2019 Health Disparities Report

Managed Care Quality and Monitoring Division
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.

- ***AMM***—*Antidepressant Medication Management*
- ***AMR***—*Asthma Medication Ratio*
- ***BCS***—*Breast Cancer Screening*
- ***CCW***—*Contraceptive Care—All Women*
- ***CCP***—*Contraceptive Care—Postpartum Women*
- ***CHL***—*Chlamydia Screening in Women*
- **CMS**—Centers for Medicare & Medicaid Services
- **DEV**—*Developmental Screening in the First Three Years of Life*
- **DHCS**—California Department of Health Care Services
- **EHR**—electronic health record
- **HEDIS®**—Healthcare Effectiveness Data and Information Set[1]
- **HIPAA**—Health Insurance Portability and Accountability Act of 1996
- **HSAG**—Health Services Advisory Group, Inc.
- **MCP**—managed care health plan
- **MMEC**—most or moderately effective contraception
- **MPL**—minimum performance level
- **N**—number
- **NCQA**—National Committee for Quality Assurance
- **PCR**—*Plan All-Cause Readmissions*

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

1. Executive Summary

Background

A health disparity is the difference in health outcomes between groups within a population.[2] To assess and improve health disparities, the California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a health disparities study using the managed care accountability set (MCAS) measures reported by the 25 full-scope Medi-Cal managed care health plans (MCPs) for reporting year 2020 with data that are derived from calendar year 2019. 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. Due to the impacts of the coronavirus disease 2019 (COVID-19), the 2019 Health Disparities Report only include 10 MCAS indicators that only utilize administrative data. Additional indicators will be added in future iterations of this report once more complete data become available. 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 beneficiaries in Medi-Cal.

To identify and understand health disparities affecting Medi-Cal beneficiaries, it is important to consider the population mix of the Medi-Cal managed care program. In 2019, the racial/ethnic distribution of the Medi-Cal managed care population consisted of the following racial/ethnic groups: Hispanic or Latino (49 percent), White (19 percent), Other or Unknown (13 percent), Asian (9 percent), Black or African American (8 percent), and Native Hawaiian or Other Pacific Islander (2 percent). In addition, the Medi-Cal managed care program's age distribution in 2019 was 18-year-olds and younger (42 percent), 19-to-64-year-olds (49 percent), and 65 and older (9 percent).[3] According to the *2003 National Healthcare Quality and Disparities Report*, disparities in access to care and quality of care were identified for the Black or African American group and Hispanic or Latino group when compared to the White group.[4] Although some disparities have narrowed since 2000, disparities continue to persist for these racial/ethnic groups as evidenced by the *2018 National Healthcare Quality and Disparities Report*, which showed that the Black or African American group and the Hispanic or Latino group experienced worse access to care when compared to the White group for 42.9 percent

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

[3] Managed Care Performance Monitoring Dashboard Report, January 2020. Available at https://www.dhcs.ca.gov/services/Documents/MMCD/Jan9-2020Release.pdf. Accessed on: Nov 29, 2020.

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

and 75.0 percent, respectively, of access to care indicators.[5] For quality measures, the Hispanic or Latino group and the Black or African American group experienced worse quality of care when compared to the White group for 34.7 percent and 40.0 percent, respectively, of quality care indicators. Given national findings on demographic disparities and to improve health care for Medi-Cal beneficiaries, DHCS requested that HSAG evaluate racial/ethnic health care disparities affecting beneficiaries enrolled in Medi-Cal MCPs.

Medi-Cal Managed Care Program and Health Disparities

DHCS' vision is to preserve and improve the health of all Californians.[6] DHCS focuses on three interconnected goals to advance this strategy:

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

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

DHCS requested that HSAG evaluate measure data collected for reporting year 2020 at the statewide level, which consists of data collected during calendar year 2019 also known as Healthcare Effectiveness Data and Information Set (HEDIS®)[7] measurement year 2019. Several measures include more than one indicator; therefore, this report will refer to indicators rather than measures. DHCS selected 10 indicators reported by the 25 full-scope Medi-Cal MCPs for inclusion in the analysis, as displayed in Table 1.1.

[5] 2018 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; April 2020. Available at: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr18/index.html. Accessed on: Nov 25, 2020.

[6] DHCS Strategy for Quality Improvement in Health Care. California Department of Healthcare Services, Jan 2017. Available at https://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2017.pdf. Accessed on Nov 25, 2020.

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

Table 1.1—MCAS Indicators

Indicators
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*
Asthma Medication Ratio—Total
Breast Cancer Screening
Chlamydia Screening in Women—Total
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years and *Ages 21–44 Years*
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years
Developmental Screening in the First Three Years of Life—Total
Plan All-Cause Readmissions—Observed Readmission Rate—Total

Due to the impacts of COVID-19 on MCPs' abilities to collect medical records, DHCS allowed MCPs three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Due to some MCPs electing to rotate hybrid measures (i.e., reporting measurement year 2018 audited hybrid rates for measurement year 2019), not all MCPs provided member-level information in the patient-level detail files for measurement year 2019. Given the differences in how MCPs reported hybrid measures for measurement year 2019 and the missing member-level information in the patient-level detail files for some MCPs, DHCS and HSAG limited the 2019–20 Health Disparities analysis to 10 administrative MCAS indicators. According to NCQA, COVID-19 did not have an impact on MCPs' abilities to report measures that only require administrative data.[8] Future iterations of the Health Disparities Report will include additional indicators reported by MCPs and additional analyses.

While the scope of the 2019–20 Health Disparities Report is limited due to the impacts of COVID-19, DHCS is committed to reporting on identified health disparities and eliminating

[8] National Committee for Quality Assurance. Coronavirus and NCQA. Available at: https://www.ncqa.org/covid/. Accessed on: Oct 21, 2020.

those health disparities. DHCS' efforts aimed at the identification and elimination of health disparities include, but are not limited to, the following:

- Expanding the Health Disparities Reports over time to include trending, when possible, and assess subpopulations with identified health disparities (e.g., Asian Subpopulation Health Disparities Report).
- Hosting a quality conference with MCPs in October 2019 to discuss health equity and solicit MCP feedback on best practices for identifying health disparities and inequities and addressing barriers preventing members from receiving care.
- Requiring each MCP to have one performance improvement project that targets a health care disparity.
- Continuing to have collaborative discussions with MCPs about best practices for addressing and improving health disparities.
- Highlighting innovative practices through brief quality improvement "Postcards" and additional supplemental resources that can be searched by various topics (e.g., social determinants of health) for MCPs to find resources to help them assist and support vulnerable members and communities of color experiencing health inequities during COVID-19.
- Developing the Preventive Services Utilization Report, which will help DHCS identify patterns of underutilization of pediatric preventive services and implement targeted improvement strategies. The first Preventive Services Utilization Report will be published in December 2020.
- Requiring MCPs to use the annual health disparities data provided by DHCS to help drive the strategic plan developed in MCPs' annual population needs assessments.
- Requiring MCPs to post notices of non-discrimination and accessibility requirements and provide written translation of these requirements and all other member information materials.
- Requesting MCPs to submit their health equity projects to DHCS on an annual basis to be considered for the Health Equity Award.

Although HSAG stratified all indicators by race/ethnicity and primary language, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. In order to ensure the methodology aligned with national standards, HSAG used CMS' *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.[9]

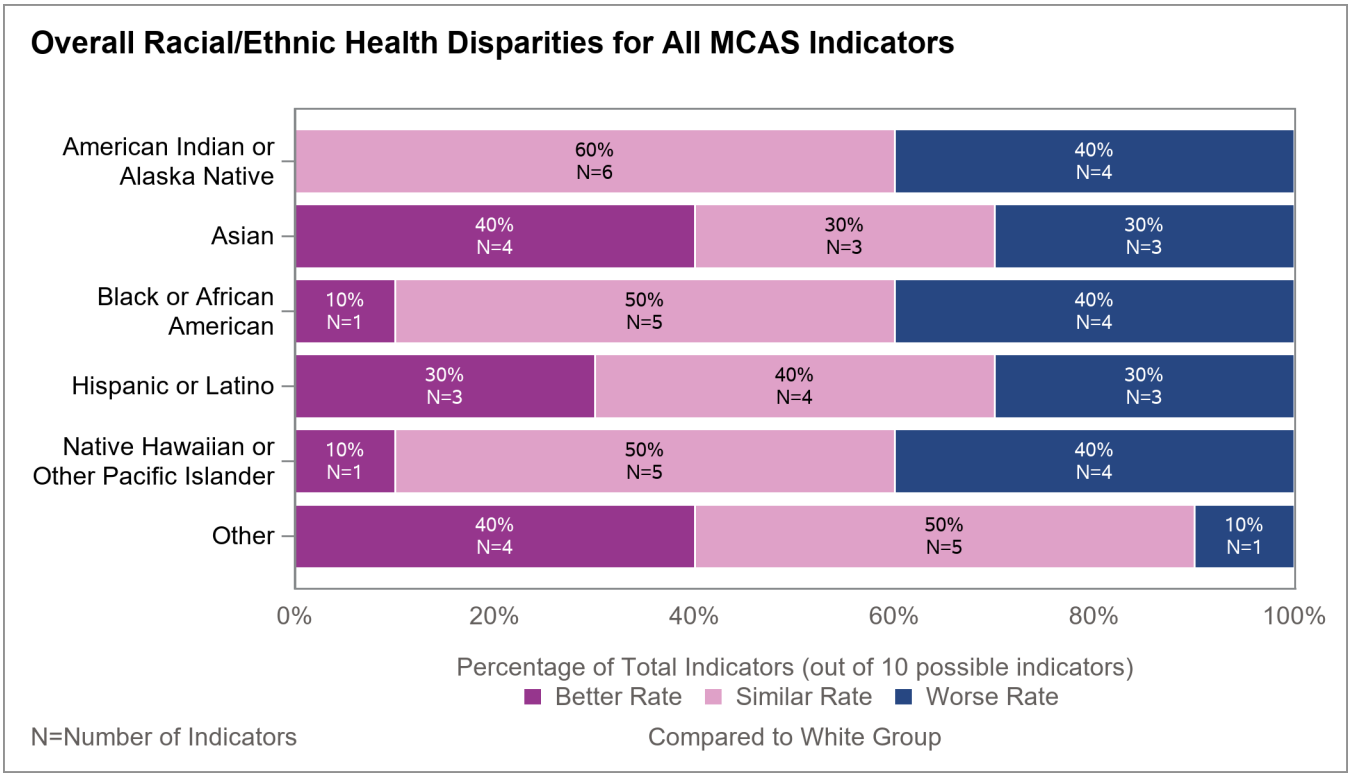
Findings for racial/ethnic health disparities are presented in Section 3 of this report, and the indicator rates stratified by primary language are located in Appendix A. Please note, HSAG uses "majority" throughout the report to refer to at least 50 percent.

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

Key Findings for Racial/Ethnic Health Disparities

Health disparities were identified when indicator rates for racial/ethnic groups were better than or worse than the rates for the White group (i.e., the reference group). If a racial/ethnic group's indicator rate was similar to the White group, then no health disparity was identified. Figure 1.1 displays the percentage and number of indicators (out of 10 possible indicators) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

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



American Indian or Alaska Native

- No rates for the American Indian or Alaska Native group were better than the rates for the White group.
- For the following indicators, the rates for the American Indian or Alaska Native group were worse than the rates for the White group:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment*
  - *Breast Cancer Screening*
  - *Developmental Screening in the First Three Years of Life—Total*

Asian

- For the following indicators, the rates for the Asian group were better than the rates for the White group:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening*
  - *Chlamydia Screening in Women—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
- For the following indicators, the rates for the Asian group were worse than the rates for the White group:
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception —60 Days—Ages 21–44 Years*

Black or African American

- For *Chlamydia Screening in Women—Total*, the rate for the Black or African American group was better than the rate for the White group.
- For the following indicators, the rates for the Black or African American group were worse than the rates for the White group:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*
  - *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception —60 Days—Ages 21–44 Years*

Hispanic or Latino

- For the following indicators, the rates for the Hispanic or Latino group were better than the rates for the White group:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening*
  - *Chlamydia Screening in Women—Total*
- For the following indicators, the rates for the Hispanic or Latino group were worse than the rates for the White group:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment*

- *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*

Native Hawaiian or Other Pacific Islander

- For *Developmental Screening in the First Three Years of Life—Total*, the rate for the Native Hawaiian or Other Pacific Islander group was better than the rate for the White group.
- For the following indicators, the rates for the Native Hawaiian or Other Pacific Islander group were worse than the rates for the White group:
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Antidepressant Medication Management—Effective Continuation Phase Treatment*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*
  - *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years*

Other

- For the following indicators, the rates for the Other group were better than the rates for the White group:
  - *Asthma Medication Ratio—Total*
  - *Breast Cancer Screening*
  - *Chlamydia Screening in Women—Total*
  - *Developmental Screening in the First Three Years of Life—Total*
- For *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years*, the rate for the Other group was worse than the rate for the White group.

Overall Conclusions and Items for Consideration

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

- The *Chlamydia Screening in Women—Total* indicator represents an area of overall strength. For this indicator, there were no negative disparities and the rates for all racial/ethnic groups were above the minimum performance level.
- The *Asthma Medication Ratio—Total* and *Breast Cancer Screening—Total* indicators represent areas of overall opportunity for improvement. While there were no negative disparities for *Asthma Medication Ratio—Total* and only one negative disparity for *Breast Cancer Screening* (American Indian or Alaska Native), this is due to the low performance for the White racial/ethnic group rather than positive performance overall. The Asian and Other racial/ethnic groups showed positive performance, with rates that were above the minimum performance levels for both indicators; however, the rates for all other racial/ethnic groups were below the minimum performance level for both indicators.
- All racial/ethnic groups had at least one *Antidepressant Medication Management* or *Contraceptive Care* indicator rate that was worse than the rate for the White group.
  - There were four racial/ethnic groups with rates worse than the rate for the White group for both *Antidepressant Medication Management* indicators. This finding also aligns with national data that shows antidepressant medication use is higher among non-Hispanic White adults.[10]
  - Only the rate for the Black or African American group fell below the minimum performance level for the *Effective Acute Phase Treatment* indicator; however, the rates for three racial/ethnic groups (Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander) fell below the minimum performance level for the *Effective Continuation Phase Treatment* indicator.
  - For the *Contraceptive Care—All Women—Most or Moderately Effective Contraception* indicators, five racial/ethnic groups had negative disparities for the *Ages 15–20 Years* indicator but only two of these negative disparities also existed for the *Ages 21–44 Years* indicator (Asian and Native Hawaiian or Pacific Islander). For the *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years* indicator, two racial/ethnic groups (Asian and Black or African American) had negative disparities. These findings suggest that most disparities related to contraceptive care are limited to the adolescent female population. This finding also aligns with national data that shows that contraception use was higher among older and non-Hispanic White women compared to adolescent and non-Hispanic Black women.[11]

[10] Brody DJ, Gu Q. Antidepressant use among adults: United States, 2015–2018. *NCHS Data Brief*. 2020; 377. Available at: https://www.cdc.gov/nchs/data/databriefs/db377-H.pdf. Accessed on: Nov 25, 2020.

