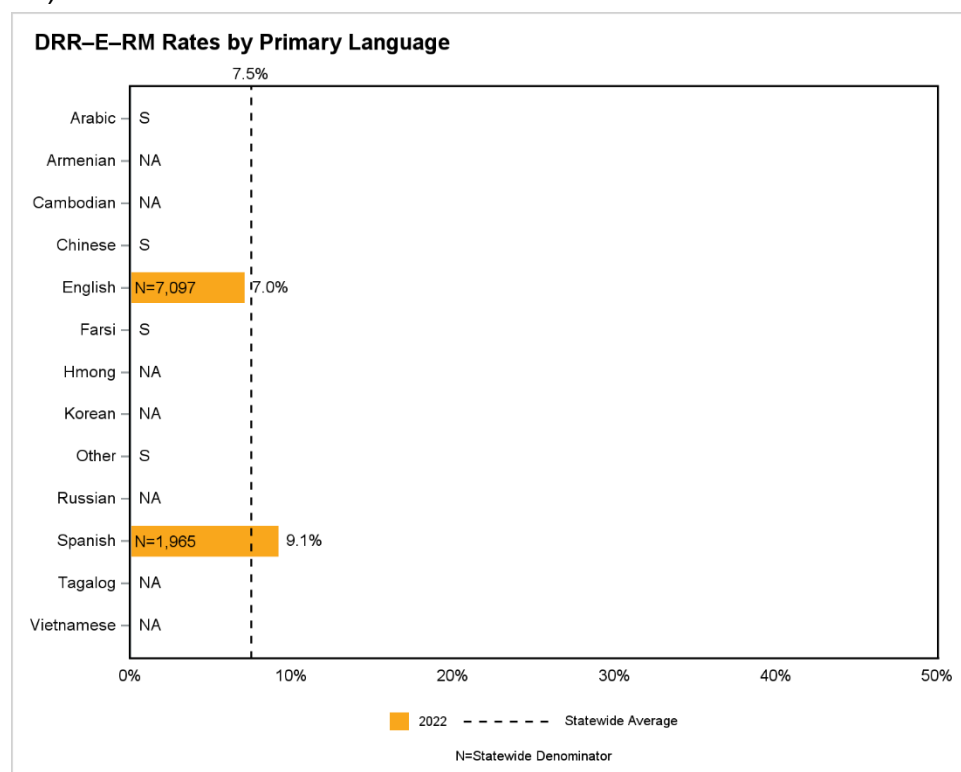


**Figure C.120—Depression Remission or Response for Adolescents and Adults—
Depression Response—Total (DRR–E–RS) Rates by Primary Language**

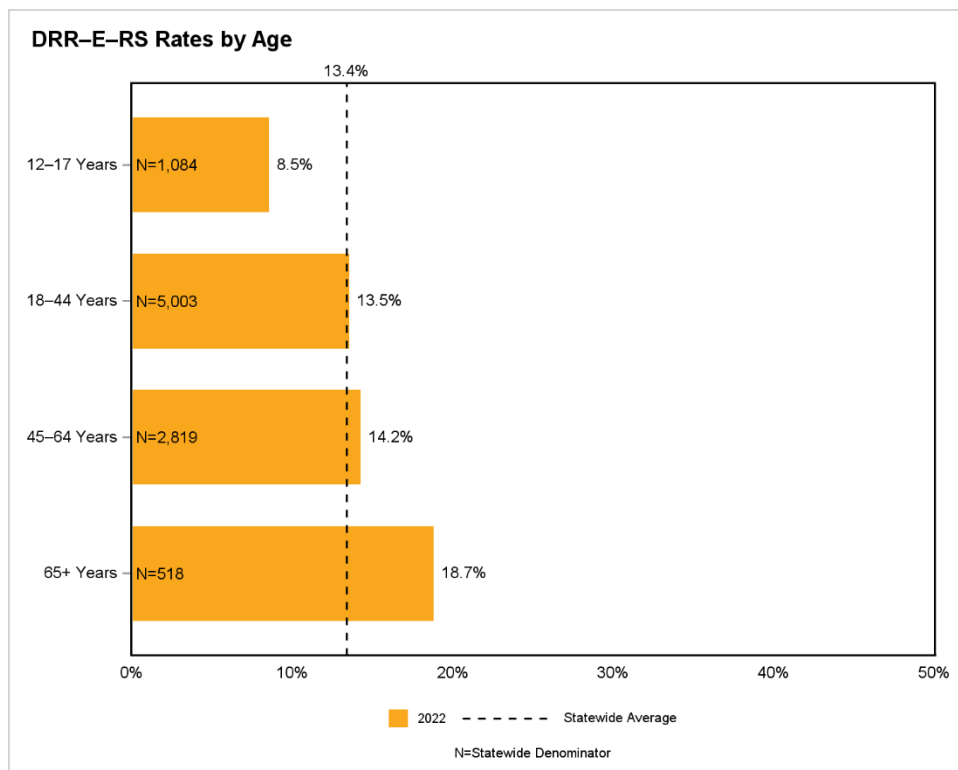
Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

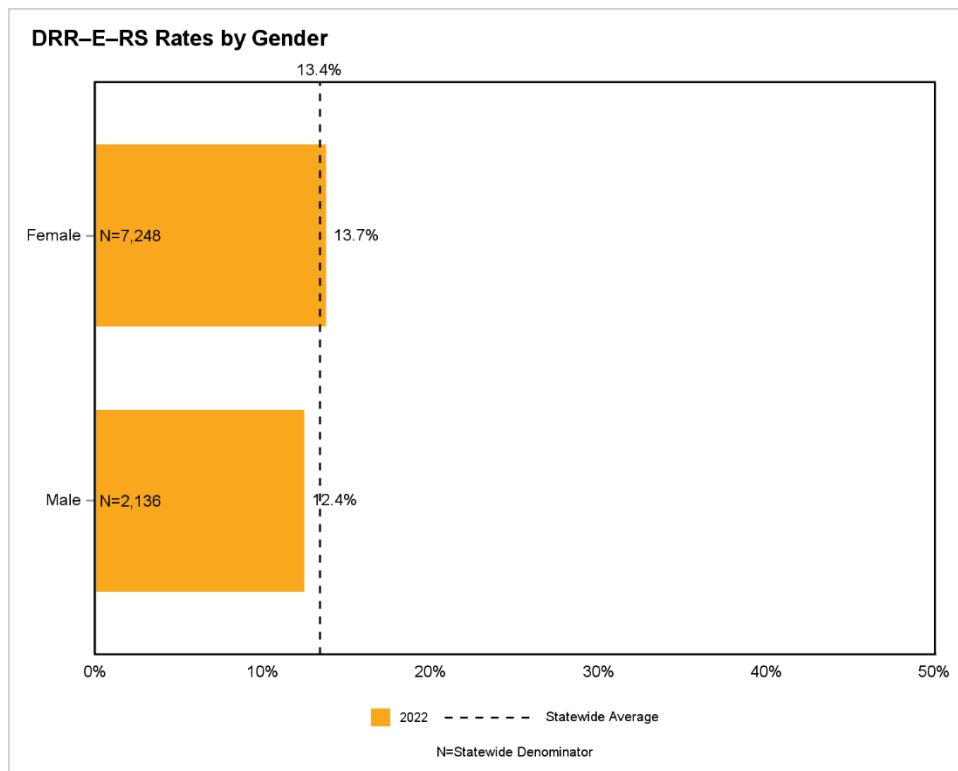


**Figure C.121—Depression Remission or Response for Adolescents and Adults—
Depression Response—Total (DRR–E–RS) Rates by Age**

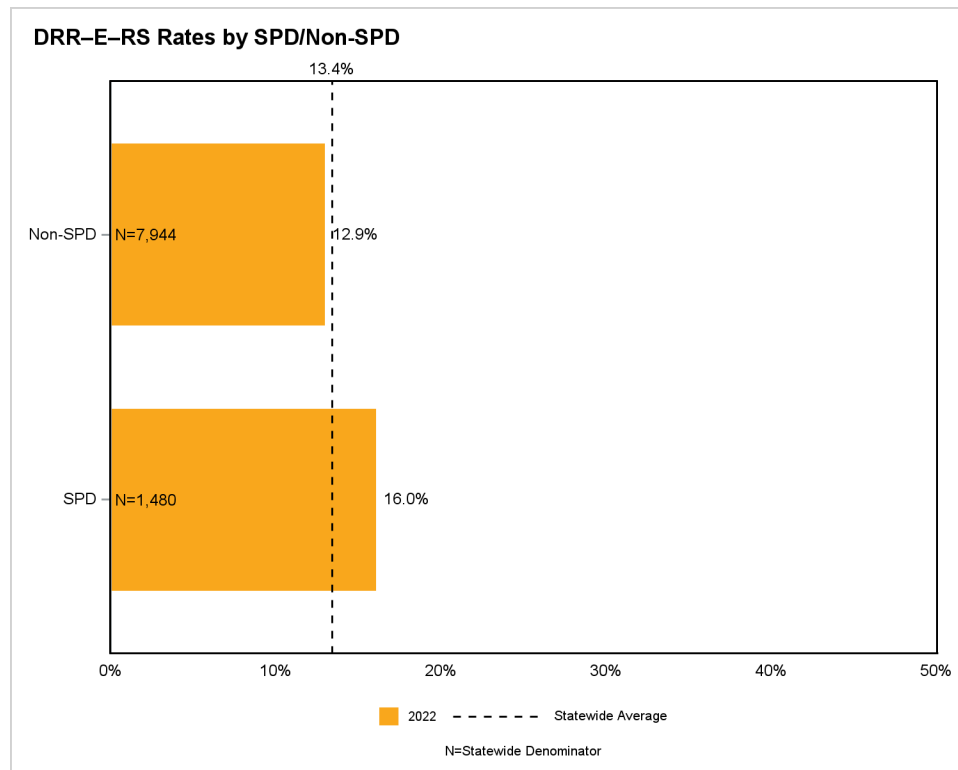


**Figure C.122—Depression Remission or Response for Adolescents and Adults—
Depression Response—Total (DRR–E–RS) Rates by Gender**

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.



**Figure C.123—Depression Remission or Response for Adolescents and Adults—
Depression Response—Total (DRR–E–RS) Rates by SPD/Non-SPD**



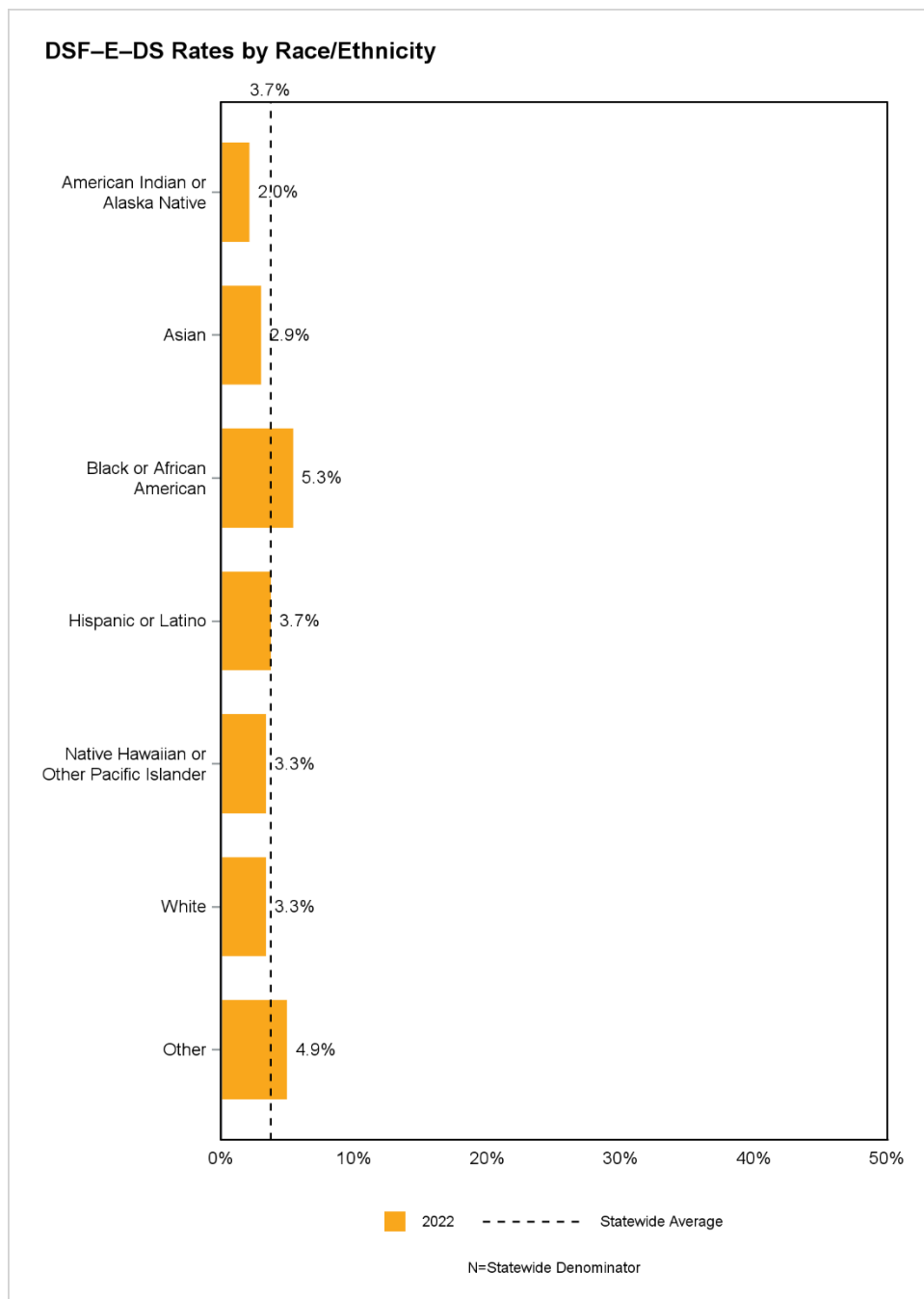
Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total (DSF–E–DS)

The *Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total (DSF–E–DS)* indicator measures the percentage of members who were screened for clinical depression using a standardized instrument.

**Figure C.124—Depression Screening and Follow-Up for Adolescents and Adults—
Depression Screening—Total (DSF–E–DS) Rates by Race/Ethnicity**

Note: The measurement year 2022 rate for the Unknown/Missing group was 3.0 percent (N=248,227).

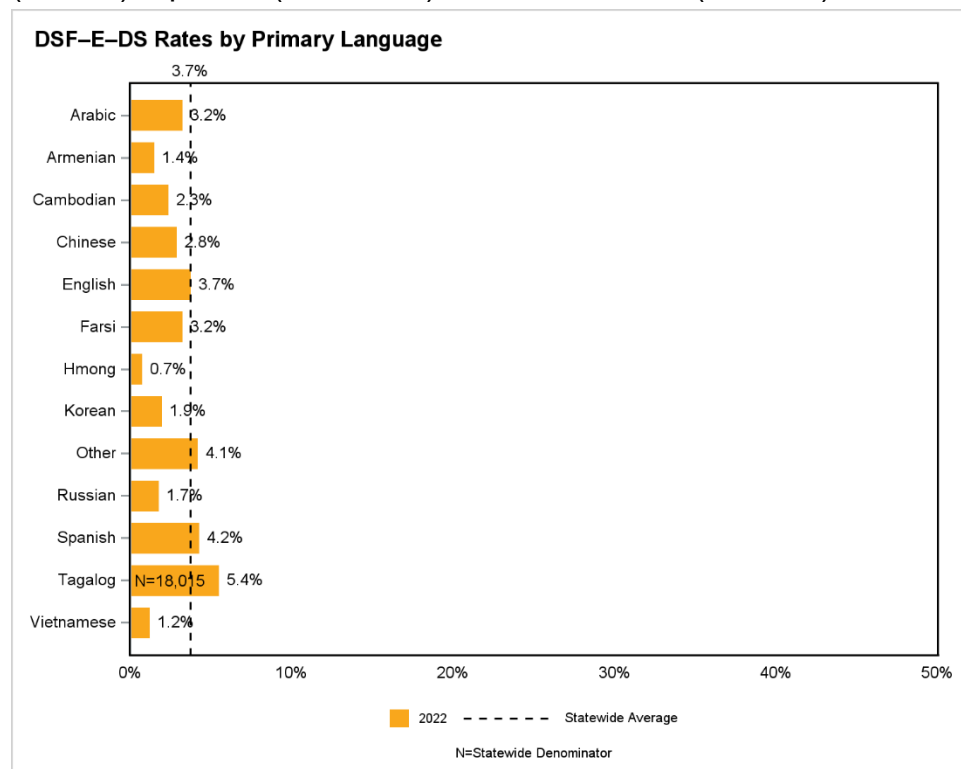
The following are the measurement year 2022 denominator sizes for select racial/ethnic groups: American Indian or Alaska Native (25,671), Asian (698,308), Black or African American (505,995), Hispanic or Latino (3,277,215), Native Hawaiian or Other Pacific Islander (14,735), White (1,163,808), and Other (656,221).



**Figure C.125—Depression Screening and Follow-Up for Adolescents and Adults—
Depression Screening—Total (DSF–E–DS) Rates by Primary Language**

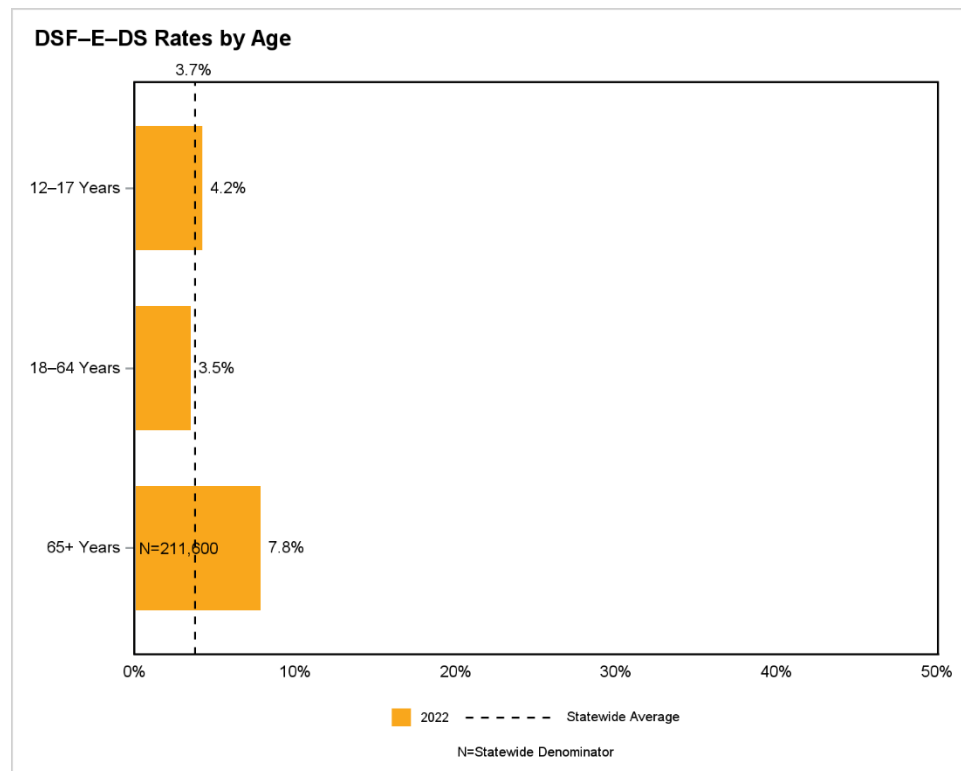
Note: The measurement year 2022 rate for the Unknown/Missing group was 4.0 percent (N=19,235).

The following are the measurement year 2022 denominator sizes for select primary language groups: Arabic (27,974), Armenian (31,051), Cambodian (7,947), Chinese (112,266), English (4,424,402), Farsi (18,898), Hmong (11,564), Korean (19,272), Other (51,732), Russian (20,850), Spanish (1,700,785), and Vietnamese (126,189).



**Figure C.126—Depression Screening and Follow-Up for Adolescents and Adults—
Depression Screening—Total (DSF–E–DS) Rates by Age**

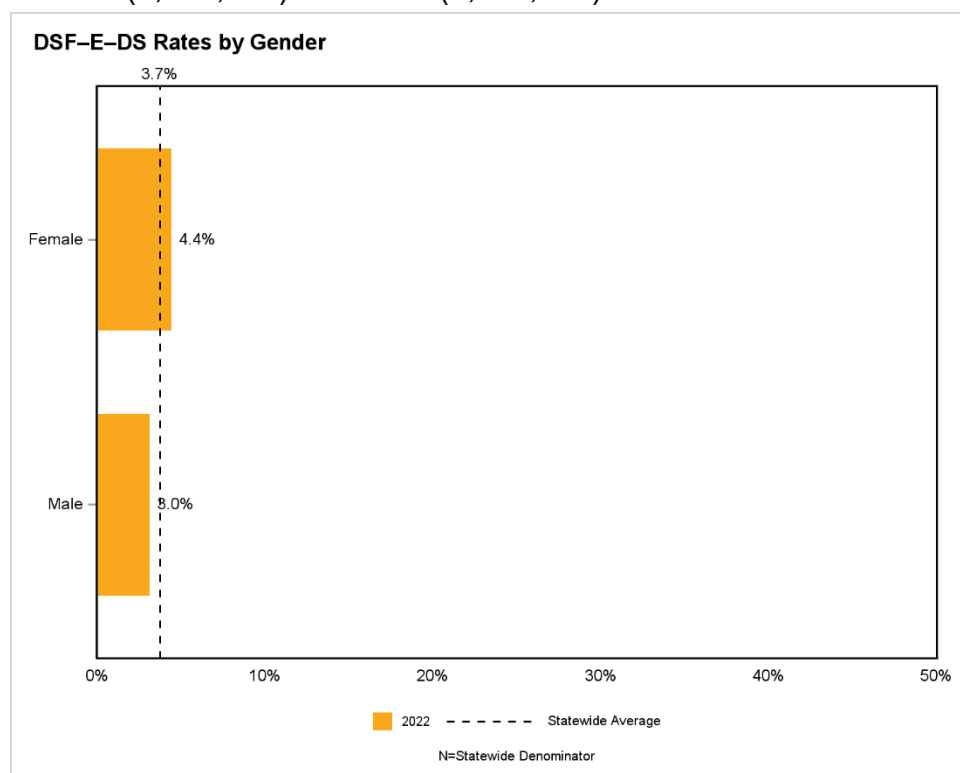
Note: The following are the measurement year 2022 denominator sizes for select age groups: 12–17 Years (1,374,438) and 18–64 Years (5,004,142).



**Figure C.127—Depression Screening and Follow-Up for Adolescents and Adults—
Depression Screening—Total (DSF-E-DS) Rates by Gender**

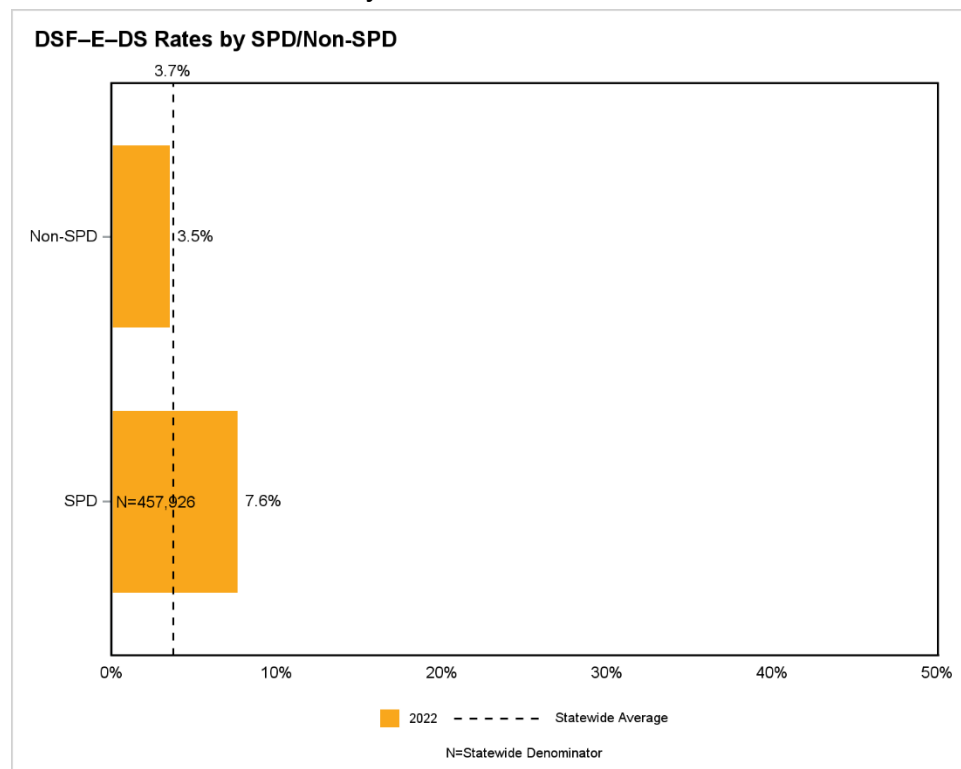
Note: The measurement year 2022 rate for the Unknown/Missing group was 3.6 percent (N=7,317).

The following are the measurement year 2022 denominator sizes for select gender groups: Female (3,456,726) and Male (3,126,137).



**Figure C.128—Depression Screening and Follow-Up for Adolescents and Adults—
Depression Screening—Total (DSF-E-DS) Rates by SPD/Non-SPD**

Note: The measurement year 2022 denominator size for the Non-SPD group was 6,132,254.

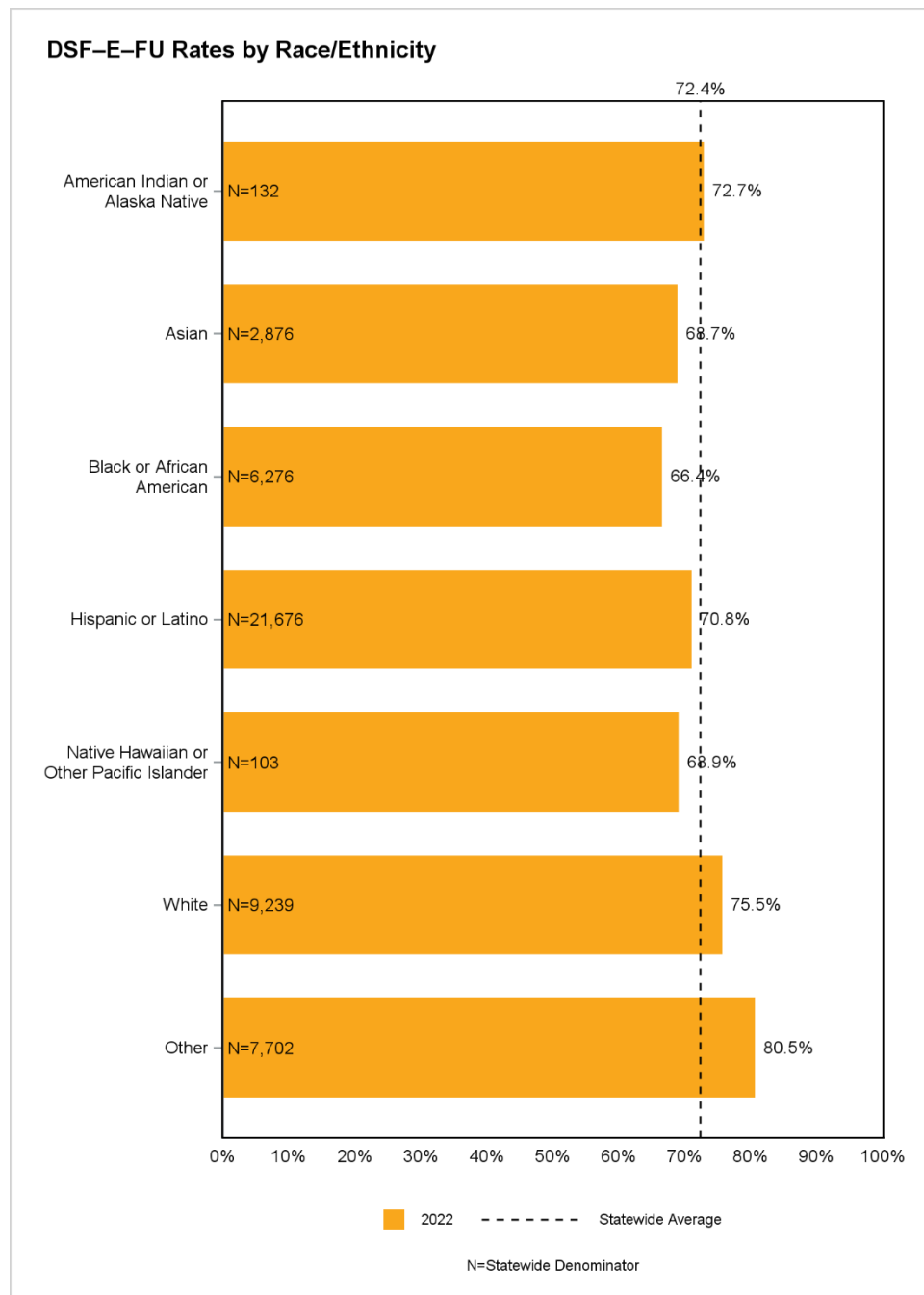


Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total (DSF-E-FU)

The *Depression Screening and Follow-Up for Adolescents and Adults—Follow-Up on Positive Screen—Total (DSF-E-FU)* indicator measures the percentage of members who received follow-up care within 30 days of a positive depression screen finding.

**Figure C.129—Depression Screening and Follow-Up for Adolescents and Adults—
Follow-Up on Positive Screen—Total (DSF-E-FU) Rates by Race/Ethnicity**

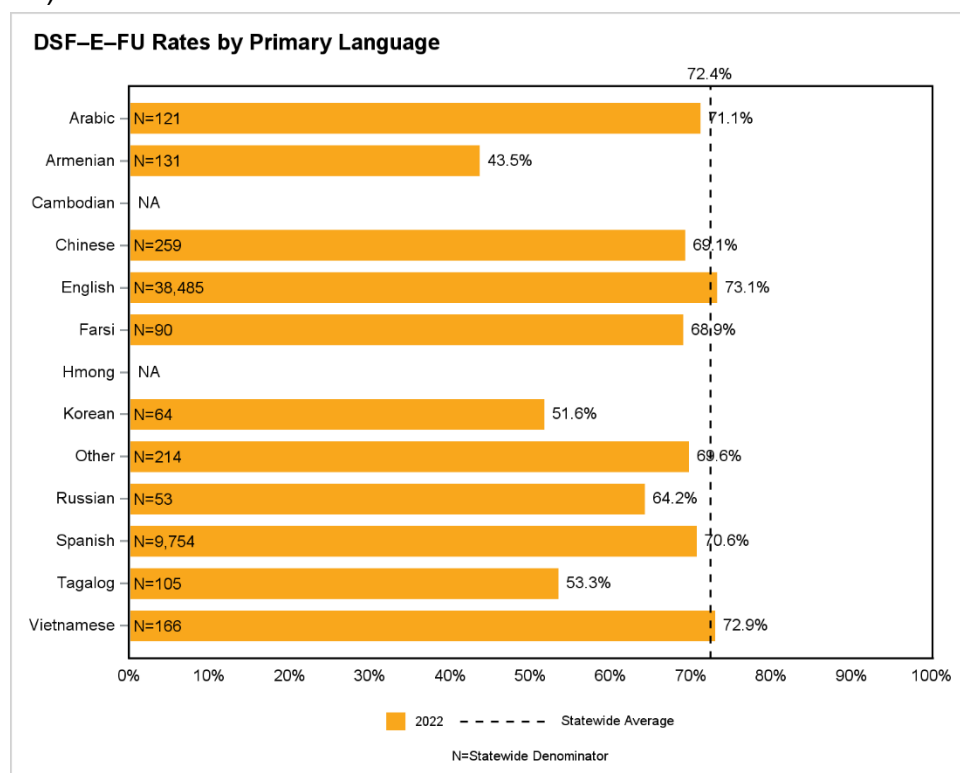
Note: The measurement year 2022 rate for the Unknown/Missing group was 66.7 percent (N=1,589).



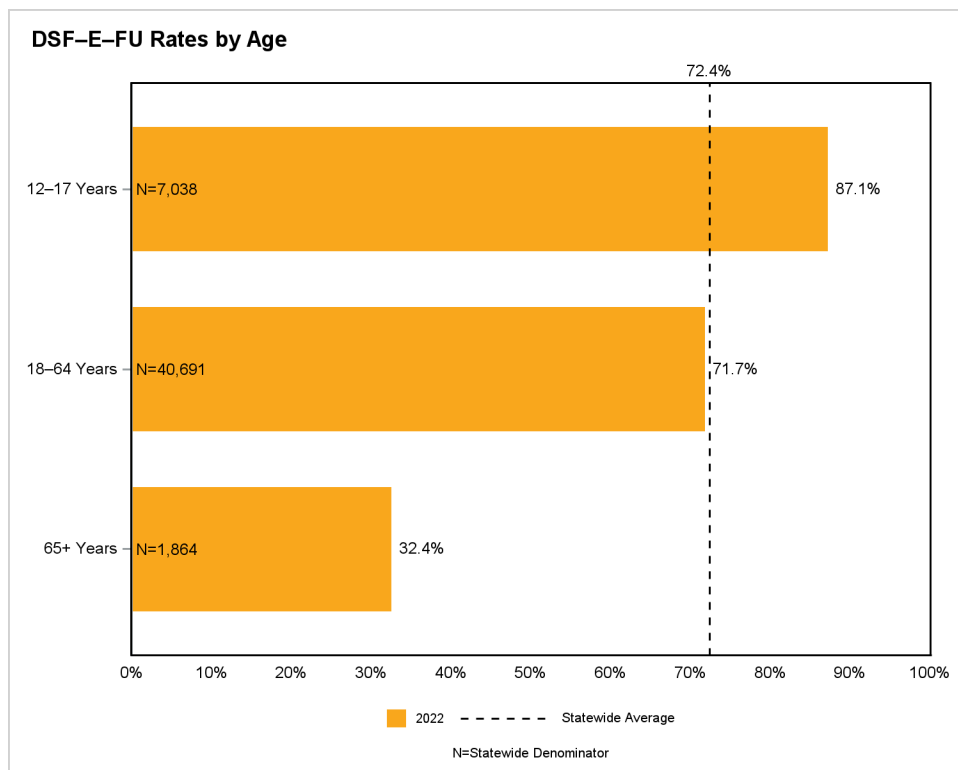
**Figure C.130—Depression Screening and Follow-Up for Adolescents and Adults—
Follow-Up on Positive Screen—Total (DSF-E-FU) Rates by Primary Language**

Note: The measurement year 2022 rate for the Unknown/Missing group was 72.5 percent (N=109).

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

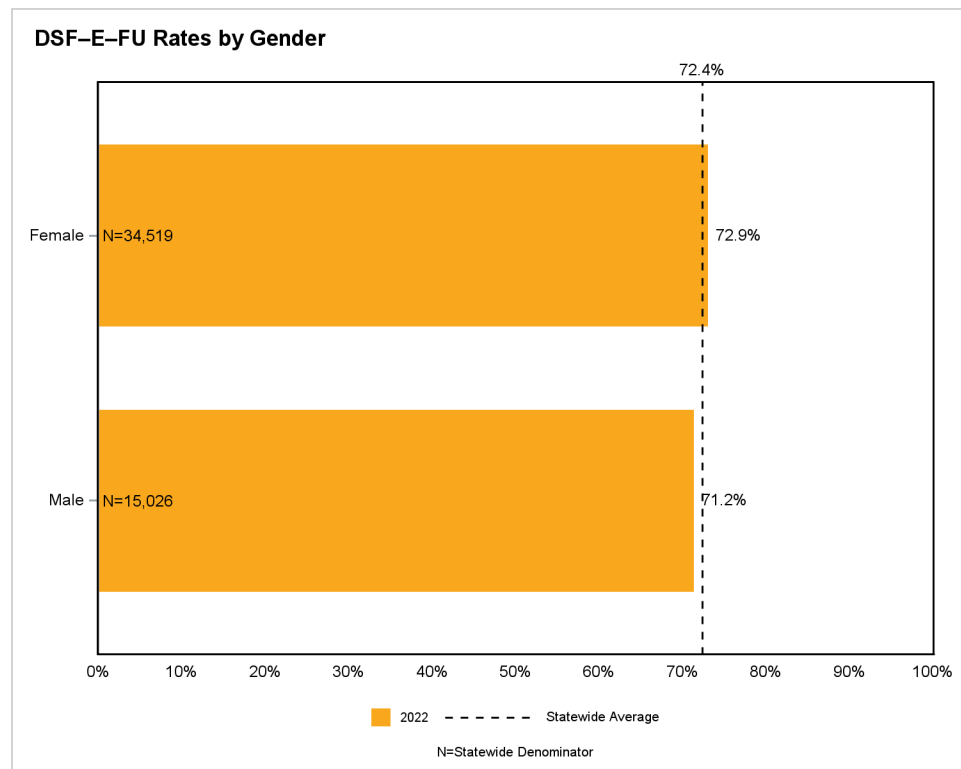


**Figure C.131—Depression Screening and Follow-Up for Adolescents and Adults—
Follow-Up on Positive Screen—Total (DSF–E–FU) Rates by Age**

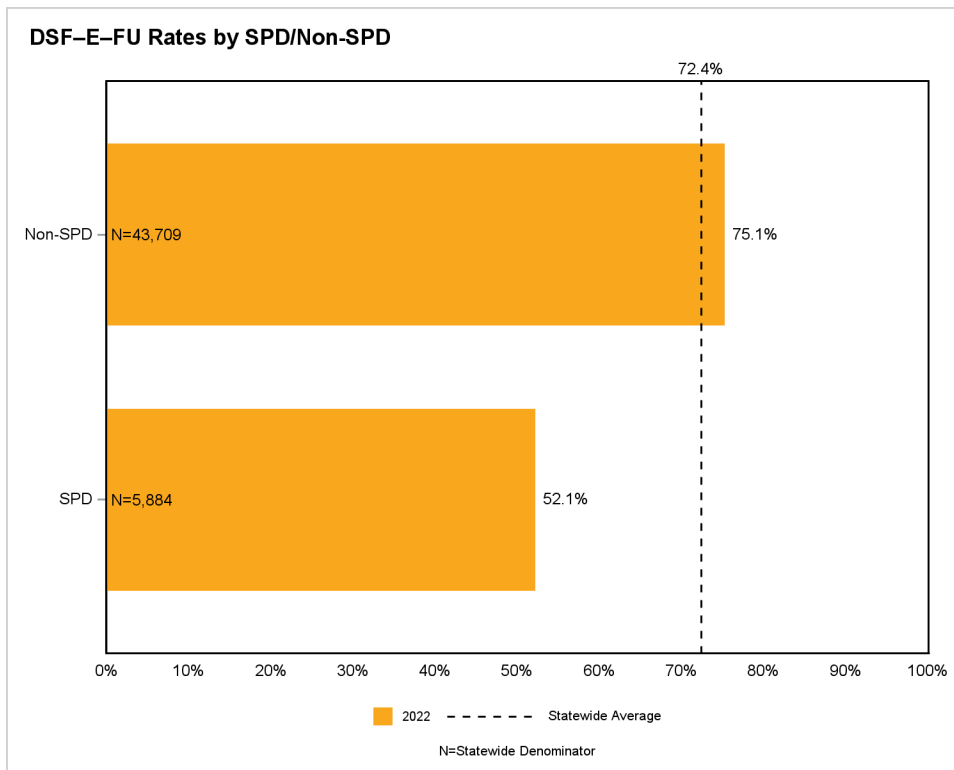


**Figure C.132—Depression Screening and Follow-Up for Adolescents and Adults—
Follow-Up on Positive Screen—Total (DSF-E-FU) Rates by Gender**

Note: The measurement year 2022 rate for the Unknown/Missing group was 79.2 percent (N=48).