[11] Daniels K, Abma JC. Current contraceptive status among women aged 15–49: United States, 2017–2019. *NCHS Data Brief*. 2020; 338. Available at: https://www.cdc.gov/nchs/data/databriefs/db388-H.pdf. Accessed on: Nov 25, 2020.

  - The rates for all racial/ethnic groups for the *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15 to 20 Years* and *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21 to 44 Years* indicators are below their respective national benchmarks.[12,13]
- The *Developmental Screening in the First Three Years of Life—Total* indicator represents an area of overall opportunity for improvement. While the rates for three racial/ethnic groups (Asian, Native Hawaiian or Other Pacific Islander, and Other) were better than the rate for the White group for this indicator, the rates for all racial/ethnic groups fell below the national benchmark.[14]

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

- For the racial/ethnic groups with rates that were worse than the rates for the White group for the *Antidepressant Medication Management* and *Contraceptive Care* indicators, DHCS should consider analyzing health disparities further to determine the additional factors that may be associated with lower rates for these indicators. While these findings align with national data,[15,16] DHCS should work with MCPs to determine the root cause (e.g., lack of access to providers, provider behavior, cultural barriers, possible incomplete data sources) driving the health disparities for antidepressant and contraceptive medications within California.

[12] "Performance on the Child Core Set Measures, FFY 2019." *Child Health Care Quality Measures*, Centers of Medicare & Medicaid Services, Oct. 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: Nov 24, 2020.

[13] "Performance on the Adult Core Set Measures, FFY 2019." *Adult Health Care Quality Measures*, Centers for Medicare & Medicaid Services, Oct. 2020. Available at: www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html. Accessed on: Nov 20, 2020.

[14] "Performance on the Child Core Set Measures, FFY 2019." *Child Health Care Quality Measures*, Centers of Medicare & Medicaid Services, Oct. 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: Nov 24, 2020.

[15] Brody DJ, Gu Q. Antidepressant use among adults: United States, 2015–2018. *NCHS Data Brief*. 2020; 377. Available at: https://www.cdc.gov/nchs/data/databriefs/db377-H.pdf. Accessed on: Nov 25, 2020.

[16] Daniels K, Abma JC. Current contraceptive status among women aged 15–49: United States, 2017–2019. *NCHS Data Brief*. 2020; 338. Available at: https://www.cdc.gov/nchs/data/databriefs/db388-H.pdf. Accessed on: Nov 25, 2020.

- DHCS should ensure that MCPs are working with providers to ensure that members with persistent asthma are prescribed the necessary medication to manage their asthma and women receive appropriate breast cancer screenings.
- DHCS should consider using the Hispanic or Latino group as the reference group for future reports, given that the Hispanic or Latino group rates were better than or similar to the rates for the White group for a majority of indicators and that the Hispanic or Latino group is larger than the White group for all indicators.

2. Reader's Guide

Introduction

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

Medi-Cal Managed Care Health Plans

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

Table 2.1—MCPs and Applicable Counties

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

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

Summary of Performance Indicators

DHCS selected 10 indicators reported by the 25 full-scope Medi-Cal MCPs for inclusion in the analysis and report. Table 2.2 displays the selected MCAS indicators included in the analysis.

Table 2.2—MCAS Indicators

Indicators
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*
Asthma Medication Ratio—Total
Breast Cancer Screening
Chlamydia Screening in Women—Total
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years and *Ages 21–44 Years*
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years
Developmental Screening in the First Three Years of Life—Total
Plan All-Cause Readmissions—Observed Readmission Rate—Total

Methodology Overview

For the 2019–20 contract year, HSAG evaluated indicator data collected for reporting year 2020 at the statewide level, which consisted of data collected during calendar year 2019 also known as HEDIS measurement year 2019. HSAG aggregated the results from the 25 full-scope MCPs and then stratified these statewide rates for all indicators by demographic stratifications (i.e., race/ethnicity and primary language).

Although HSAG stratified all indicators by race/ethnicity and primary language, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. To ensure the methodology aligned with national standards, HSAG used CMS' *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.[17]

The information below provides a high-level overview of the health disparities analyses conducted on the reporting year 2020 data for DHCS. For the detailed methodology, please see Appendix B.

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

Data Sources

HSAG received a CA-required patient-level detail file from each MCP for each HEDIS reporting unit containing member-level information, including the Medi-Cal client identification number, date of birth, and member months 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 Excel reporting files. Additionally, DHCS provided supplemental files with demographic data (e.g., date of birth, gender, ZIP Code, race/ethnicity, primary language) from DHCS' Management Information System/Decision Support System data system.

Statistical Analysis

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

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

- Better Rate = The absolute difference from the reference group was greater than or equal to 3 percentage points, the *p*-value of the coefficient of the logistic regression was less than 0.05, and the rate for the racial/ethnic group was higher or more favorable than the rate for the reference group. In other words, the reference group showed a health disparity compared to the racial/ethnic group being evaluated.
- Worse Rate = The absolute difference from the reference group was greater than or equal to 3 percentage points, the *p*-value of the coefficient of the logistic regression was less than 0.05, and the rate for the racial/ethnic group was lower or less favorable than the rate for the reference group. In other words, the racial/ethnic group being evaluated showed a health disparity compared to the reference group.

- Similar Rate = The absolute difference from the reference group was less than 3 percentage points or the *p*-value of the coefficient of the logistic regression was greater than or equal to 0.05. This means no health disparities were identified when the racial/ethnic group was compared to the reference group.

Evaluating Results

Within Section 3 of this report, HSAG presents the statewide racial/ethnic health disparity analyses for the 10 indicators listed in Table 2.2 within horizontal bar graphs. Within Appendix A, HSAG also presents indicator rates for the primary language demographic stratifications; however, statistical analysis was not performed on these demographic stratifications to identify health disparities.

Additionally, Section 4 displays California-wide choropleth maps to show the geographic variability at the county level for five indicators (*Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, *Asthma Medication Ratio—Total*, *Breast Cancer Screening*, and *Chlamydia Screening in Women—Total*).

Figure Interpretation

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

Additionally, the figures also display the minimum performance level, when applicable, as established by DHCS, which represents NCQA's Quality Compass® national Medicaid health maintenance organization 50th percentile.[18] Of note, the minimum performance level is displayed not as a statistical benchmark for health disparities but to provide more information about overall performance for a specific indicator. Minimum performance level percentile data (i.e., Quality Compass rates) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to minimum performance levels are illustrated within this report using proxy displays (i.e., the dotted line). Within each applicable figure, "MPL" represents the minimum performance level for an

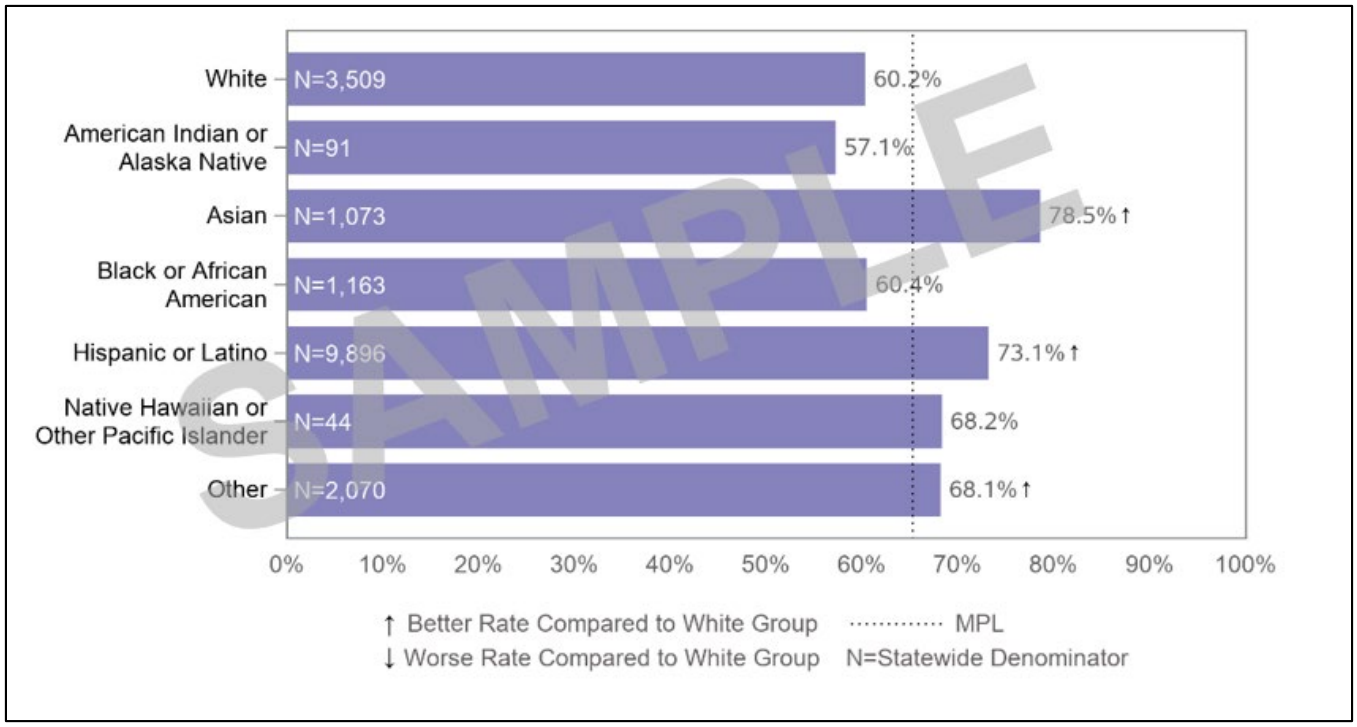
[18] Quality Compass® is a registered trademark of the NCQA.

indicator, where applicable. An example of the horizontal bar graph figure is shown in Figure 2.1. All data in the sample figure are mock data.

Figure 2.1—Sample Indicator-Level Horizontal Bar Graph by Race/Ethnicity Figure

Note: The rate for the Unknown/Missing group was 60.9 percent (N=75).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.

FIGURE CONTAINS MOCK DATA

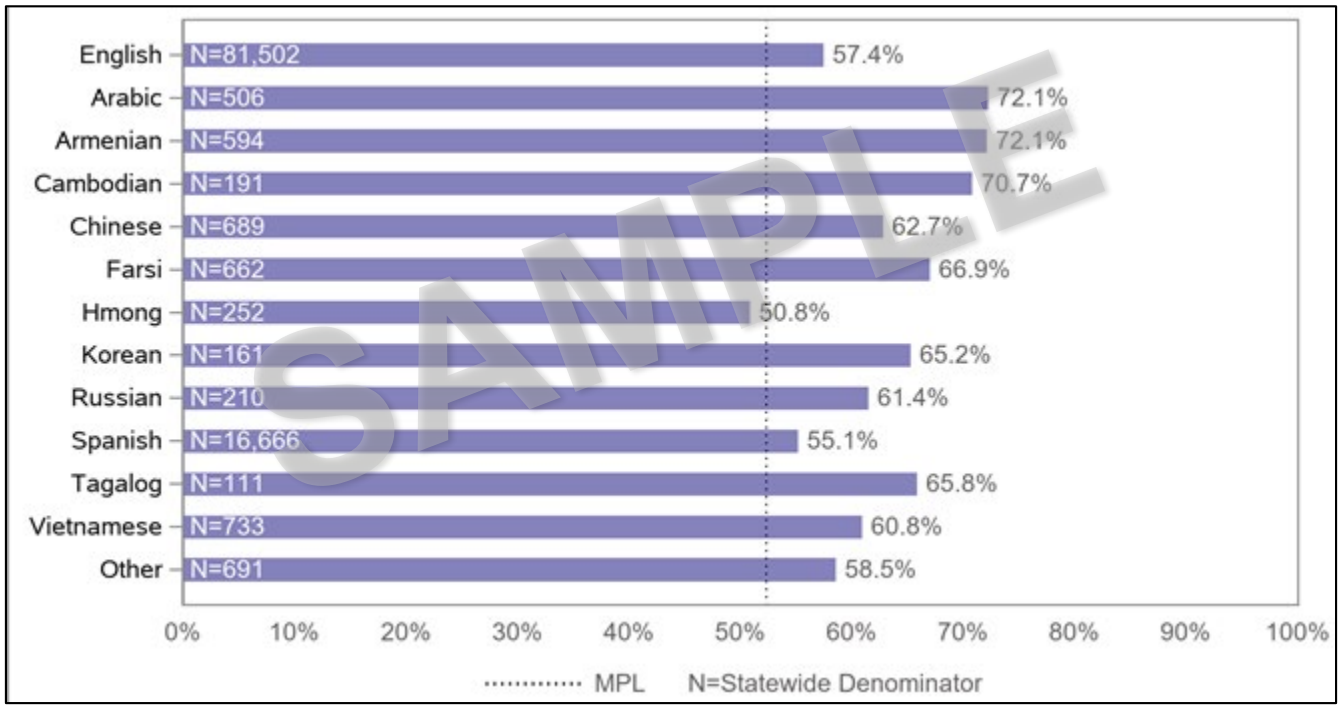


Within Appendix A, horizontal bar graphs display the indicator rates by primary language. Statistical analysis was not performed on the primary language demographic stratifications to identify health disparities; therefore, these rates are for information only. When available, the figures also display the minimum performance level for the corresponding indicator that represents the national Medicaid 50th percentile and, as noted previously, is displayed not as a statistical benchmark for health disparities but to provide more information about overall performance for a specific indicator. "MPL" represents the minimum performance level for an indicator, where applicable. "N" represents the total statewide denominator for an indicator for a particular group. A "Note" is included above each figure displaying the statewide denominator and rate for the "Unknown/Missing" group for the corresponding stratification, where applicable. An example of the horizontal bar graph by primary language is shown in Figure 2.2. All data in the sample figure are mock data.

Figure 2.2—Sample Indicator-Level Horizontal Bar Graph by Primary Language Figure

Note: The rate for the Unknown/Missing age group was 62.2 percent (N=262).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.