**Figure C.133—Depression Screening and Follow-Up for Adolescents and Adults—
Follow-Up on Positive Screen—Total (DSF–E–FU) Rates by SPD/Non-SPD**



Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* indicator measures the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test.

Figure C.134—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 78.1 percent (N=3,037) and 77.6 percent (N=4,669), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.6 percent and 82.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 79.9 percent.

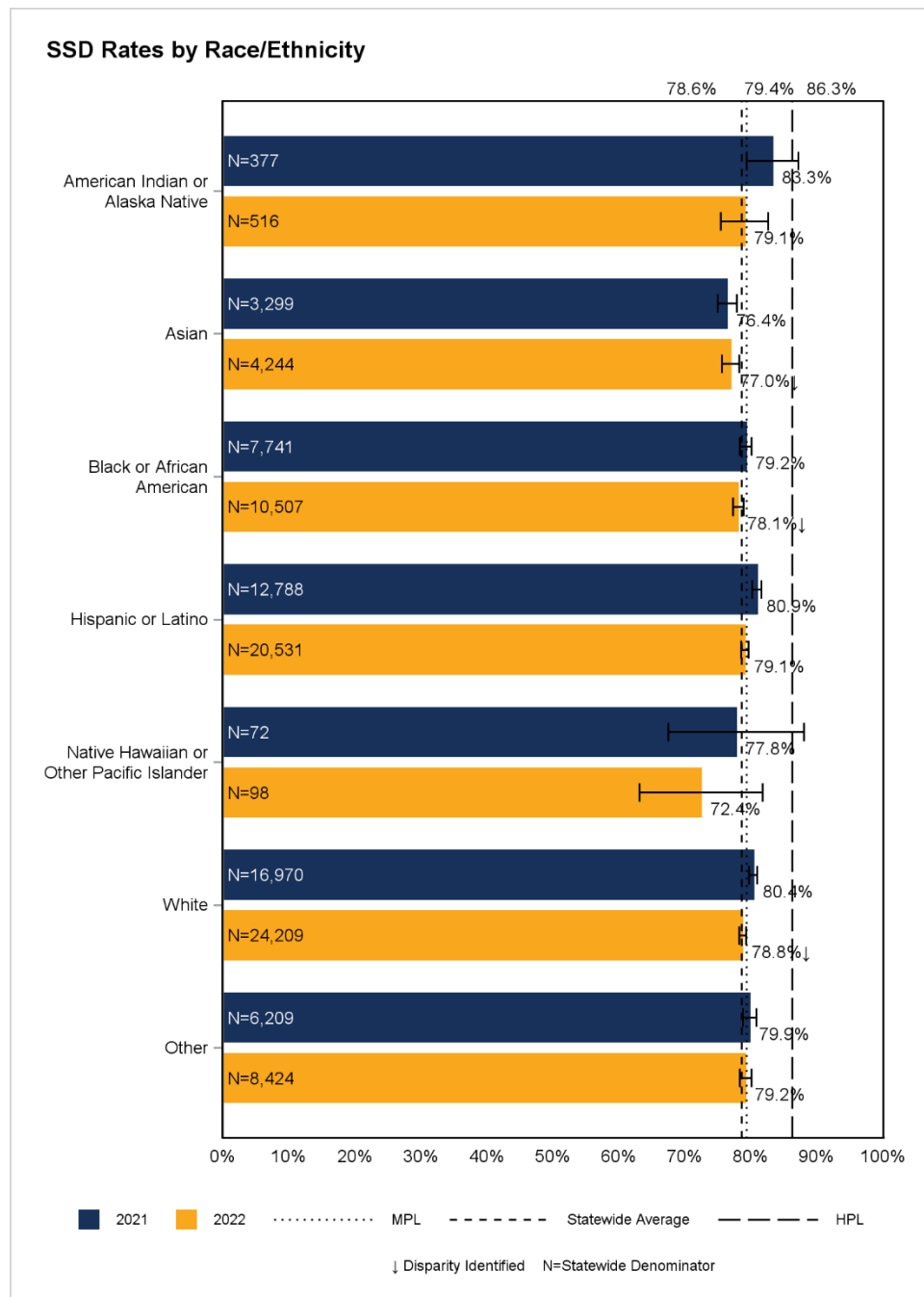


Figure C.135—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 78.2 percent (N=1,140) and 79.9 percent (N=1,376), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.6 percent and 82.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 79.9 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

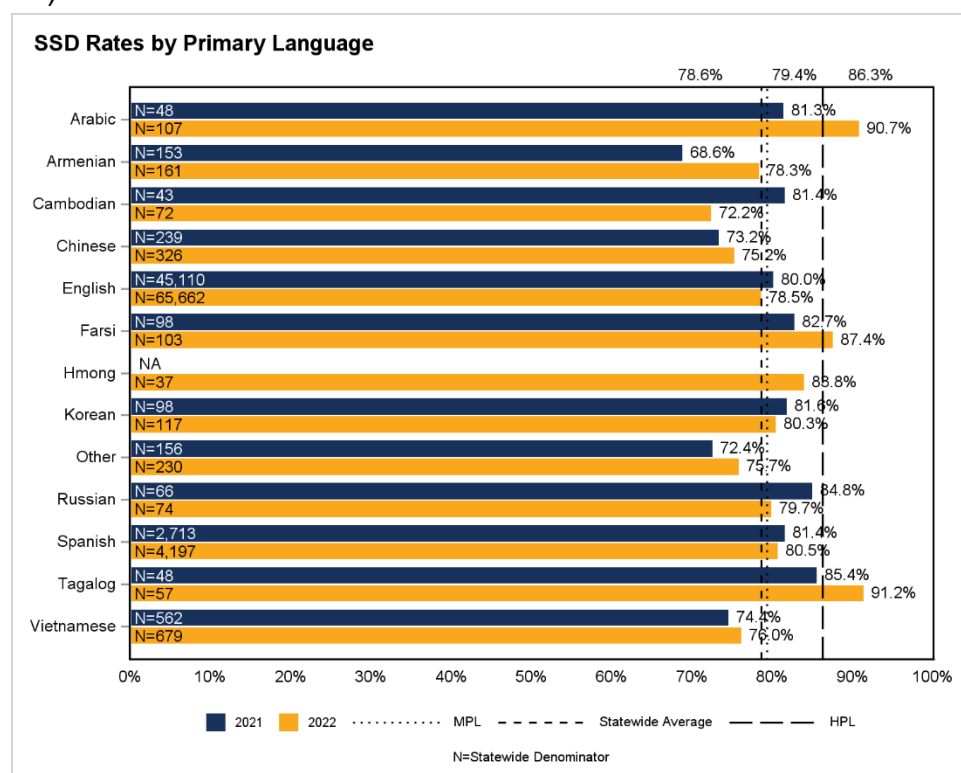


Figure C.136—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Rates by Gender

Note: The measurement year 2021 rate for the Unknown/Missing group was suppressed due to small denominator. The measurement year 2022 rate for the Unknown/Missing group was 91.7 percent (N=72).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.6 percent and 82.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 79.9 percent.

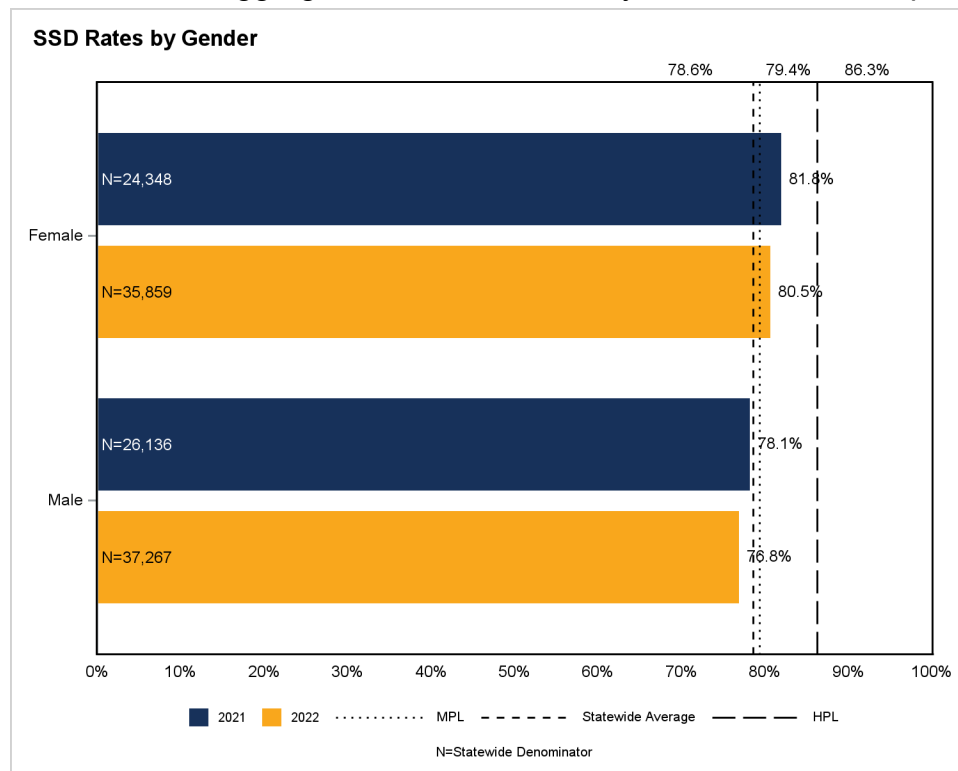
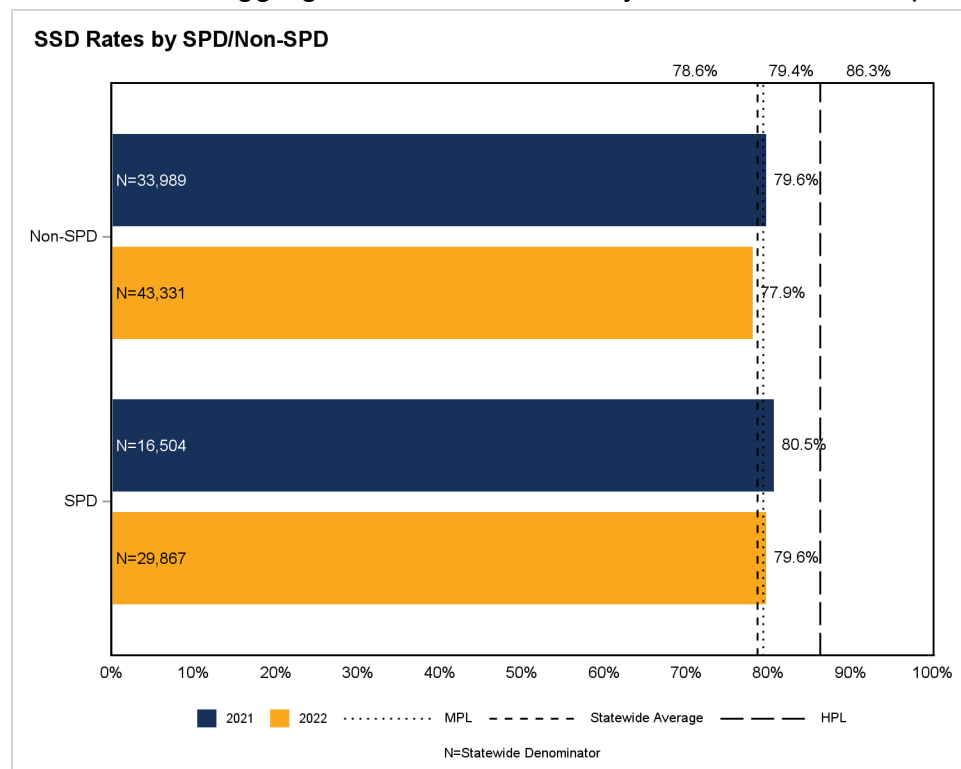


Figure C.137—Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 76.6 percent and 82.5 percent, respectively.

The statewide aggregate for measurement year 2021 was 79.9 percent.



Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA-7)

The *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA-7)* indicator measures the percentage of emergency department visits among members 13 years of age and older with a principal diagnosis of substance use disorder, or any diagnosis of drug overdose, for which there was follow-up within 7 days of the emergency department visit.

Figure C.138—Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA-7) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 18.4 percent (N=2,256).

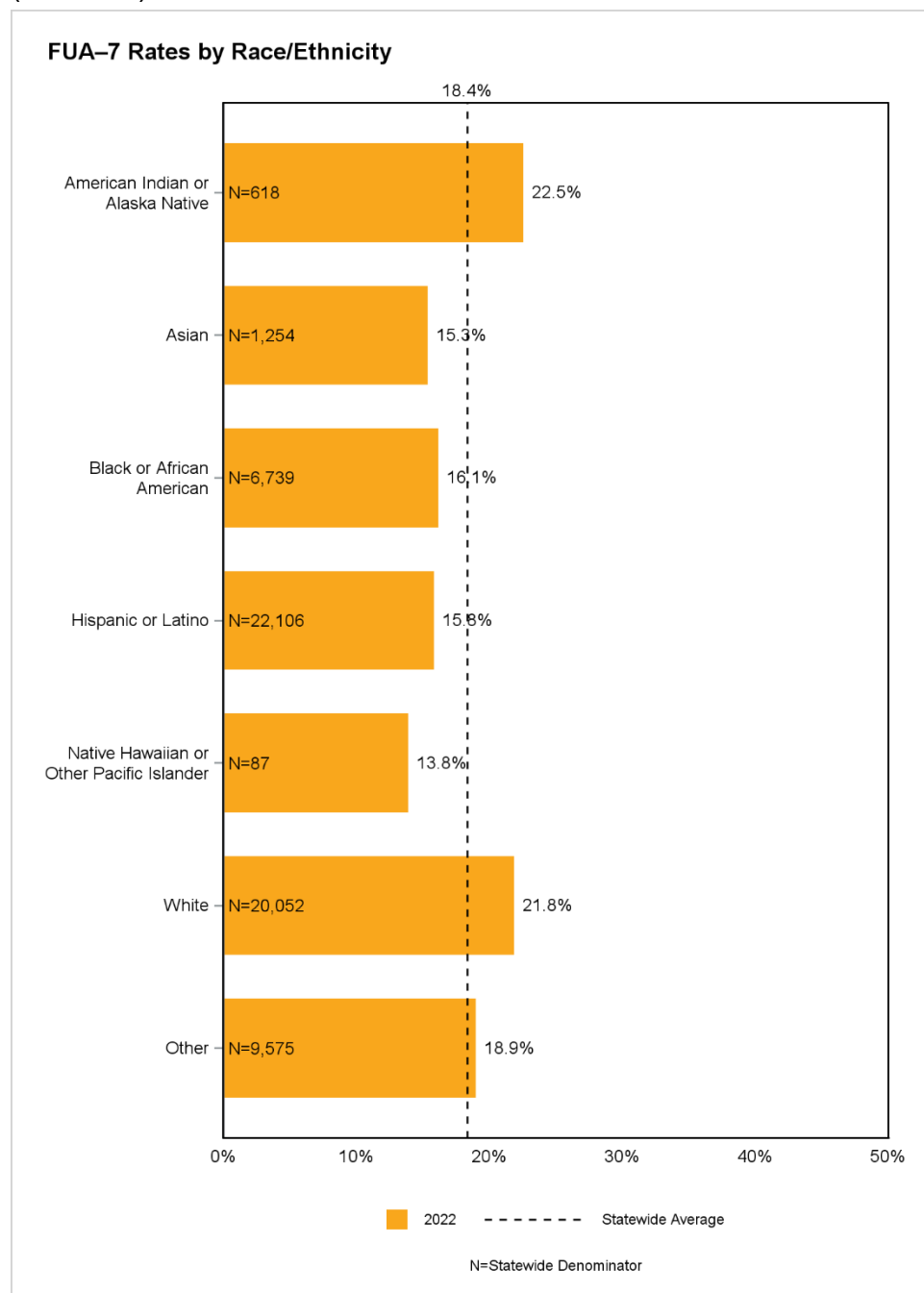


Figure C.139—Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA-7) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was 17.4 percent (N=86).

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

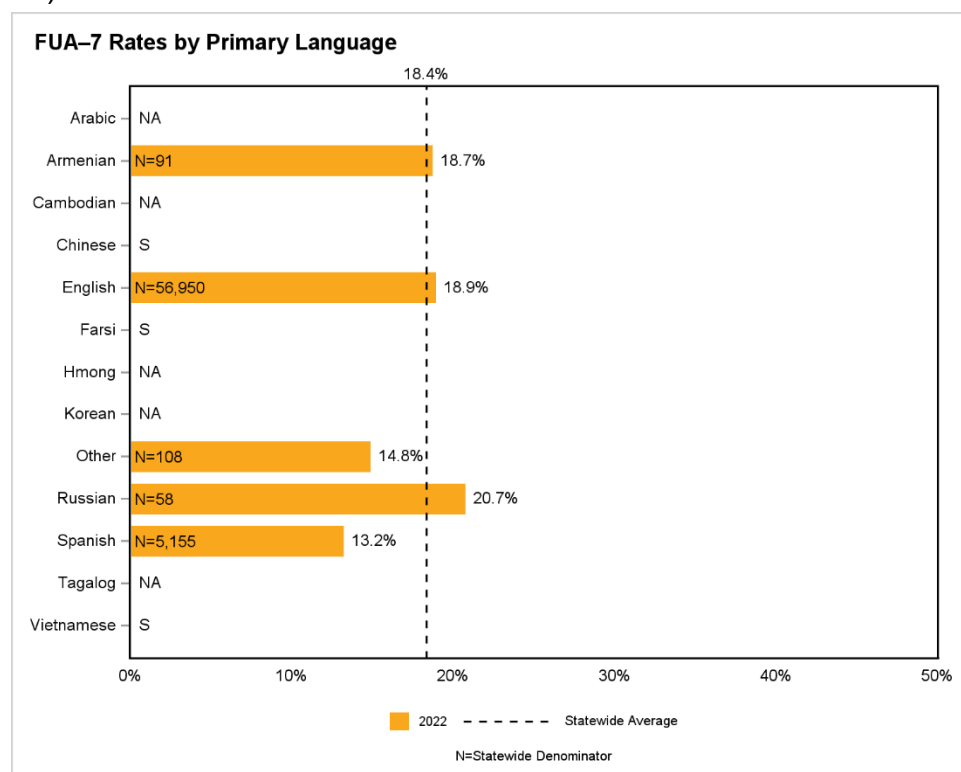


Figure C.140—Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA-7) Rates by Age

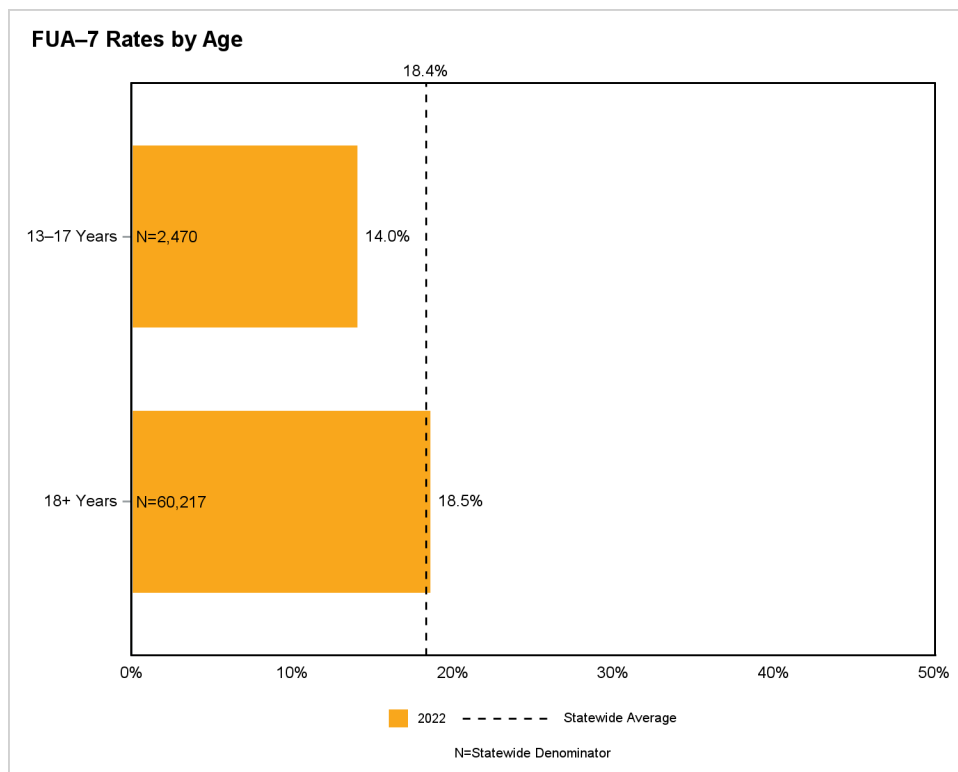


Figure C.141—Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA-7) Rates by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.

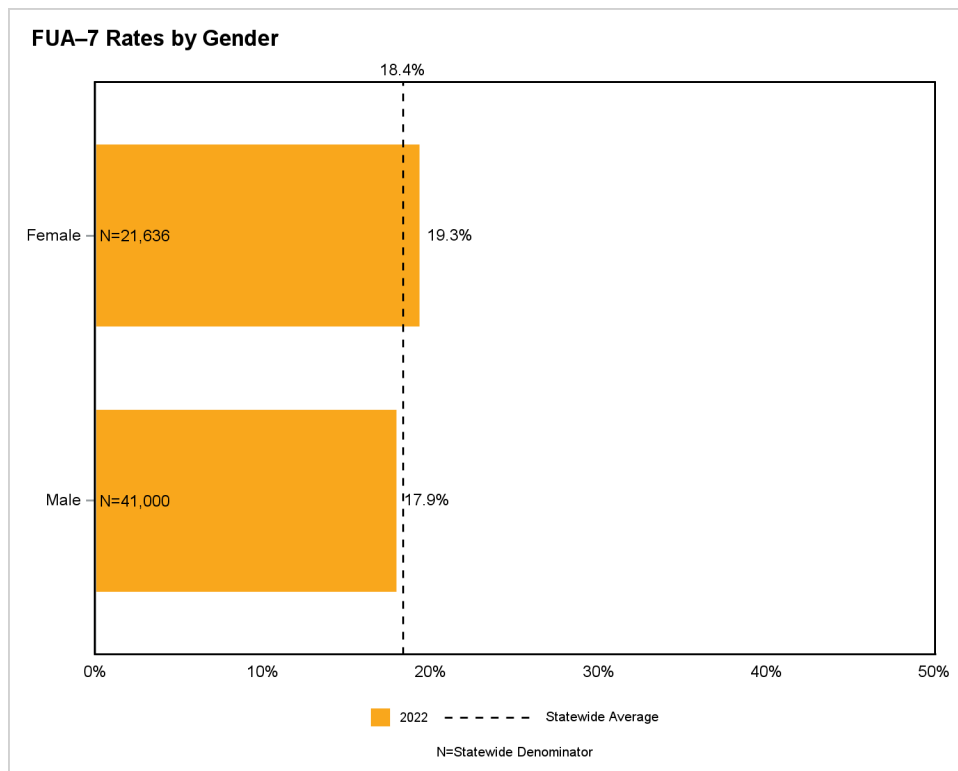
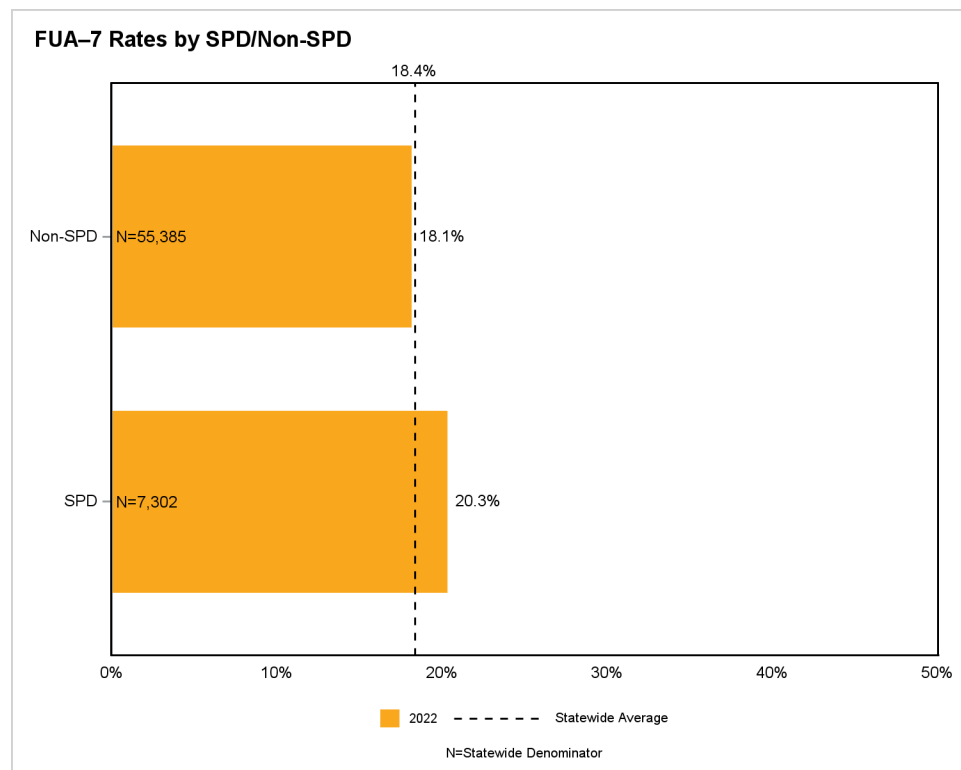


Figure C.142—Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA-7) Rates by SPD/Non-SPD



Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30)

The *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30)* indicator measures the percentage of emergency department visits among members 13 years of age and older with a principal diagnosis of substance use disorder, or any diagnosis of drug overdose, for which there was follow-up within 30 days of the emergency department visit.

Figure C.143—Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 28.0 percent (N=2,256).

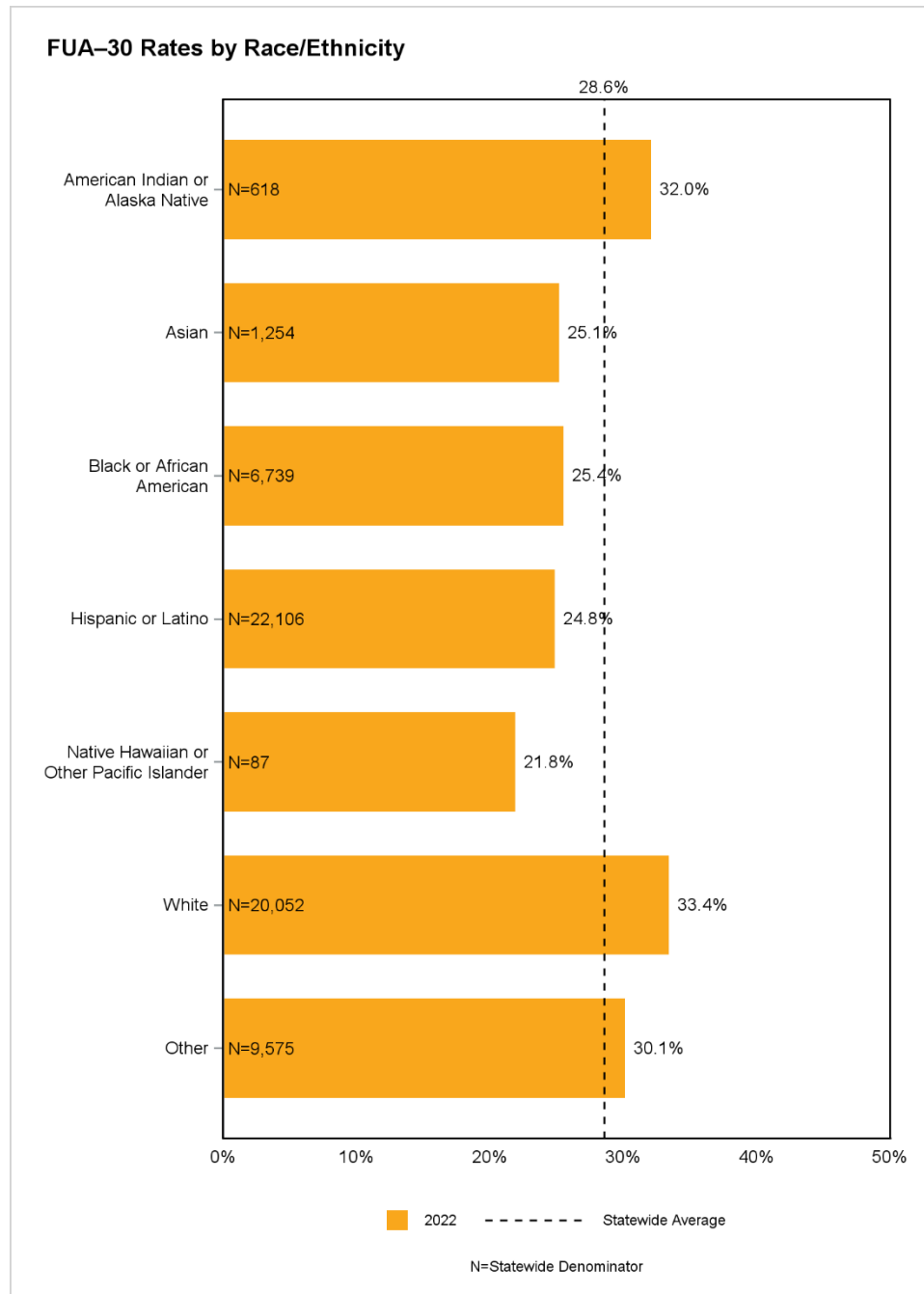


Figure C.144—Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was 20.9 percent (N=86).

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

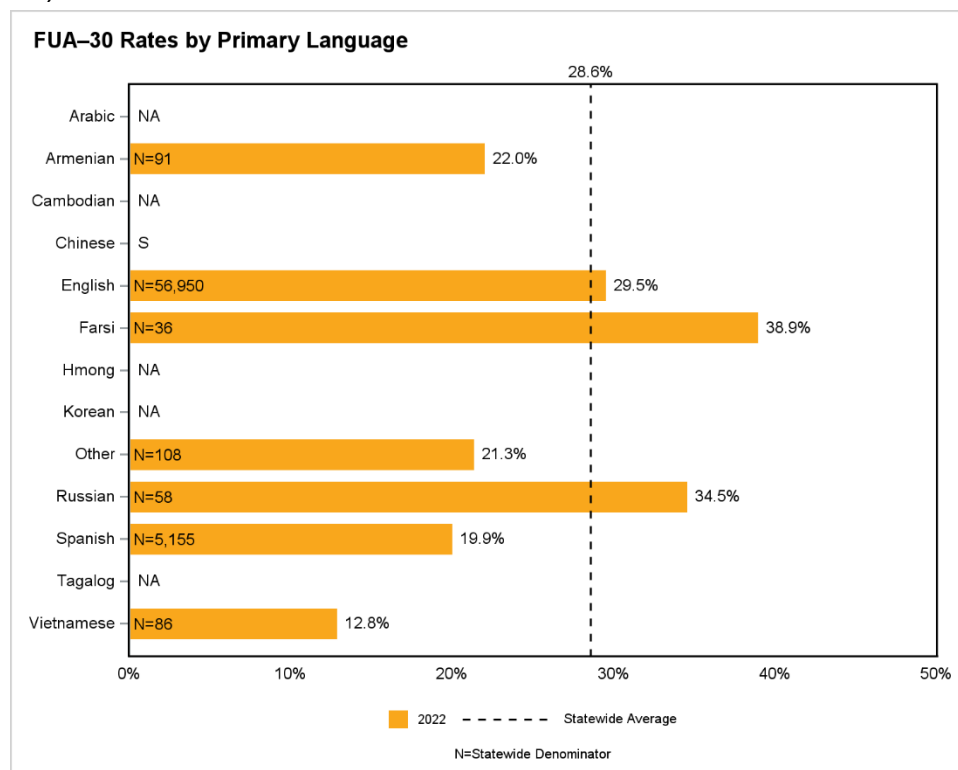


Figure C.145—Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30) Rates by Age

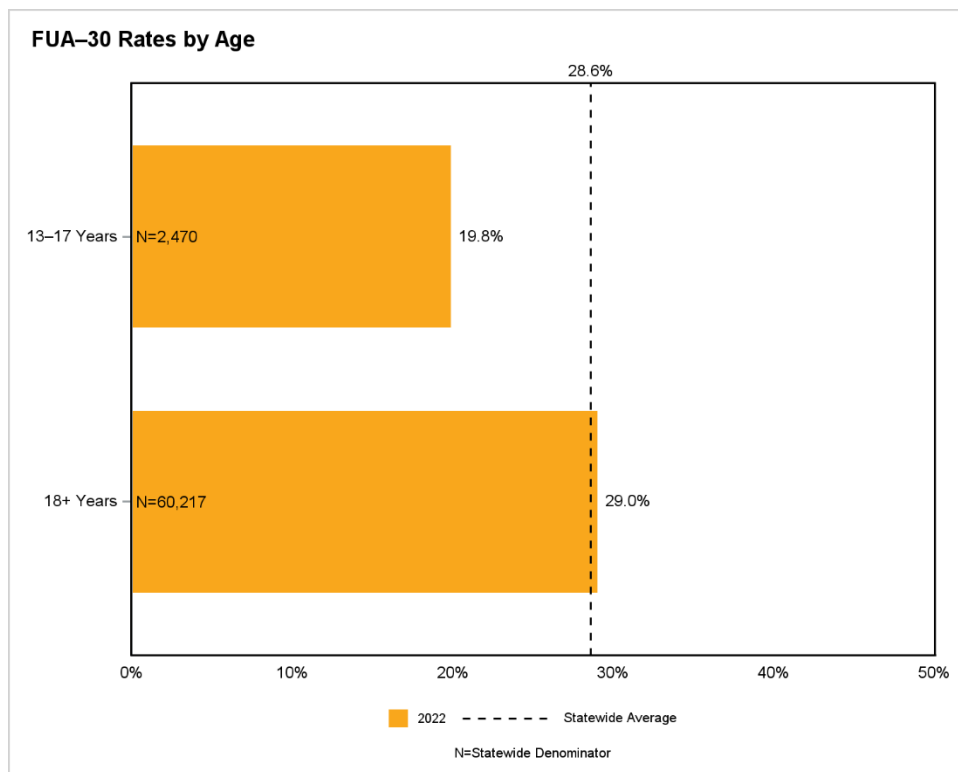


Figure C.146—Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30) Rates by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.

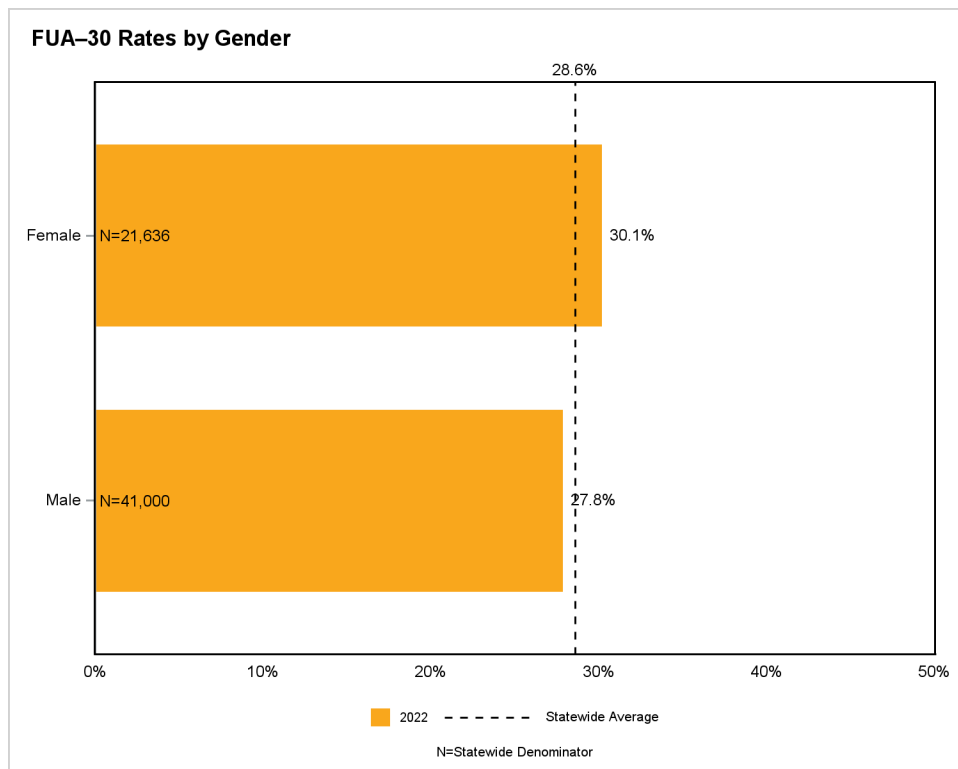


Figure C.147—Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30) Rates by SPD/Non-SPD



Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7)

The *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total (FUM-7)* indicator measures the percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 7 days of the emergency department visit.

Figure C.148—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7) Rates by Race/Ethnicity

The measurement year 2021 and 2022 rates for the Unknown/Missing group were 23.6 percent (N=2,380) and 33.8 percent (N=2,492), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.6 percent and 61.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 23.3 percent.

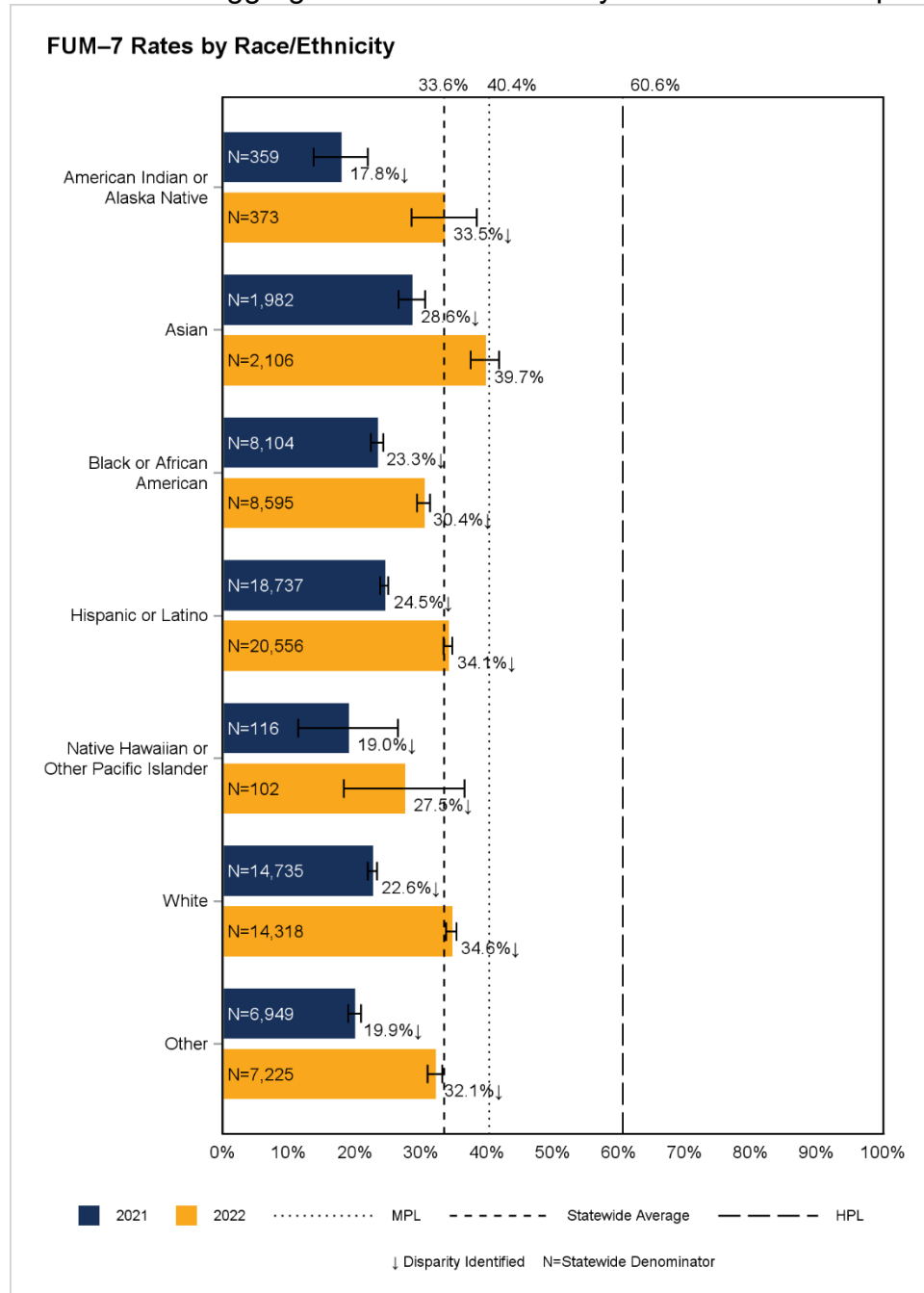


Figure C.149—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 27.3 percent (N=253) and 34.4 percent (N=244), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.6 percent and 61.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 23.3 percent.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

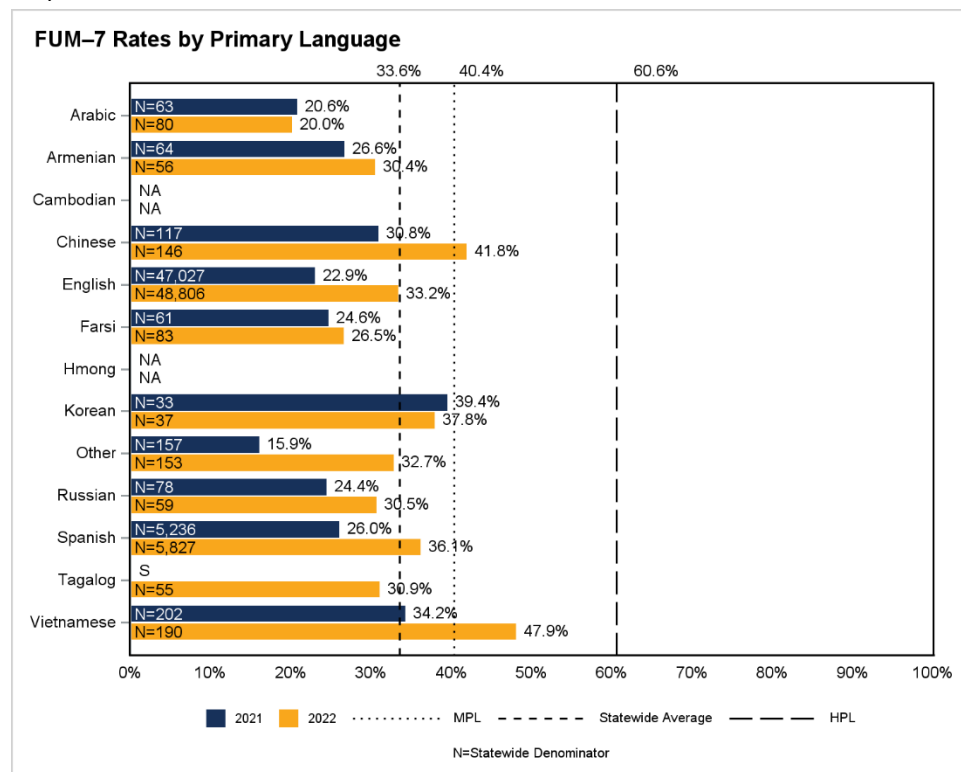


Figure C.150—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.6 percent and 61.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 23.3 percent.

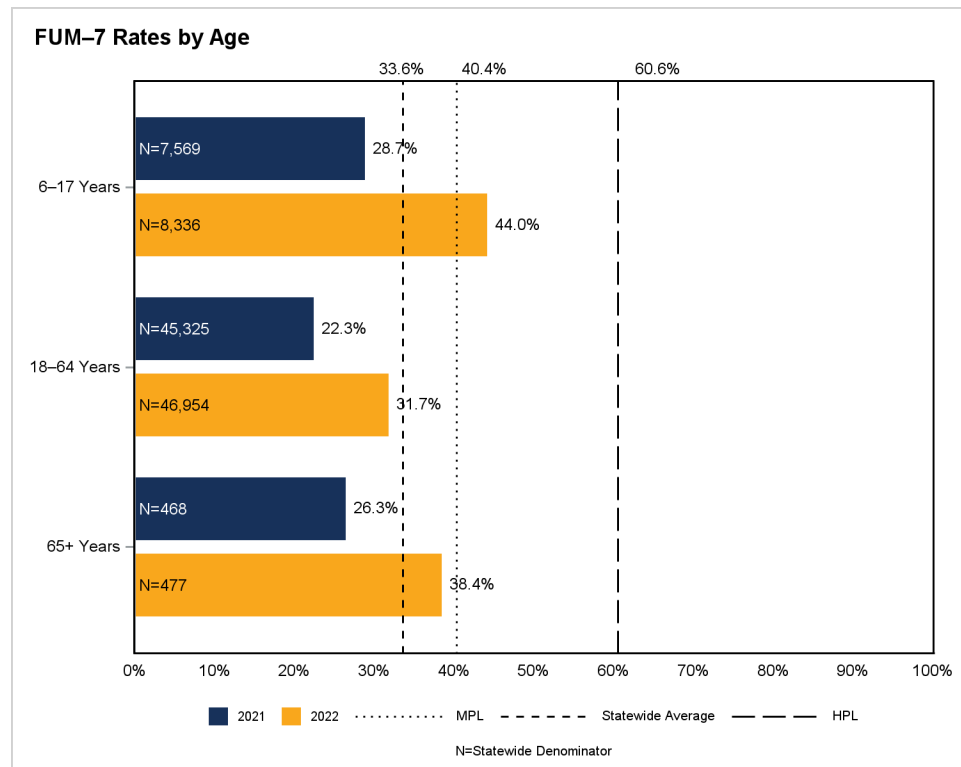


Figure C.151—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7) Rates by Gender

Note: The measurement year 2021 rate for the Unknown/Missing group was suppressed due to a small denominator. The measurement year 2022 rate for the Unknown/Missing group was 28.9 percent (N=45).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.6 percent and 61.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 23.3 percent.

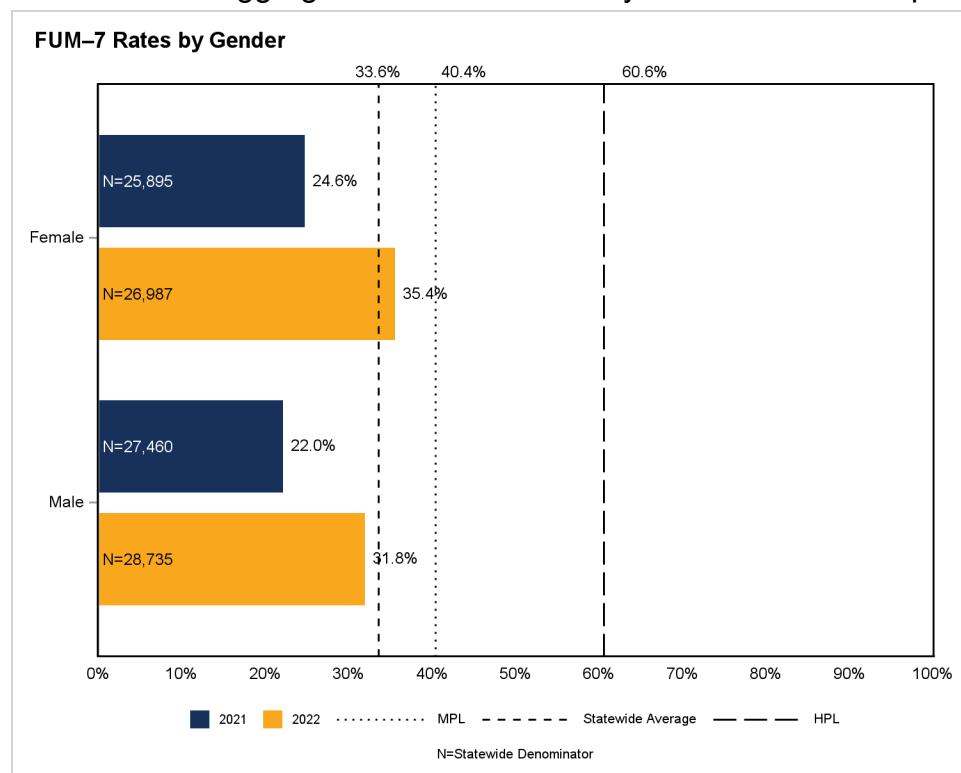
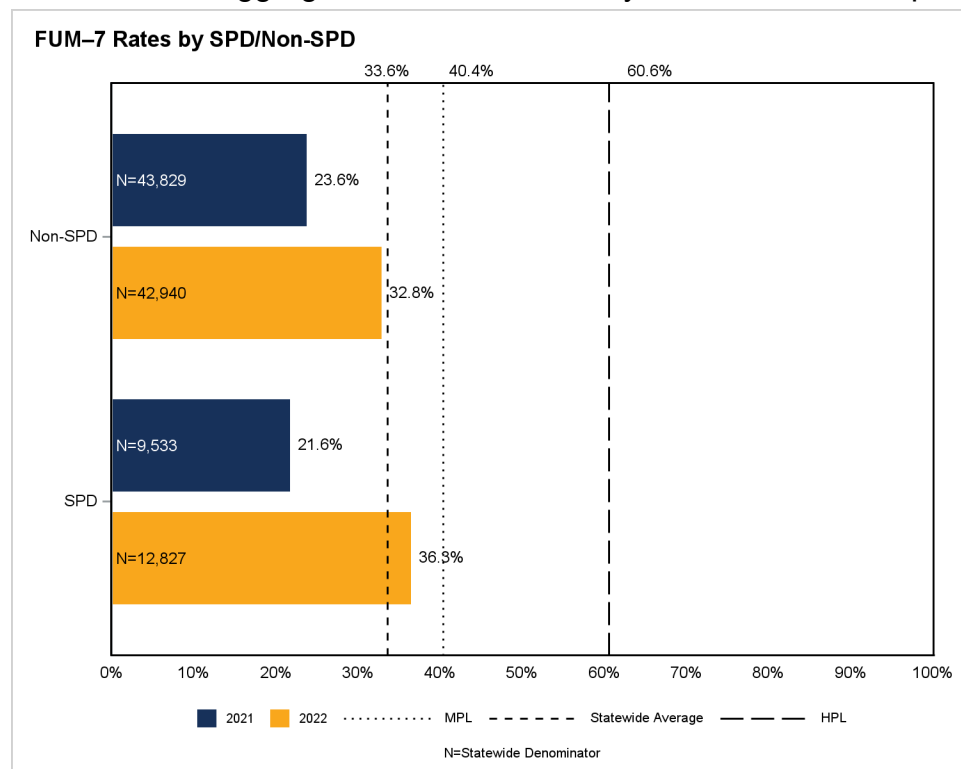


Figure C.152—Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 38.6 percent and 61.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 23.3 percent.



Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)

The *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total (FUM-30)* indicator measures the percentage of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within 30 days of the emergency department visit.

Figure C.153—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30) Rates by Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 35.4 percent (N=2,380) and 47.4 percent (N=2,492), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.5 percent and 74.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 34.8 percent.

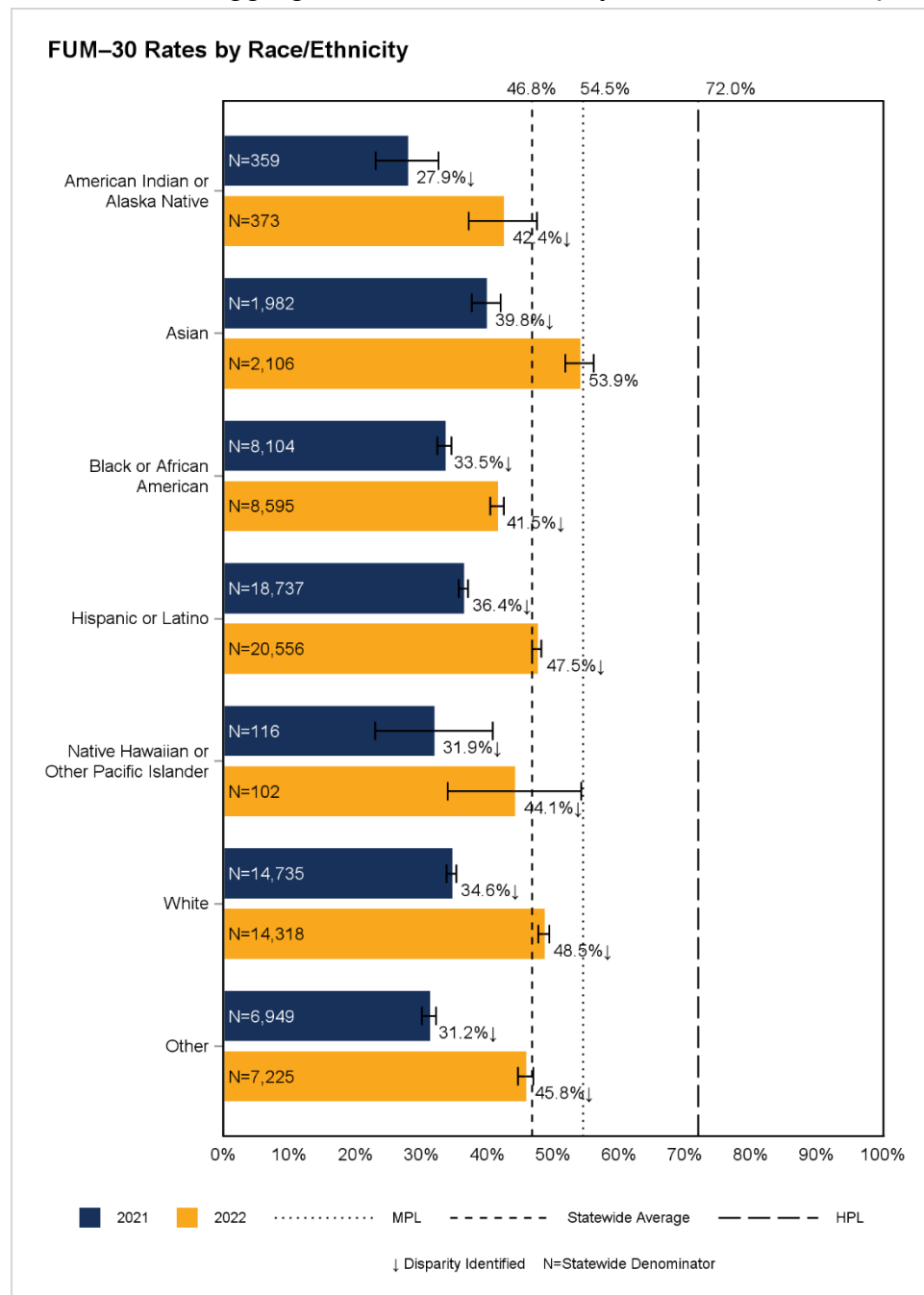


Figure C.154—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 40.7 percent (N=253) and 45.9 percent (N=244), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.5 percent and 74.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 34.8 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

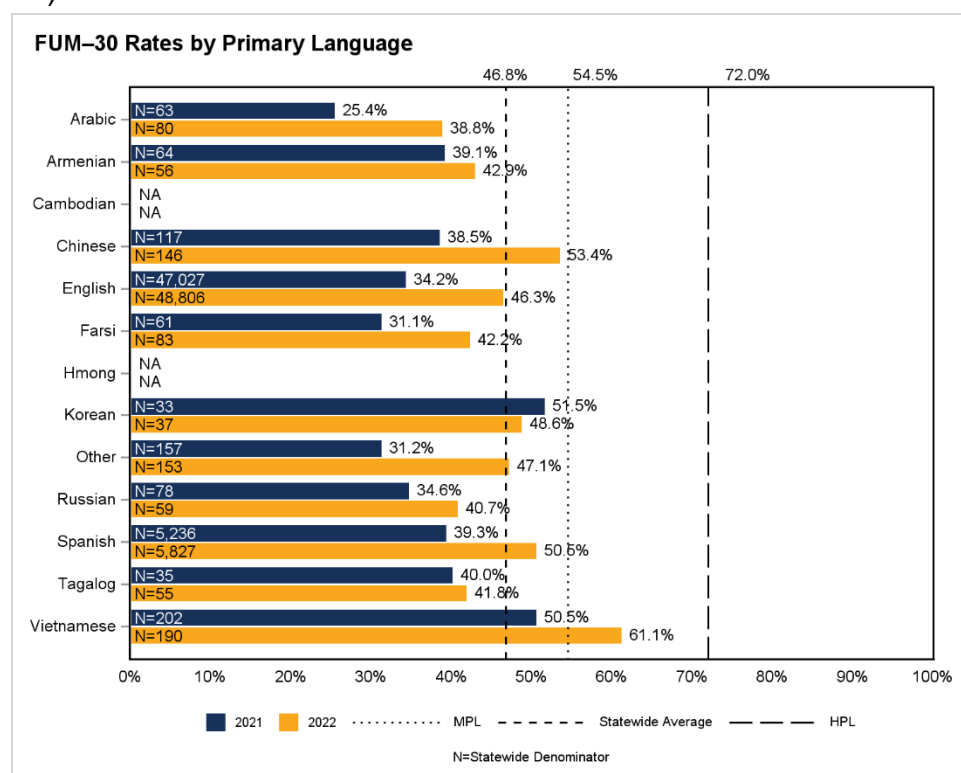


Figure C.155—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.5 percent and 74.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 34.8 percent.

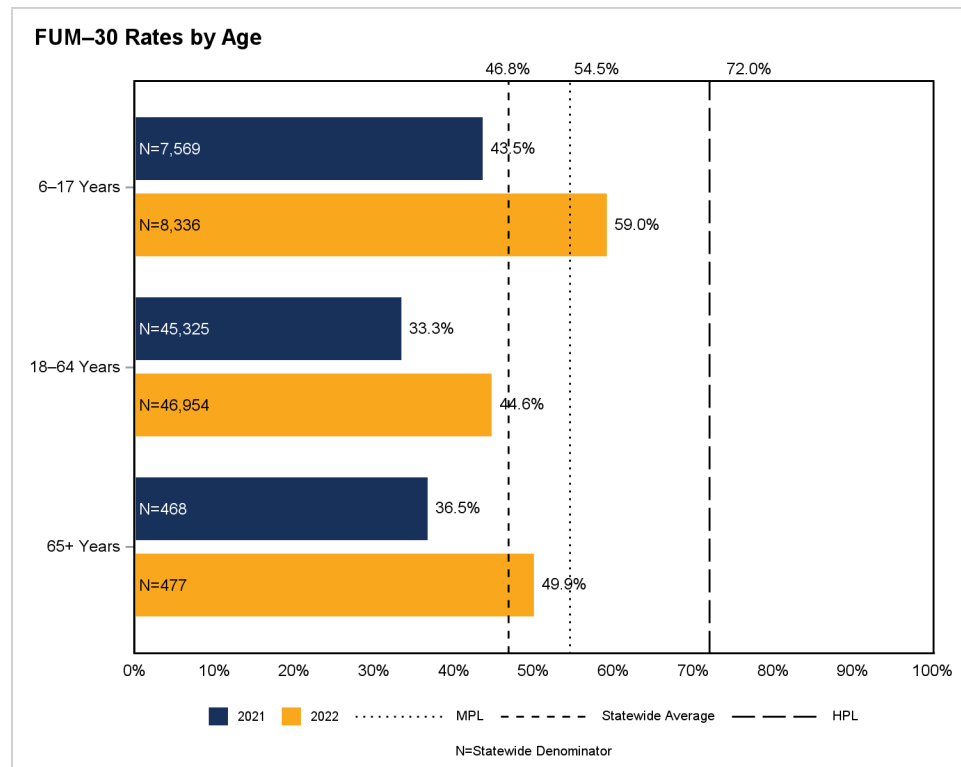


Figure C.156—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30) Rates by Gender

Note: The measurement year 2021 rate for the Unknown/Missing group was suppressed due to a small denominator. The measurement year 2022 rate for the Unknown/Missing group was 40.0 percent (N=45).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.5 percent and 74.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 34.8 percent.

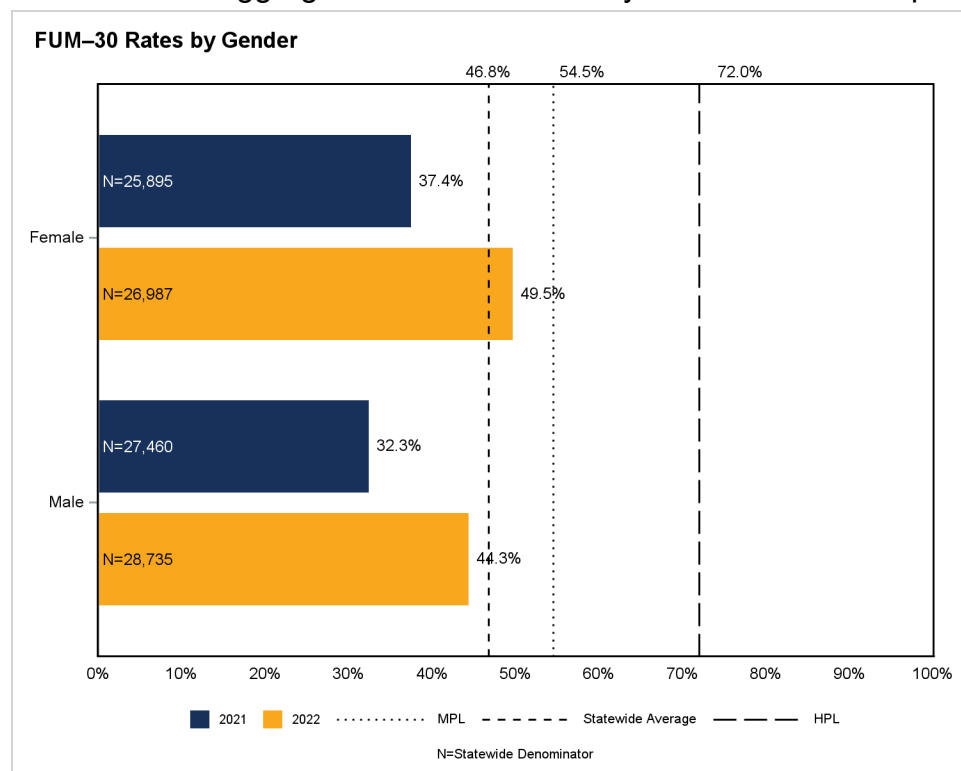
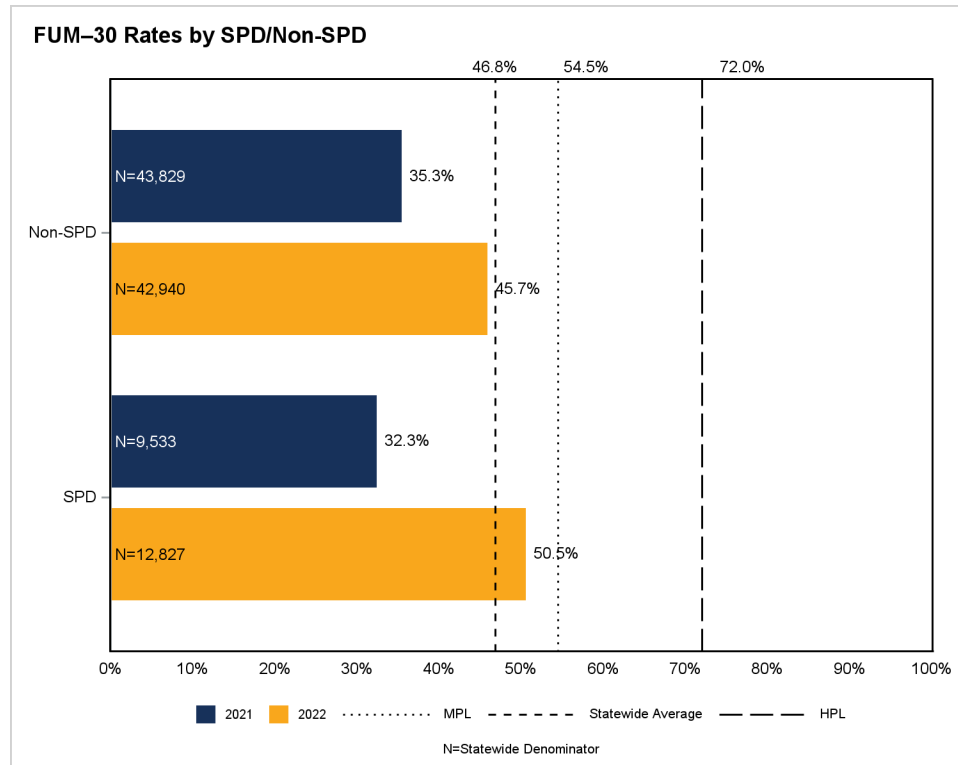


Figure C.157—Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 53.5 percent and 74.4 percent, respectively.

The statewide aggregate for measurement year 2021 was 34.8 percent.



Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD-Init)

The *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD-Init)* indicator measures the percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.

Figure C.158—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD-Init) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 39.5 percent (N=744) and 46.4 percent (N=844), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 44.5 percent and 56.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 42.1 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

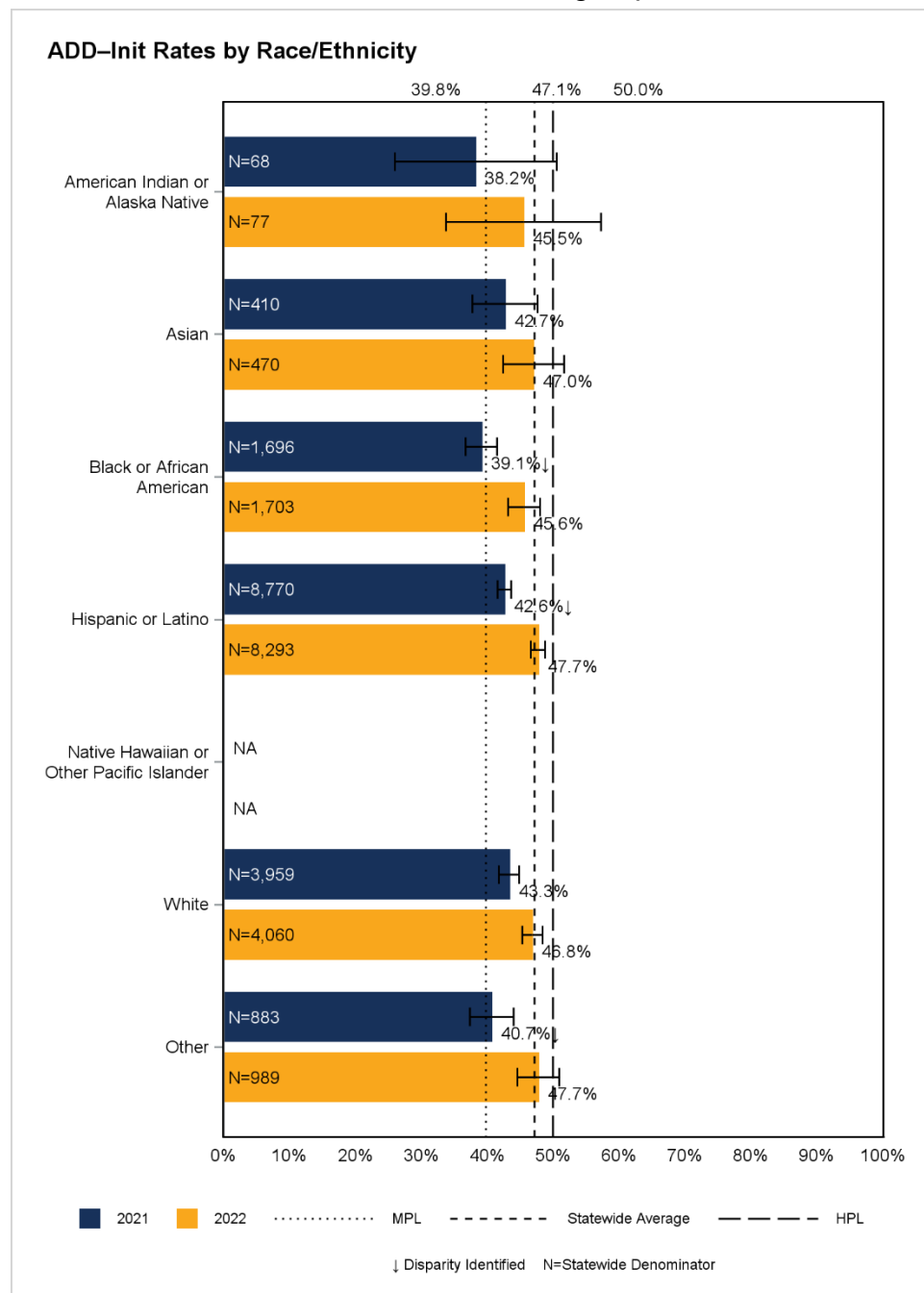


Figure C.159—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD-Init) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 44.5 percent and 56.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 42.1 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

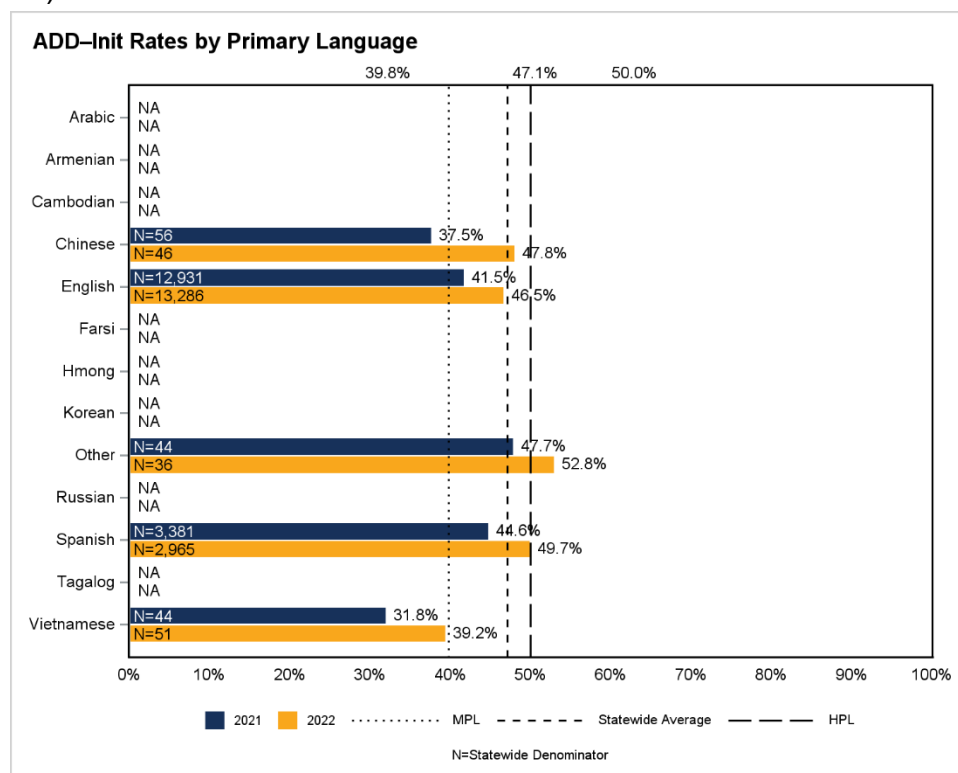


Figure C.160—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD-Init) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 44.5 percent and 56.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 42.1 percent.