FIGURE CONTAINS MOCK DATA



Choropleth Map Interpretation

The choropleth maps highlight regional performance differences for the select indicators. SAG first assigned a county to each member based on the county code provided in the DHCS demographic file. If the county code was missing for a member in the demographic data file, HSAG utilized the ZIP Code to determine the appropriate county. HSAG then calculated county-level rates for each indicator listed previously by summing the numerators and denominators for all members within a county. For each indicator, HSAG calculated performance quintiles based on county performance (i.e., 20th percentile, 40th percentile, 60th percentile, and 80th percentile). HSAG then determined which quintile each county fell into (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 2.3. Please note, HSAG shaded counties with numerators less than 11 or denominators less than 30 white to indicate the rate was suppressed.

Table 2.3—Statewide Performance Quintile Thresholds and Corresponding Colors

Statewide Performance 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

Cautions and Limitations

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. For the *Chlamydia Screening in Women—Total* and *Breast Cancer Screening* indicators, HSAG only kept members who were identified as female in the demographic file. Additionally, HSAG included the "Unknown/Missing" group for race/ethnicity and primary language 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.

COVID-19 Impacts on Reporting

Due to the impacts of COVID-19 on MCPs' abilities to collect medical records, DHCS allowed the MCPs three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.

- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Due to some MCPs electing to rotate hybrid measures, not all MCPs provided member-level information in the patient-level detail files for reporting year 2020. Given the differences in how MCPs reported hybrid measures for reporting year 2020 and the missing member-level information in the patient-level detail files, the 2019–20 Health Disparities analysis was limited to 10 administrative MCAS indicators. According to NCQA, COVID-19 did not have an impact on the MCPs' abilities to report measures that only require administrative data.[19] Future iterations of the Health Disparities Report will include additional indicators reported by MCPs.

Electronic Health Record Data

Due to inconsistent reporting of electronic health record (EHR) data by MCPs, differences in rates for the *Developmental Screening in the First Three Years of Life—Total* indicator may be indicative of data completeness rather than performance.

[19] National Committee for Quality Assurance. Coronavirus and NCQA. Available at: https://www.ncqa.org/covid/ Accessed on: Oct 21, 2020.

3. Findings

The Findings section presents the racial/ethnic health disparities results for each MCAS indicator included in the 2019 Health Disparities Report.

Racial/Ethnic Health Disparities

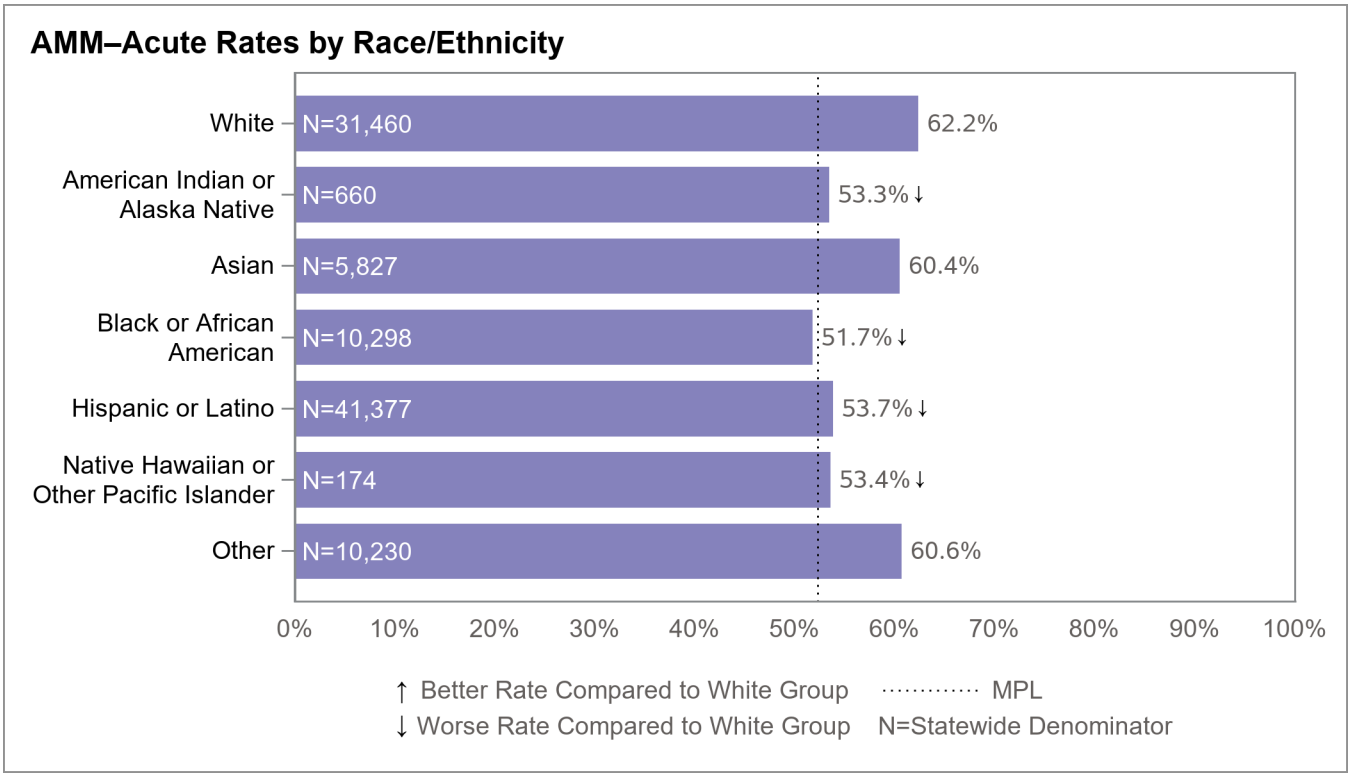
Figure 3.1 through Figure 3.10 display the racial/ethnic health disparities for each MCAS indicator. For each figure, the arrows highlight health disparities and indicate when the rates for the specific racial/ethnic groups were better than or worse than the rate for the White group. If the rate for the specific racial/ethnic group was similar to the rate for the White group, then no health disparity was identified and an arrow is not present.

Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–Acute)

The *Antidepressant Medication Management—Effective Acute Phase Treatment (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 3.1 displays the statewide *Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–Acute)* rate and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.1—Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–Acute) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 59.7 percent (N=3,204).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.



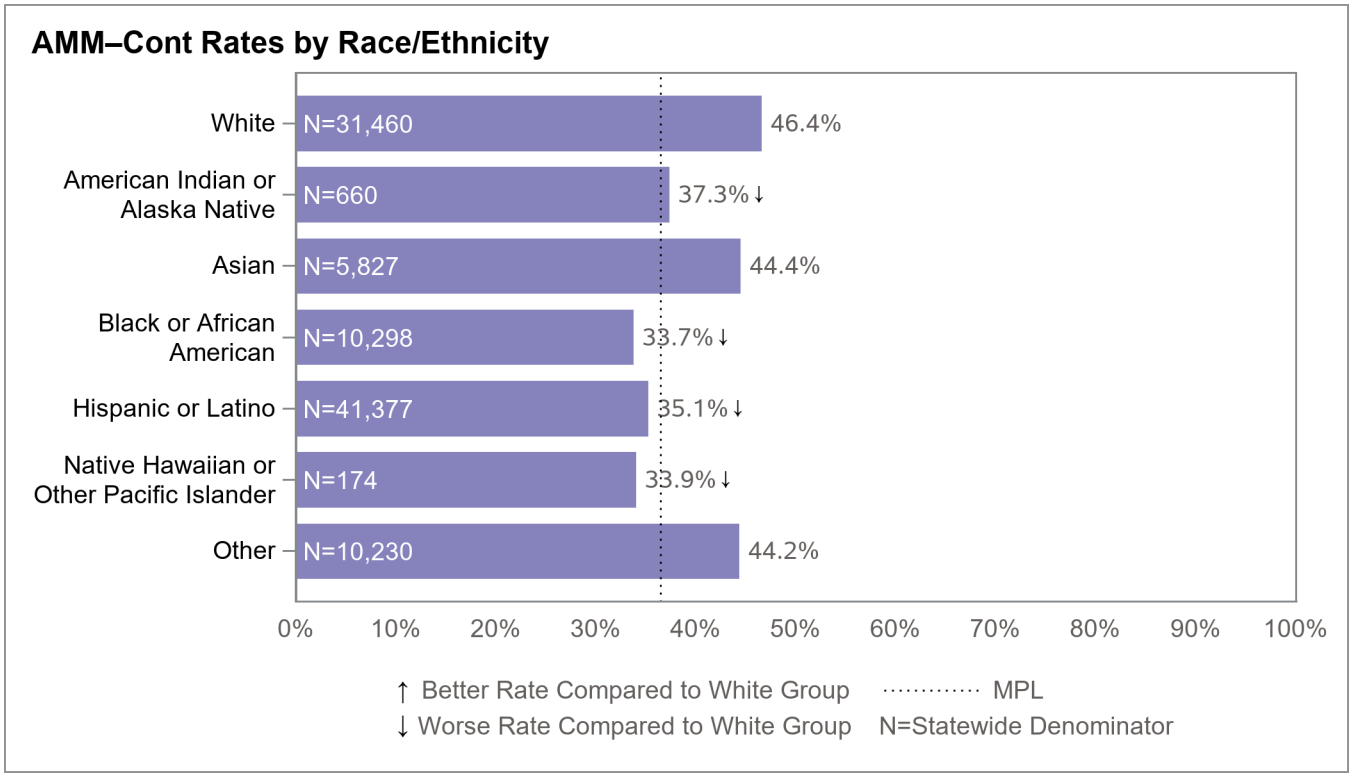
- The rates for all racial/ethnic groups ranged from 51.7 percent for the Black or African American group to 62.2 percent for the White group.
- Four health disparities were identified for the *Antidepressant Medication Management—Effective Acute Phase Treatment* indicator:
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.
  - The rate for the Hispanic or Latino group was worse than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander group was worse than the rate for the White group.
- The rate for the Black or African American group was below the minimum performance level for this indicator.

Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–Cont)

The *Antidepressant Medication Management—Effective Continuation Phase Treatment (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 3.2 displays the statewide *Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–Cont)* rate and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.2—Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–Cont) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 43.4 percent (N=3,204).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.



- The rates for all racial/ethnic groups ranged from 33.7 percent for the Black or African American group to 46.4 percent for the White group.
- Four health disparities were identified for the *Antidepressant Medication Management—Effective Continuation Phase Treatment* indicator:
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.

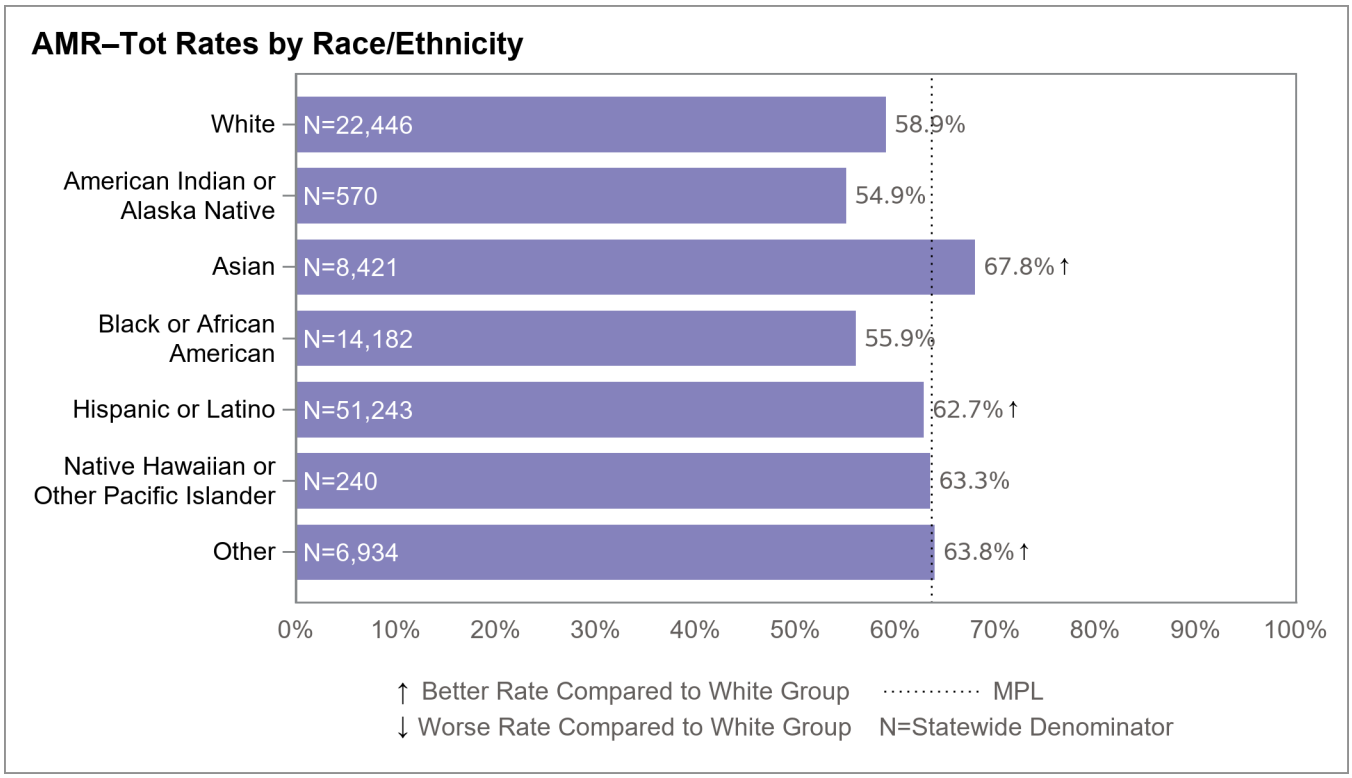
  - The rate for the Black or African American group was worse than the rate for the White group.
  - The rate for the Hispanic or Latino group was worse than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander group was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - Black or African American
  - Hispanic or Latino
  - Native Hawaiian or Other Pacific Islander

Asthma Medication Ratio—Total (AMR–Tot)

The *Asthma Medication Ratio—Total* (*AMR–Tot*) 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 3.3 displays the statewide *Asthma Medication Ratio—Total* (*AMR–Tot*) rate and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.3—Asthma Medication Ratio—Total (AMR–Tot) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 63.9 percent (N=3,582).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.



- The rates for all racial/ethnic groups ranged from 54.9 percent for the American Indian or Alaska Native group to 67.8 percent for the Asian group.
- Three health disparities were identified for the *Asthma Medication Ratio—Total* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White
  - American Indian or Alaska Native

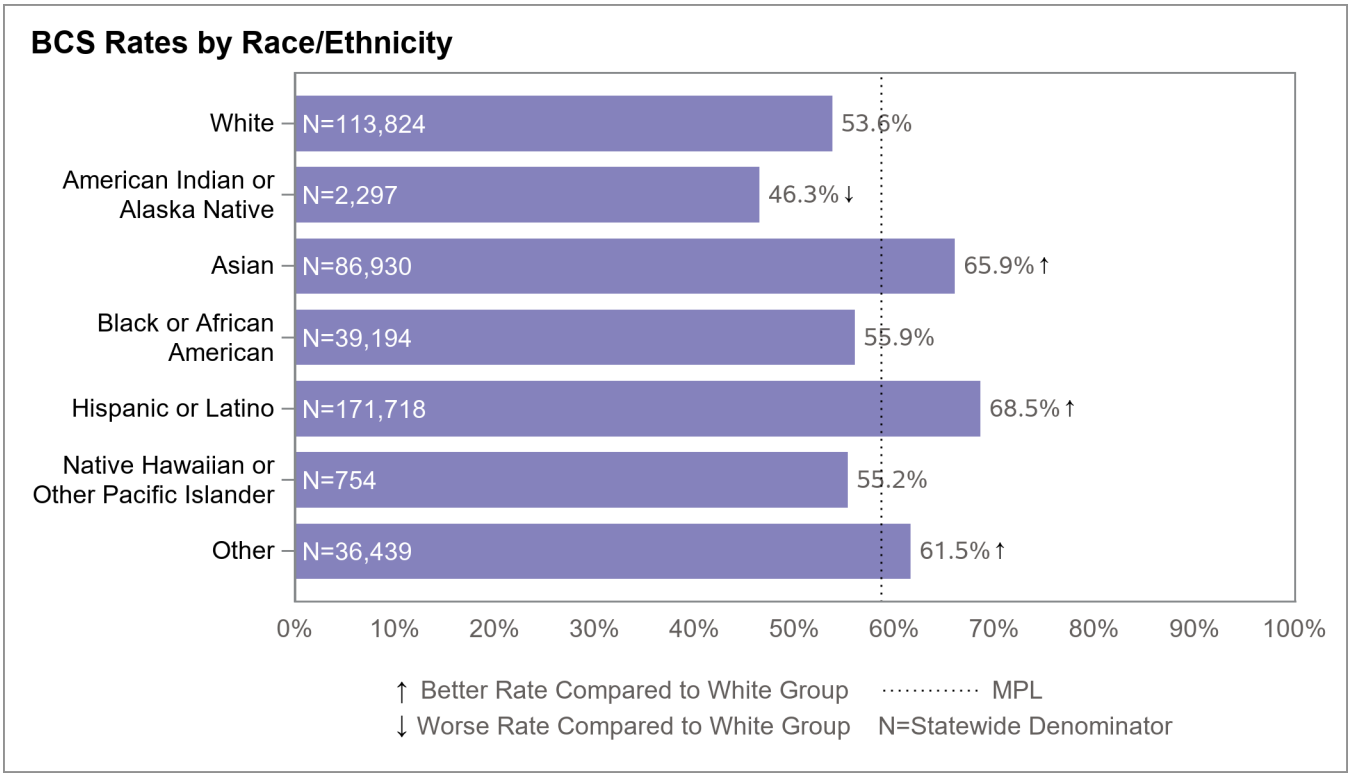
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander

Breast Cancer Screening (BCS)

The *Breast Cancer Screening* (*BCS*) indicator measures the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer. Figure 3.4 displays the statewide *Breast Cancer Screening* (*BCS*) rate and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.4—Breast Cancer Screening (BCS) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 56.8 percent (N=18,916).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.



- The rates for all racial/ethnic groups ranged from 46.3 percent for the American Indian or Alaska Native group to 68.5 percent for the Hispanic or Latino group.
- Four health disparities were identified for the *Breast Cancer Screening* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.
- The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - White

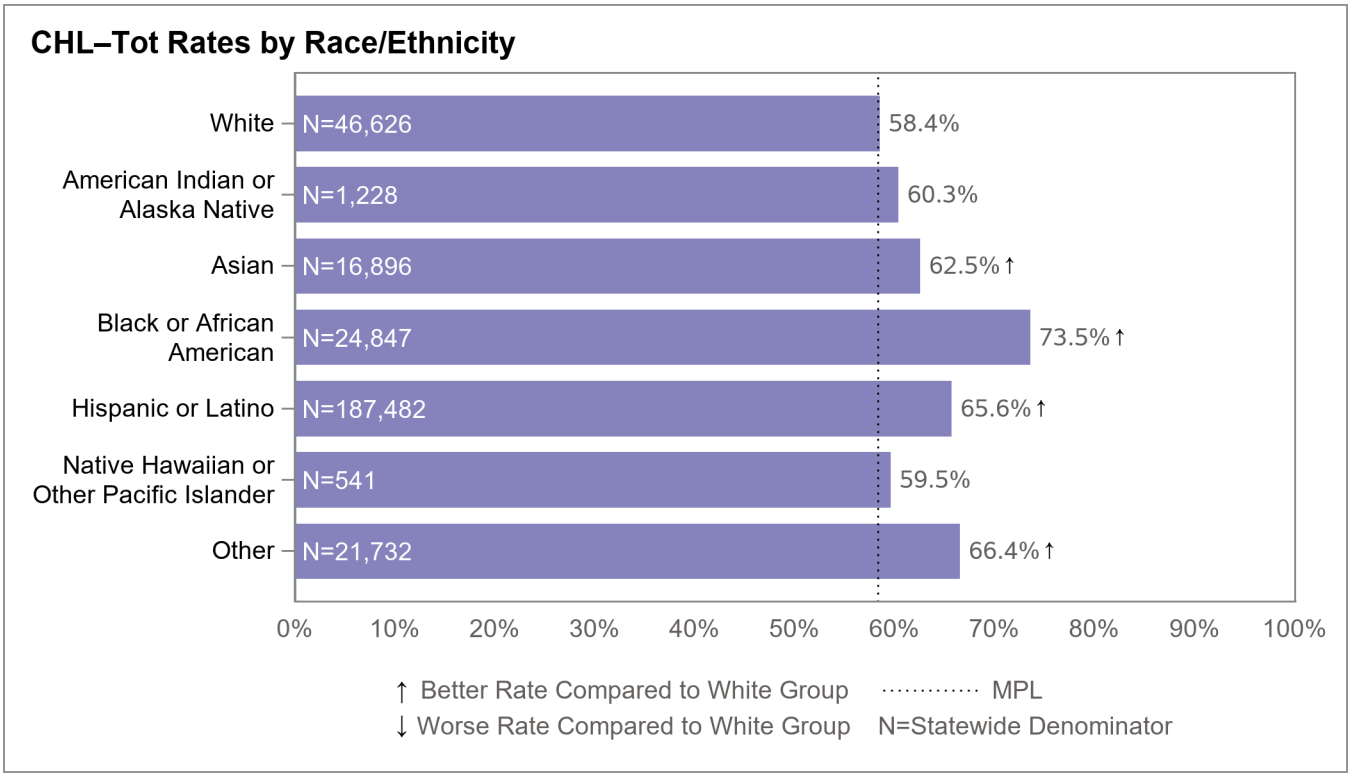
- American Indian or Alaska Native
- Black or African American
- Native Hawaiian or Other Pacific Islander

Chlamydia Screening in Women—Total (CHL–Tot)

The *Chlamydia Screening in Women—Total (CHL–Tot)* 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 3.5 displays the statewide *Chlamydia Screening in Women—Total (CHL–Tot)* rate and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.5—Chlamydia Screening in Women—Total (CHL–Tot) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 58.8 percent (N=6,301).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.



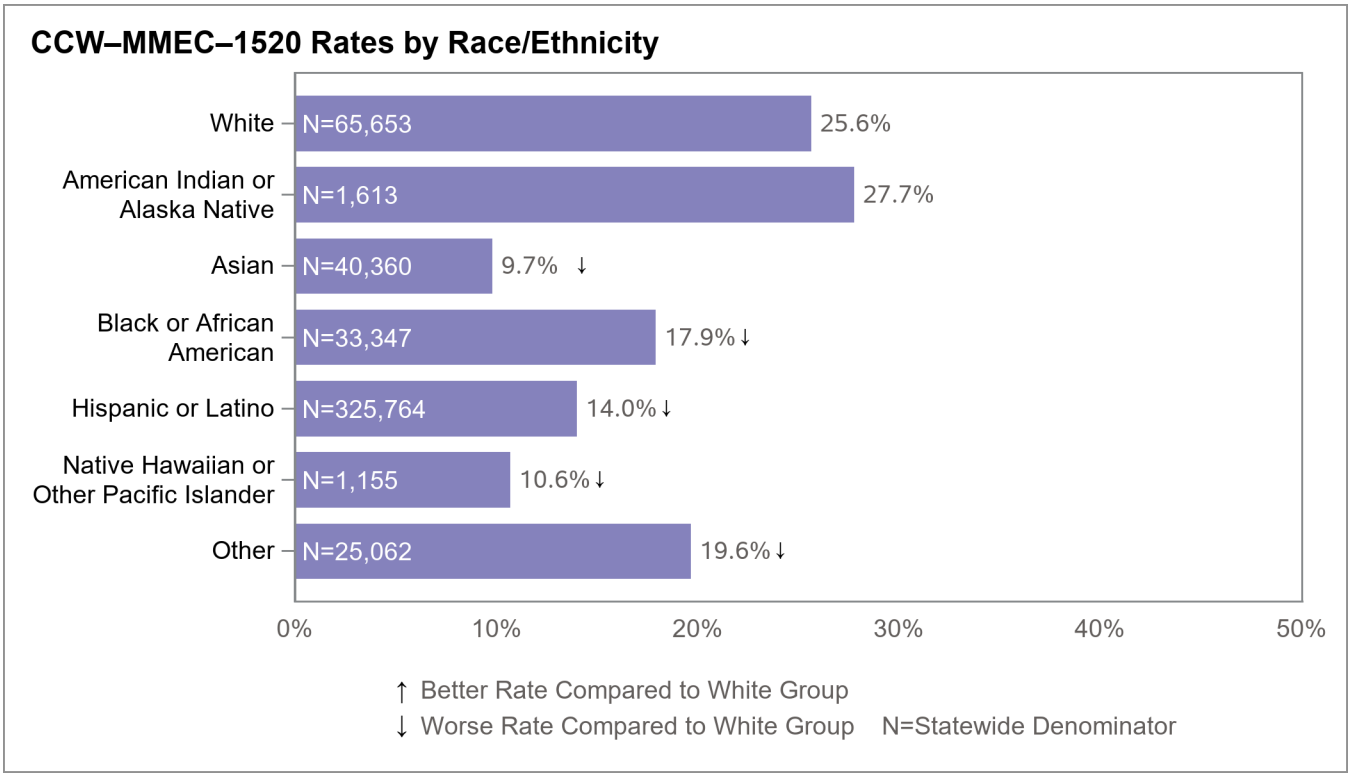
- The rates for all racial/ethnic groups ranged from 58.4 percent for the White group to 73.5 percent for the Black or African American group.
- Four health disparities were identified for the *Chlamydia Screening in Women—Total* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Black or African American group was better than the rate for the White group.
  - The rate for the Hispanic or Latino group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
- No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

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 3.6 displays the statewide *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520)* rate and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.6—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 15.7 percent (N=10,291).
The *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years* indicator does not have an established minimum performance level.



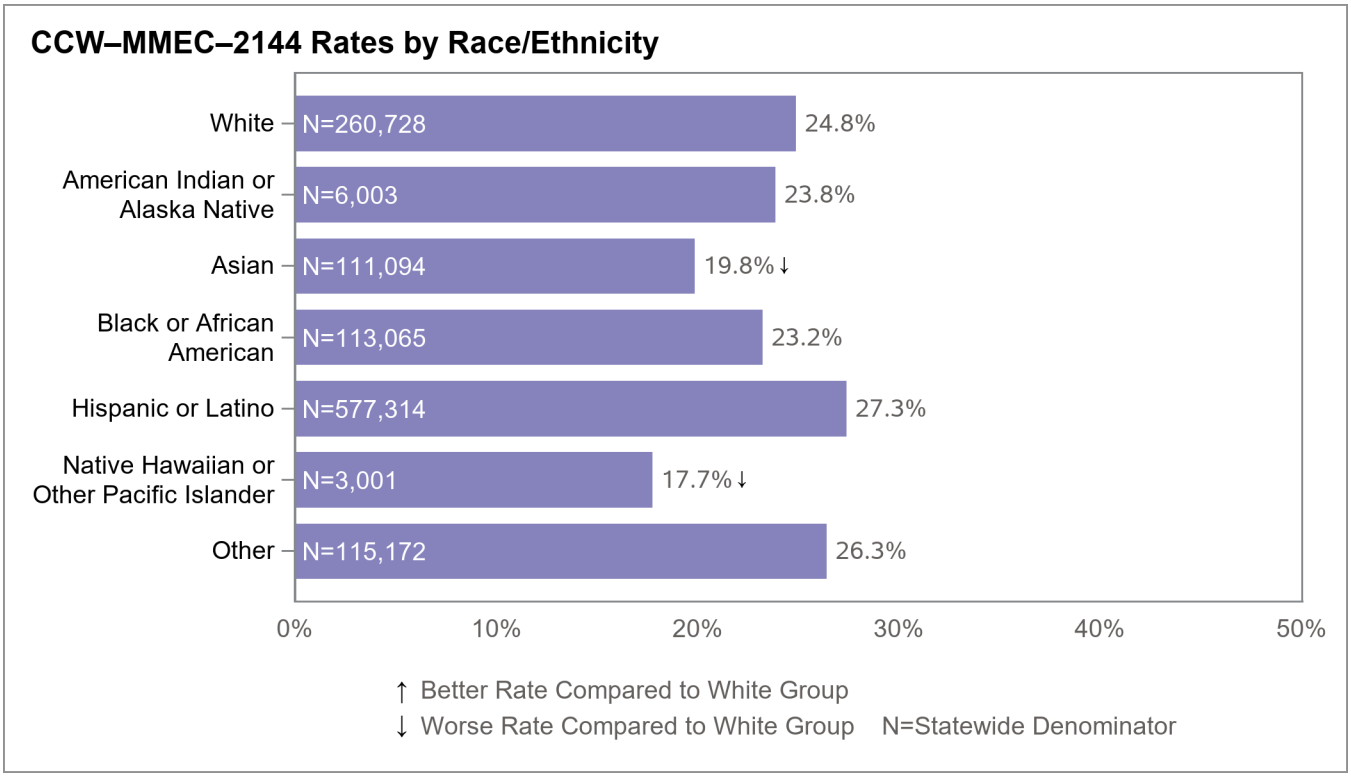
- The rates for all racial/ethnic groups ranged from 9.7 percent for the Asian group to 27.7 percent for the American Indian or Alaska Native group.
- Five health disparities were identified for the *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years* indicator:
  - The rate for the Asian group was worse than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.
  - The rate for the Hispanic or Latino group was worse than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander group was worse than the rate for the White group.
  - The rate for the Other group was worse than the rate for the White group.