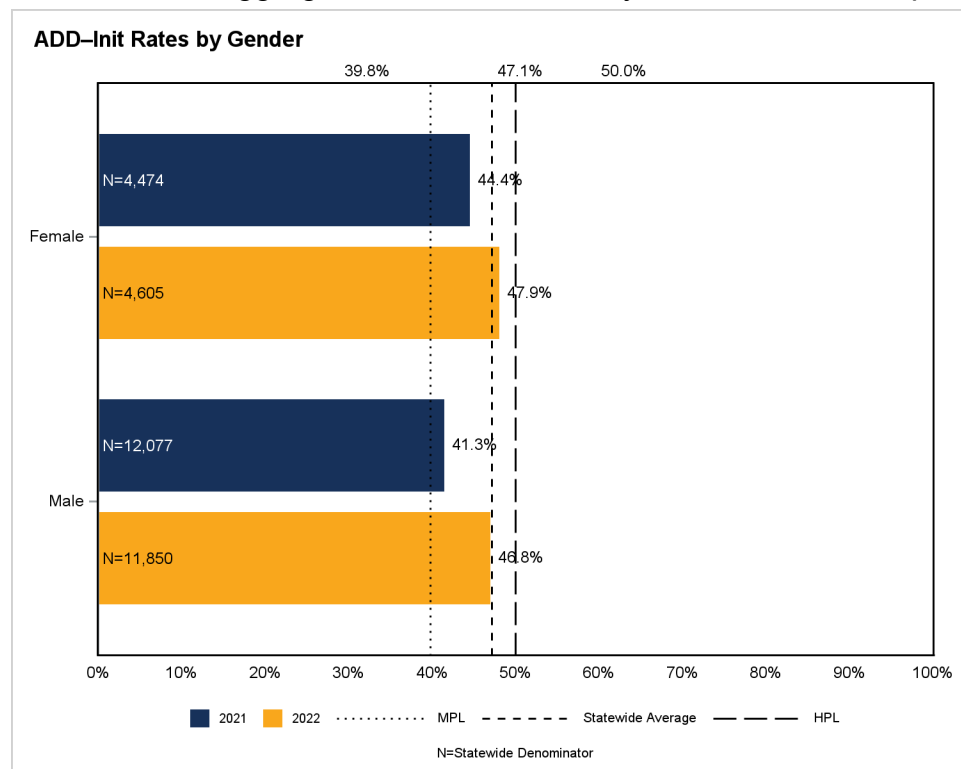
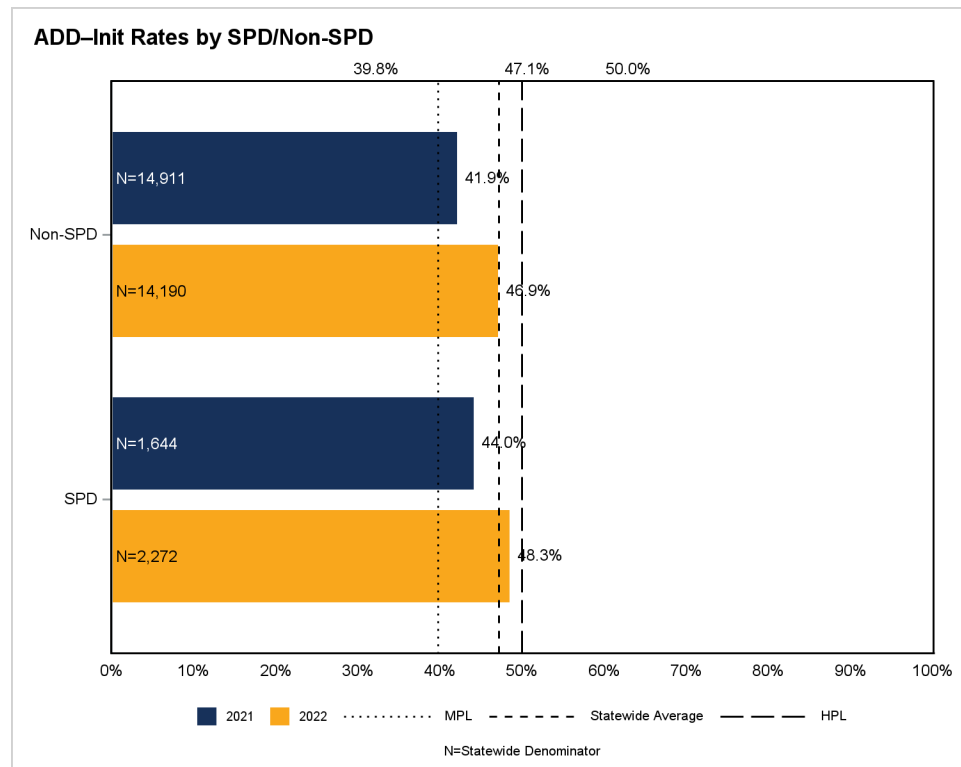


Figure C.161—Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD–Init) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 44.5 percent and 56.0 percent, respectively.

The statewide aggregate for measurement year 2021 was 42.1 percent.



Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD–C&M)

The *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD–C&M)* indicator measures the percentage of members 6 to 12 years of age with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the initiation phase ended.

Figure C.162—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD–C&M) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 49.7 percent (N=183) and 54.9 percent (N=266), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.0 percent and 67.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 49.4 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

ADD-C&M Rates by Race/Ethnicity

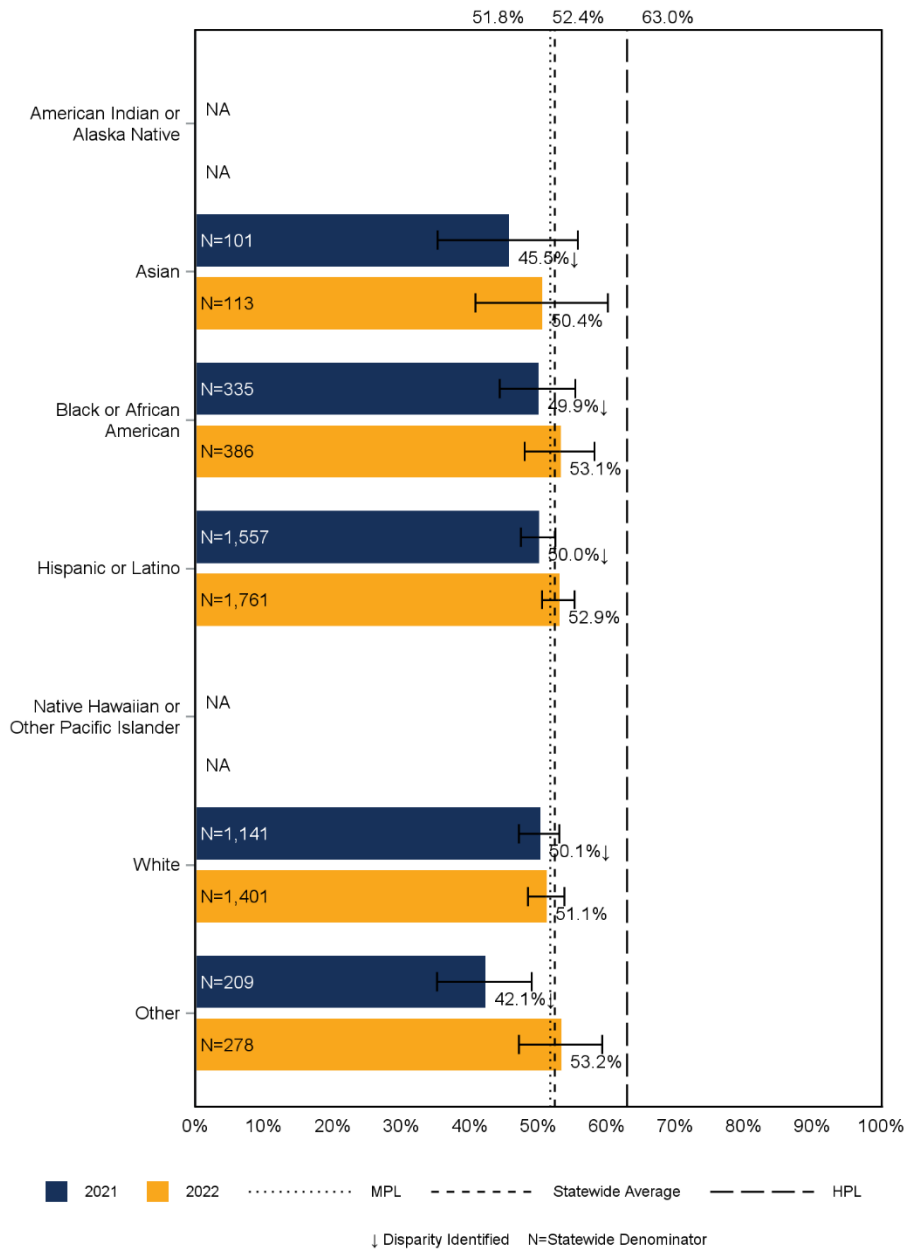


Figure C.163—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD-C&M) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.0 percent and 67.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 49.4 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

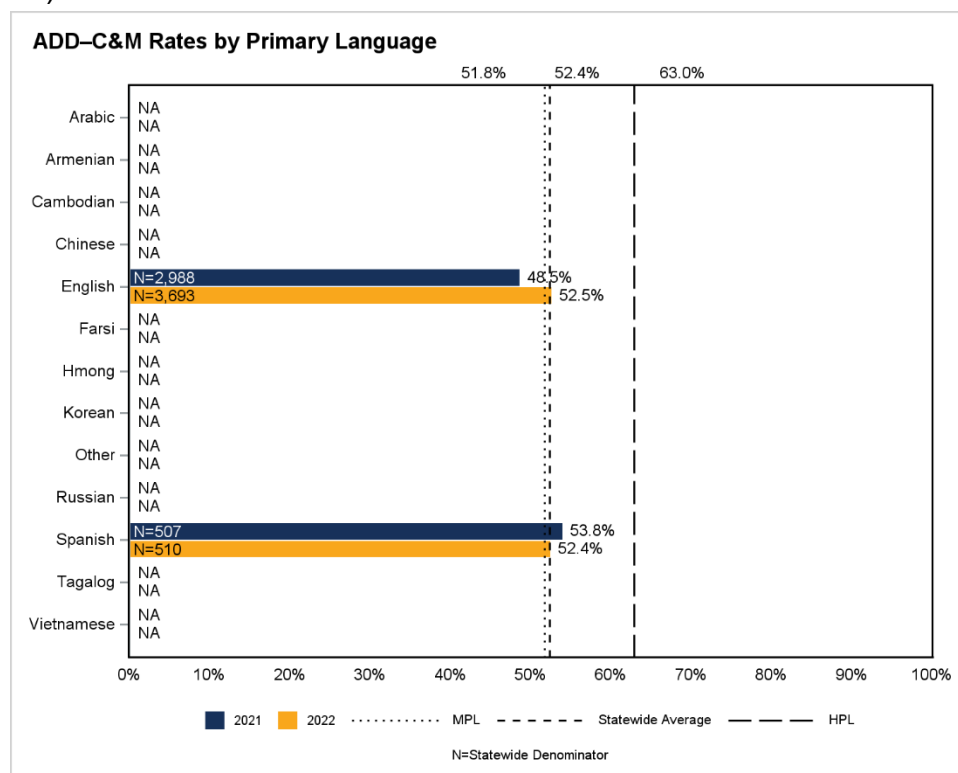


Figure C.164—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD-C&M) Rates by Gender

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.0 percent and 67.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 49.4 percent.

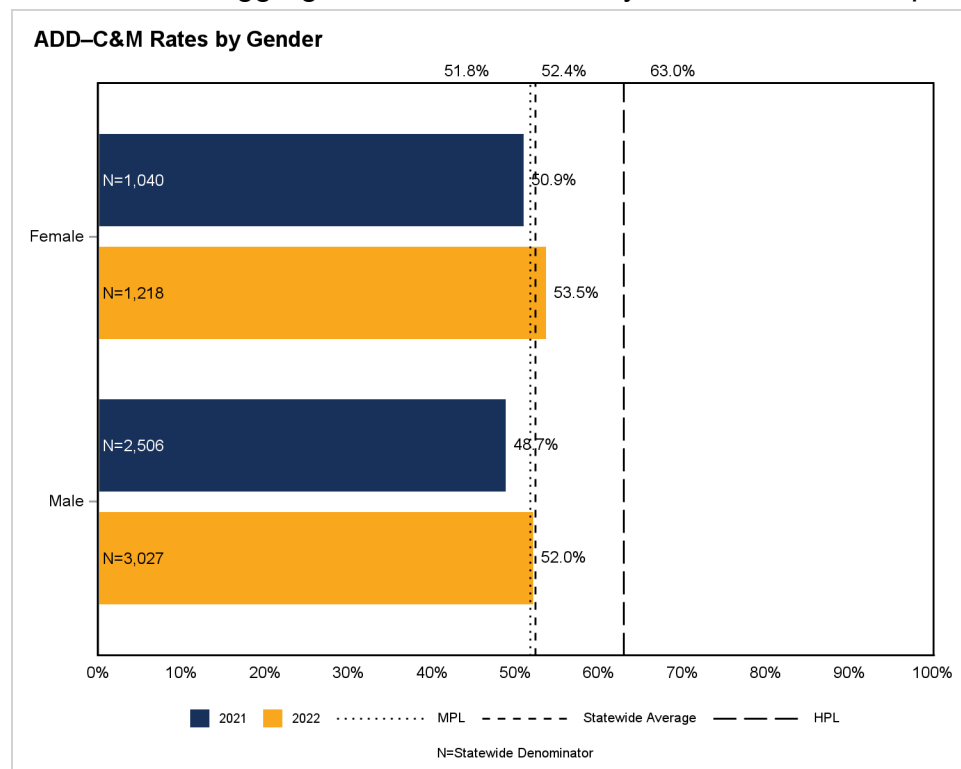
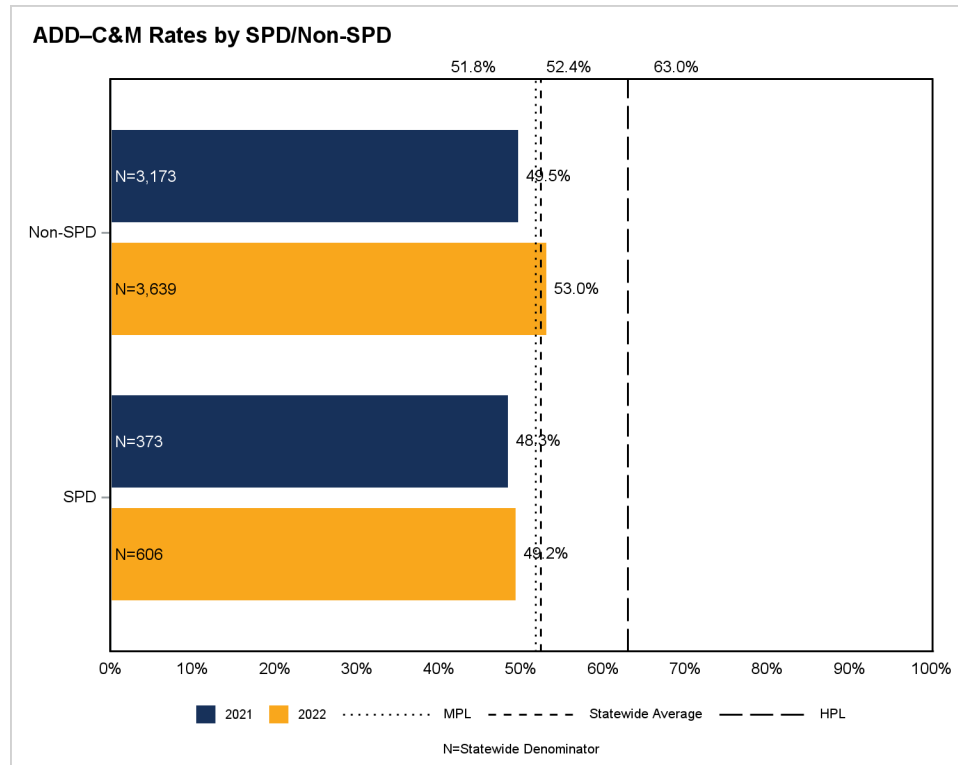


Figure C.165—Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase (ADD-C&M) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 56.0 percent and 67.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 49.4 percent.



Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM-B)

The *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM-B)* indicator measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and received blood glucose testing.

Figure C.166—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM-B) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 59.4 percent (N=335) and 54.4 percent (N=663), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 48.5 percent and 61.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 62.6 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

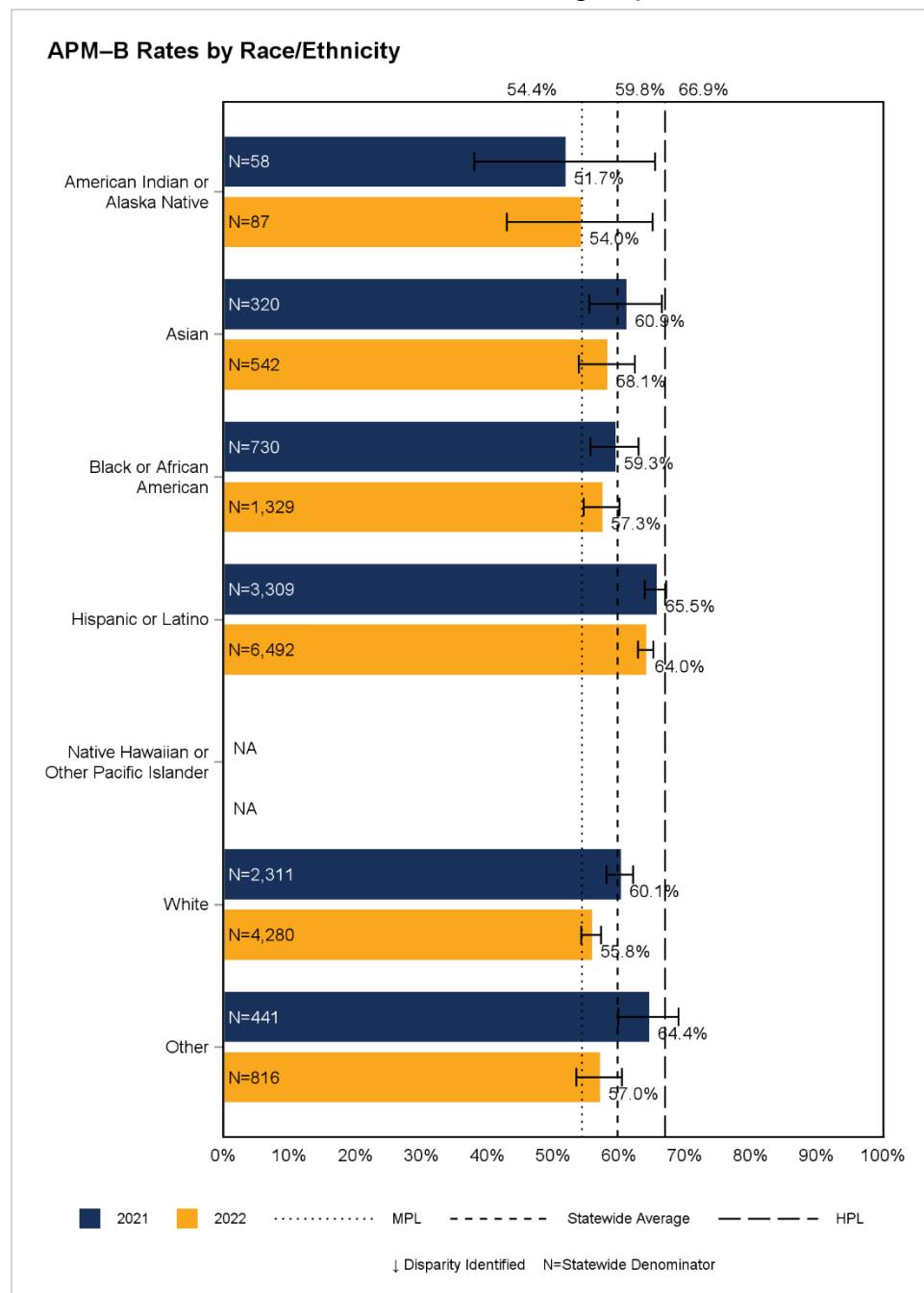


Figure C.167—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM-B) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 48.5 percent and 61.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 62.6 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

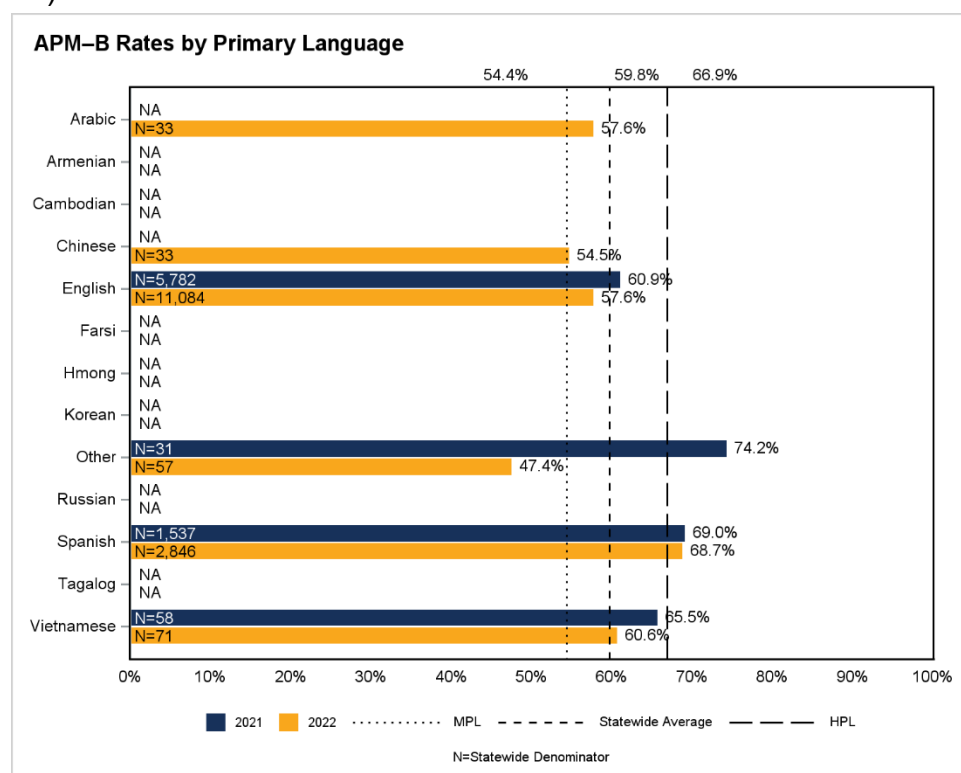


Figure C.168—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM-B) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 48.5 percent and 61.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 62.6 percent.

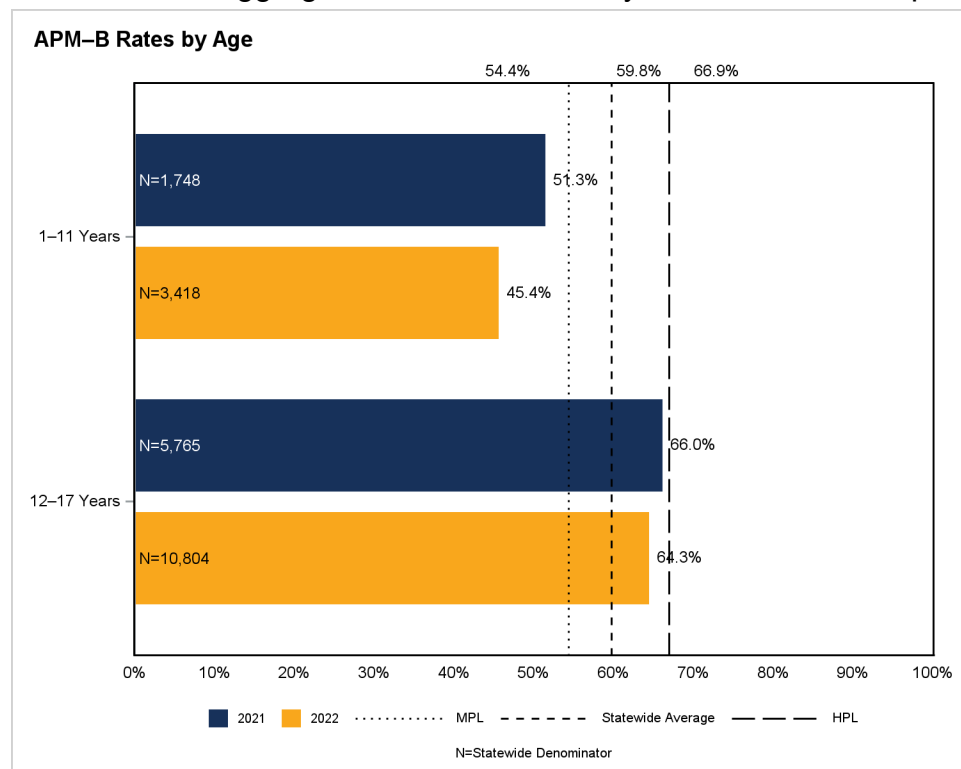


Figure C.169—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM-B) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 48.5 percent and 61.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 62.6 percent.

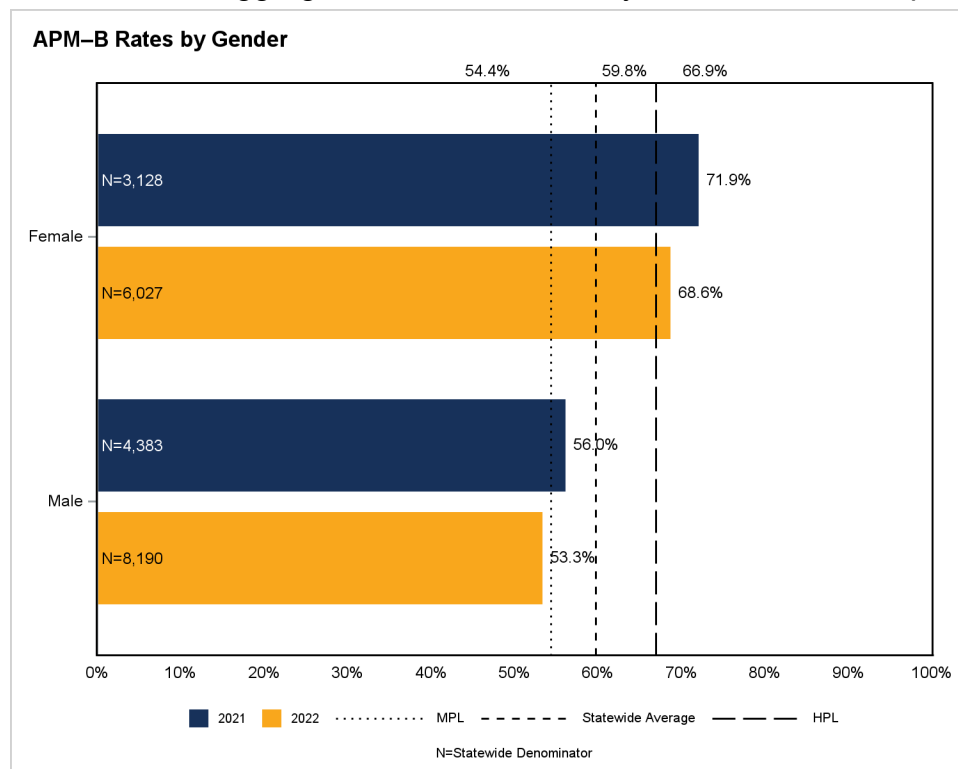
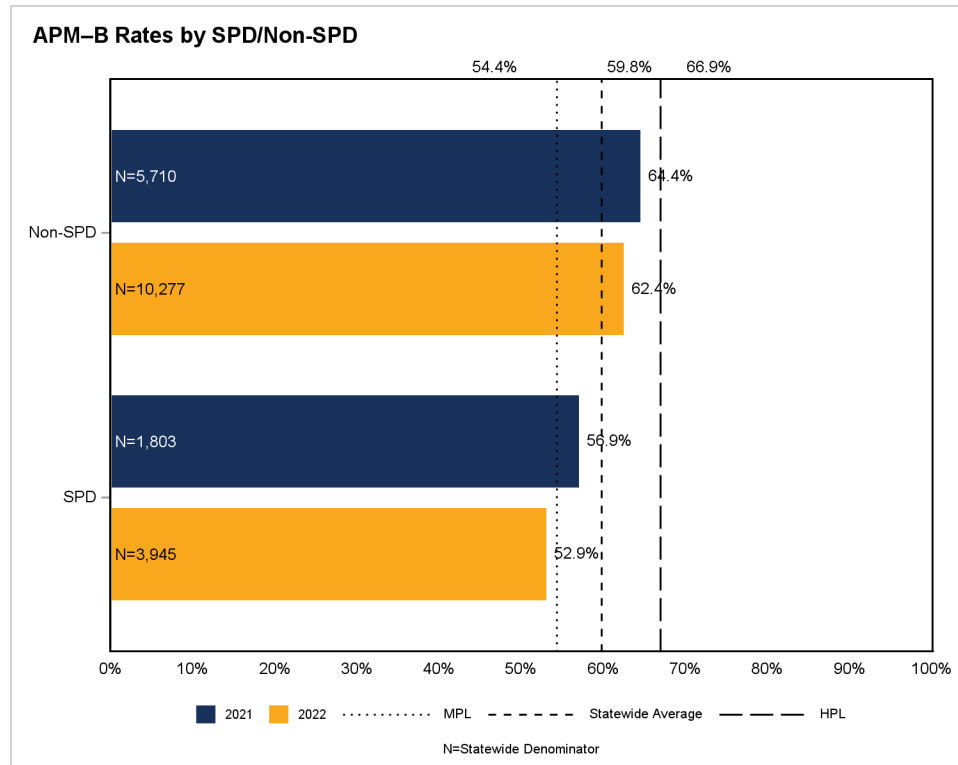


Figure C.170—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM-B) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 48.5 percent and 61.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 62.6 percent.



Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (APM-C)

The *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (APM-C)* indicator measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and received cholesterol testing.

Figure C.171—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (APM-C) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 42.1 percent (N=335) and 36.2 percent (N=663), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 32.0 percent and 46.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 45.3 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

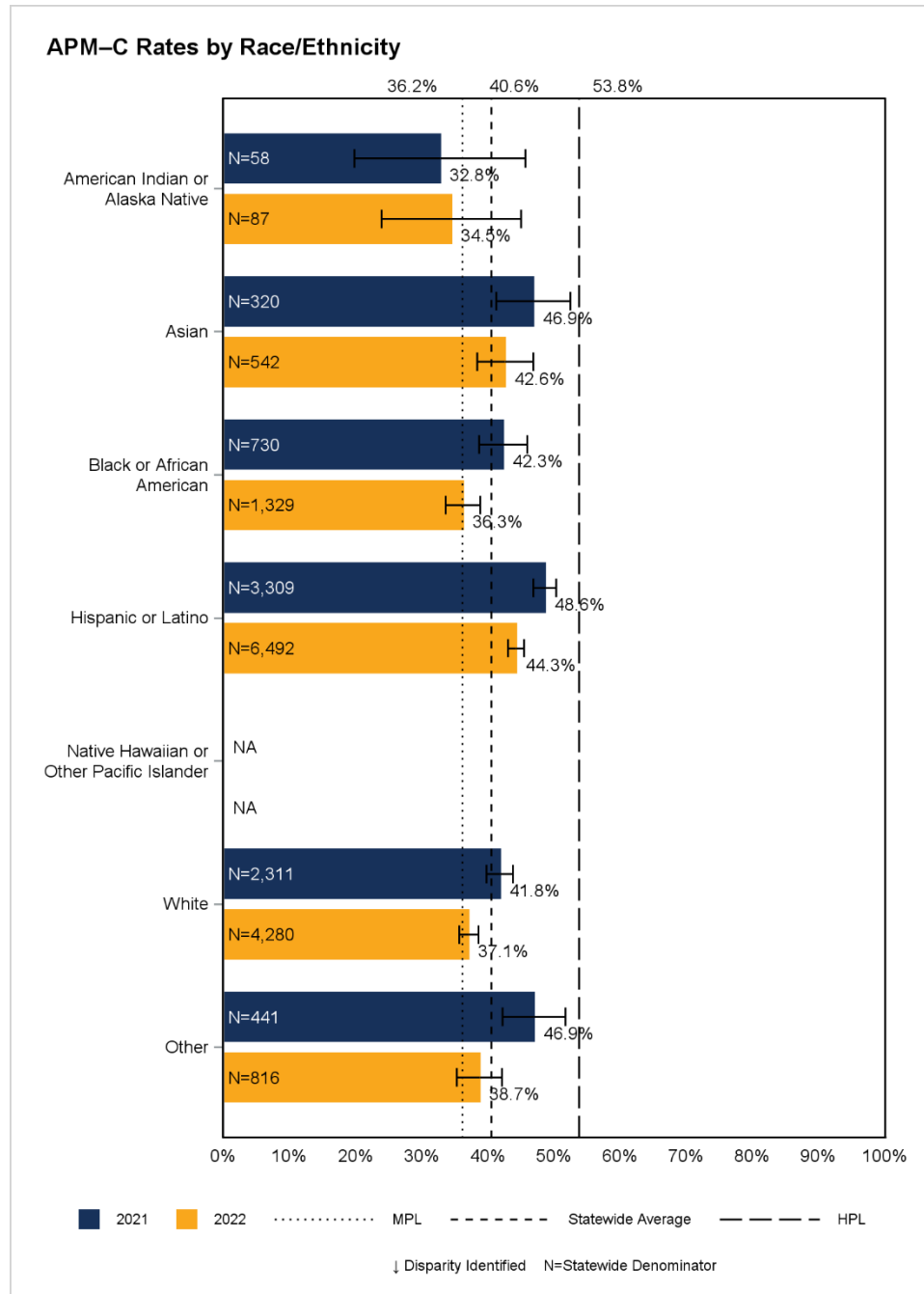


Figure C.172—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (APM–C) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 32.0 percent and 46.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 45.3 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

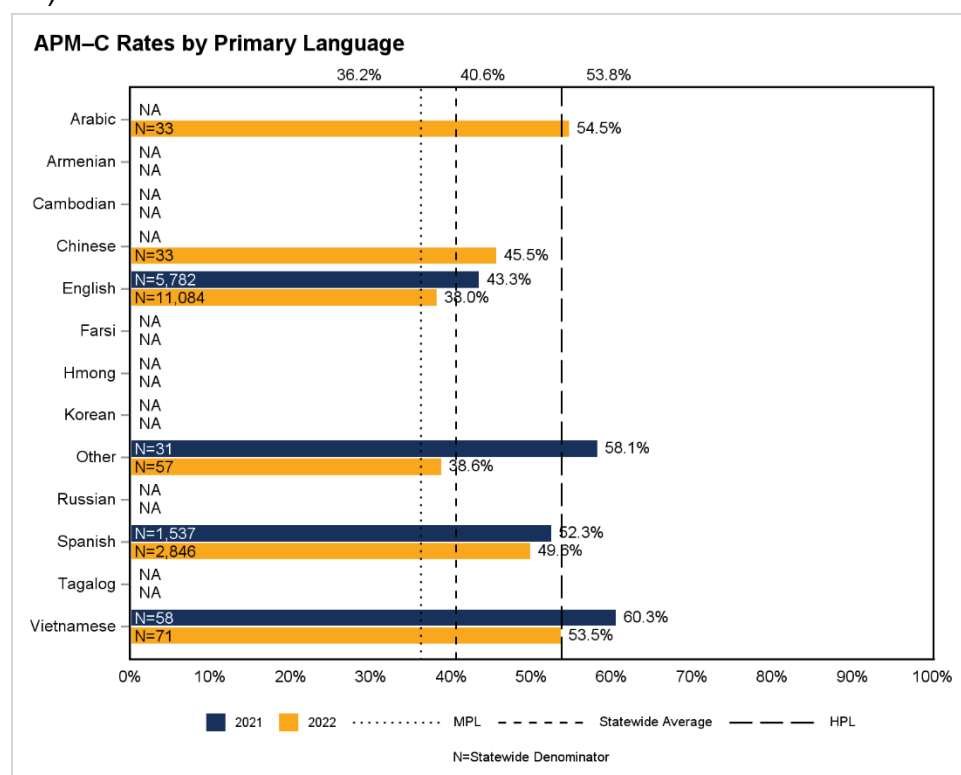


Figure C.173—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (APM-C) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 32.0 percent and 46.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 45.3 percent.

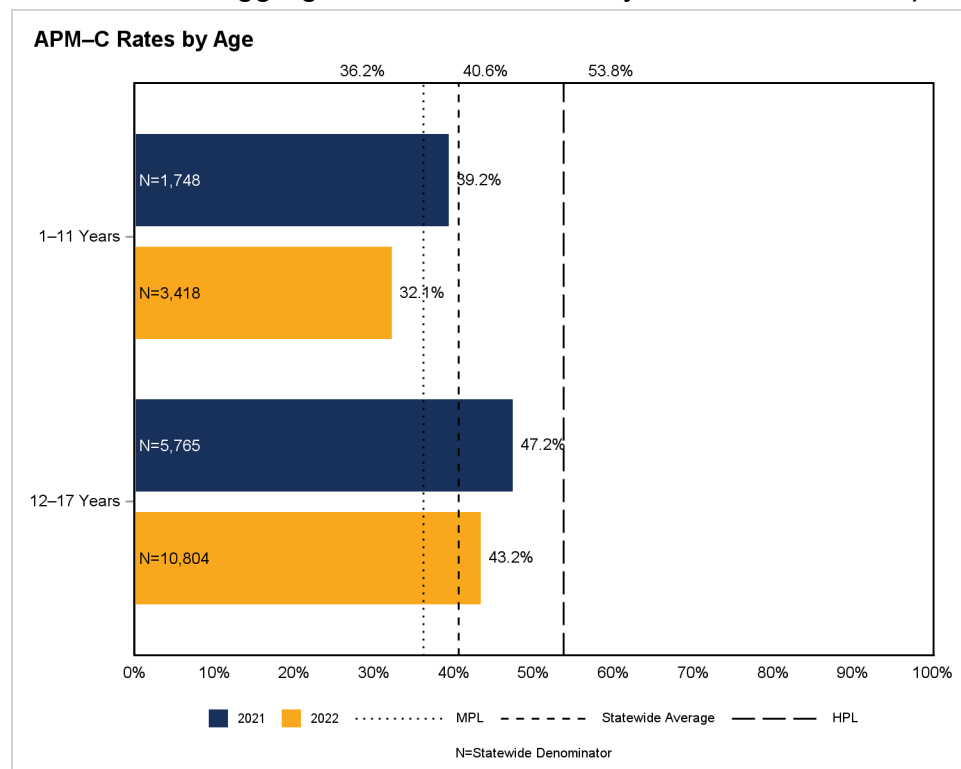


Figure C.174—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (APM-C) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 32.0 percent and 46.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 45.3 percent.