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 3.7 displays the statewide *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144)* rate and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.7—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 22.1 percent (N=37,260).
The *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years* indicator does not have an established minimum performance level.



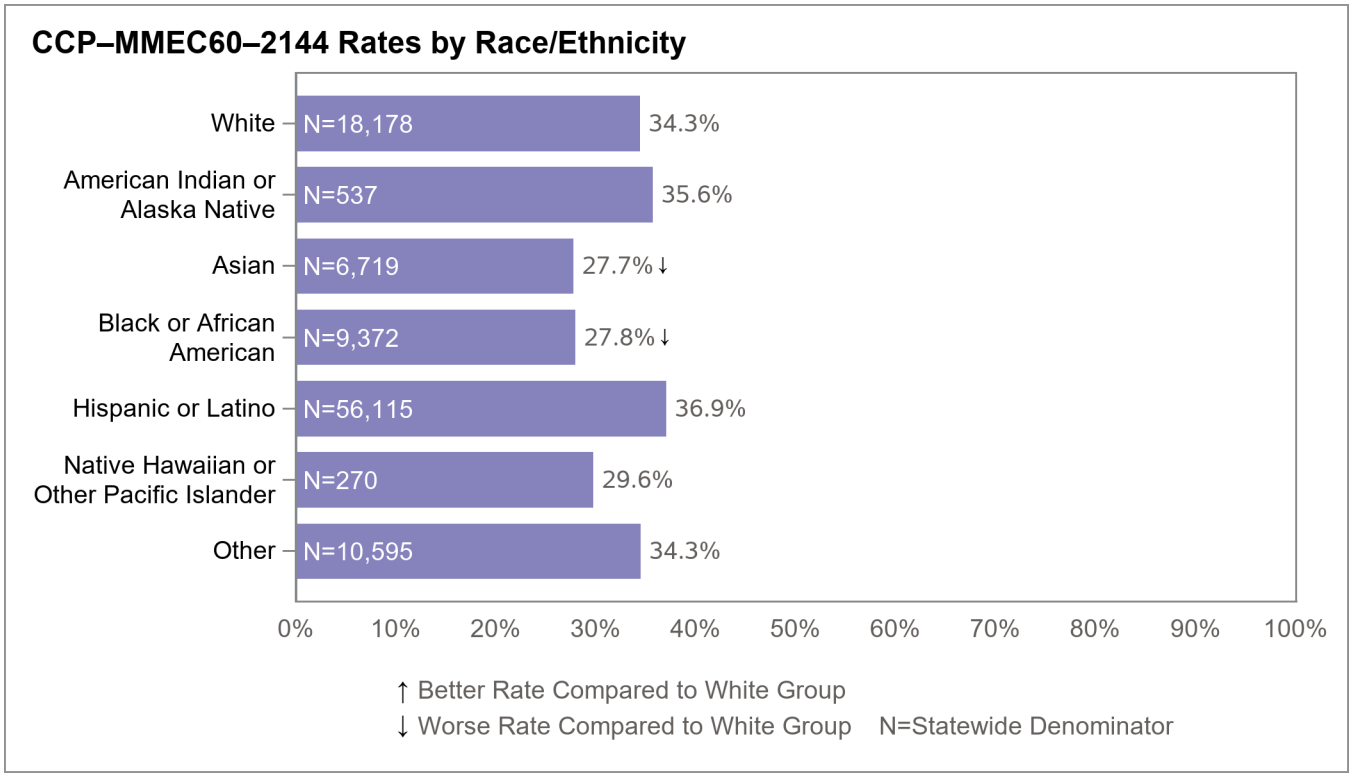
- The rates for all racial/ethnic groups ranged from 17.7 percent for the Native Hawaiian or Other Pacific Islander group to 27.3 percent for the Hispanic or Latino group.
- Two health disparities were identified for the *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years* indicator:
  - The rate for the Asian group was worse than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander group was worse than the rate for the White group.

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 and were provided a most effective or moderately effective method of contraception within 60 days of delivery. Figure 3.8 displays the statewide *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144)* rate and denominator for each racial/ethnic group in addition to identified health disparities.

Figure 3.8—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 33.5 percent (N=2,339).
The *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years* indicator does not have an established minimum performance level.



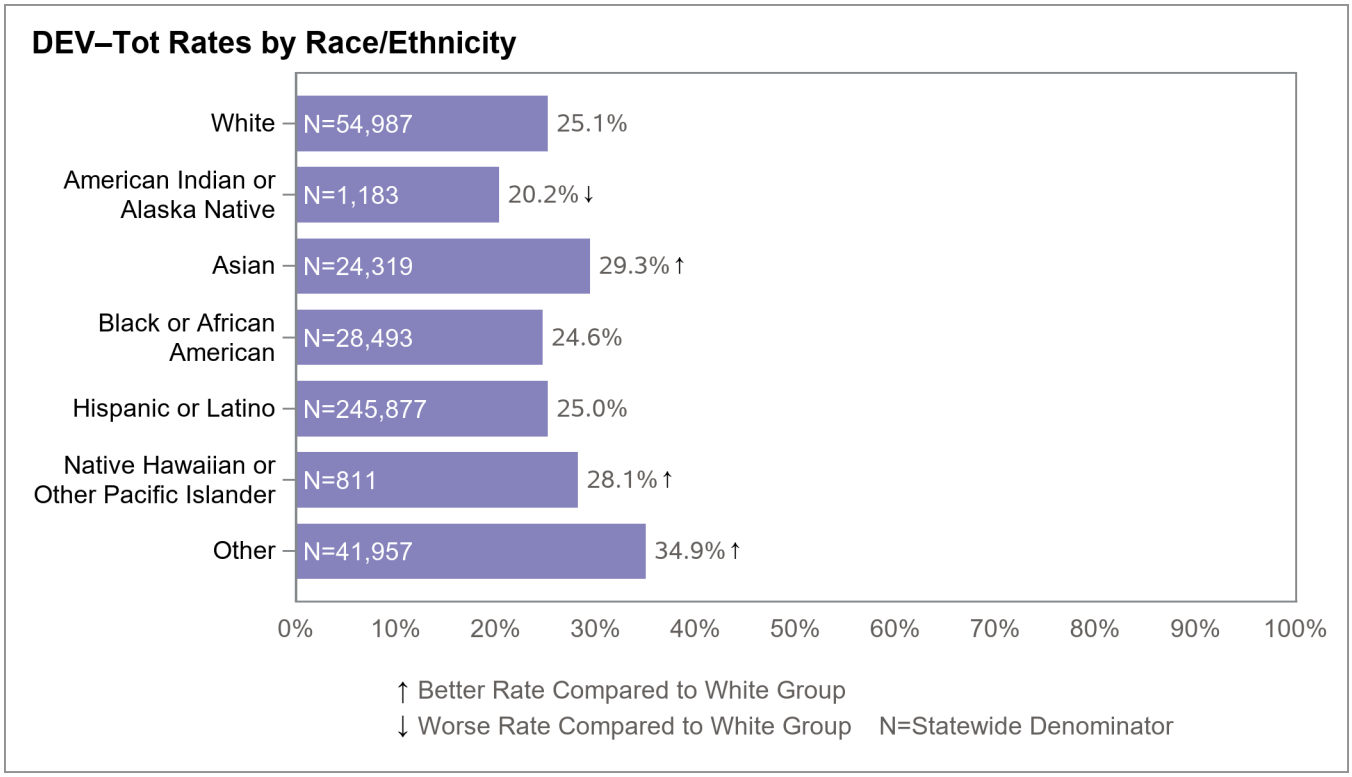
- The rates for all racial/ethnic groups ranged from 27.7 percent for the Asian group to 36.9 percent for the Hispanic or Latino group.
- Two health disparities were identified for the *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years* indicator:
  - The rate for the Asian group was worse than the rate for the White group.
  - The rate for the Black or African American group was worse than the rate for the White group.

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

The *Developmental Screening in the First Three Years of Life—Total (DEV–Tot)* 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. Figure 3.9 displays the statewide *Developmental Screening in the First Three Years of Life—Total (DEV–Tot)* rate and denominator for each racial/ethnic group in addition to identified health disparities. Due to inconsistent reporting of EHR data by MCPs, differences in rates may be indicative of data completeness rather than performance.

Figure 3.9—Developmental Screening in the First Three Years of Life—Total (DEV–Tot) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 17.9 percent (N=46,285).
The *Developmental Screening in the First Three Years of Life—Total* indicator does not have an established minimum performance level.



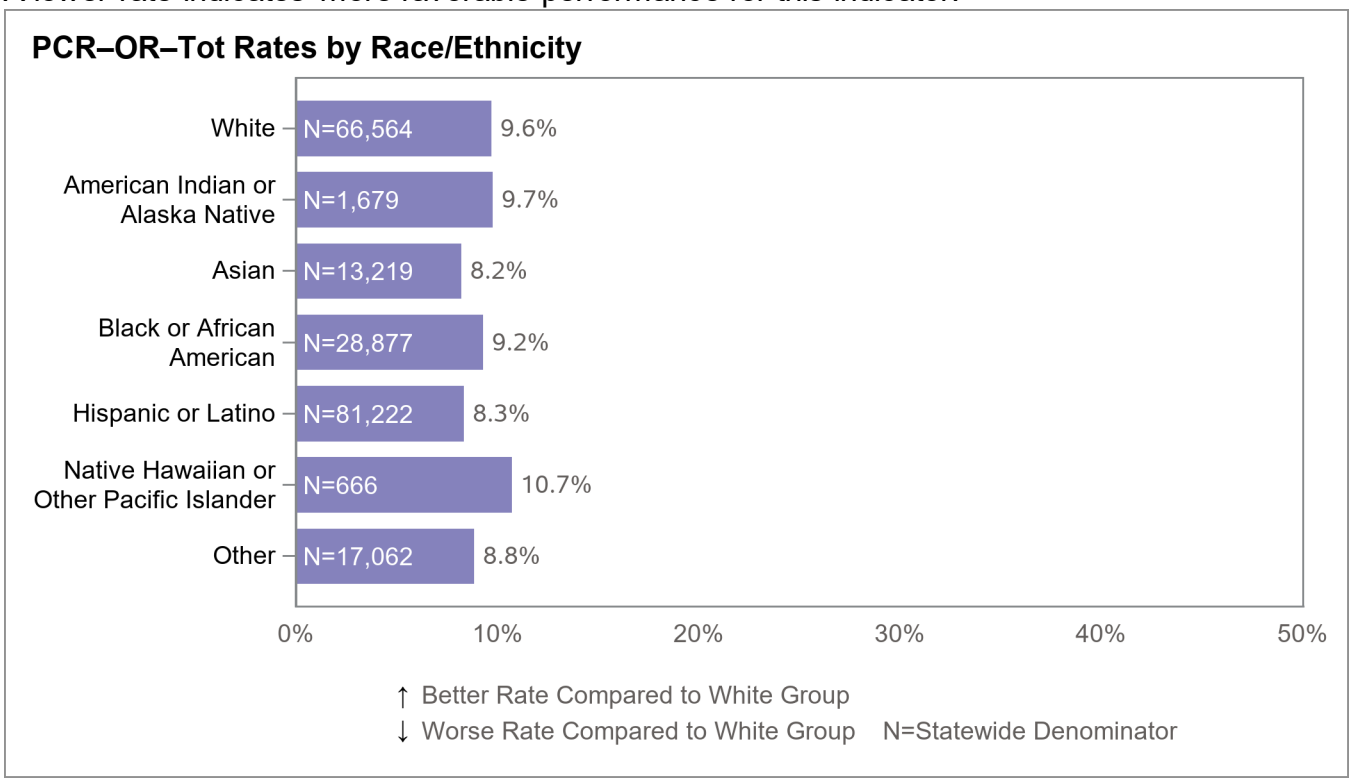
- The rates for all racial/ethnic groups ranged from 20.2 percent for the American Indian or Alaska Native group to 34.9 percent for the Other group.
- Four health disparities were identified for the *Developmental Screening in the First Three Years of Life—Total* indicator:
  - The rate for the Asian group was better than the rate for the White group.
  - The rate for the Native Hawaiian or Other Pacific Islander group was better than the rate for the White group.
  - The rate for the Other group was better than the rate for the White group.
  - The rate for the American Indian or Alaska Native group was worse than the rate for the White group.

Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR–Tot)

The *Plan All Cause Readmissions—Observed Readmission Rate—Total (PCR–OR–Tot)* indicator measures the percentage of members 18 years of age and older who had an acute inpatient and observation stay during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days of discharge. Figure 3.10 displays the statewide *Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR–Tot)* rate and denominator for each racial/ethnic group in addition to identified health disparities. A lower rate indicates more favorable performance for this indicator.

Figure 3.10—Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR–Tot) Rates by Race/Ethnicity

Note: The rate for the Unknown/Missing group was 9.4 percent (N=7,501).
The *Plan All-Cause Readmissions—Observed Readmission Rate—Total* indicator does not have an established minimum performance level.
A lower rate indicates more favorable performance for this indicator.



- The rates for all racial/ethnic groups ranged from 10.7 percent for the Native Hawaiian or Other Pacific Islander group to 8.2 percent for the Asian group.
- No health disparities were identified for the *Plan All-Cause Readmissions—Observed Readmission Rate—Total* indicator.

4. Geographic Variability by County for Select Indicators

The Geographic Variability by County for Select Indicators section presents county performance for four indicators identified by DHCS (*Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*, *Asthma Medication Ratio—Total*, *Breast Cancer Screening*, and *Chlamydia Screening in Women—Total*).

As a reference for the Geographic Variability by County figures, Figure 4.1 displays a map of California with all counties labeled.

Figure 4.1—California Map by County

Figure 4.2— Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–Acute) Geographic Variability by County

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

AMM–Acute Geographic Variability by County

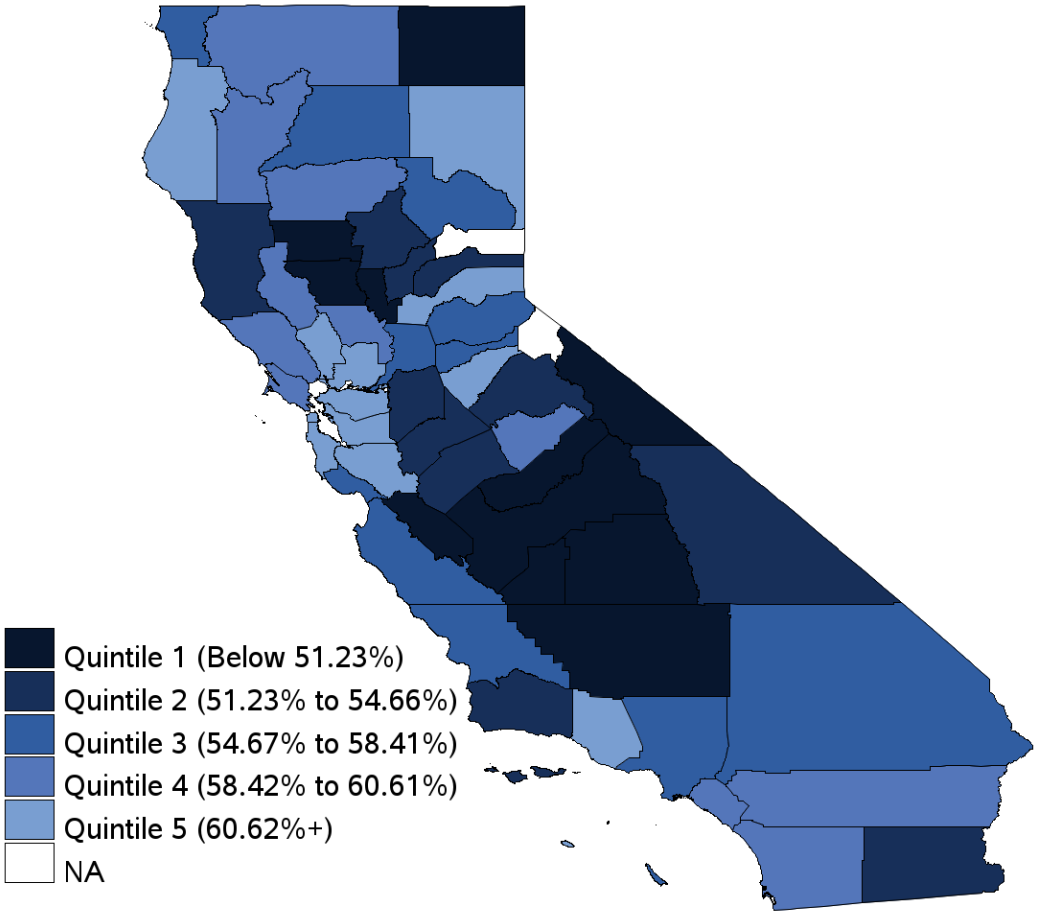


Figure 4.3—Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–Cont) Geographic Variability by County

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

AMM–Cont Geographic Variability by County

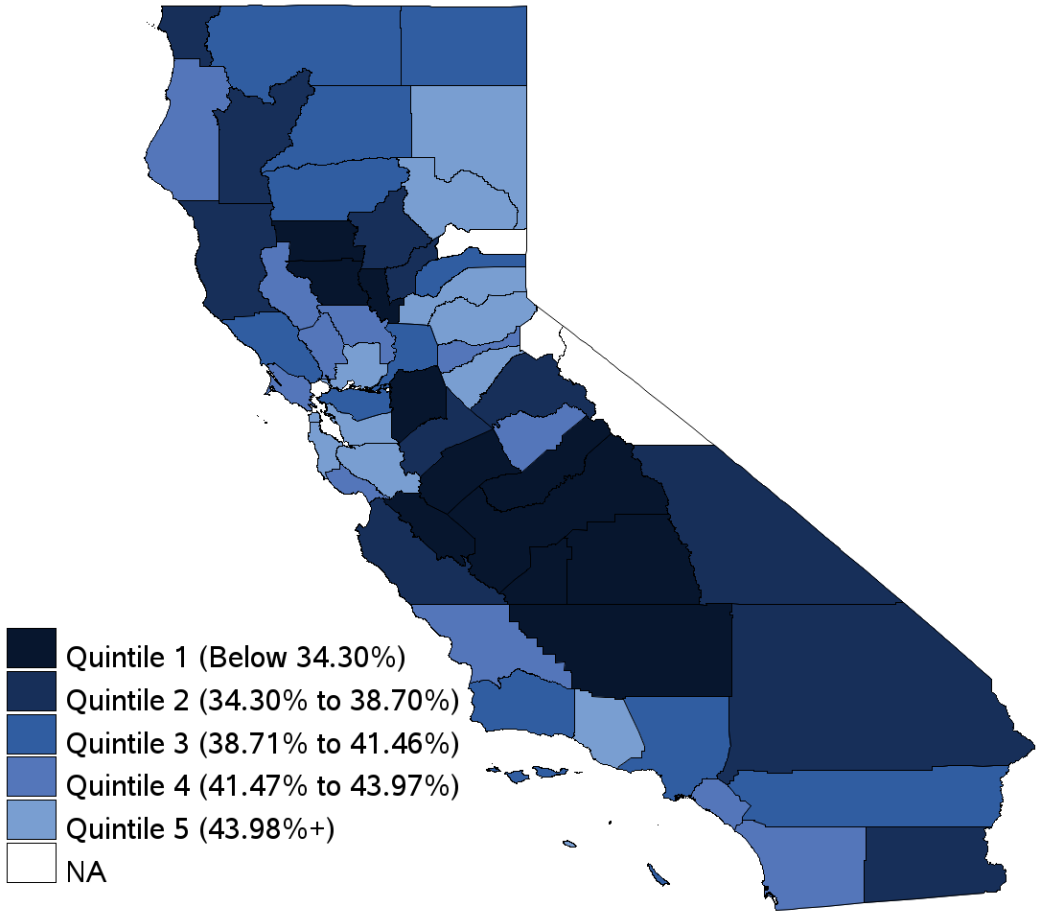


Figure 4.4—Asthma Medication Ratio—Total (AMR–Tot) Geographic Variability by County

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

AMR–Tot Geographic Variability by County

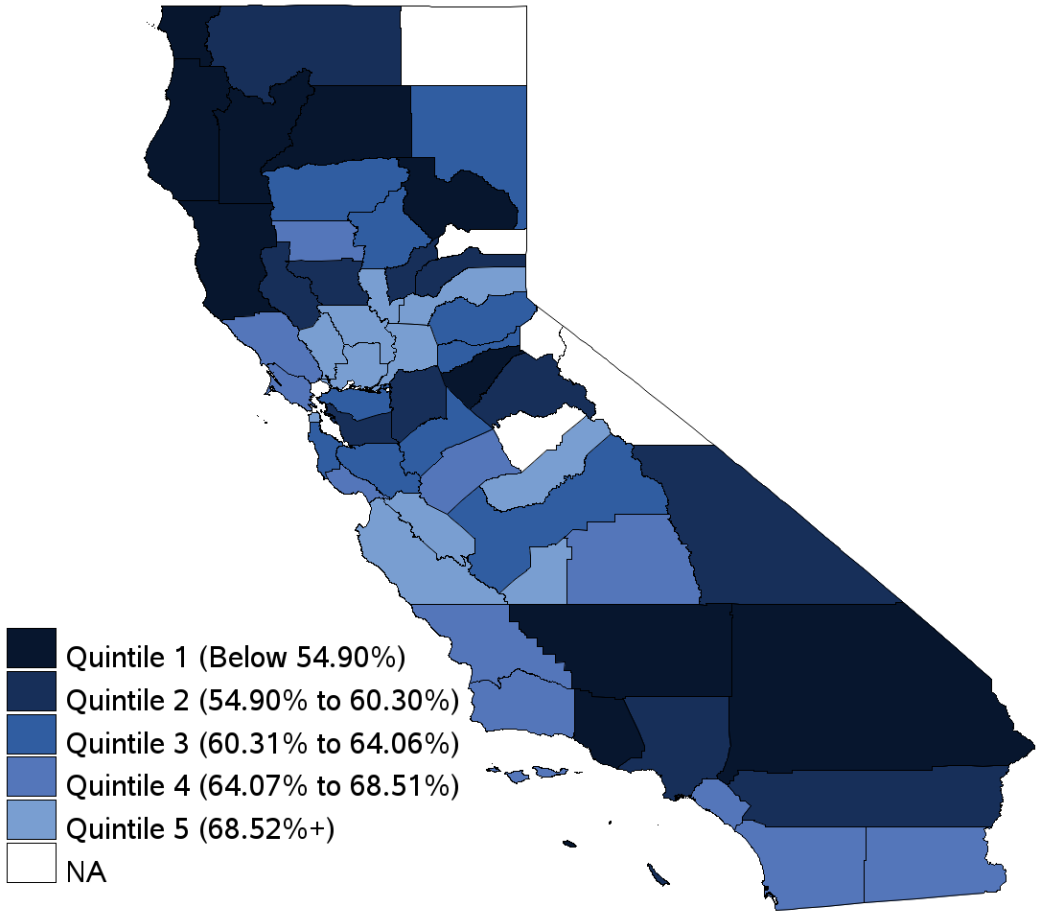


Figure 4.5—Breast Cancer Screening (BCS) Geographic Variability by County

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

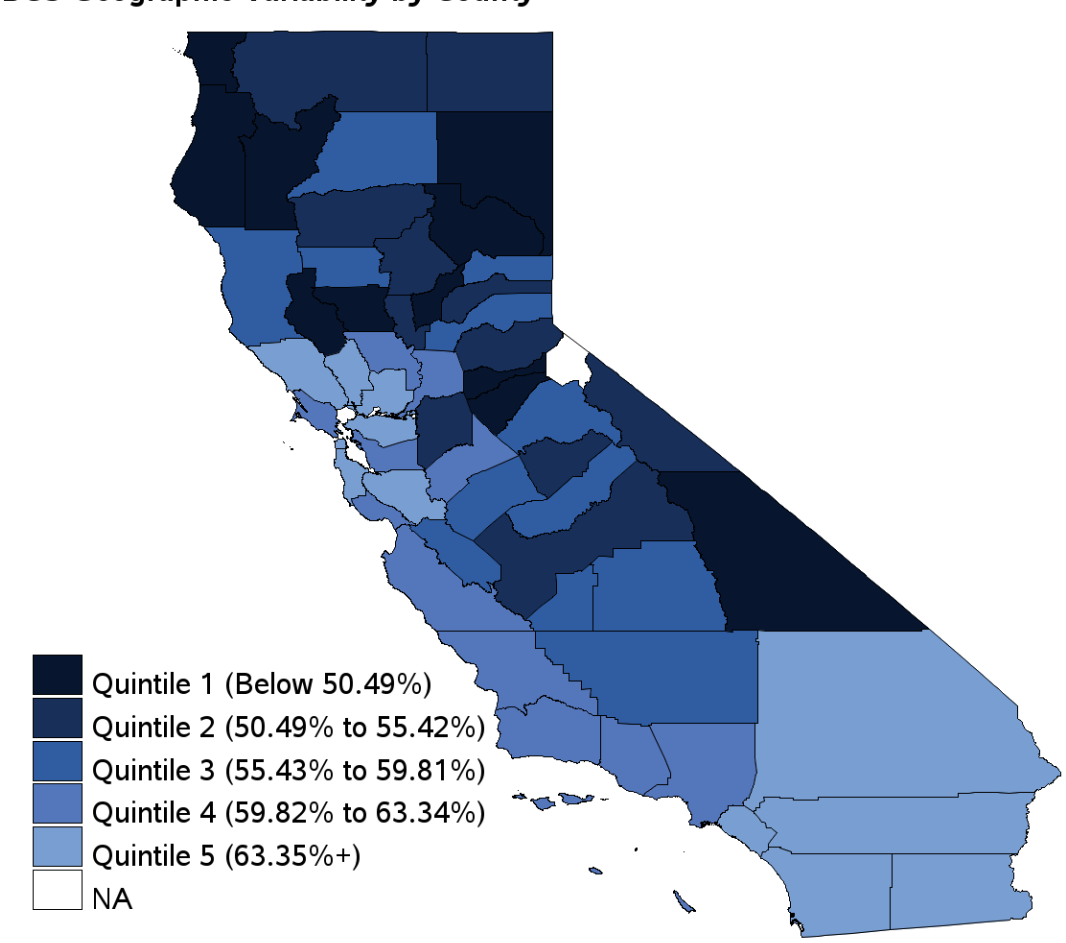
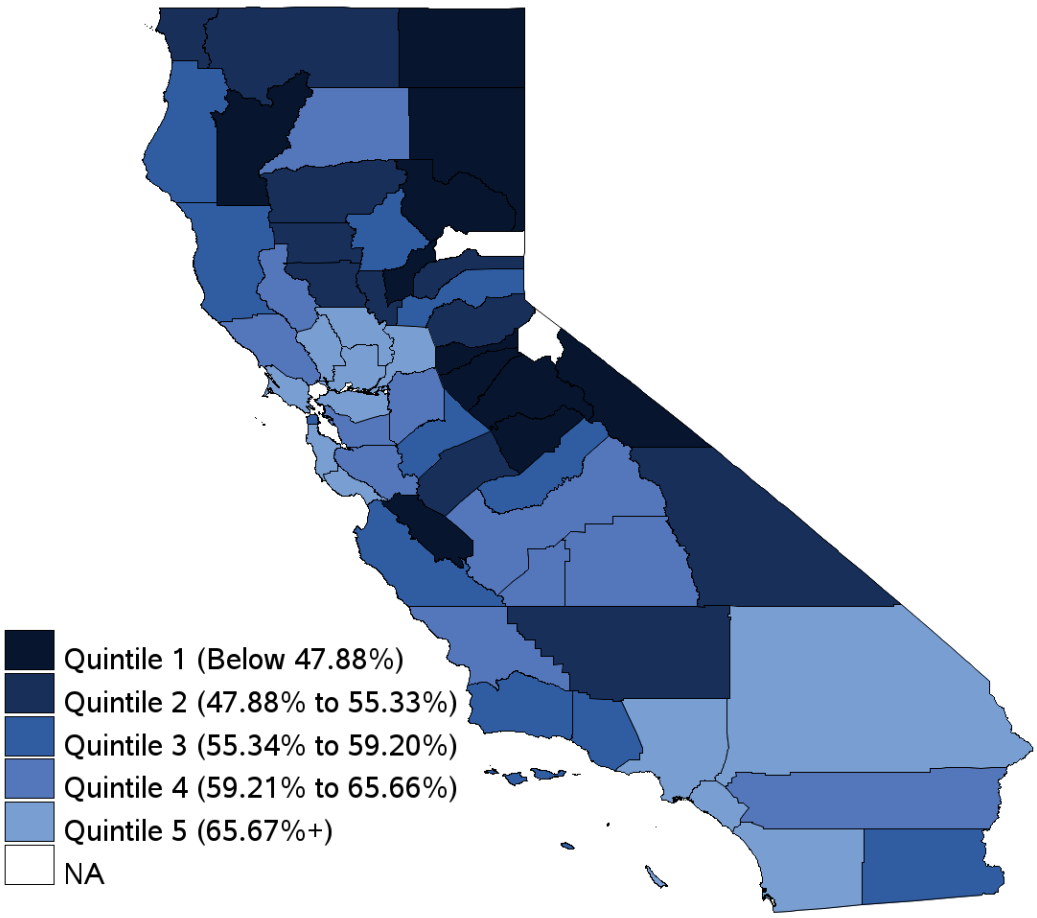


Figure 4.6—Chlamydia Screening in Women—Total (CHL–Tot) Geographic Variability by County

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

CHL–Tot Geographic Variability by County



Appendix A. Demographic Stratification Results

Appendix A presents the primary language stratification results for each MCAS indicator.