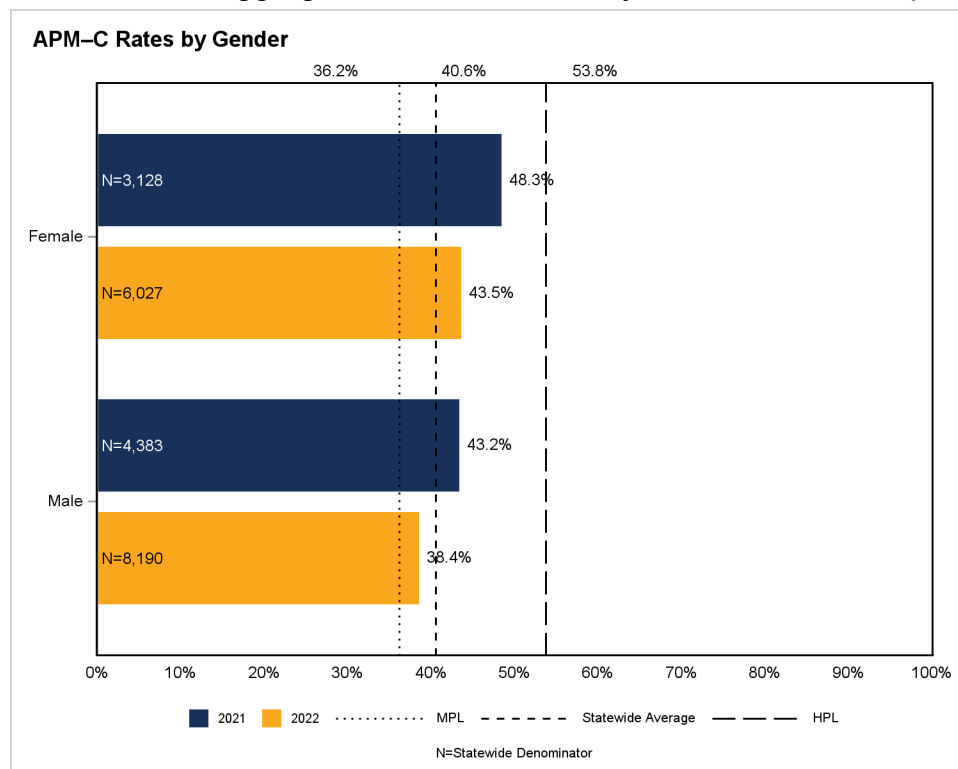
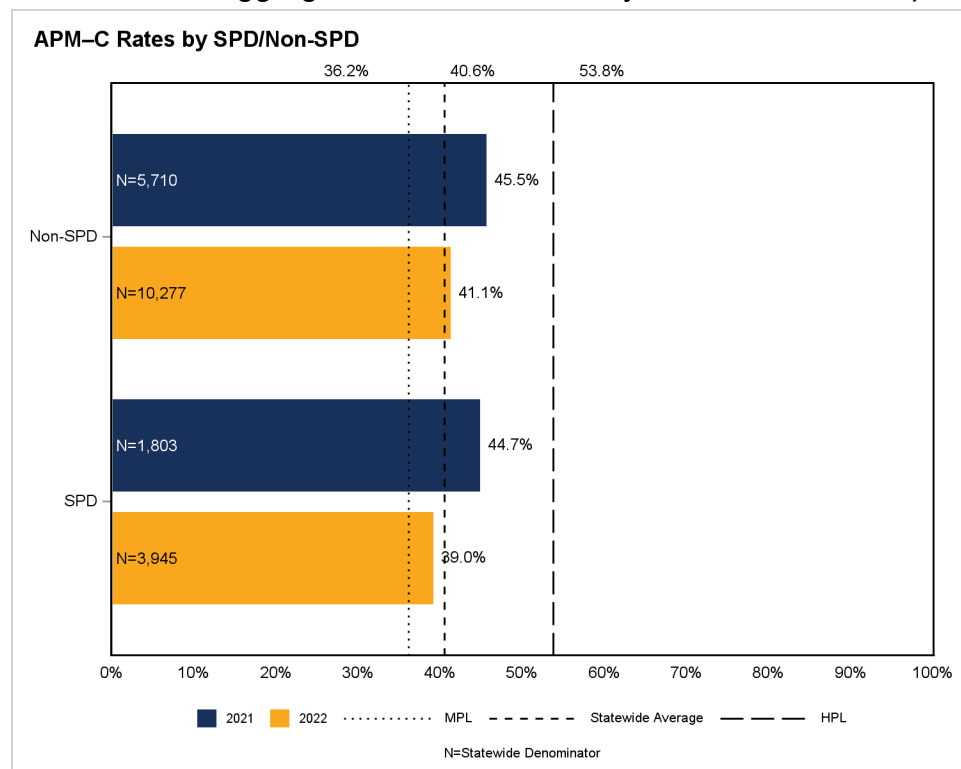


Figure C.175—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total (APM-C) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 32.0 percent and 46.7 percent, respectively.

The statewide aggregate for measurement year 2021 was 45.3 percent.



Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC)

The *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC)* indicator measures the percentage of children and adolescents 1 to 17 years of age who had two or more antipsychotic prescriptions and received blood glucose and cholesterol testing.

Figure C.176—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 40.3 percent (N=335) and 35.6 percent (N=663), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 30.6 percent and 44.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 44.0 percent.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

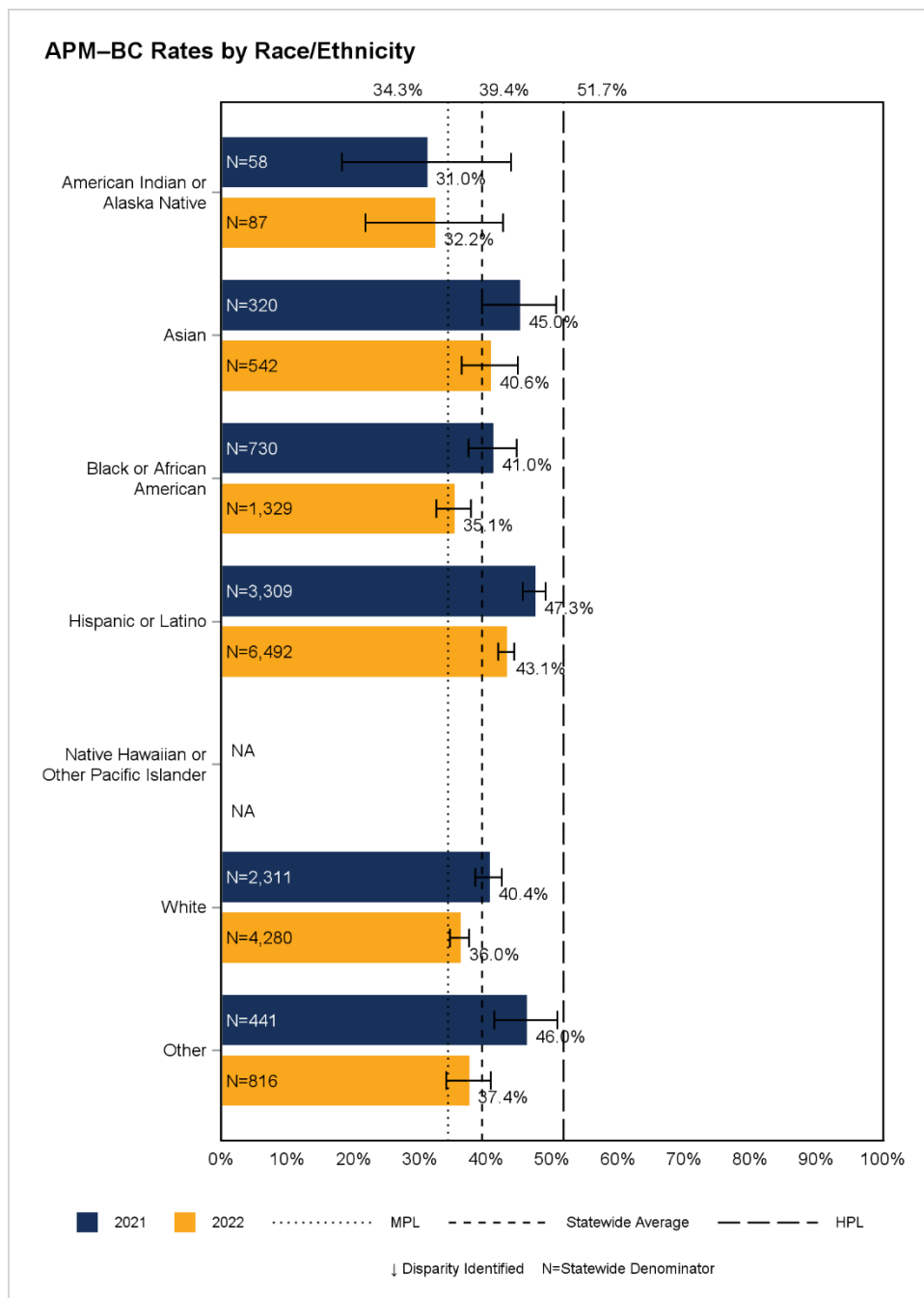


Figure C.177—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 30.6 percent and 44.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 44.0 percent.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

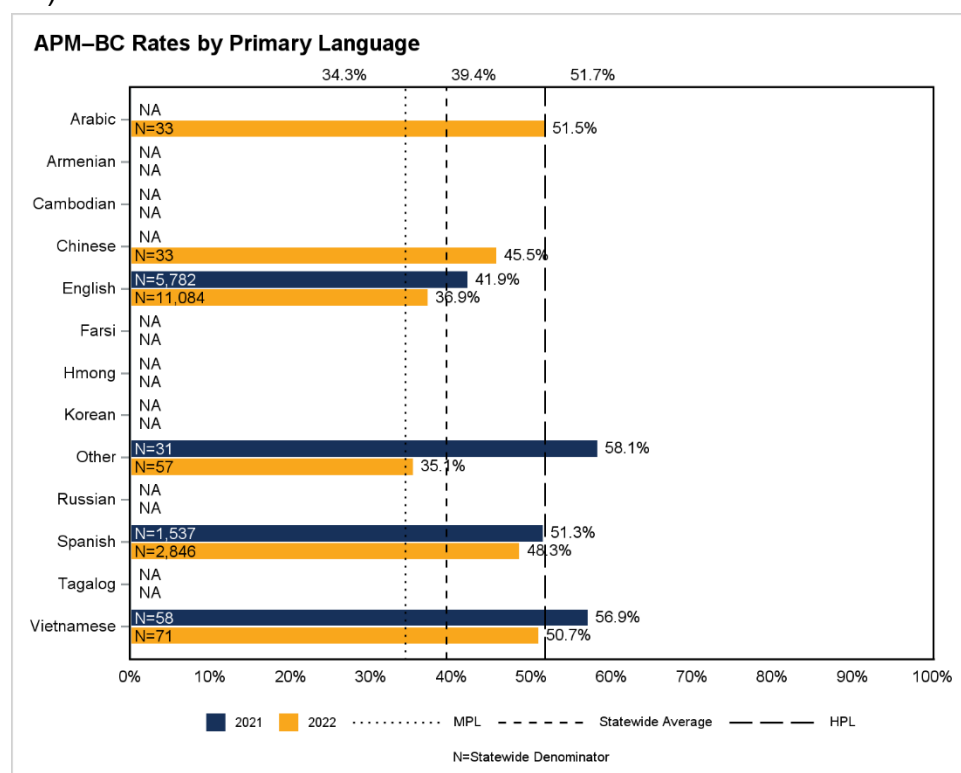


Figure C.178—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM-BC) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 30.6 percent and 44.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 44.0 percent.

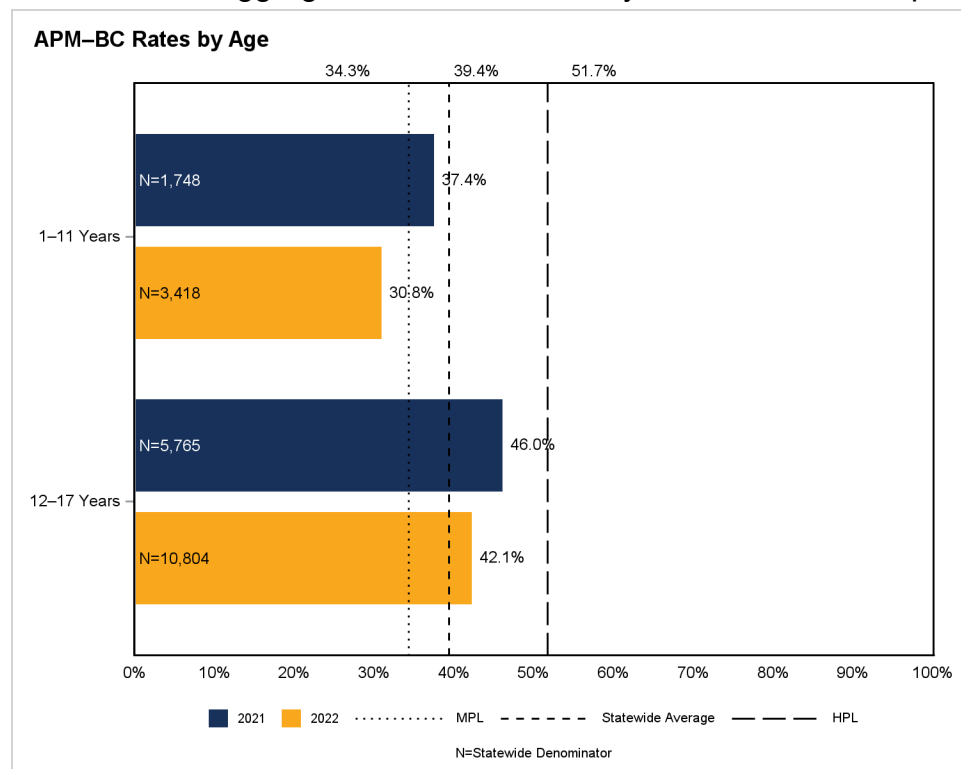


Figure C.179—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 30.6 percent and 44.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 44.0 percent.

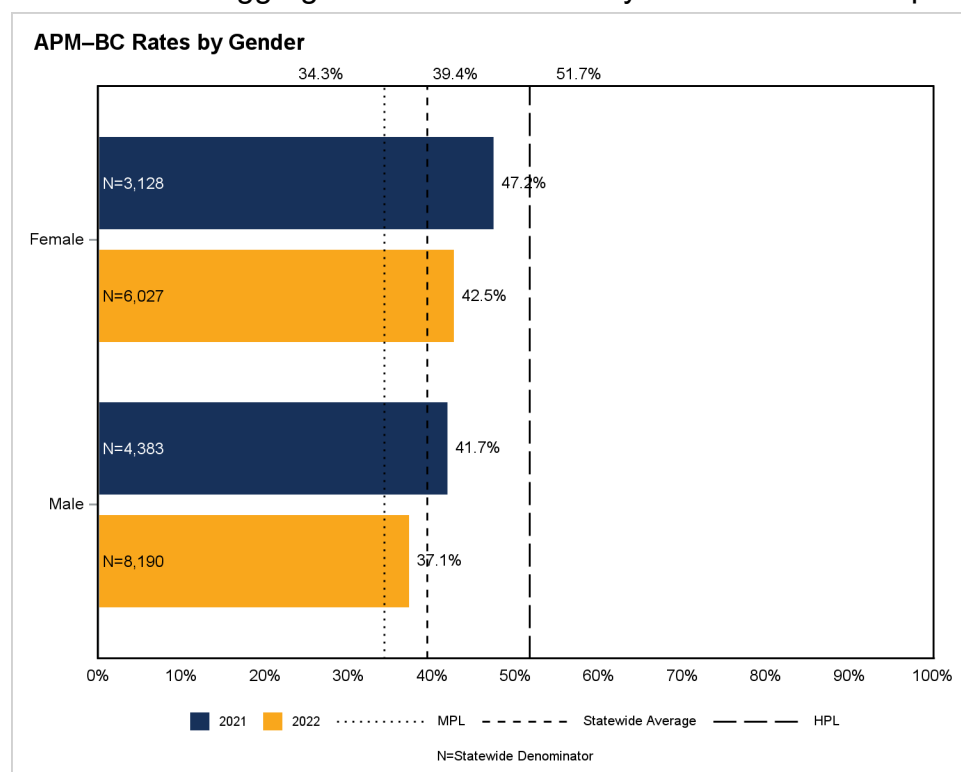
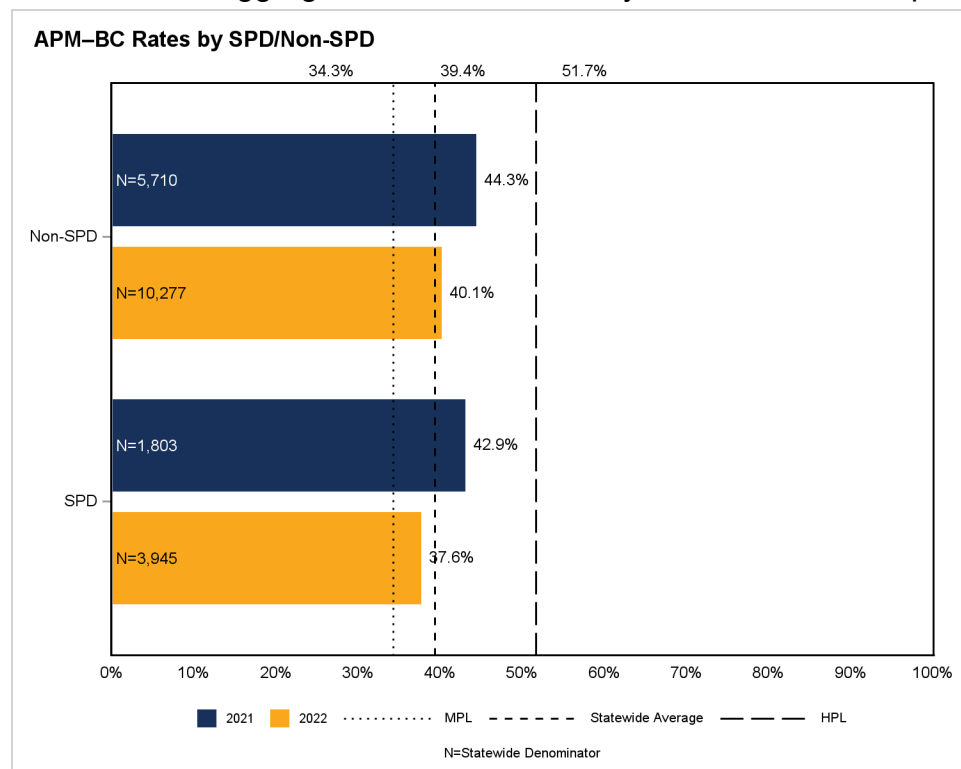


Figure C.180—Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (APM–BC) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 30.6 percent and 44.6 percent, respectively.

The statewide aggregate for measurement year 2021 was 44.0 percent.



Pharmacotherapy for Opioid Use Disorder (POD)

The *Pharmacotherapy for Opioid Use Disorder (POD)* indicator measures the percentage of new opioid use disorder pharmacotherapy events with opioid use disorder pharmacotherapy for 180 or more days among members 16 years of age and older with a diagnosis of opioid use disorder.

Figure C.181—Pharmacotherapy for Opioid Use Disorder (POD) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 26.3 percent (N=729).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

NA indicates the rate for the racial/ethnic group had a small denominator (i.e., less than 30).

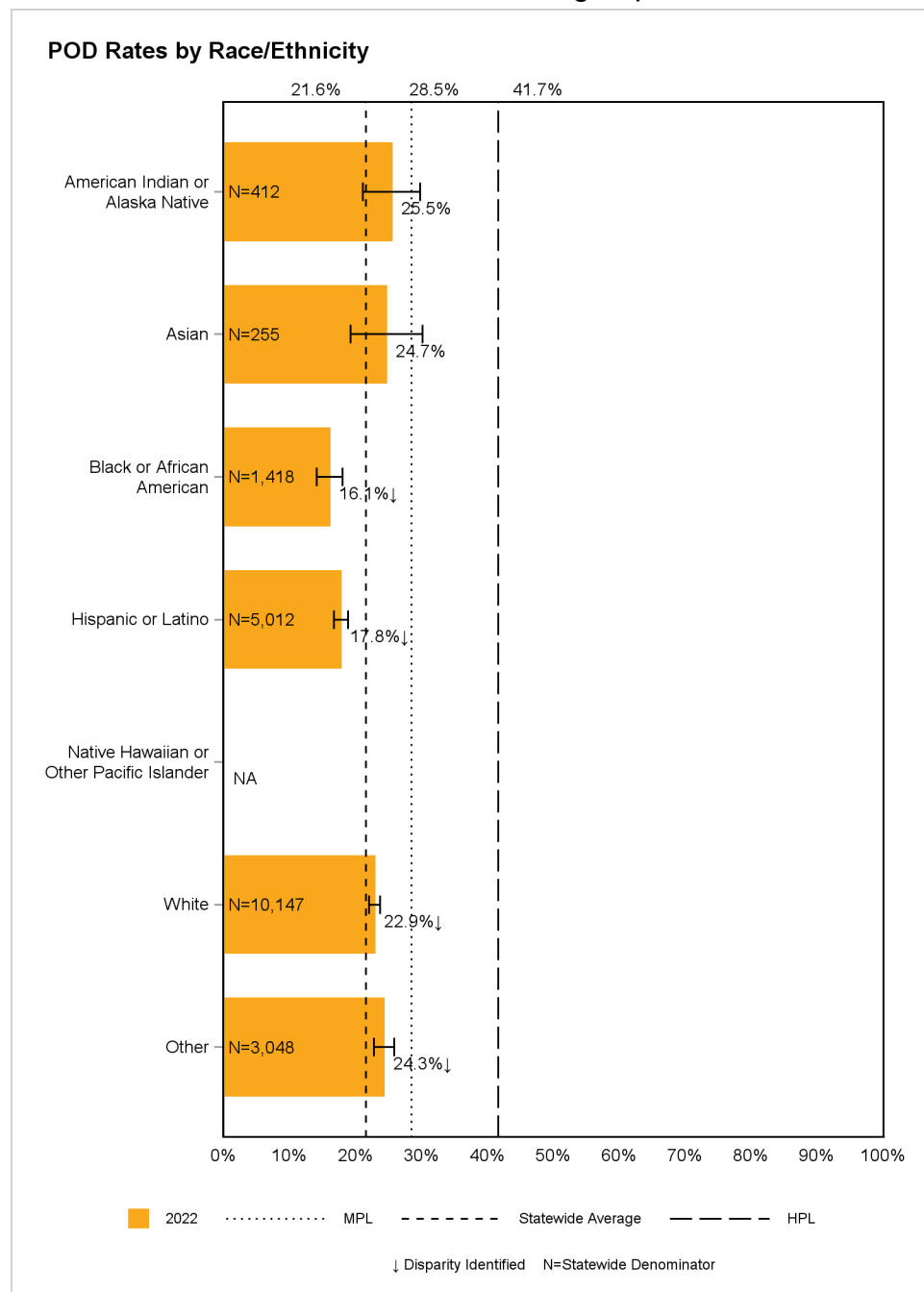


Figure C.182—Pharmacotherapy for Opioid Use Disorder (POD) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

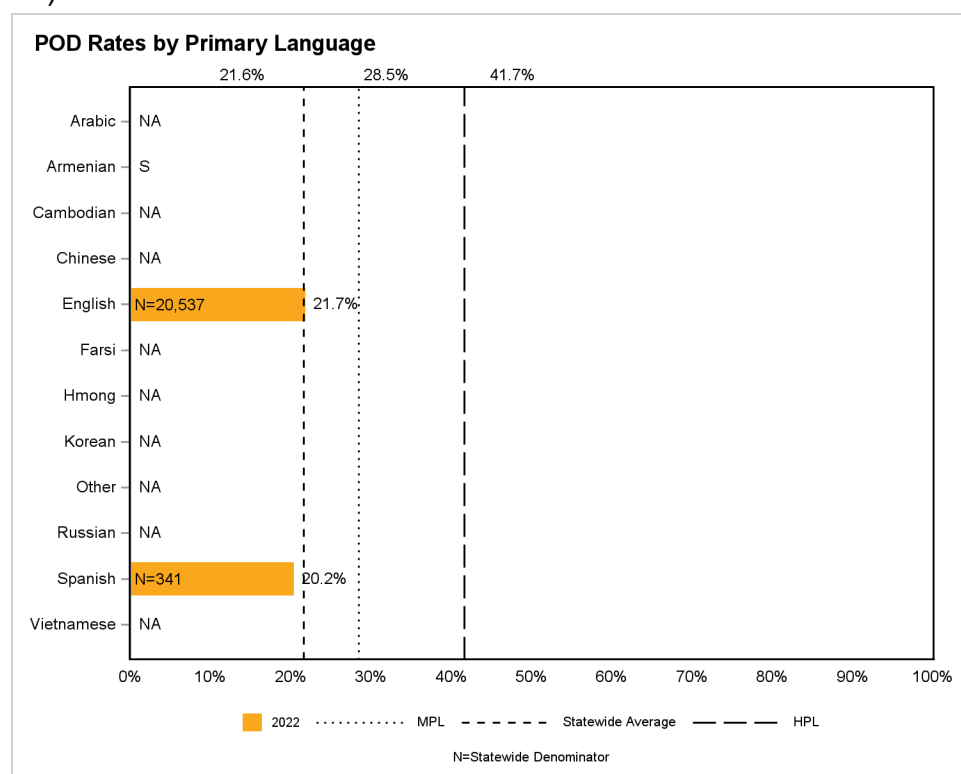


Figure C.183—Pharmacotherapy for Opioid Use Disorder (POD) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

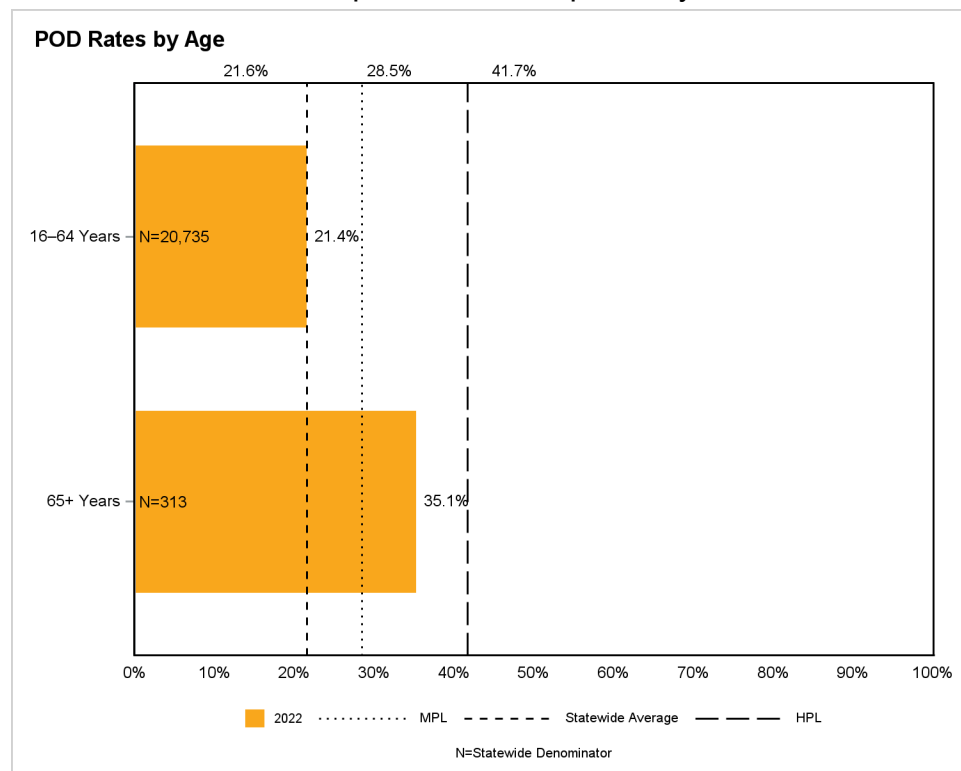


Figure C.184—Pharmacotherapy for Opioid Use Disorder (POD) Rates by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group was suppressed due to a small denominator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

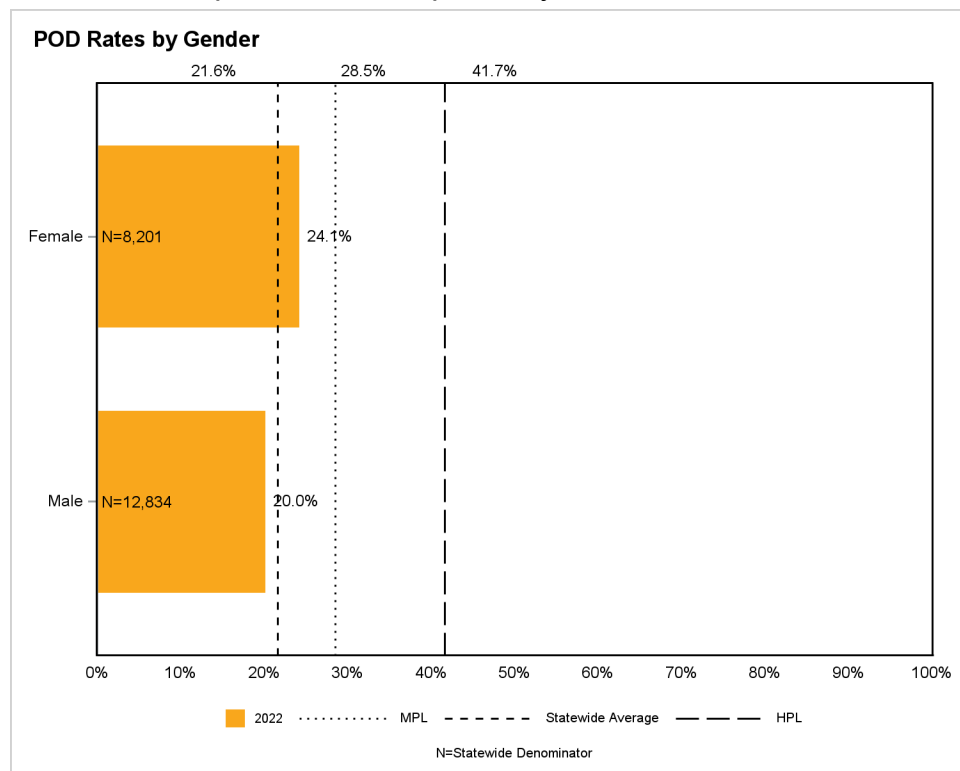
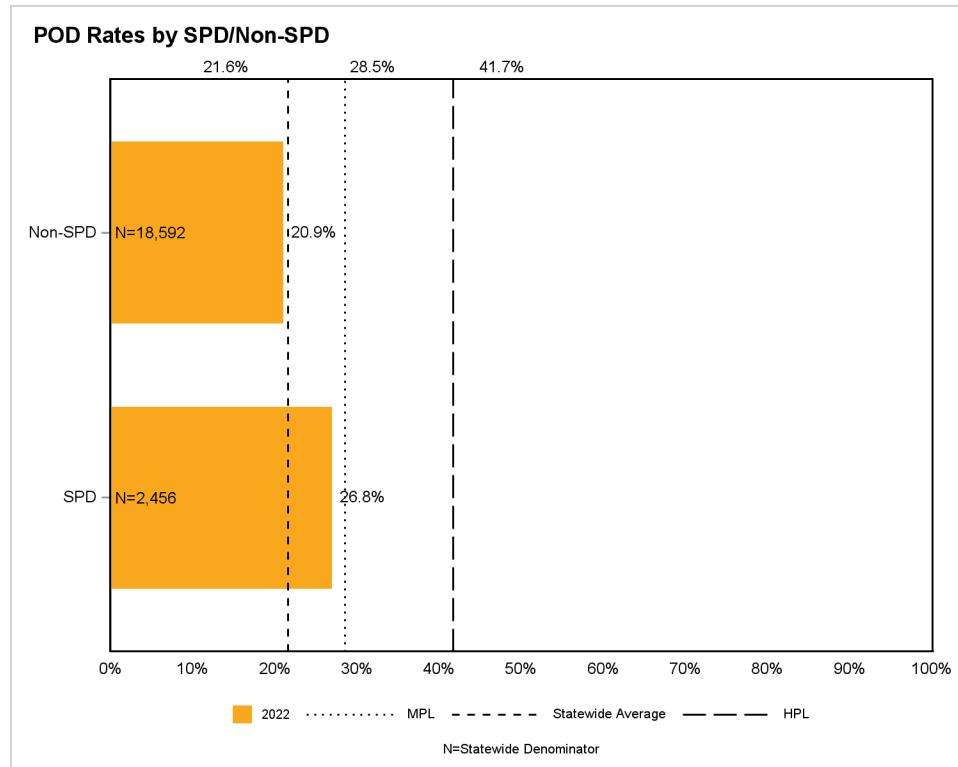


Figure C.185—Pharmacotherapy for Opioid Use Disorder (POD) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.



Chronic Disease Management Domain

Figure C.186 through Figure C.215 display the demographic stratification results for the Chronic Disease Management Domain.

Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)

The *Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)* indicator measures the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.