Primary Language

Figure A.1 through Figure A.10 display the statewide rates by each primary language group for each indicator. Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of June 2017. Please note, the rate for the Unknown/Missing group is only included as a note if the rate met the minimum denominator (i.e., 30 or more) and minimum numerator (i.e., 11 or more) requirements.

Figure A.1—Antidepressant Medication Management—Effective Acute Phase Treatment (AMM–Acute) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 62.2 percent (N=262).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.

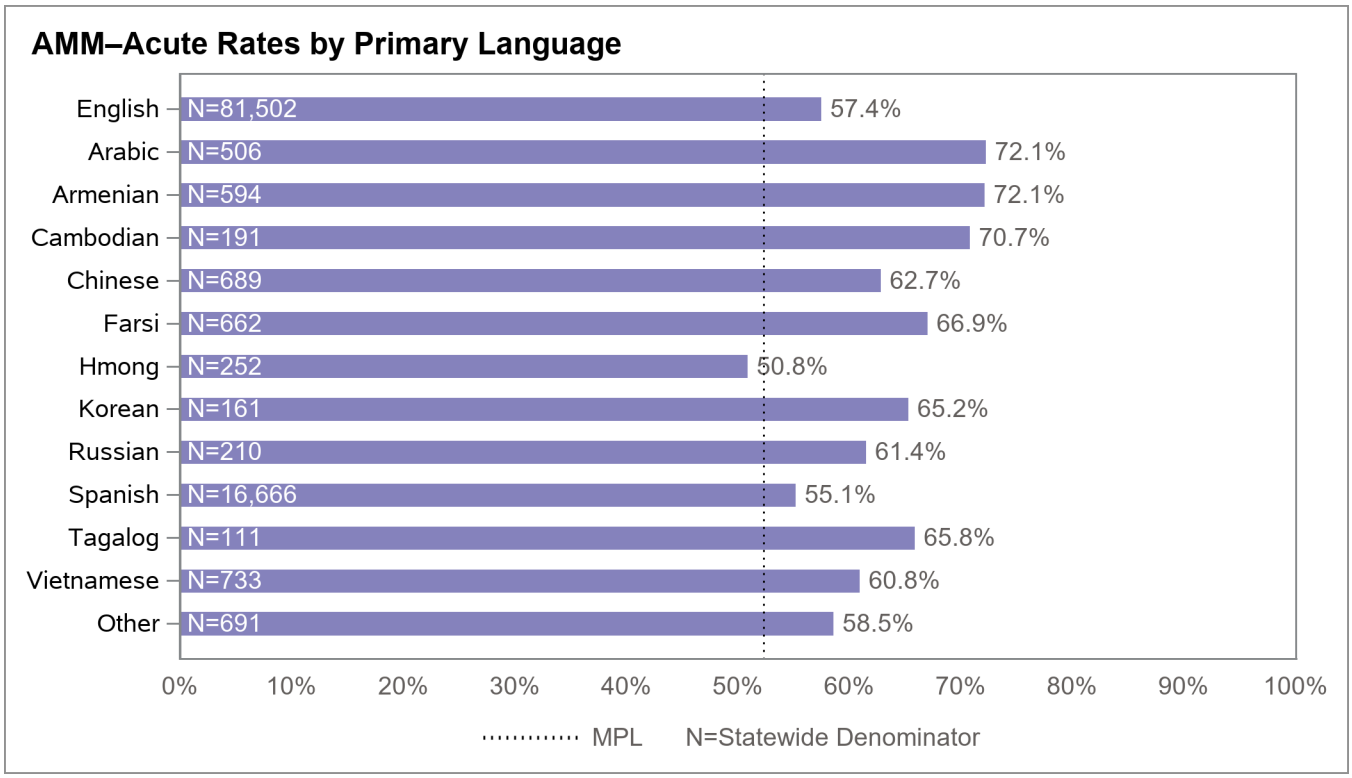


Figure A.2—Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM–Cont) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 45.0 percent (N=262).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.

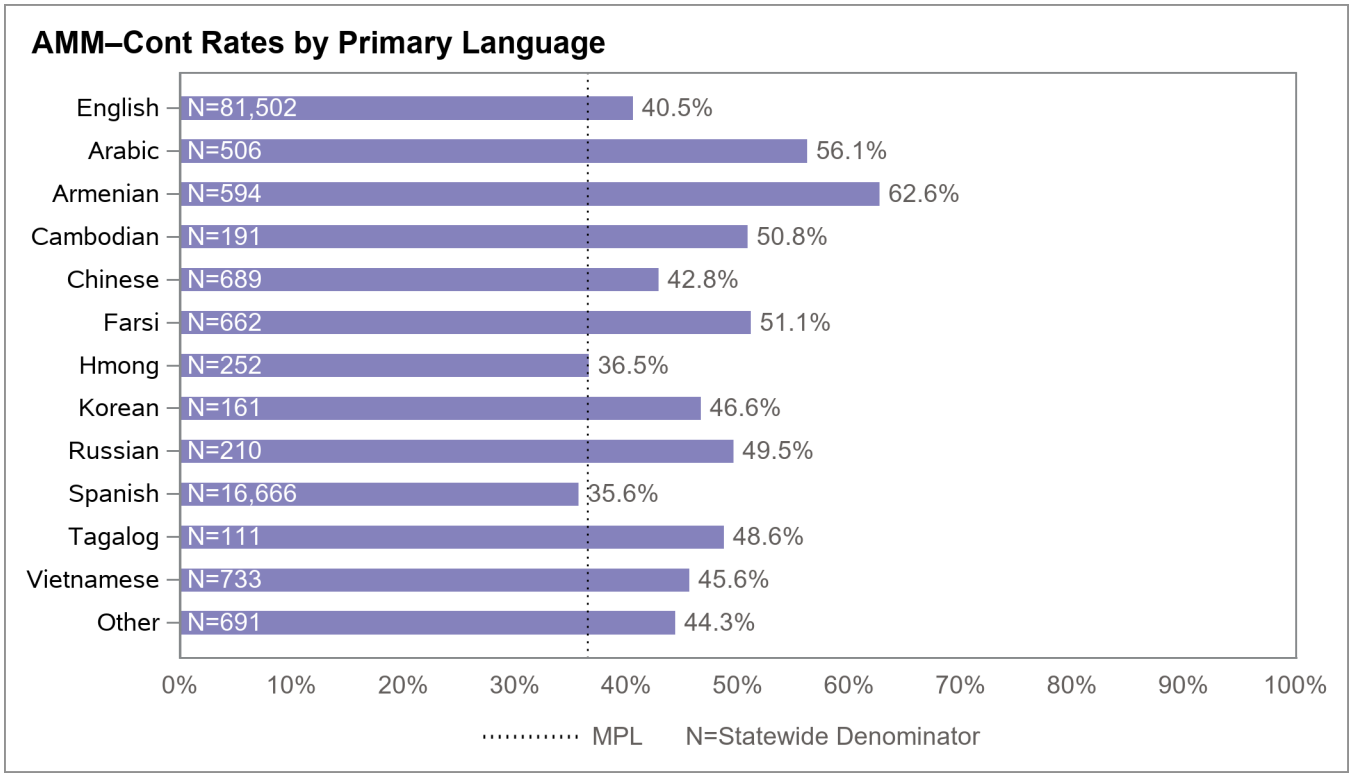


Figure A.3—Asthma Medication Ratio—Total (AMR–Tot) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 65.9 percent (N=314).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.

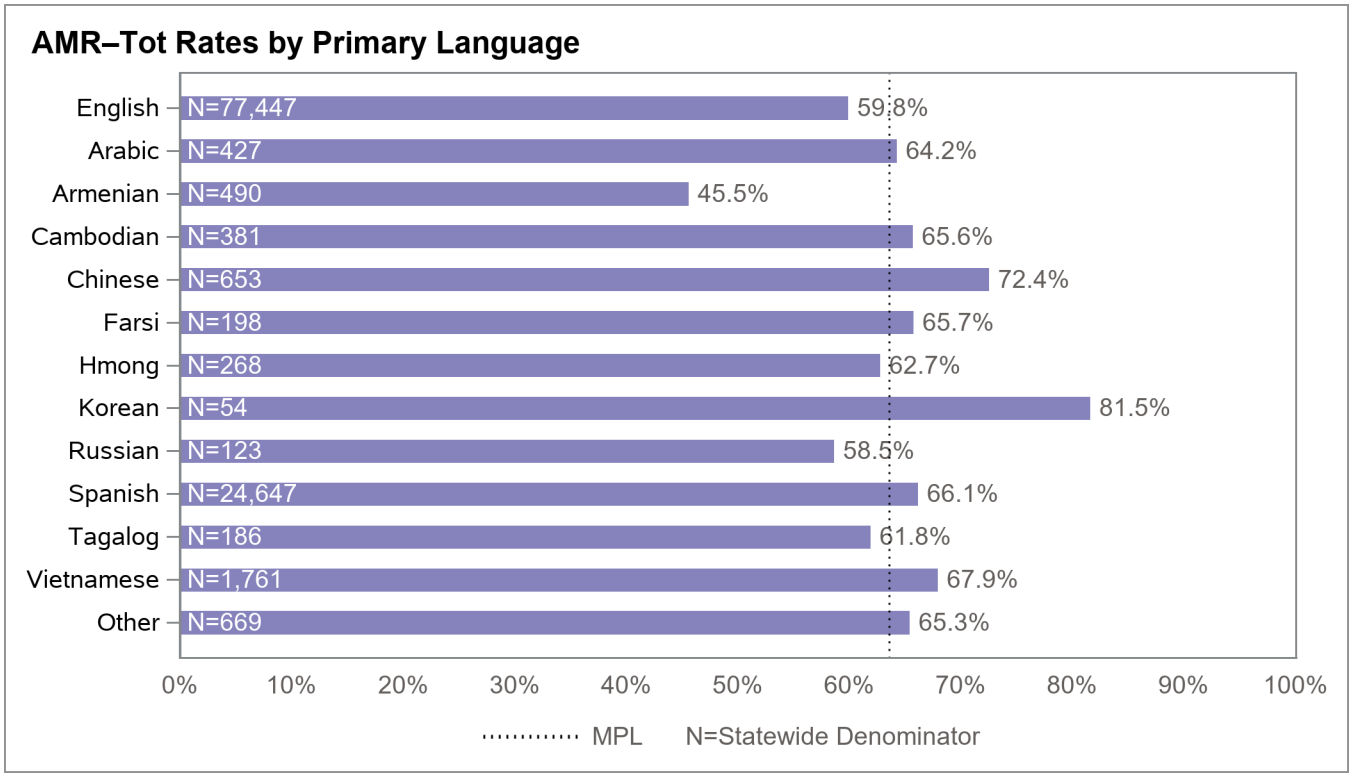


Figure A.4—Breast Cancer Screening (BCS) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 46.5 percent (N=3,726).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.

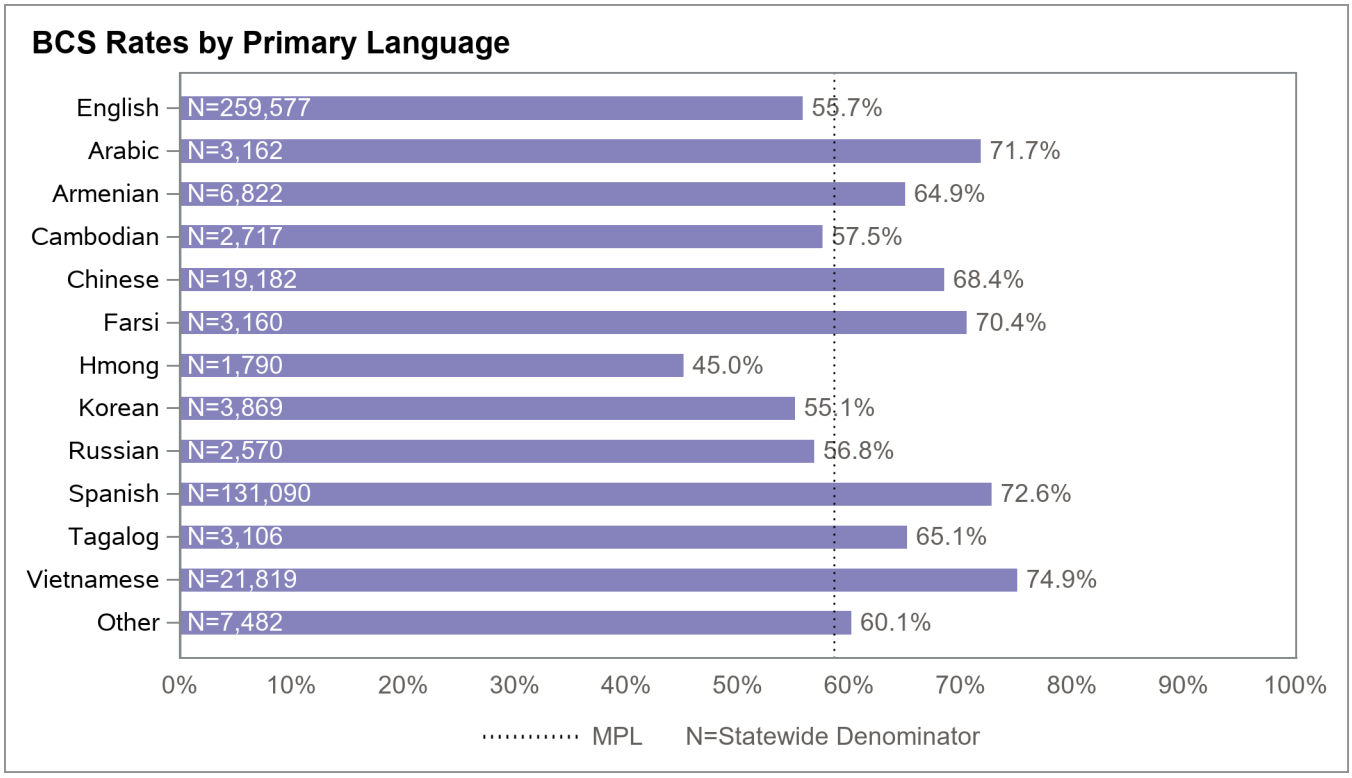


Figure A.5—Chlamydia Screening in Women—Total (CHL–Tot) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 51.7 percent (N=87).
The minimum performance level represents the national Medicaid 50th percentile for this indicator.