Figure C.186—Adults’ Access to Preventive/Ambulatory Health Services—Total (AAP) Rates by Race/Ethnicity

Note: The measurement year 2022 rate for the Unknown/Missing group was 61.5 percent (N=236,916).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

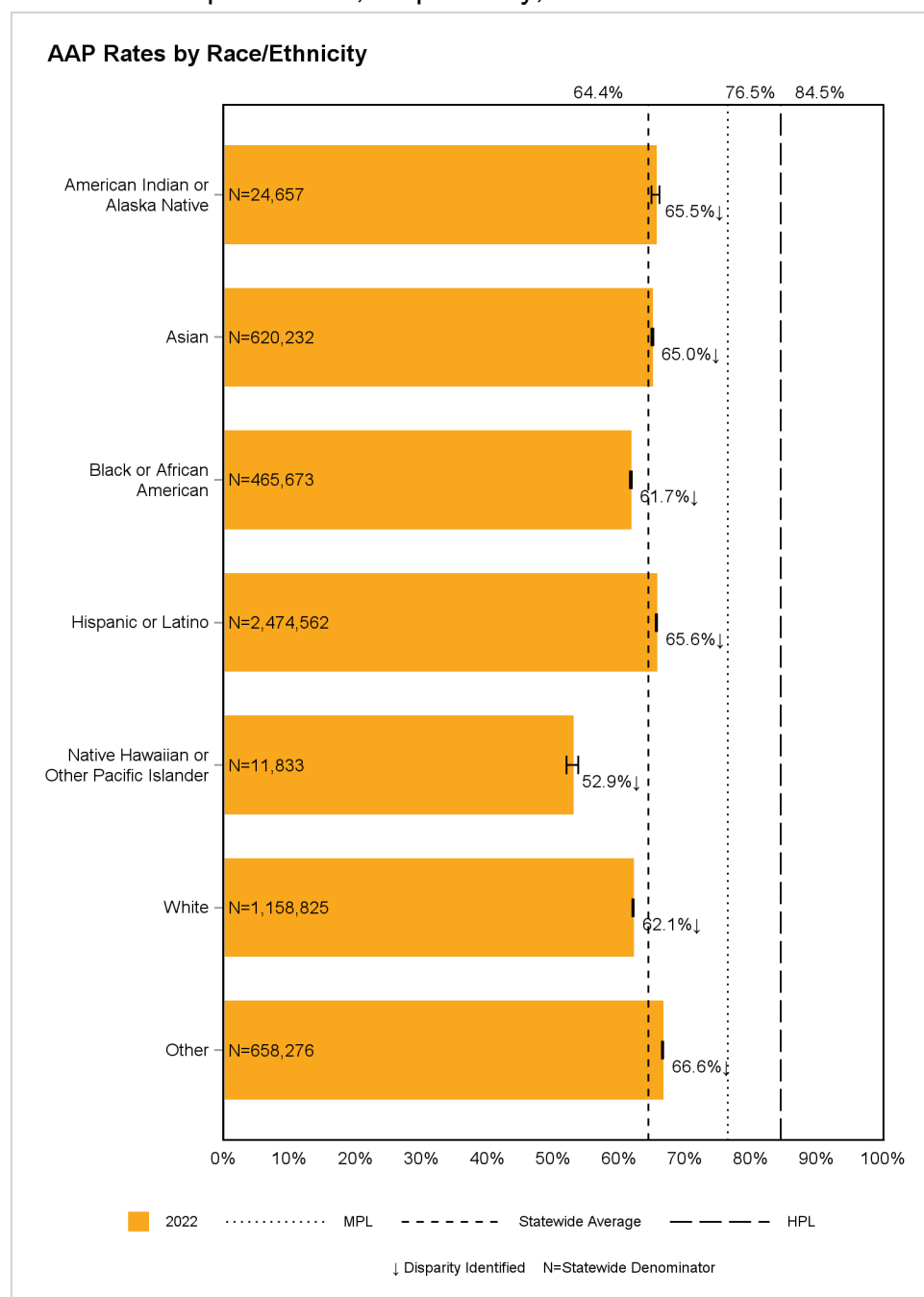


Figure C.187—Adults’ Access to Preventive/Ambulatory Health Services—Total (AAP) Rates by Primary Language

Note: The measurement year 2022 rate for the Unknown/Missing group was 70.7 percent (N=21,439).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

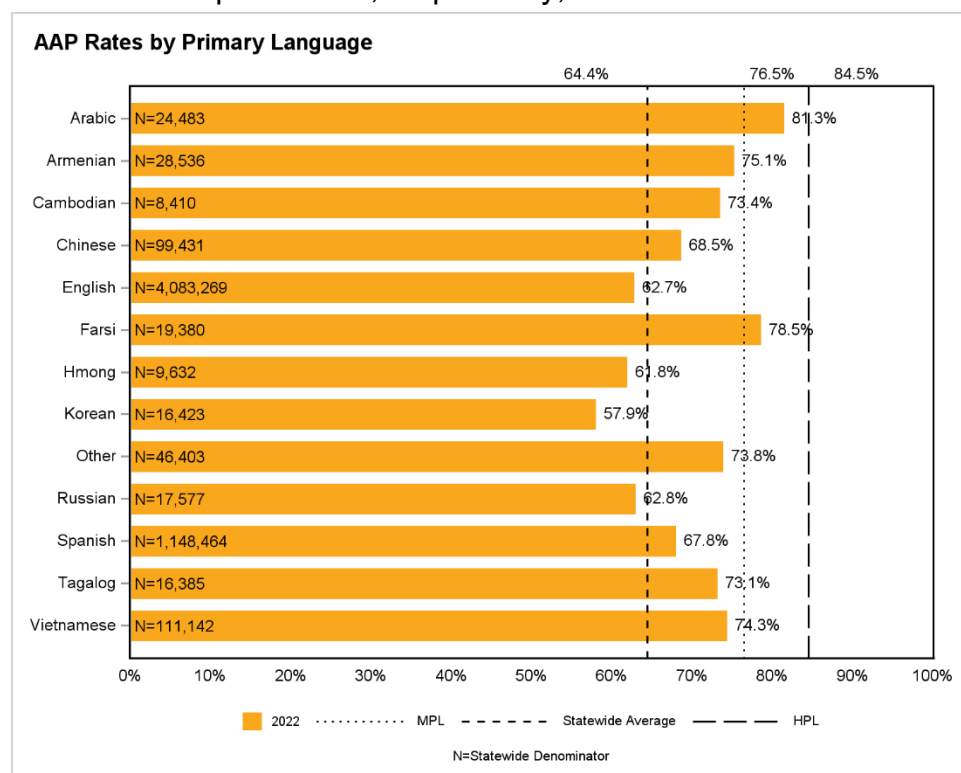


Figure C.188—Adults’ Access to Preventive/Ambulatory Health Services—Total (AAP) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

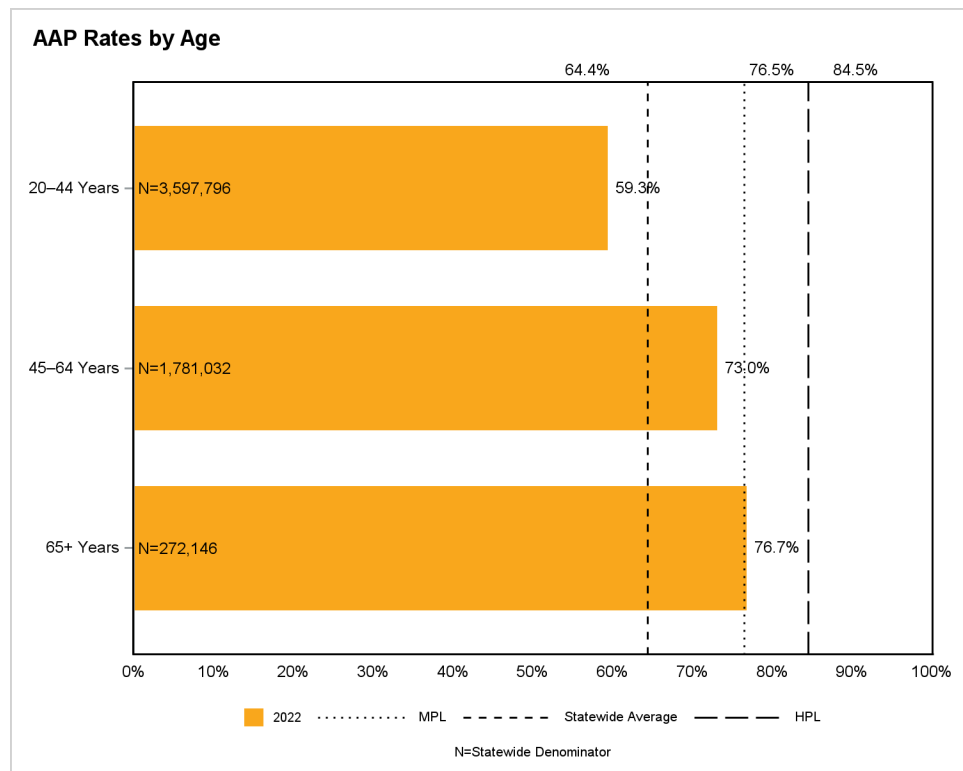


Figure C.189—Adults' Access to Preventive/Ambulatory Health Services—Total (AAP) Rates by Gender

Note: The measurement year 2022 rate for the Unknown/Missing group was 81.6 percent (N=8,010).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

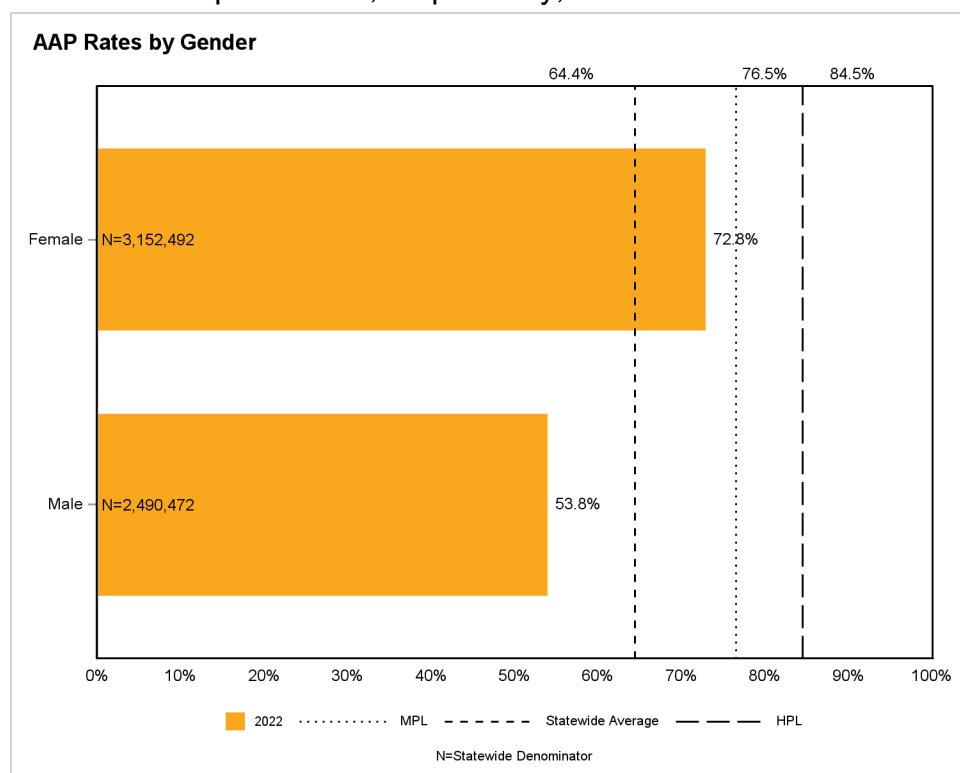
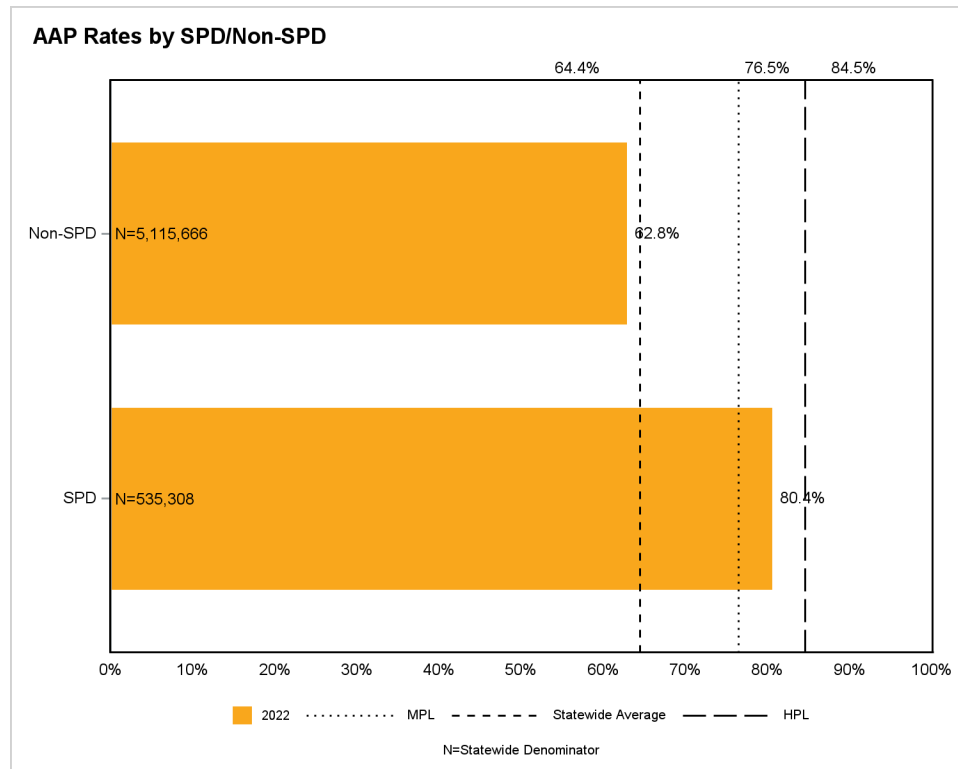


Figure C.190—Adults' Access to Preventive/Ambulatory Health Services—Total (AAP) Rates by SPD/Non-SPD

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.



Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total (AMB-ED)

The *Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total (AMB-ED)* indicator summarizes utilization of ambulatory care for emergency department visits.

Figure C.191—Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total (AMB-ED) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 383.3 (N=5,801,146) and 468.4 (N=6,818,881) emergency department visits per 1,000 member years, respectively.

A higher or lower rate does not necessarily indicate better or worse performance.

The measurement year 2021 statewide aggregate was 404.0 emergency department visits per 1,000 member years.

AMB-ED Rates by Race/Ethnicity

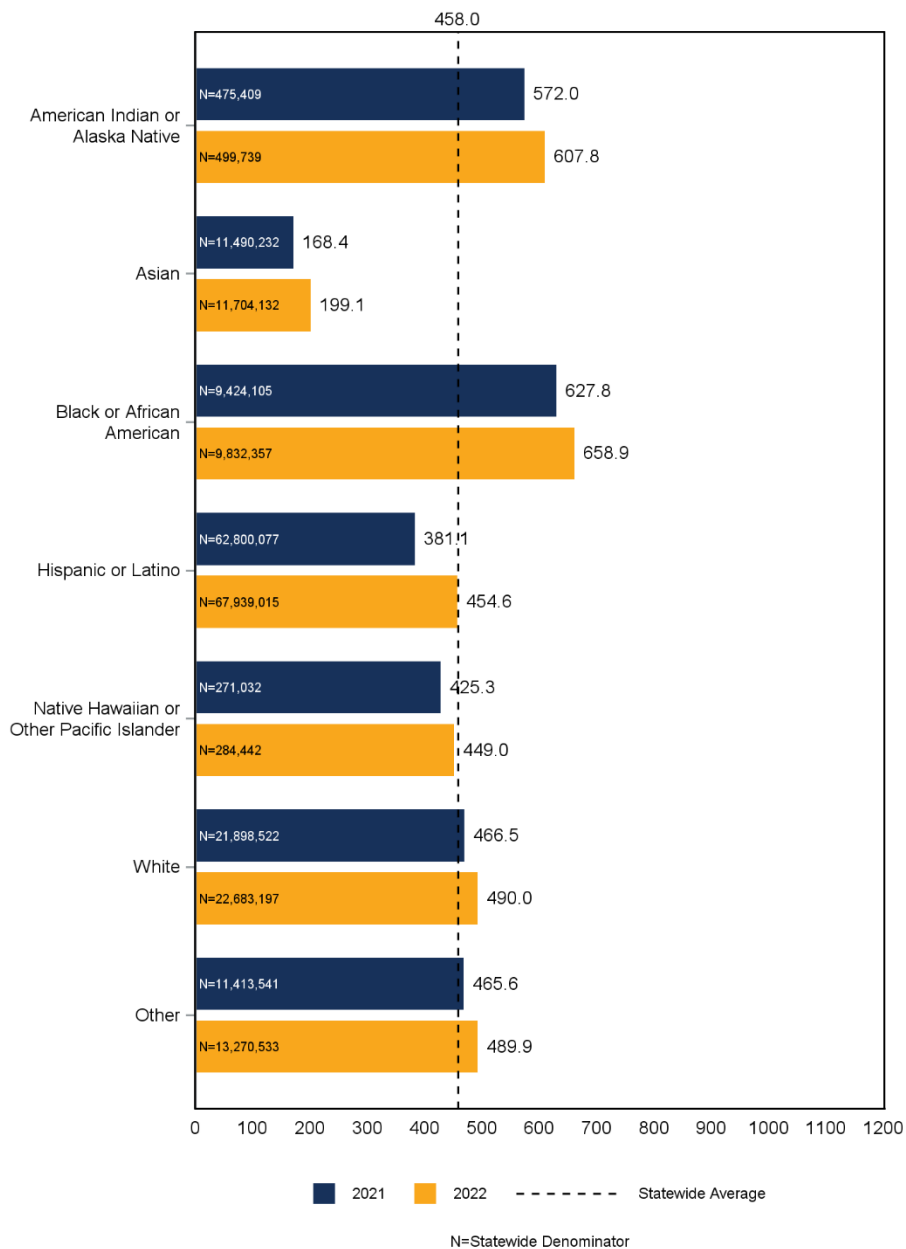


Figure C.192—Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total (AMB-ED) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 311.5 (N=262,627) and 451.7 (N=349,647) emergency department visits per 1,000 member years, respectively.

A higher or lower rate does not necessarily indicate better or worse performance.

The measurement year 2021 statewide aggregate was 404.0 emergency department visits per 1,000 member years.

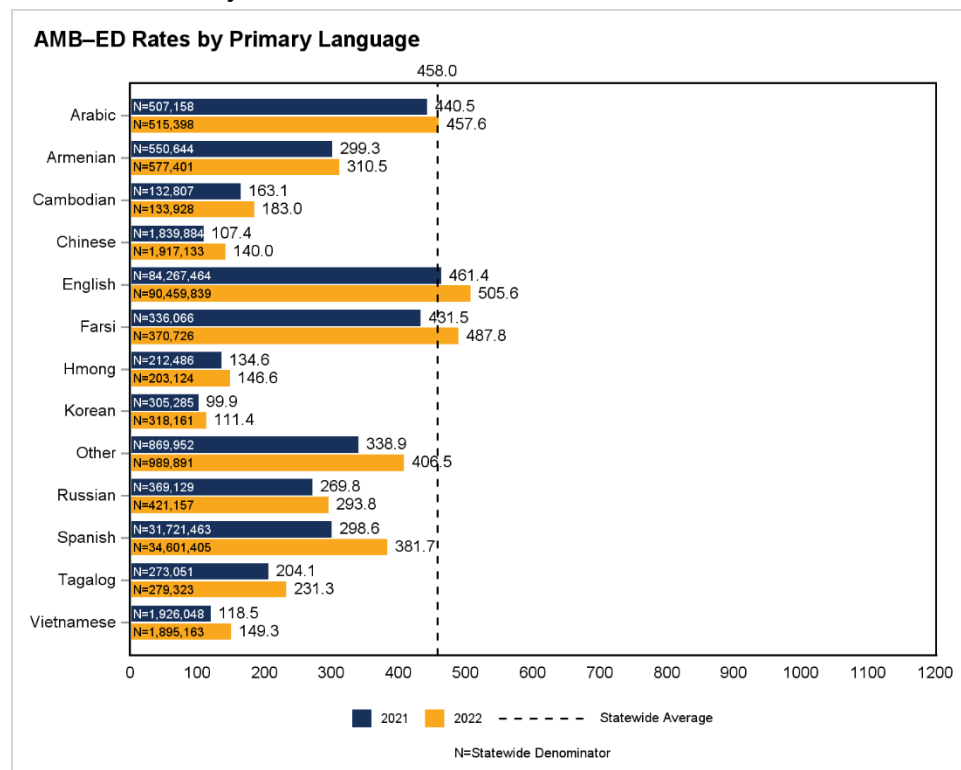


Figure C.193—Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total (AMB-ED) Rates by Age

Note: A higher or lower rate does not necessarily indicate better or worse performance.

The measurement year 2021 statewide aggregate was 404.0 emergency department visits per 1,000 member years.

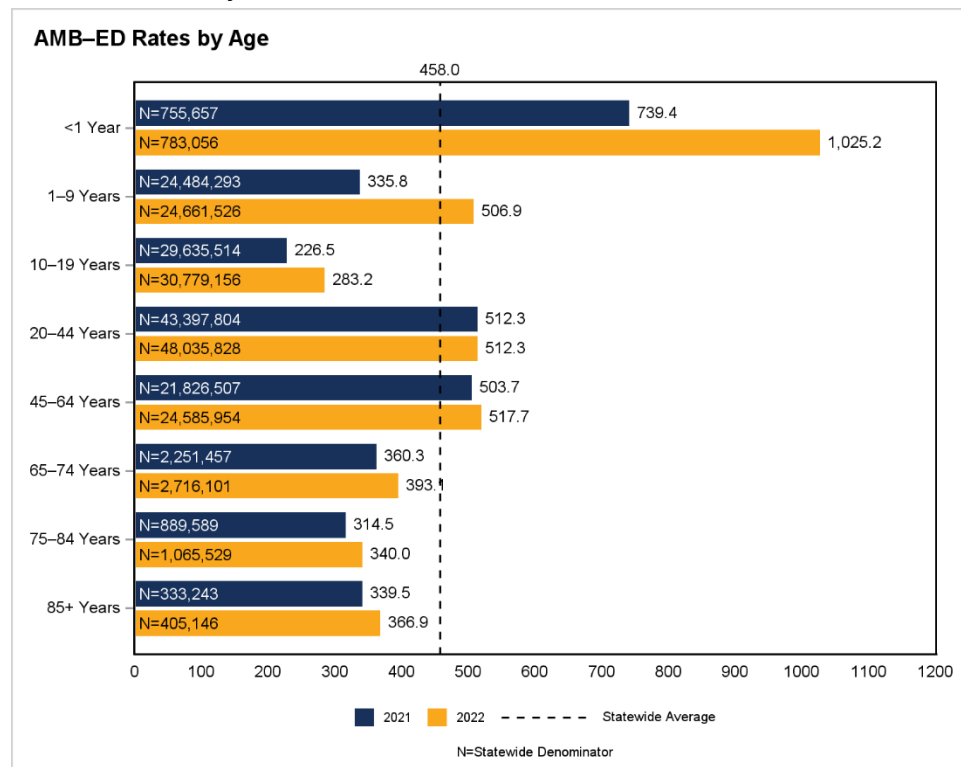


Figure C.194—Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total (AMB-ED) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 448.1 (N=48,286) and 646.4 (N=158,597) emergency department visits per 1,000 member years, respectively.

A higher or lower rate does not necessarily indicate better or worse performance.

The measurement year 2021 statewide aggregate was 404.0 emergency department visits per 1,000 member years.

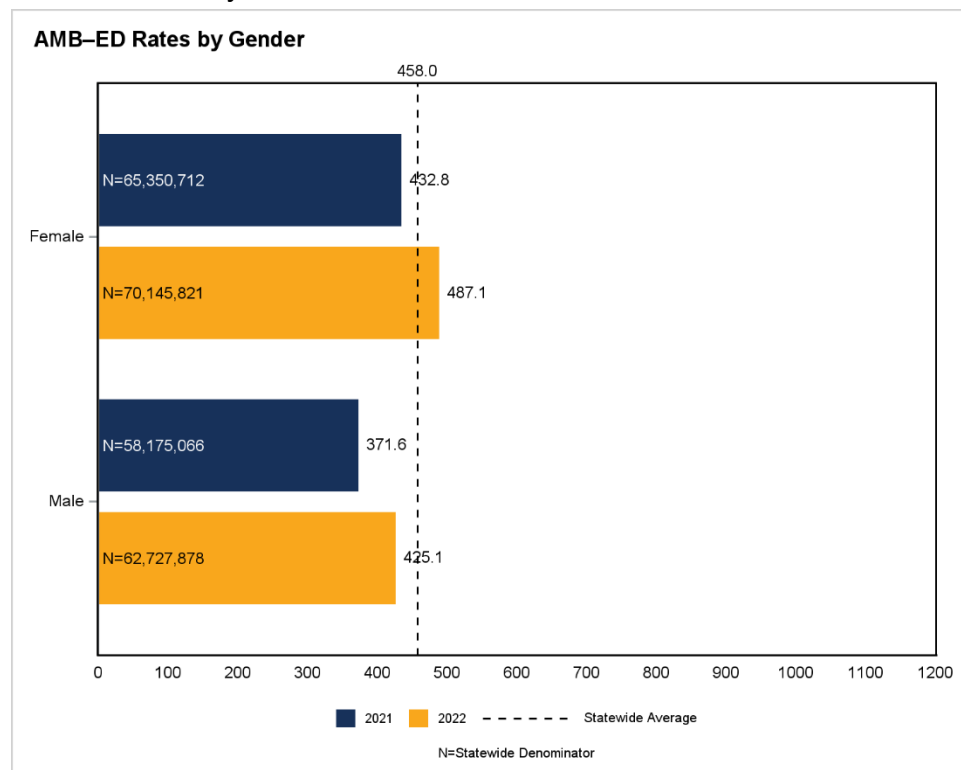
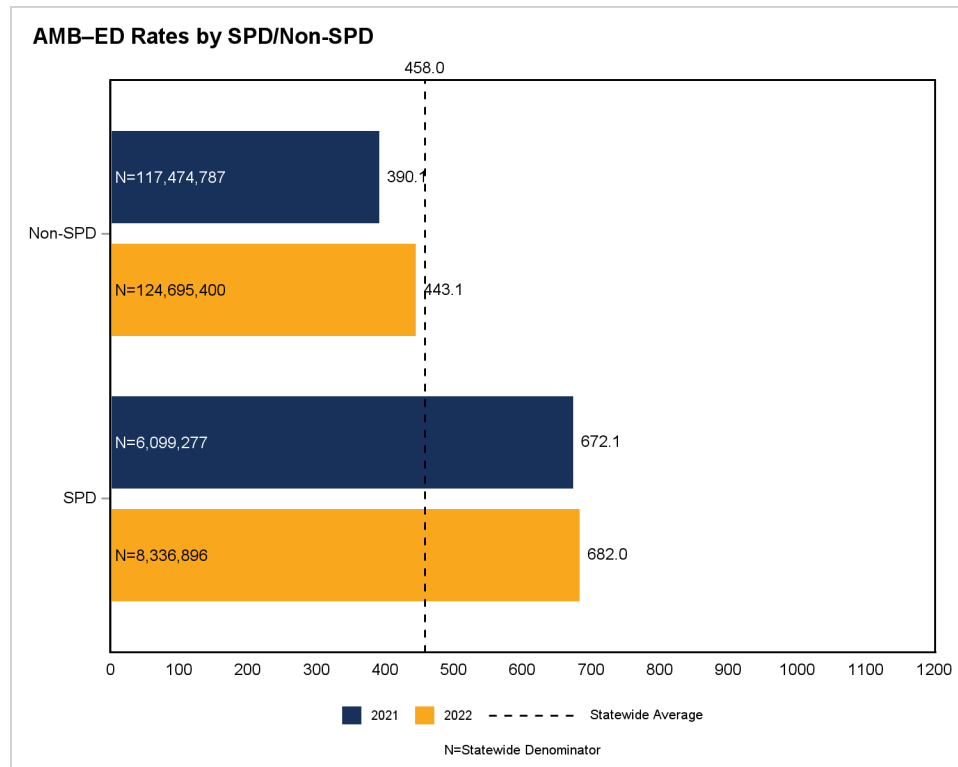


Figure C.195—Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total (AMB-ED) Rates by SPD/Non-SPD

Note: A higher or lower rate does not necessarily indicate better or worse performance.

The measurement year 2021 statewide aggregate was 404.0 emergency department visits per 1,000 member years.



Asthma Medication Ratio—Total (AMR)

The *Asthma Medication Ratio—Total (AMR)* indicator measures the percentage of members 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 C.196—Asthma Medication Ratio—Total (AMR) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 65.9 percent (N=3,529) and 68.0 percent (N=3,606), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 64.8 percent and 75.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.0 percent.

AMR Rates by Race/Ethnicity

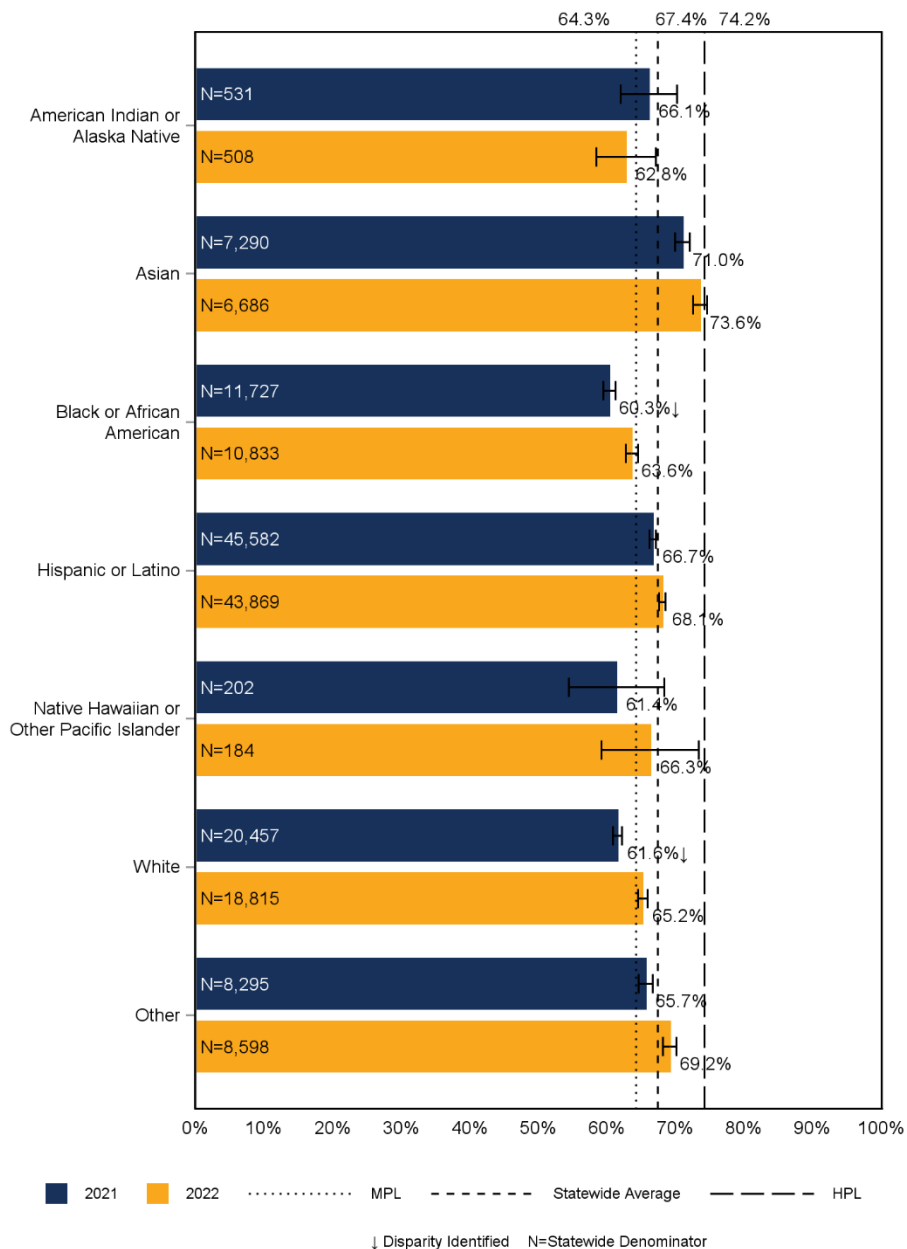


Figure C.197—Asthma Medication Ratio—Total (AMR) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 63.8 percent (N=207) and 68.6 percent (N=185), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 64.8 percent and 75.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.0 percent.

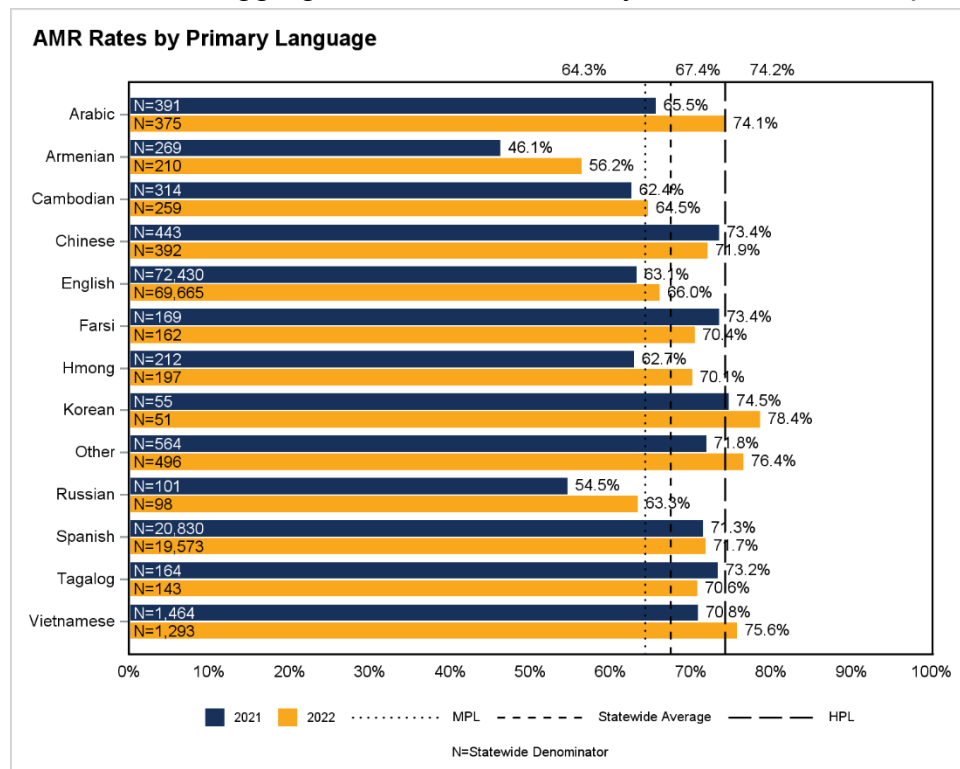


Figure C.198—Asthma Medication Ratio—Total (AMR) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 64.8 percent and 75.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.0 percent.

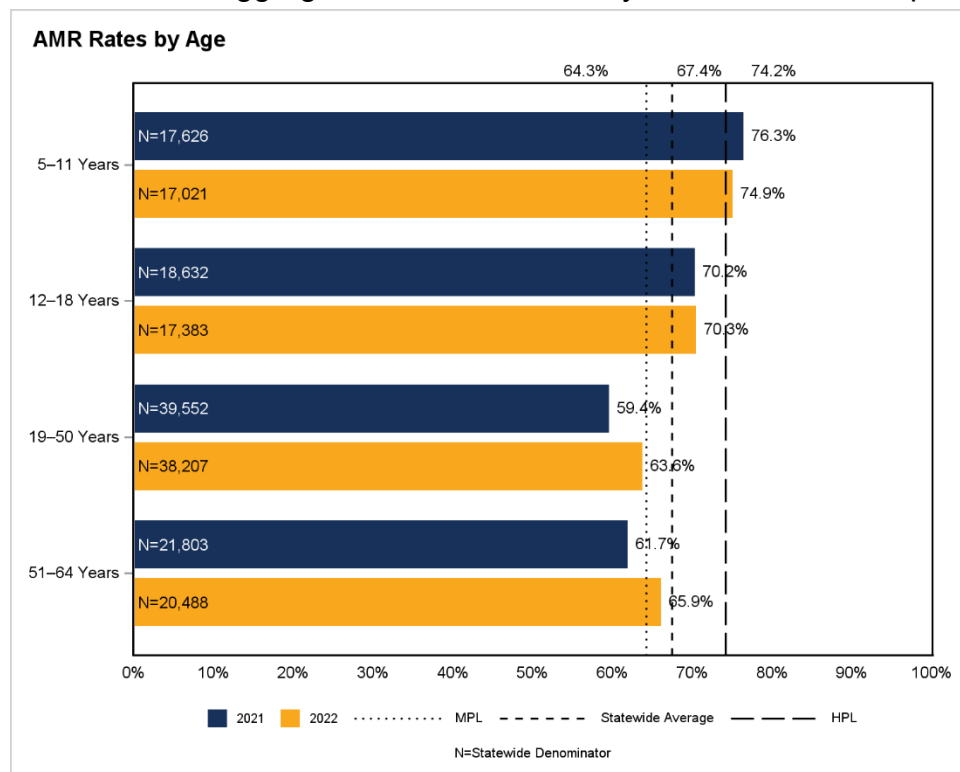


Figure C.199—Asthma Medication Ratio—Total (AMR) Rates by Gender

Note: The measurement year 2021 rate for the Unknown/Missing group was suppressed due to a small denominator. The measurement year 2022 rate for the Unknown/Missing group was 60.0 percent (N=45).

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 64.8 percent and 75.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.0 percent.

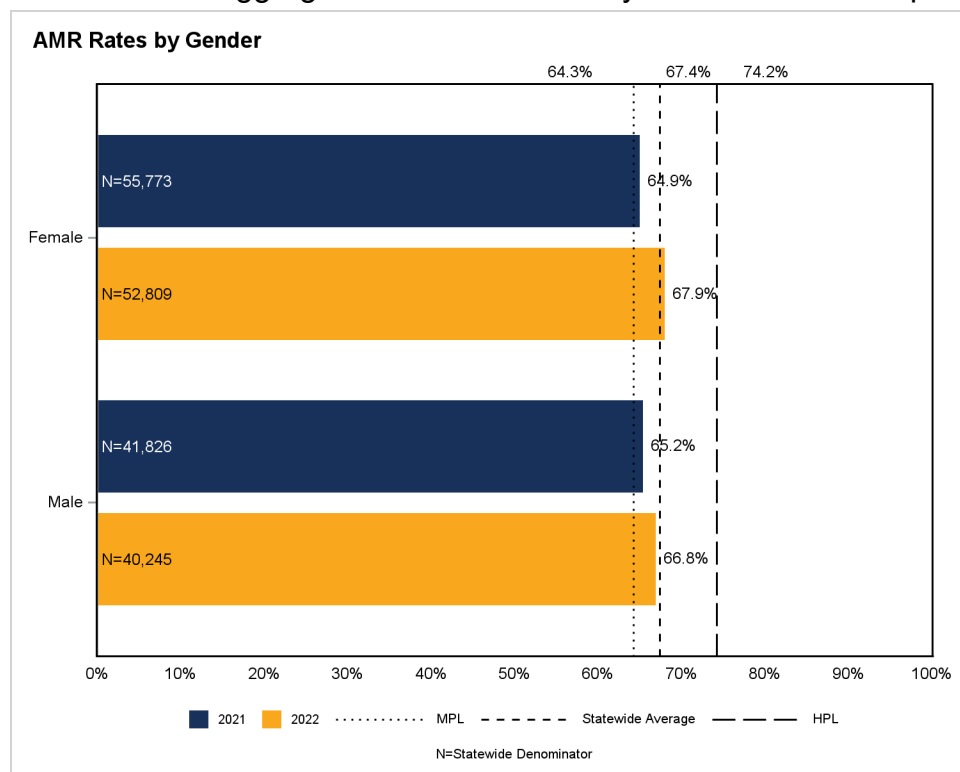
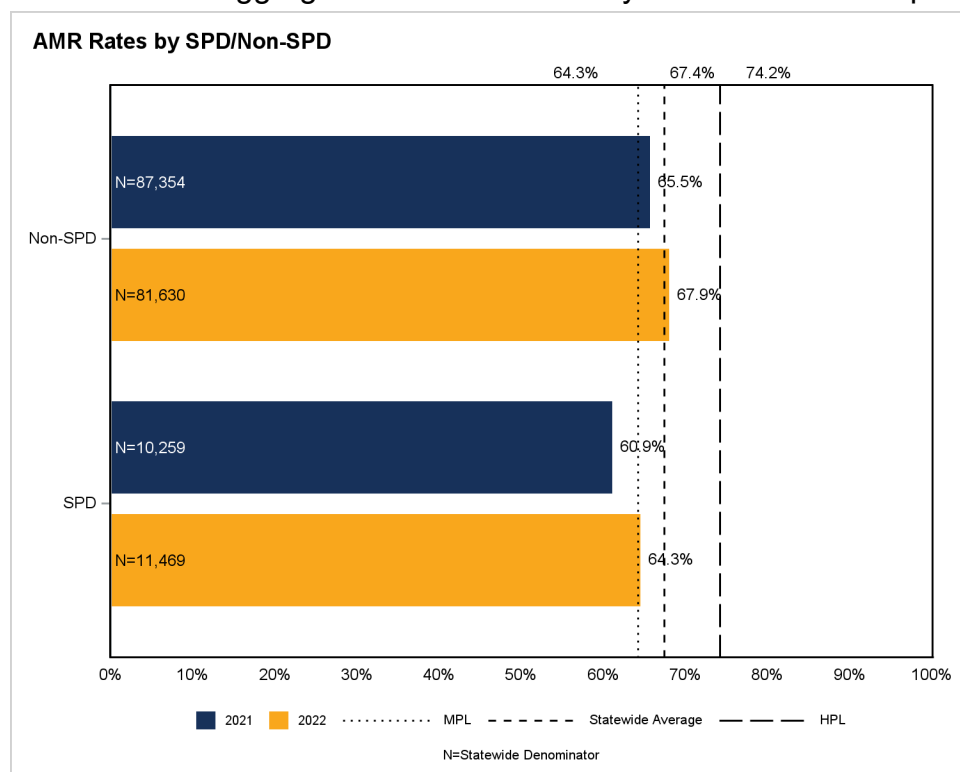


Figure C.200—Asthma Medication Ratio—Total (AMR) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 64.8 percent and 75.3 percent, respectively.

The statewide aggregate for measurement year 2021 was 65.0 percent.

**Controlling High Blood Pressure—Total (CBP)**

The *Controlling High Blood Pressure—Total (CBP)* indicator measures the percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg).

Figure C.201—Controlling High Blood Pressure—Total (CBP) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 56.9 percent (N=837) and 61.3 percent (N=848), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 55.4 percent and 66.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 58.8 percent.

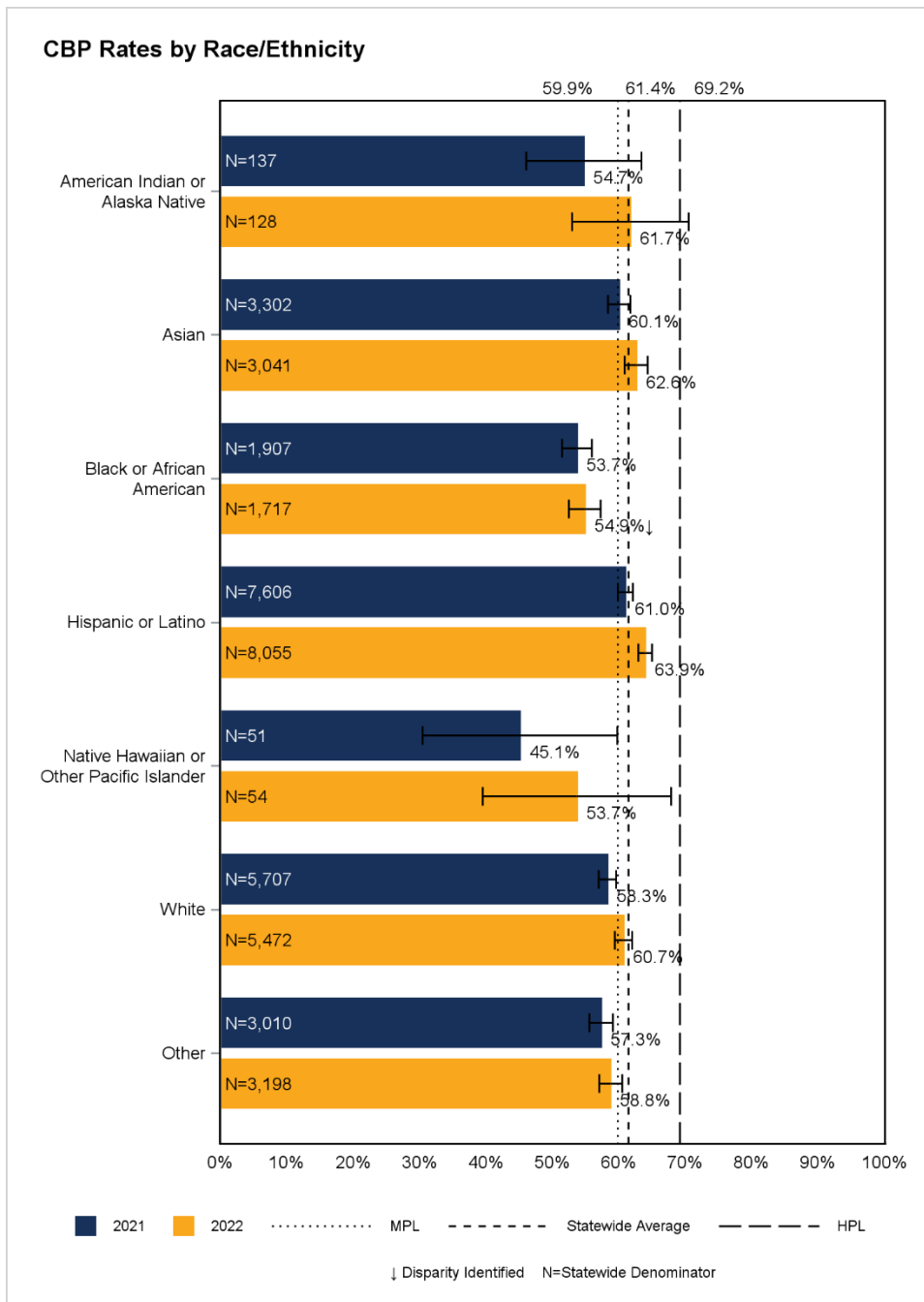


Figure C.202—Controlling High Blood Pressure—Total (CBP) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 68.0 percent (N=100) and 62.9 percent (N=89), respectively.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 55.4 percent and 66.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 58.8 percent.

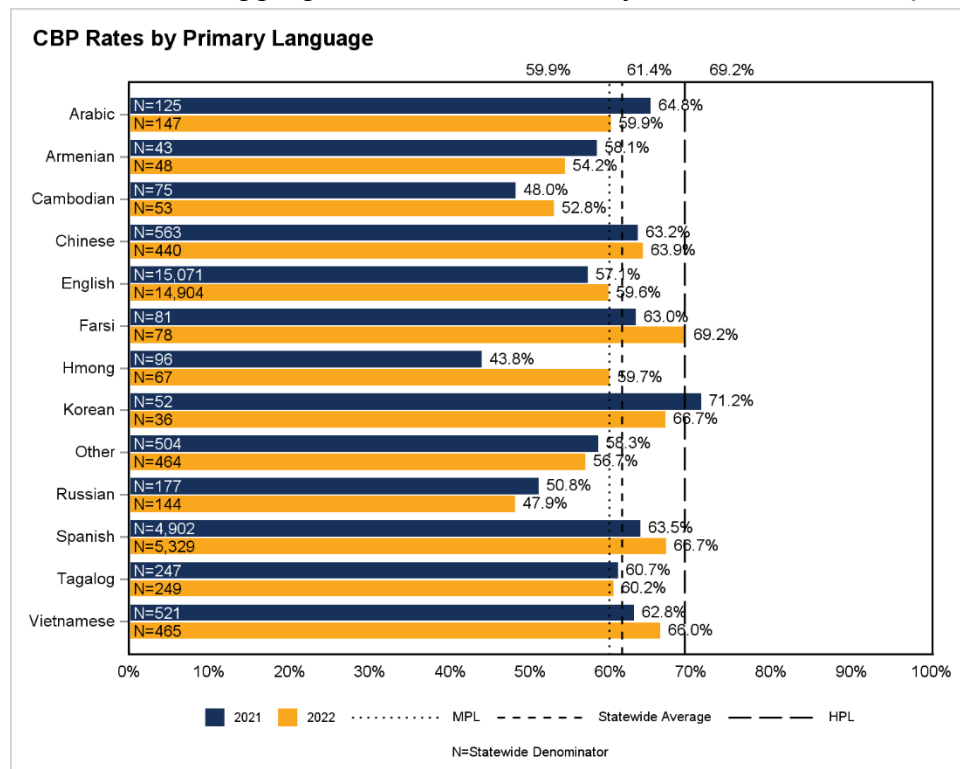


Figure C.203—Controlling High Blood Pressure—Total (CBP) Rates by Age

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 55.4 percent and 66.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 58.8 percent.

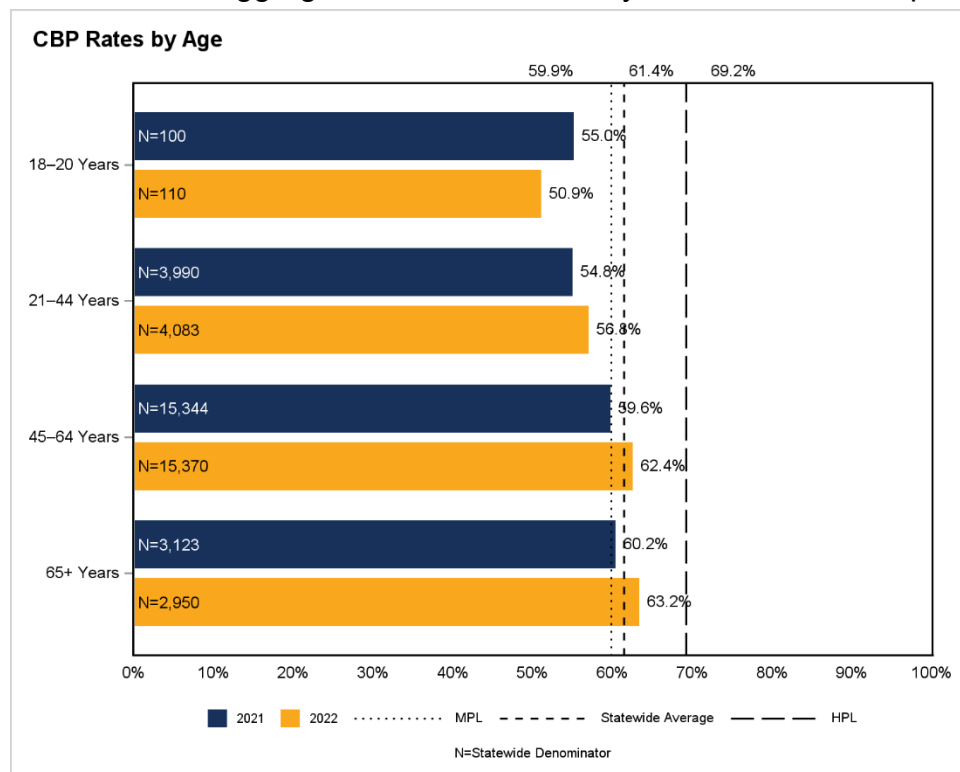


Figure C.204—Controlling High Blood Pressure—Total (CBP) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 55.4 percent and 66.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 58.8 percent.

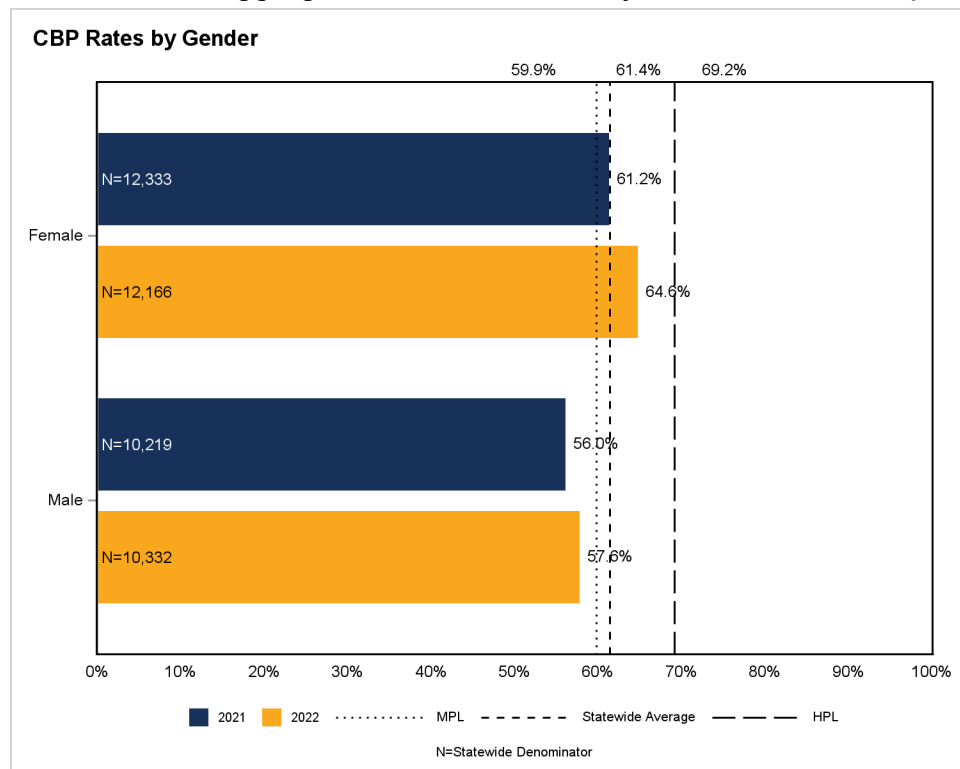
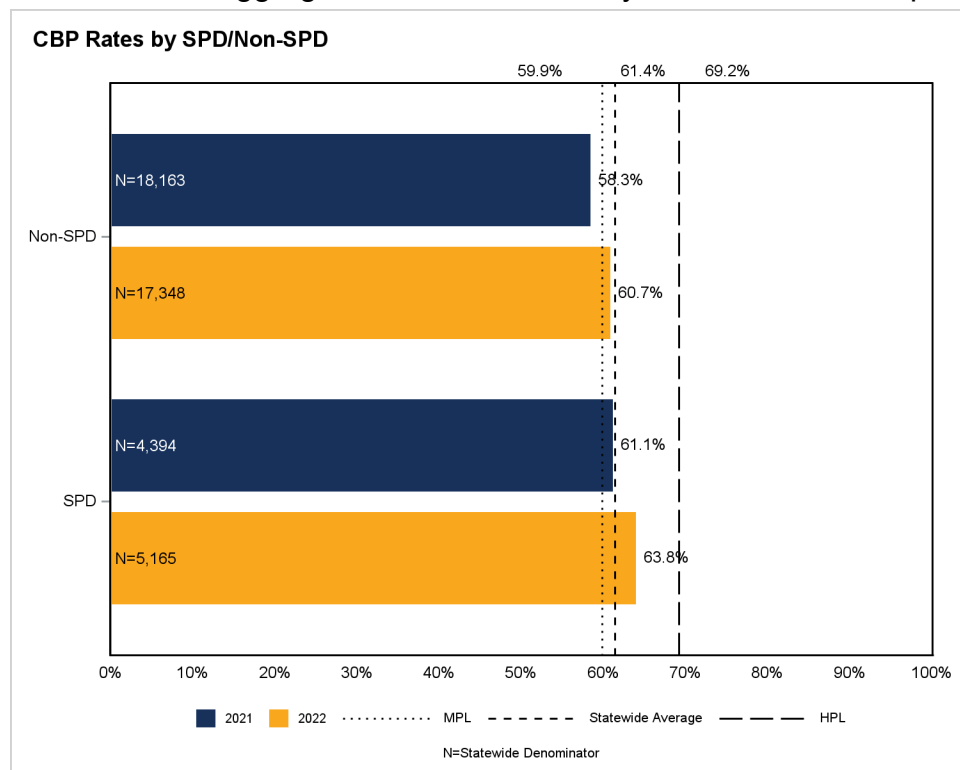


Figure C.205—Controlling High Blood Pressure—Total (CBP) Rates by SPD/Non-SPD

Note: The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 55.4 percent and 66.8 percent, respectively.

The statewide aggregate for measurement year 2021 was 58.8 percent.



HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)

The *Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)* indicator measures the percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose most recently documented HbA1c level was greater than 9.0 percent.

Figure C.206—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 37.0 percent (N=808) and 36.6 percent (N=872), respectively.

A lower rate indicates more favorable performance for this indicator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 43.2 percent and 34.1 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.1 percent.

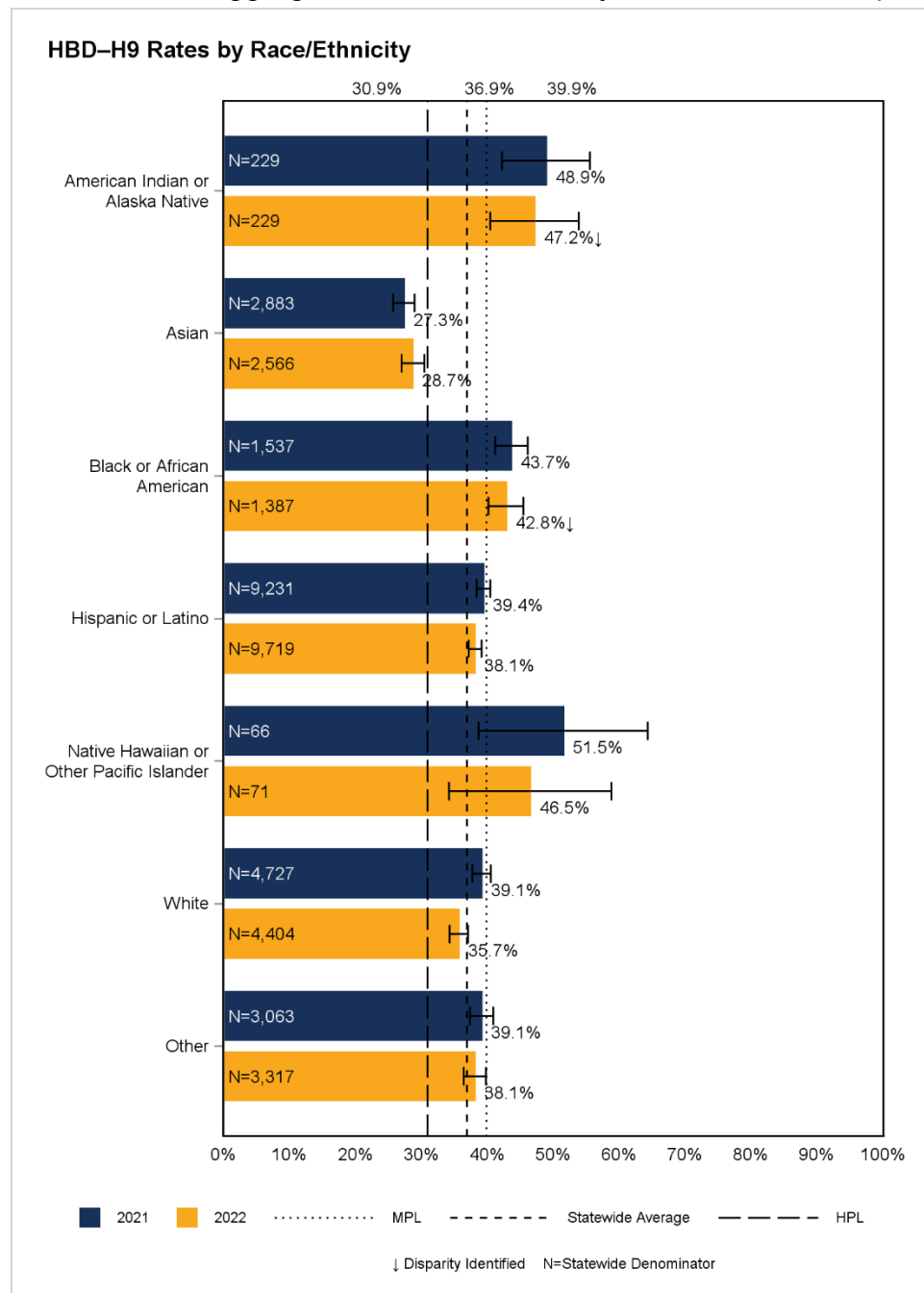


Figure C.207—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 27.5 percent (N=102) and 32.9 percent (N=82), respectively.

A lower rate indicates more favorable performance for this indicator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 43.2 percent and 34.1 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.1 percent.

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 DHCS Data De-Identification Guidelines (DDG) V2.2 de-identification standard.

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

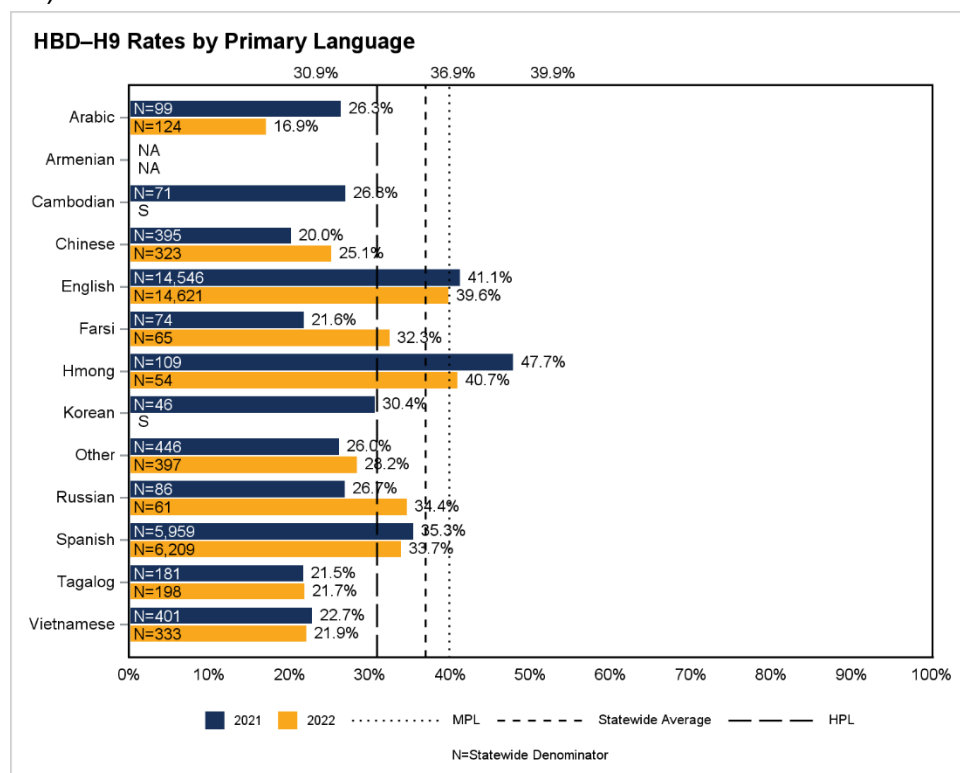


Figure C.208—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9) Rates by Age

A lower rate indicates more favorable performance for this indicator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 43.2 percent and 34.1 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.1 percent.

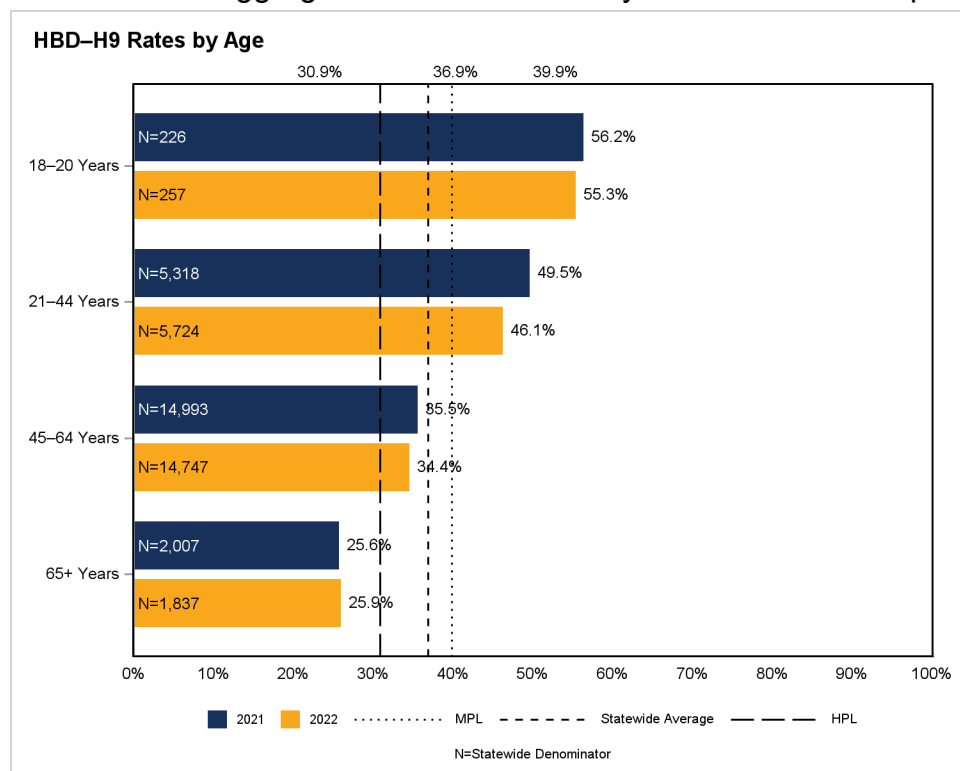


Figure C.209—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9) Rates by Gender

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were suppressed due to small denominators.

A lower rate indicates more favorable performance for this indicator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 43.2 percent and 34.1 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.1 percent.

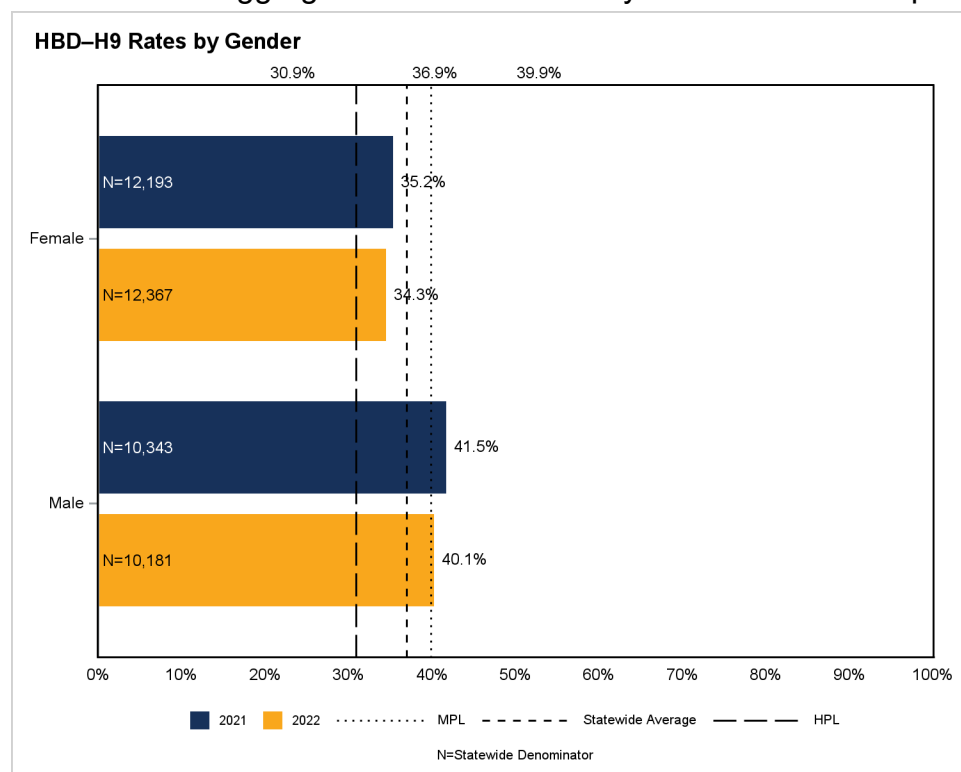


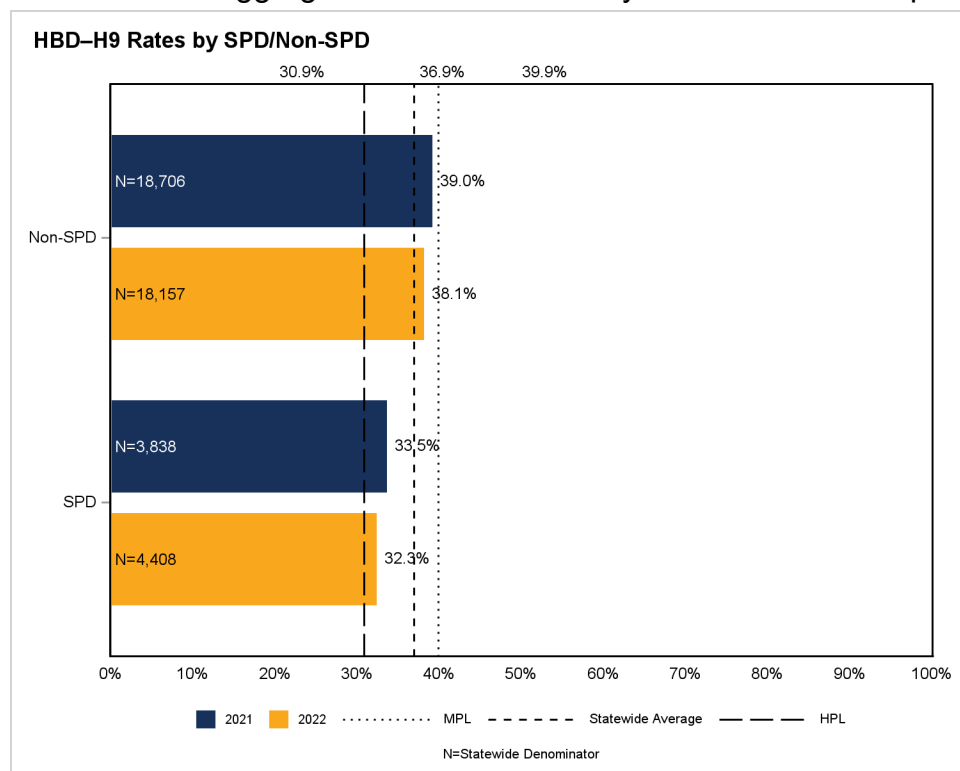
Figure C.210—HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9) Rates by SPD/Non-SPD

A lower rate indicates more favorable performance for this indicator.

The minimum performance level and high performance level represent the national Medicaid 50th and 90th percentiles, respectively, for this indicator.

The minimum performance level and high performance level for measurement year 2021 were 43.2 percent and 34.1 percent, respectively.

The statewide aggregate for measurement year 2021 was 38.1 percent.



Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR)

The *Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR)* indicator measures the percentage of acute inpatient hospital stays for members 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 C.211—Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR) Rates by Race/Ethnicity

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 9.3 percent (N=7,933) and 9.2 percent (N=8,637), respectively.

A lower rate indicates more favorable performance for this indicator.

The statewide aggregate for measurement year 2021 was 9.2 percent.

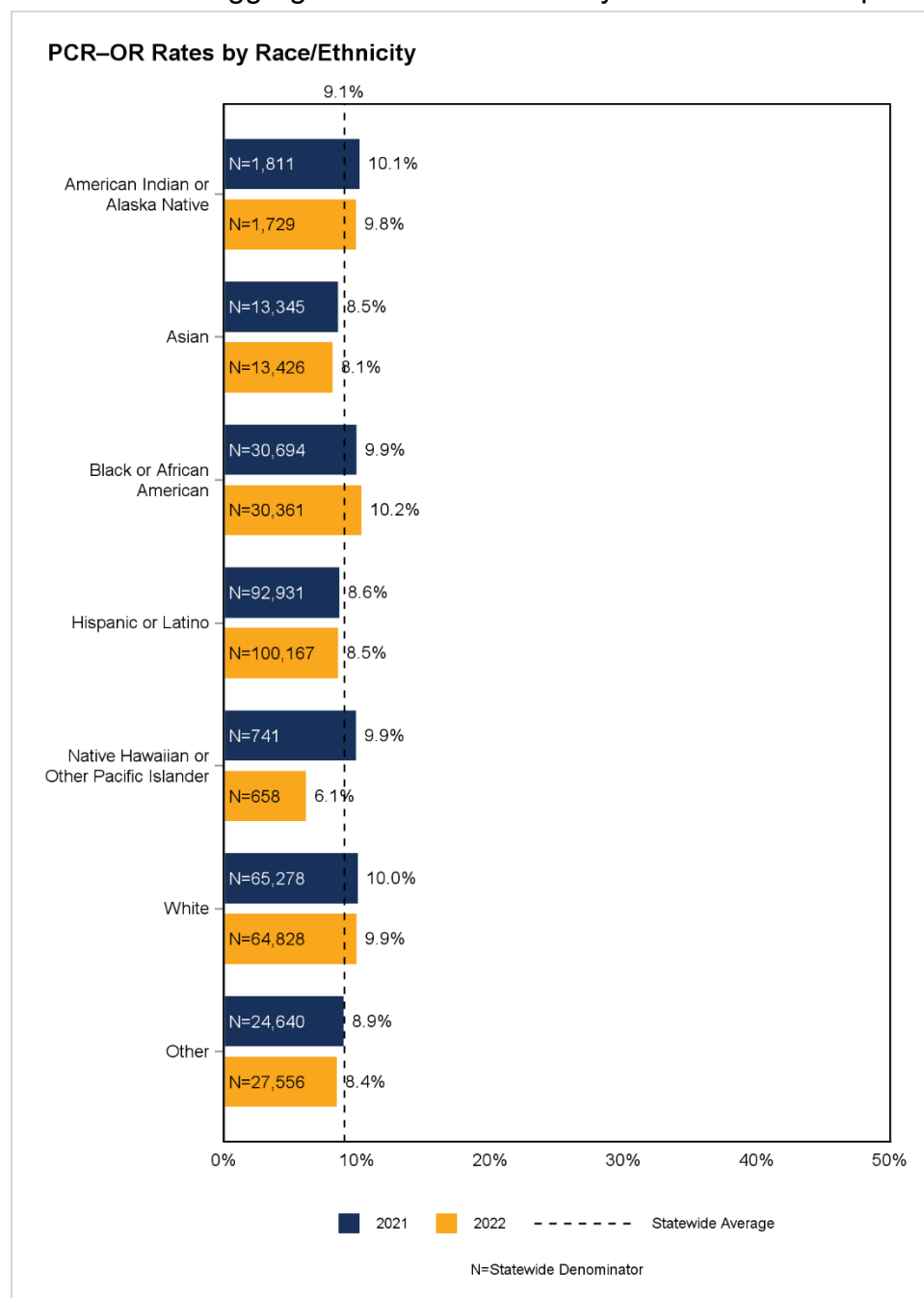


Figure C.212—Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR) Rates by Primary Language

Note: The measurement year 2021 and 2022 rates for the Unknown/Missing group were 10.3 percent (N=937) and 10.2 percent (N=1,054), respectively.

A lower rate indicates more favorable performance for this indicator.

The statewide aggregate for measurement year 2021 was 9.2 percent.

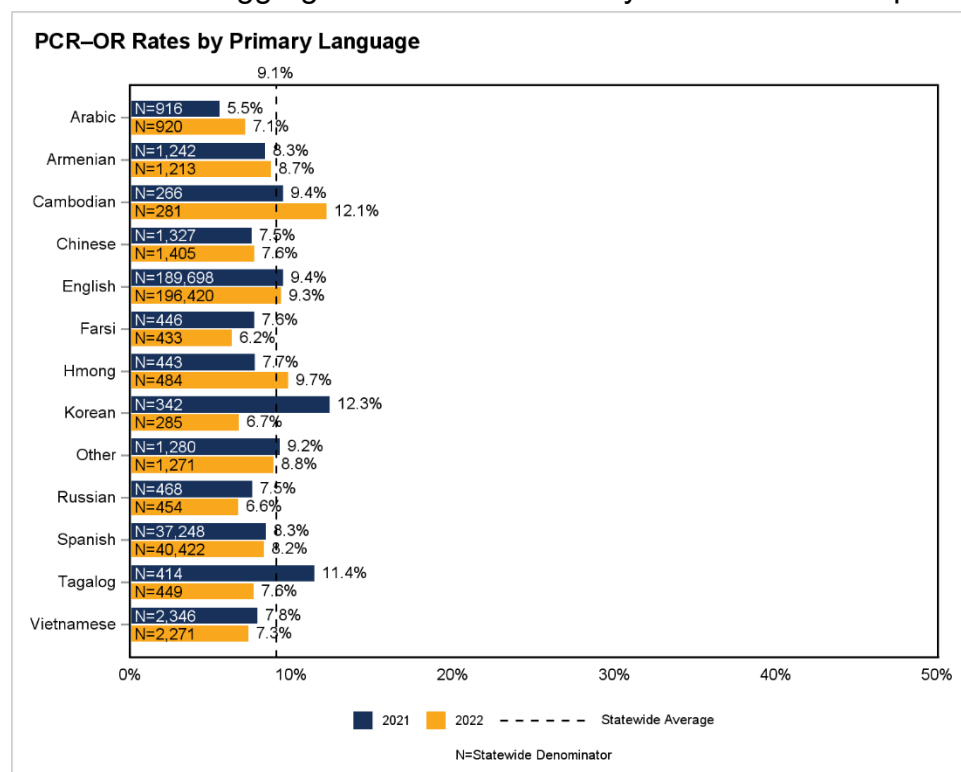


Figure C.213—Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR-OR) Rates by Age

Note: A lower rate indicates more favorable performance for this indicator.
The statewide aggregate for measurement year 2021 was 9.2 percent.

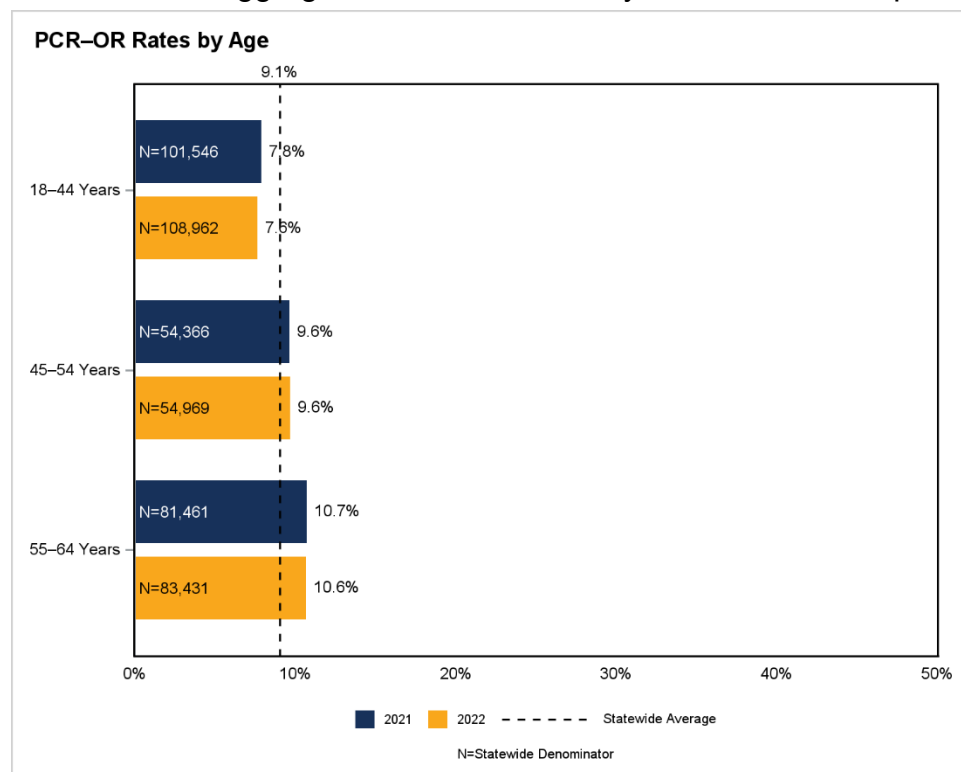


Figure C.214—Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR) Rates by Gender

Note: The measurement year 2021 rate for the Unknown/Missing group was suppressed due to a small denominator. The measurement year 2022 rate for the Unknown/Missing group was 8.0 percent (N=325).

A lower rate indicates more favorable performance for this indicator.

The statewide aggregate for measurement year 2021 was 9.2 percent.

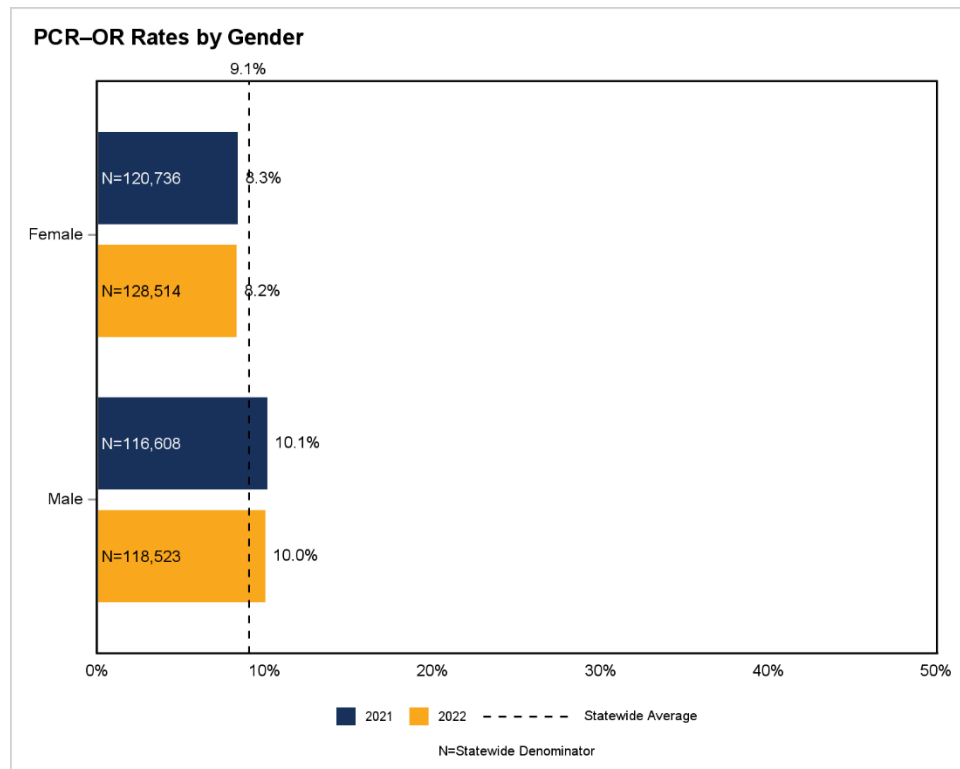
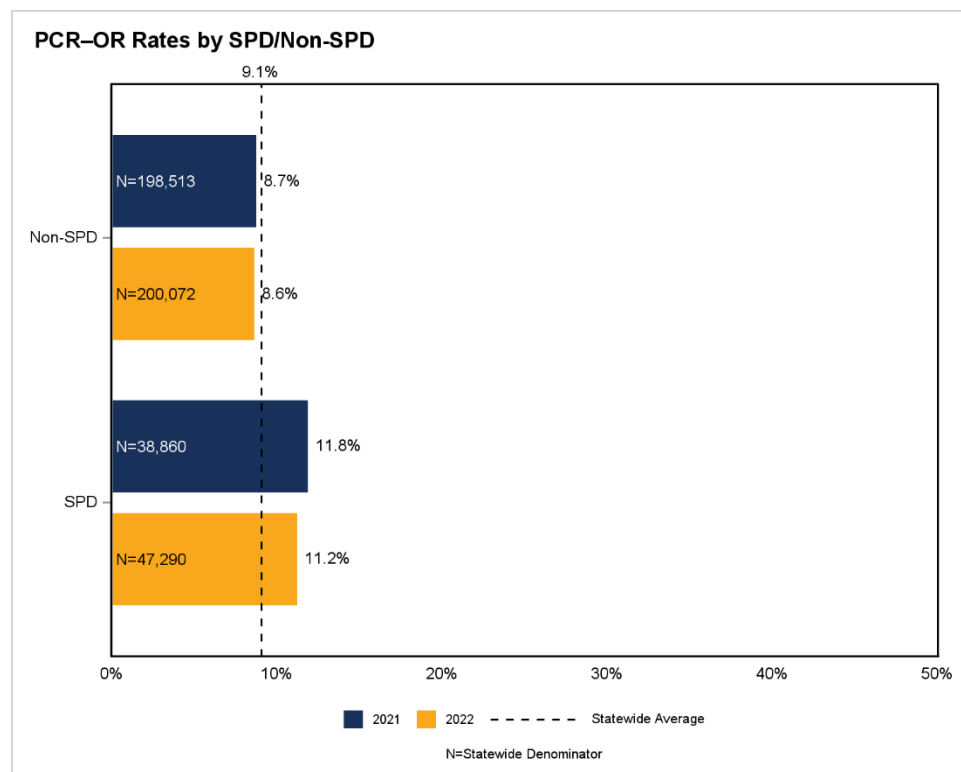


Figure C.215—Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR) Rates by SPD/Non-SPD

Note: A lower rate indicates more favorable performance for this indicator.
The statewide aggregate for measurement year 2021 was 9.2 percent.



Appendix D. Methodology

Overview

Within its Comprehensive Quality Strategy, the California Department of Health Care Services (DHCS) identifies a Health Equity Framework focused on improved data collection and stratification, increased workforce diversity and cultural responsiveness, and efforts to eliminate health disparities in order to achieve more equitable health outcomes for Medi-Cal members.¹⁶ To address the need to understand and identify health disparities among Medi-Cal managed care health plan (MCP) members, DHCS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a health disparities study using the Managed Care Accountability Set (MCAS) measures reported by the 25 Medi-Cal MCPs for measurement year 2022 with data derived from calendar year 2022. MCAS measures reflect clinical quality, timeliness, and access to care provided by MCPs to their members, and each MCP is required to report audited MCAS results to DHCS annually. The goal of the health disparities analysis is to improve health care for Medi-Cal members by evaluating the health care disparities affecting members enrolled in Medi-Cal MCPs. This report does not include data for fee-for-service members in Medi-Cal.

For the 2022–23 contract year, HSAG evaluated measure data collected for measurement year 2022 at the statewide level. Several measures include more than one indicator; therefore, this report will refer to indicators rather than measures. For each indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the Healthcare Effectiveness Data and Information Set (HEDIS®)¹⁷ specifications for the Medicaid population or by the Centers for Medicare & Medicaid Services' (CMS') Core Set of Adult Health Care Quality Measures for Medicaid and Core Set of Children's Health Care Quality Measures for Medicaid and the Children's Health Insurance Program (CHIP) (Adult and Child Core Set) specifications. HSAG aggregated results from 25 MCPs and then stratified the statewide rates for the MCAS indicators by the following demographic stratifications:

- ◆ Race/Ethnicity
- ◆ Primary Language
- ◆ Age
- ◆ Gender
- ◆ Seniors and Persons with Disabilities (SPD) and non-SPD populations
- ◆ Healthy Places Index (HPI) quartile (for select indicators)

¹⁶ State of California Department of Health Care Services. Comprehensive Quality Strategy. February 2022. Available at: <https://www.dhcs.ca.gov/services/Documents/Formatted-Combined-CQS-2-4-22.pdf>. Accessed on: Jan 31, 2024.

¹⁷ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- ◆ County
- ◆ Region

Although HSAG stratified all indicators by race/ethnicity, primary language, age, gender, SPD/non-SPD populations, HPI quartile (only for select indicators), county, region, delivery type model, and population density, HSAG only identified racial/ethnic health disparities based on comparisons to the minimum performance levels (i.e., the 2022 NCQA Quality Compass® national Medicaid 50th percentiles)¹⁸ for the HEDIS MCAS indicators and the median state performance rates (i.e., the 50th percentiles) from CMS' Federal Fiscal Year (FFY) 2020 Child and Adult Health Care Quality Measures data set for the non-HEDIS MCAS indicators, when available.¹⁹ Additionally, HSAG compared measurement year 2022 results to measurement year 2021 results, where applicable.

Data Sources

HSAG received a California-required patient-level detail file from each MCP for each HEDIS reporting unit. The measurement year 2022 patient-level detail files followed HSAG's patient-level detail file instructions and included the Medi-Cal client identification number and date of birth for members included in the audited MCP-calculated indicator rates. Additionally, the patient-level detail files indicated whether a member was included in the numerator and/or denominator for each applicable MCP-calculated 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 and non-HEDIS Microsoft (MS) Excel reporting files. Please note, it is possible that non-certified eligible members were included by some or all MCPs in the measurement year 2022 rates. HSAG used these patient-level detail files, along with supplemental files (e.g., demographic data provided by DHCS), to perform the evaluation. HSAG obtained the following data elements from the demographic file from DHCS' Management Information System/Decision Support System data system:

- ◆ Member's Medi-Cal Client Identification Number
- ◆ Date of Birth
- ◆ ZIP Code
- ◆ Gender
- ◆ Race/Ethnicity
- ◆ Primary Language

¹⁸ Quality Compass® is a registered trademark of NCQA.

¹⁹ Given that CMS transitioned to the Quality Measure Reporting (QMR) system, state reporting for measurement year 2020 was delayed; therefore, FFY 2021 benchmarks are unavailable. As a result, HSAG compared measurement years 2021 and 2022 rates for applicable non-HEDIS MCAS indicators to the FFY 2020 benchmarks.

- ◆ County
- ◆ SPD/non-SPD Populations

In order to present trending results, HSAG used the combined patient-level detail file (i.e., patient-level detail files combined with supplemental demographic data provided by DHCS) created for the 2021 Health Disparity Study. For more detailed information regarding data sources and combining data for measurement year 2021, please refer to the methodology presented in the *2021 Health Disparities Report*.²⁰

HSAG also downloaded the HPI 3.0 Master File from the Public Health Alliance of Southern California website which contains data regarding the demographic composition of various communities, stratified by ZIP Code (e.g., average household income, education level, supermarket availability).²¹

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 members 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, 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 as the patient-level detail file. 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 measurement year 2022.
 - If HSAG could not recover the missing demographic values from a record within measurement year 2022, then the most recent non-missing observation from measurement year 2021 was used.

²⁰ State of California Department of Health Care Services. 2021 Health Disparities Report. May 2023. Available at: <https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2021-22-Health-Disparities-Report-F3.pdf>. Accessed on: Jan 31, 2024.

²¹ Public Health Alliance of Southern California. The California Healthy Places Index. Available at: <https://www.healthyplacesindex.org/>. Accessed on: Jan 31, 2024.

- ◆ If HSAG could not obtain data for the missing demographic values, then a value of “Unknown/Missing” was assigned.

Step 3: HSAG combined the demographic file to the patient-level detail file by Medi-Cal client identification number and prioritized matches within the same reporting unit first, using records from other reporting units when necessary, using the same logic as in Step 2. Additionally, to avoid combining a parent record with a child record that contained 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.²² 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. If HSAG could not obtain county data from the demographic file, then HSAG did the following:

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

Step 4: HSAG combined the combined patient-level detail file with the HPI Master File by ZIP Code. If HSAG could not obtain the ZIP Code data from the demographic file for a given member, then HSAG assigned a ZIP Code of “Unknown/Missing” and HPI information for the given member was not matched.

Indicators and Stratifications

Table D.1 displays the indicators included in the analysis, the reporting methodology for each indicator, the age groups for each indicator, and the available benchmarks for each indicator. Because the age parameters for each indicator differ, HSAG collaborated with DHCS to define the age groups listed in Table D.1 for each indicator.

Due to NCQA’s recommendation for a break in trending (indicated with a *), benchmark unavailability (indicated with a ^), or limitations with the data (indicated with a +), HSAG was unable to perform analyses to identify health disparities for the following indicators:

²² The Gold Coast MCP was missing date of birth data in the patient-level detail files for a large portion of their members. To address this, HSAG did not require date of birth as part of the matching criteria and used DHCS-provided demographic data to obtain date of birth for these members.

- ◆ Measurement year 2021
 - *Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total*^{*,23}
 - *Plan All-Cause Readmissions—Observed Readmission Rate—Total*[^]
- ◆ Measurement year 2022
 - *Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total*^{*}
 - *Colorectal Cancer Screening—Total*[^]
 - *Depression Remission or Response for Adolescents and Adults*[^]
 - *Depression Screening and Follow-Up for Adolescents and Adults*[^]
 - *Follow-Up After Emergency Department Visit for Substance Use*^{*}
 - *Plan All-Cause Readmissions—Observed Readmission Rate—Total*[^]
 - *Postpartum Depression Screening and Follow-Up*[^]
 - *Prenatal Depression Screening and Follow-Up*[^]

For indicators where HSAG was unable to identify health disparities for only measurement year 2021, trending results were presented and disparities were identified for measurement year 2022. For indicators where HSAG was unable to identify health disparities for both measurement years 2021 and 2022, HSAG stratified these indicators by race/ethnicity, primary language, age, gender, SPD/non-SPD populations, HPI quartile, county, region, delivery type model, and population density, where applicable, and presented the results in an appendix to the report and/or within the rate spreadsheets for DHCS' internal use.

Table D.1—Indicators, Reporting Methodology, Age Groups, and Benchmarking Sources

A = administrative methodology (claims/encounter data and supplemental administrative data sources)

H = hybrid methodology (a combination of claims/encounter data and medical record review data). For all hybrid measures, MCPs have the option to report the measure using either the hybrid or administrative reporting methodology.

ECDS = Electronic Clinical Data Systems methodology (can include electronic health record [EHR] data, health information exchange data, clinical registry data, case management registry data, and administrative claims/encounter data)

N/A indicates HSAG was unable to compare rates to national benchmarks due to NCQA's recommendation for a break in trending, benchmark unavailability, or limitations with the data.

* Indicates a lower rate is better.

^ Indicates a higher or lower rate does not necessarily indicate better or worse performance.

²³ NCQA changed the *Ambulatory Care* measure from per 1,000 member months to per 1,000 member years for measurement year 2022. According to NCQA allowances, HSAG recalculated the measurement year 2021 *Ambulatory Care—Emergency Department Visits* indicator rates to be per 1,000 member years in order to trend to measurement year 2022 rates.

* Given that CMS transitioned to the QMR system, state reporting for measurement year 2020 was delayed; therefore, FFY 2021 benchmarks are unavailable. As a result, HSAG compared measurement years 2021 and 2022 rates to the FFY 2020 benchmarks.

Indicator	Reporting Methodology	Age Groups	Benchmarks
Children's Health			
<i>Child and Adolescent Well-Care Visits—Total (WCV)</i>	A	3–11 Years; 12–17 Years; 18–21 Years	NCQA 2021 and 2022 Quality Compass
<i>Childhood Immunization Status—Combination 10 (CIS–10)</i>	H	2 Years	NCQA 2021 and 2022 Quality Compass
<i>Developmental Screening in the First Three Years of Life—Total (DEV)*</i>	A	1 Year; 2 Years; 3 Years	FFY 2020 CMS Child Core Set
<i>Immunizations for Adolescents—Combination 2 (Meningococcal; Tetanus, Diphtheria Toxoids, and Acellular Pertussis [Tdap]; and Human Papillomavirus [HPV]) (IMA–2)</i>	H	13 Years	NCQA 2021 and 2022 Quality Compass
<i>Lead Screening in Children (LSC)</i>	H	2 Years	NCQA 2022 Quality Compass
<i>Topical Fluoride for Children—Dental Services—Total (TFL–DS), Oral Health Services—Total (TFL–OH), and Dental or Oral Health Services—Total (TFL–DO)</i>	A	1–2 Years; 3–5 Years; 6–7 Years; 8–9 Years; 10–11 Years; 12–14 Years; 15–18 Years; 19–20 Years	N/A
<i>Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6+) and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2+)</i>	A	15 Months; 30 Months	NCQA 2021 and 2022 Quality Compass

Indicator	Reporting Methodology	Age Groups	Benchmarks
Reproductive Health			
<i>Chlamydia Screening in Women—Total (CHL)</i>	A	16–20 Years; 21–24 Years	NCQA 2021 and 2022 Quality Compass
<i>Contraceptive Care—All Women—Most or Moderately Effective Contraception (CCW–MMEC)⁺</i>	A	15–20 Years; 21–44 Years	FFY 2020 Adult and Child Core Set
<i>Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days (CCP–MMEC60)⁺</i>	A	15–20 Years; 21–44 Years	FFY 2020 Adult and Child Core Set
<i>Postpartum Depression Screening and Follow-Up—Depression Screening (PDS–E–DS) and Follow-Up on Positive Screen (PDS–E–FU)</i>	ECDS	<18 Years; 18–20 Years; 21–34 Years; 35–44 Years; 45+ Years	N/A
<i>Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) and Timeliness of Prenatal Care (PPC–Pre)</i>	H	<18 Years; 18–20 Years; 21–34 Years; 35–44 Years; 45+ Years	NCQA 2021 and 2022 Quality Compass
<i>Prenatal Depression Screening and Follow-Up—Depression Screening (PND–E–DS) and Follow-Up on Positive Screen (PND–E–FU)</i>	ECDS	<18 Years; 18–20 Years; 21–34 Years; 35–44 Years; 45+ Years	N/A
<i>Prenatal Immunization Status—Combination (Influenza and Tdap) (PRS–E)</i>	ECDS	<18 Years; 18–20 Years; 21–34 Years; 35–44 Years; 45+ Years	NCQA 2022 Quality Compass

Indicator	Reporting Methodology	Age Groups	Benchmarks
Cancer Prevention			
<i>Breast Cancer Screening—Total (BCS)</i>	A	50–64 Years; 65–74 Years	NCQA 2021 and 2022 Quality Compass
<i>Cervical Cancer Screening (CCS)</i>	H	21–64 Years	NCQA 2021 and 2022 Quality Compass
<i>Colorectal Cancer Screening—Total (COL)</i>	A	46–49 Years; 50–75 Years	N/A
Behavioral Health			
<i>Antidepressant Medication Management—Effective Acute Phase Treatment—Total (AMM–Acute) and Effective Continuation Phase Treatment—Total (AMM–Cont)</i>	A	18+ Years	NCQA 2021 and 2022 Quality Compass
<i>Depression Remission or Response for Adolescents and Adults—Follow-Up PHQ-9—Total (DRR–E–PHQ), Depression Remission—Total (DRR–E–RM), and Depression Response—Total (DRR–E–RS)</i>	ECDS	12–17 Years; 18–44 Years; 45–64 Years; 65+ Years	N/A
<i>Depression Screening and Follow-Up for Adolescents and Adults—Depression Screening—Total (DSF–E–DS) and Follow-Up on Positive Screen—Total (DSF–E–FU)</i>	ECDS	12–17 Years; 18–64 Years; 65+ Years	N/A
<i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</i>	A	18–64 Years	NCQA 2021 and 2022 Quality Compass
<i>Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up (FUA–7) and 30-Day Follow-Up (FUA–30)</i>	A	13–17 Years; 18+ Years	N/A

Indicator	Reporting Methodology	Age Groups	Benchmarks
<i>Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up (FUM-7) and 30-Day Follow-Up (FUM-30)</i>	A	6–17 Years; 18–64 Years; 65+ Years	NCQA 2021 and 2022 Quality Compass
<i>Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication—Initiation Phase (ADD-Init) and Continuation and Maintenance Phase (ADD-C&M)</i>	A	6–12 Years	NCQA 2021 and 2022 Quality Compass
<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total (APM-B), Cholesterol Testing—Total (APM-C), and Blood Glucose and Cholesterol Testing—Total (APM-BC)</i>	A	1–11 Years; 12–17 Years	NCQA 2021 and 2022 Quality Compass
<i>Pharmacotherapy for Opioid Use Disorder (POD)</i>	A	16–64 Years; 65+ Years	NCQA 2022 Quality Compass
Chronic Disease Management			
<i>Adults' Access to Preventive/Ambulatory Health Services—Total (AAP)</i>	A	20–44 Years; 45–64 Years; 65+ Years	NCQA 2022 Quality Compass
<i>Ambulatory Care—Emergency Department Visits per 1,000 Member Years—Total (AMB-ED)^</i>	A	<1 Years; 1–9 Years; 10–19 Years; 20–44 Years; 45–64 Years; 65–74 Years; 75–84 Years; 85+ Years	N/A
<i>Asthma Medication Ratio—Total (AMR)</i>	A	5–11 Years; 12–18 Years; 19–50 Years; 51–64 Years	NCQA 2021 and 2022 Quality Compass

Indicator	Reporting Methodology	Age Groups	Benchmarks
<i>Controlling High Blood Pressure—Total (CBP)</i>	H	18–20 Years; 21–44 Years; 45–64 Years; 65+ Years	NCQA 2021 and 2022 Quality Compass
<i>Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD–H9)*</i>	H	18–20 Years; 21–44 Years; 45–64 Years; 65+ Years	NCQA 2021 and 2022 Quality Compass
<i>Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR)*</i>	A	18–44 Years; 45–54 Years; 55–64 Years	N/A

Table D.2 displays the demographic stratification groups for race/ethnicity, primary language, age, gender, and SPD/non-SPD populations.

Table D.2—Demographic Stratification Groups

* Indicates primary language stratifications were derived from the current threshold languages for Medi-Cal managed care counties as of April 2021. All non-threshold languages were included in the “Other” primary language group.

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 D.3 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 D.1 for more detail)

Stratification	Groups
Gender	Male or Female
SPD ²⁴	SPD and non-SPD

Table D.3 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 D.2. 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.

Table D.3—Racial/Ethnic Stratification Groups

*Some “Other Pacific Islanders” who would not be considered part of the Asian racial/ethnic group were included in the Asian racial/ethnic group due to limitations of existing data fields (i.e., the data do not allow HSAG to parse out racial/ethnic groups that may not be considered Asian).

Stratification	Groups
Hispanic or Latino	Hispanic or Latinx
White	White
Black or African American	Black or African American
Asian	Filipino, Amerasian, Chinese, Cambodian, Japanese, Korean, Asian Indian, Laotian, Vietnamese, Hmong, 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

HSAG also calculated regional-level rates for each indicator listed in Table D.1 where possible. The regional stratifications groups for county, delivery type model, population density, and geographic region are listed in Table D.4.

²⁴ SPD was defined in alignment with the DHCS-approved Medi-Cal SPD Aid Codes_HEDIS MY21_Updated 121421 document shared with the MCPs.

Table D.4—Regional Stratification Groups

*The Imperial and San Benito delivery models are not included in the delivery type model analysis since the rates for those models are represented in the county stratifications.

^ HSAG classified members as living in either rural or urban areas by comparing their ZIP Codes from the DHCS-provided demographic data to the Rural-Urban Commuting Area (RUCA) designations.²⁵ Since more than one RUCA designation maps to a single ZIP Code, HSAG used the RUCA value that made up the majority of the population living within each ZIP Code. Also, any ZIP Codes that did not match to a RUCA designation were considered rural.

Stratification	Groups
County	Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, Yuba
Delivery Type Model*	County Organized Health Systems, Geographic Managed Care, Two-Plan (i.e., Local Initiative or Commercial Plan), Regional
Population Density^	Urban, Rural
Geographic Region	Central Coast, Southeastern, San Francisco Bay/Sacramento, North/Mountain, San Joaquin Valley, Southern Coast

Table D.5 displays how the counties listed in Table D.4 are grouped into geographic regions based on where MCPs operate and which MCPs collaborate with each other to improve health outcomes within the regions they operate.

²⁵ U.S. Department of Agriculture: Economic Research Service. Rural-Urban Commuting Area Codes.

Table D.5—Geographic Regions and Applicable Counties

Geographic Region	Counties
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
Southeastern	Imperial, Riverside, San Bernardino
San Francisco Bay/Sacramento	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma, Sacramento
North/Mountain	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, Tuolumne, Placer, El Dorado, Sutter, Yolo, Yuba
San Joaquin Valley	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare
Southern Coast	Los Angeles, Orange County, San Diego

Rate Spreadsheets

After performing the analyses, HSAG compiled and produced indicator rate spreadsheets in a MS Excel format that provided all indicator-level data for all stratifications (i.e., race/ethnicity, primary language, age, gender, SPD/non-SPD populations, region, county, population density, and delivery type model). HSAG produced one statewide and 25 MCP-specific rate spreadsheets that contain applicable numerator, denominator, eligible population, demographic, and rate data for each reporting unit. The statewide spreadsheet also contains cross-tabulation between race/ethnicity and region. HSAG created a suppressed and non-suppressed version of the statewide spreadsheets. All MCP-specific rate spreadsheets were non-suppressed.

Statistical Analysis

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

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

Using the member-level files created from matching the demographic records with the indicator files, HSAG performed a statewide-level health disparity analysis of the racial/ethnic demographic stratification using national benchmarks and calculating a 95 percent confidence interval around each racial/ethnic group's rate. HSAG calculated a statewide aggregate for each MCAS indicator by summing the numerators and denominators reported by each MCP reporting unit. To facilitate this, HSAG performed the procedures described below.

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 applicable benchmarks:

- ◆ The minimum performance levels (i.e., the 2021 and 2022 NCQA Quality Compass national Medicaid 50th percentiles) for the HEDIS MCAS indicators, when available.
- ◆ The median state performance rates (i.e., the 50th percentiles) from the CMS' FFY 2020 Child and Adult Health Care Quality Measures data set for non-HEDIS MCAS indicators, when available.

For each indicator, HSAG calculated a 95 percent confidence interval around each racial/ethnic group's rate following NCQA's methodology:

$$\begin{aligned} \text{lower interval} &= \text{rate} - 1.96 \sqrt{\frac{\text{rate}(1 - \text{rate})}{\text{denominator}}} - \frac{1}{2 \times \text{denominator}} \\ \text{upper interval} &= \text{rate} + 1.96 \sqrt{\frac{\text{rate}(1 - \text{rate})}{\text{denominator}}} + \frac{1}{2 \times \text{denominator}} \end{aligned}$$

For this report, a health disparity was defined as a rate for a racial/ethnic group that was worse than the reference rate (i.e., the minimum performance level or median state performance rate) and the upper interval of the 95 percent confidence interval was below the minimum performance level/median state performance rate. If the upper interval of the 95 percent confidence interval was at or above the minimum performance level/median state performance rate, then no disparity was identified.

Statewide-Level Racial/Ethnic Highest Performing Group Analysis

HSAG performed a statewide-level racial/ethnic highest performing analysis for each MCAS indicator. Specifically, HSAG calculated the proportion of each racial/ethnic group's rate from the highest performing group rate using the following formula:

$$\frac{\text{Racial Ethnic Rate}}{\text{Highest Performing Racial Ethnic Rate}}$$

For lower is better indicators, HSAG used the following formula:

$$\frac{1 - \text{Racial Ethnic Rate}}{1 - \text{Highest Performing Racial Ethnic Rate}}$$

Healthy Places Index Analysis

HSAG performed a HPI analysis for each of the nine key MCAS indicators that DHCS selected for this analysis, stratified by race/ethnicity and HPI quartile. HSAG combined the HPI score and percentile to the patient-level detail file based on member ZIP Code. For more information about combining the patient-level detail file and HPI data, please refer to the "Combining Data" section of this methodology.

Based on the HPI percentile identified for each ZIP Code, each member was placed into a quartile range (i.e., HPI percentile values below the 25th percentile were placed into quartile 1, values at or above the 25th but below the 50th percentile were placed into quartile 2, values at or above the 50th but below the 75th percentile were placed into quartile 3, and values at or above the 75th percentile were placed into quartile 4). HSAG then calculated rates by summing the numerators and denominators for all members within a racial/ethnic group-HPI quartile combination. For example, *Controlling High Blood Pressure (CBP)* indicator rates for each racial/ethnic group-HPI quartile combination (e.g., the *CBP* indicator rates for the Black or African American racial/ethnic group in HPI quartile 1) were presented in a single bar chart. The nine key MCAS indicators that DHCS selected for the HPI analysis were:

- ◆ *Child and Adolescent Well-Care Visits (WCV)*
- ◆ *Childhood Immunization Status—Combination 10 (CIS-10)*
- ◆ *Controlling High Blood Pressure—Total (CBP)*
- ◆ *HbA1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent) (HBD-H9)*
- ◆ *Immunizations for Adolescents—Combination 2 (IMA-2)*

- ◆ *Prenatal and Postpartum Care—Postpartum Care (PPC–Pst)*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre)*
- ◆ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6)*
- ◆ *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30–2)*

Regional Analysis

For each indicator-racial/ethnic group combination, HSAG created a color-coded map to display county-level rate improvements and declines based on performance changes relative to other counties. To do this, HSAG calculated differences from measurement year 2021 to measurement year 2022 for each county based on comparisons to the minimum performance level/median state performance rate. Based on these differences, HSAG then calculated performance quintiles (i.e., 20th percentile, 40th percentile, 60th percentile, and 80th percentile) and determined into which quintile each county fell (e.g., below the 20th percentile, between the 20th and 40th percentiles). HSAG shaded each county based on the corresponding quintiles as displayed in Table D.6.

Table D.6—Trending Quintile Thresholds and Corresponding Colors

Quintile	Performance Thresholds and Corresponding Colors
NA	Small denominator or suppressed rate
Quintile 1 (least favorable change)	Below the 20th percentile
Quintile 2	At or above the 20th percentile but below the 40th percentile
Quintile 3	At or above the 40th percentile but below the 60th percentile
Quintile 4	At or above the 60th percentile but below the 80th percentile
Quintile 5 (most favorable change)	At or above the 80th percentile

HSAG also produced current year (i.e., measurement year 2022) maps for each indicator-racial/ethnic group combination to identify counties that may be driving the changes presented in the trending maps. To do this, HSAG calculated the current year rate for each county and mirrored the approach used for the trending-level maps to calculate performance quintiles and determine into which quintile each county fell. HSAG shaded each county based on the corresponding quintiles as displayed in Table D.7.

Table D.7—Current Year Quintile Thresholds and Corresponding Colors

Quintile	Performance Thresholds and Corresponding Colors
NA	Small denominator or suppressed rate
Quintile 1 (least favorable rates)	Below the 20th percentile
Quintile 2	At or above the 20th percentile but below the 40th percentile
Quintile 3	At or above the 40th percentile but below the 60th percentile
Quintile 4	At or above the 60th percentile but below the 80th percentile
Quintile 5 (most favorable rates)	At or above the 80th percentile

Determining Key Findings Analysis

Given DHCS' interest in limiting the results presented in the body of the health disparities reports to highlight more actionable findings, HSAG only presented key findings and/or Bold Goals measures in the body of the report. HSAG only considered a result a key finding if at least one of the following criteria was met:

- ◆ **Persistent Disparity:** Racial/ethnic disparities that persisted between measurement years (i.e., a racial/ethnic disparity that existed in both measurement years 2021 and 2022).
 - **Persistent Disparity—Improved:** Persistent racial/ethnic disparities for which the distance between the rate for the racial/ethnic group and the minimum performance level/median state performance rate decreased from measurement year 2021 to measurement year 2022.
 - **Persistent Disparity—Worsened:** Persistent racial/ethnic disparities for which the distance between the rate for the racial/ethnic group and the minimum performance level/median state performance rate increased from measurement year 2021 to measurement year 2022.
- ◆ **New Disparity:** Racial/ethnic disparities that did not exist in measurement year 2021 but exist in measurement year 2022.
- ◆ **Eliminated Disparity:** Racial/ethnic disparities that existed in measurement year 2021 but did not exist in measurement year 2022.
- ◆ **Widespread Disparity:** Racial/ethnic disparities that were widespread (i.e., disparities that existed across a large number of racial/ethnic groups or a certain racial/ethnic group had disparities across multiple indicators/domains).

- ◆ Large Disparity: Racial/ethnic disparities that were large (e.g., racial/ethnic rates that were below the minimum performance level/median state performance rate by at least a 10 percent relative difference).
- ◆ Emerging Disparity: Racial/ethnic group indicator rates that were not a disparity in measurement year 2021 or 2022, but would be at risk of becoming a disparity in measurement year 2023 if the indicator rate continued to decline at a similar rate relative to the minimum performance level/median state performance rate.

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 numerator divided by the total denominator as a percentage, unless otherwise indicated.

HSAG produced horizontal bar graphs for each indicator to display the rates for each racial/ethnic group in alphabetical order. HSAG included the following data elements on the bar graphs, where applicable:

- ◆ Performance rates for each racial/ethnic group for measurement years 2021 and 2022
- ◆ Reference lines and values for the high performance level²⁶, when available; minimum performance level/median state performance rate; and statewide aggregate for measurement year 2022
 - Please note, measurement year 2021 values for the high performance level, minimum performance level/median state performance rate, and statewide aggregate were reported in the footnote above each figure, where applicable.
- ◆ Confidence intervals for each racial/ethnic rate
- ◆ Indication of a disparity using a downward arrow

In addition, HSAG produced a horizontal stacked bar graph for each domain (i.e., Children's Health, Reproductive Health, Cancer Prevention, Behavioral Health, and Chronic Disease Management) that displays the percentage of indicators for each racial/ethnic group that were:

- ◆ Persistent (i.e., present in both measurement year 2021 and 2022)
- ◆ New (i.e., present in measurement year 2022 but not in measurement year 2021)
- ◆ Eliminated (i.e., present in measurement year 2021 but not in measurement year 2022)
- ◆ Not identified (i.e., not present in either measurement year 2021 or 2022)

²⁶ The high performance level is defined as the 2021 and 2022 NCQA national Medicaid 90th percentile.

A similar horizontal stacked bar graph was created to display overall racial/ethnic health disparities for all indicators analyzed in this study.

HSAG also displayed current and trending county-level maps for racial/ethnic group-indicator combinations with results that were considered to be key findings. All maps produced, including those not presented in the body of the health disparities report, were included in a separate MS Word document for DHCS' internal use.

Within the Demographic Stratification Appendix of the health disparities report, HSAG also presented indicator rates for the primary language, age, gender, and SPD status demographic stratifications; however, HSAG did not perform statistical analysis on these demographic stratifications to identify health disparities. For each indicator, HSAG created horizontal bar graphs with reference lines for the statewide aggregate, high performance level (when available), and minimum performance level/median state performance rate (when available). If an indicator did not have national benchmarks, only the statewide aggregate rate was presented. Additionally, this Appendix presented results stratified by racial/ethnic group that were not considered to be key findings, and statistical analyses to identify health disparities were performed on these results, where possible.

Within the Highest Performing Group Appendix of the health disparities report, HSAG displayed summary graphics for each domain that highlight each racial/ethnic group's performance compared to the highest performing group for each indicator. HSAG also displayed individual indicator graphics organized by domain that display rate ratios with a footnote above the graphic to indicate the rate for the highest performing group for that indicator.

Within the HPI Appendix of the health disparities report, HSAG displayed graphics for each of the nine key indicators identified by DHCS. For each indicator, HSAG displayed bar graphs that displayed the indicator rate for each HPI quartile-racial/ethnic group combination.

HSAG also produced a patient-level detail SAS dataset for DHCS' internal use containing numerator and denominator information for each indicator along with the following demographic variables: age, gender, race/ethnicity, primary language, SPD status, county, region, delivery type model, and HPI quartile.

Caveats

Hybrid Indicators

For hybrid measures/indicators, NCQA recommends the submission of a sample of 411 members 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 were based on fewer than 411 members, 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 Members

To match the age parameters for each indicator, HSAG limited the analysis to members whose age was in one of the valid age groups for each indicator, as defined in Table D.1. For the indicators in the Reproductive Health domain, as well as the *Breast Cancer Screening* and *Cervical Cancer Screening* measures, HSAG only kept members who were identified as female in the demographic file. Additionally, HSAG included the rates for “Unknown/Missing” race/ethnicity, primary language, and gender groups in the formal report as a footnote above the figures.

Health Disparities Results

While HSAG identified health disparities in this analysis, data were not available and analyses were not performed related to the cause of the health disparities. Therefore, conclusions cannot be drawn about the cause of any health disparities identified. Additionally, the use of national benchmarks as the reference for identifying disparities results in disparities being captured based on low performance relative to national standards rather than differences in rates between racial/ethnic groups.

EHR Data

Due to unreliable reporting of electronic health record data by MCPs, caution should be exercised when interpreting the *Depression Remission or Response for Adolescents and Adults*, *Depression Screening and Follow-Up for Adolescents and Adults*, *Postpartum Depression Screening and Follow-Up*, *Prenatal Depression Screening and Follow-Up*, and *Prenatal Immunization Status* indicator rates in the health disparities analysis.

Adult and Child Core Set Median State Performance Rates

HSAG used the NCQA 2021 and 2022 Quality Compass benchmarks to identify disparities for the HEDIS MCAS indicators, HSAG compared non-HEDIS MCAS indicators to the FFY 2020 Adult and Child Core Set median state performance rates, where possible. Adult and Child Core Set median state performance rates are established using statewide measure rates. This differs from the NCQA 2021 and 2022 Quality Compass benchmark methodology, which is established using individual health plan information.

Appendix E. California Map Labeled by County and Region

California Counties and Geographic Regions

Figure E.1 displays a map of California with all counties labeled, and Figure E.2 displays a map of California with all counties shaded to their appropriate geographic region.

Figure E.1—California Map by County



Figure E.2—California Map by Region