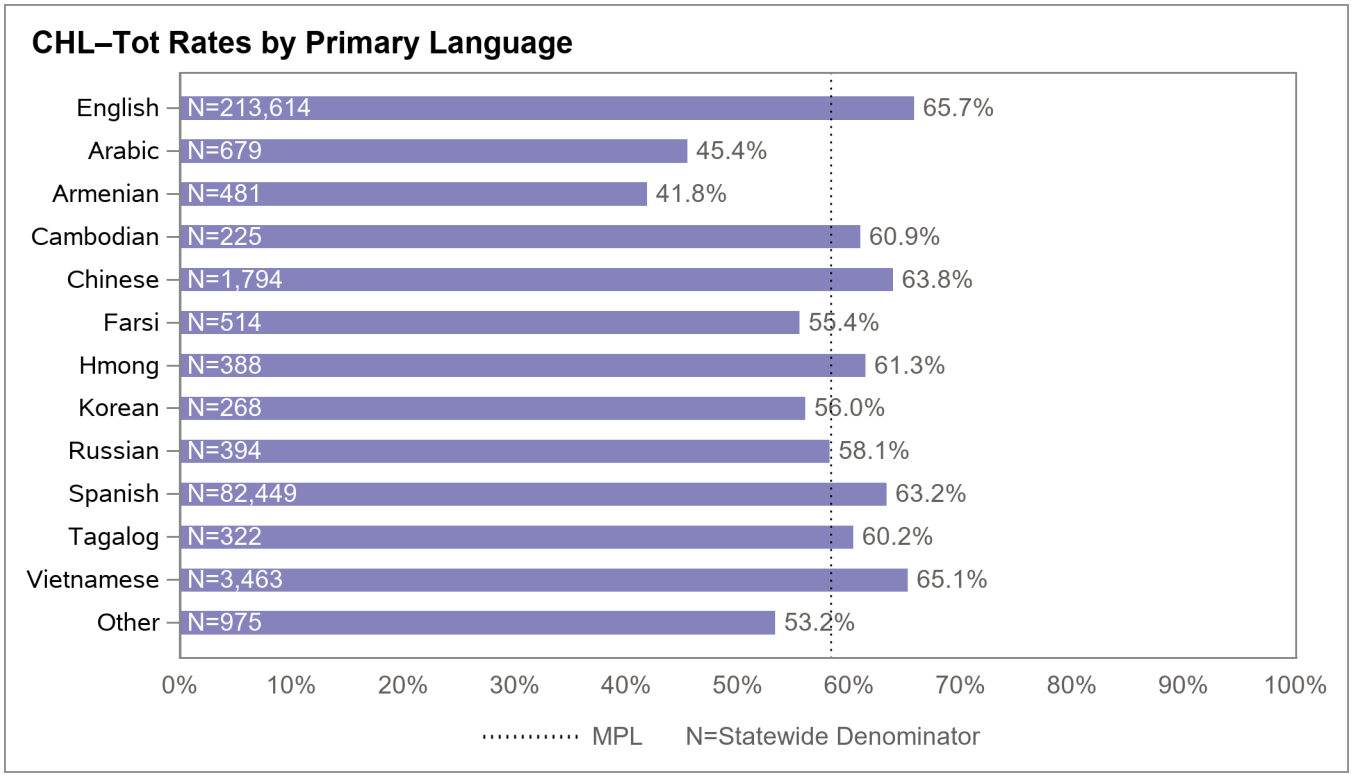


Figure A.6—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years (CCW–MMEC–1520) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 8.6 percent (N=186).
Note: The denominator for the Armenian group was N=1,601.

The *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years* indicator does not have an established minimum performance level.

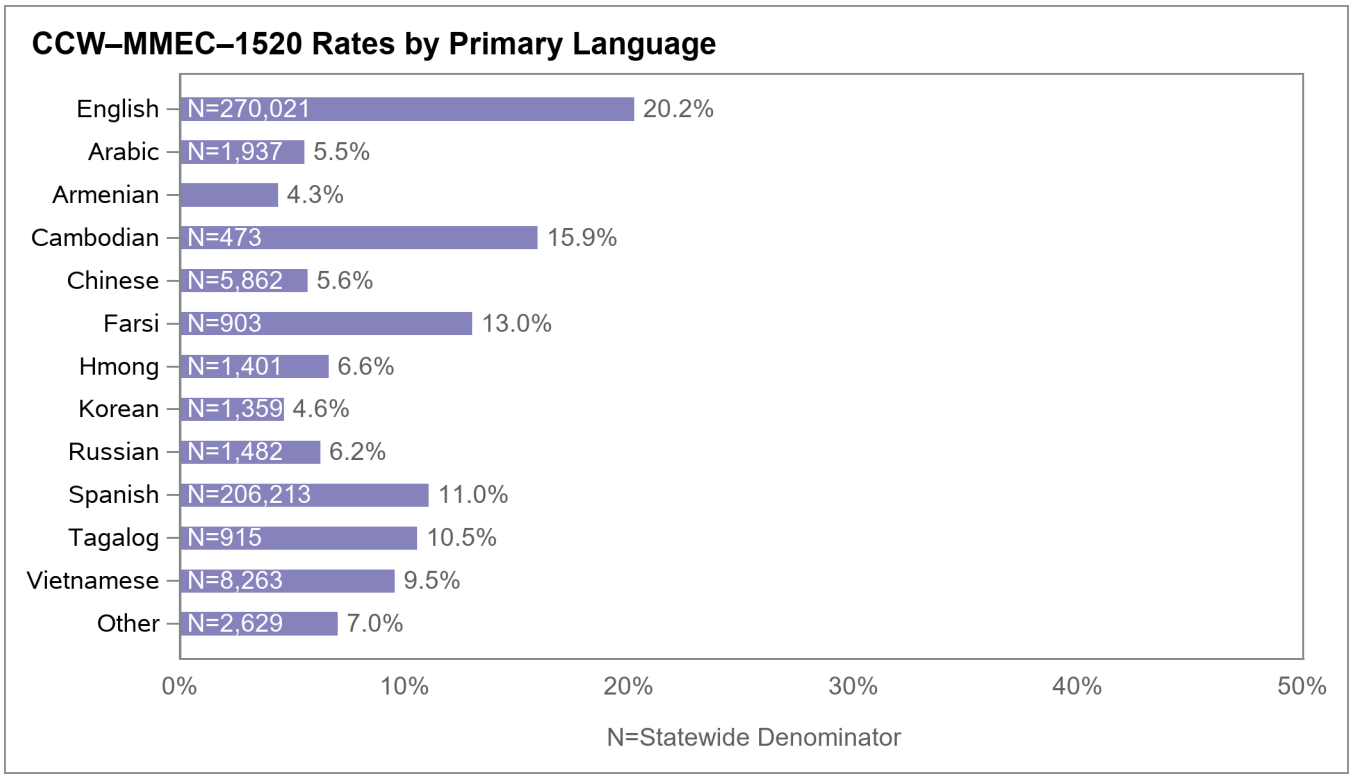


Figure A.7—Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 16.1 percent (N=2,285).

The *Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years* indicator does not have an established minimum performance level.

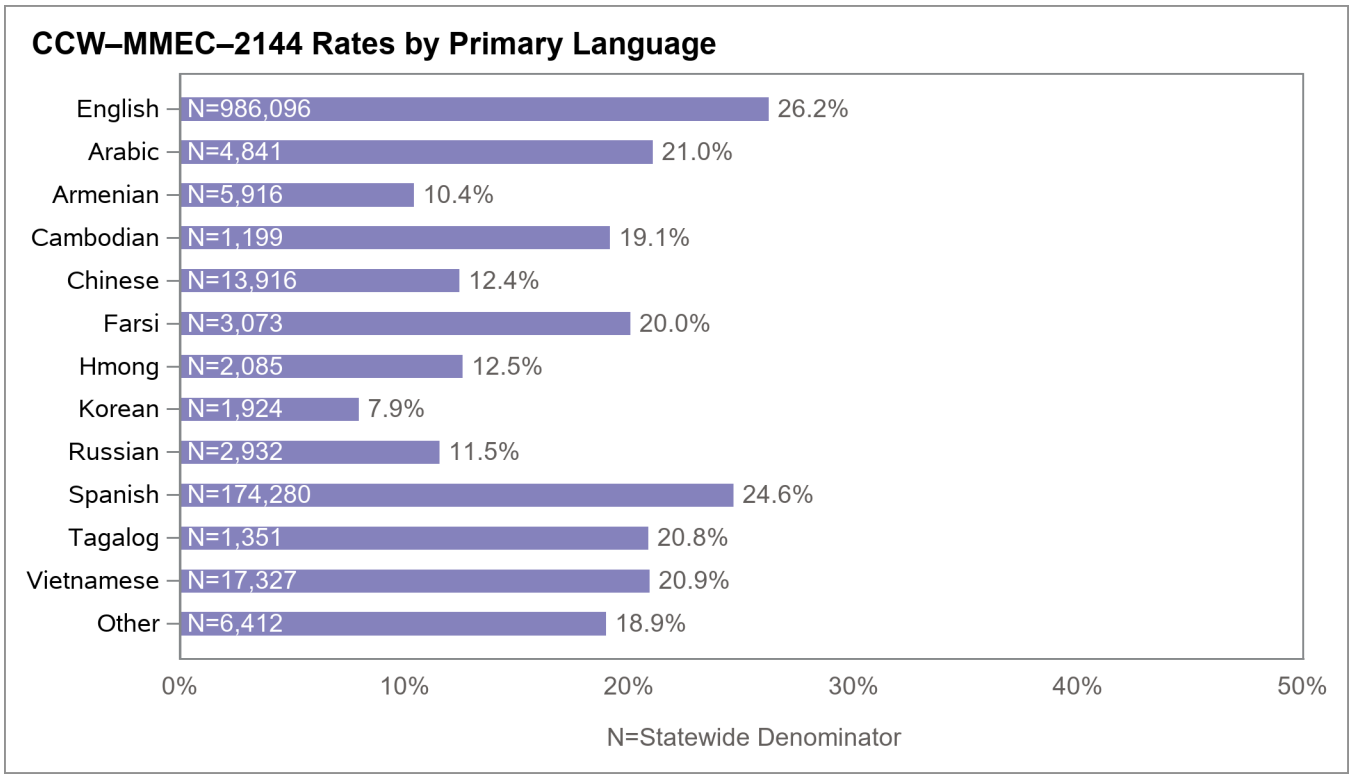


Figure A.8—Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years (CCP–MMEC60–2144) Rates by Primary Language

S indicates fewer than 11 cases exist in the numerator for the primary language group; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule's de-identification standard.

The *Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years* indicator does not have an established minimum performance level.

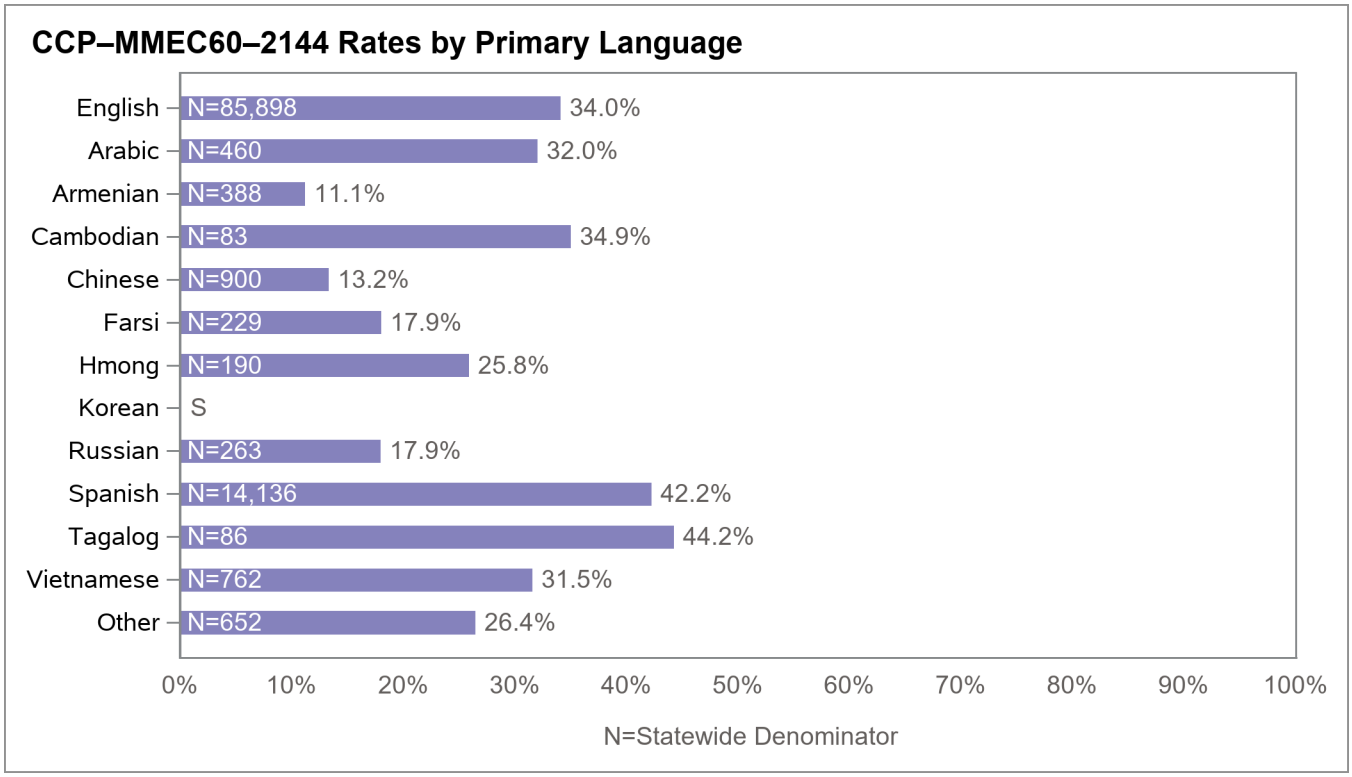


Figure A.9—Developmental Screening in the First Three Years of Life—Total (DEV–Tot) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 21.0 percent (N=538).
The *Developmental Screening in the First Three Years of Life—Total* indicator does not have an established minimum performance level.

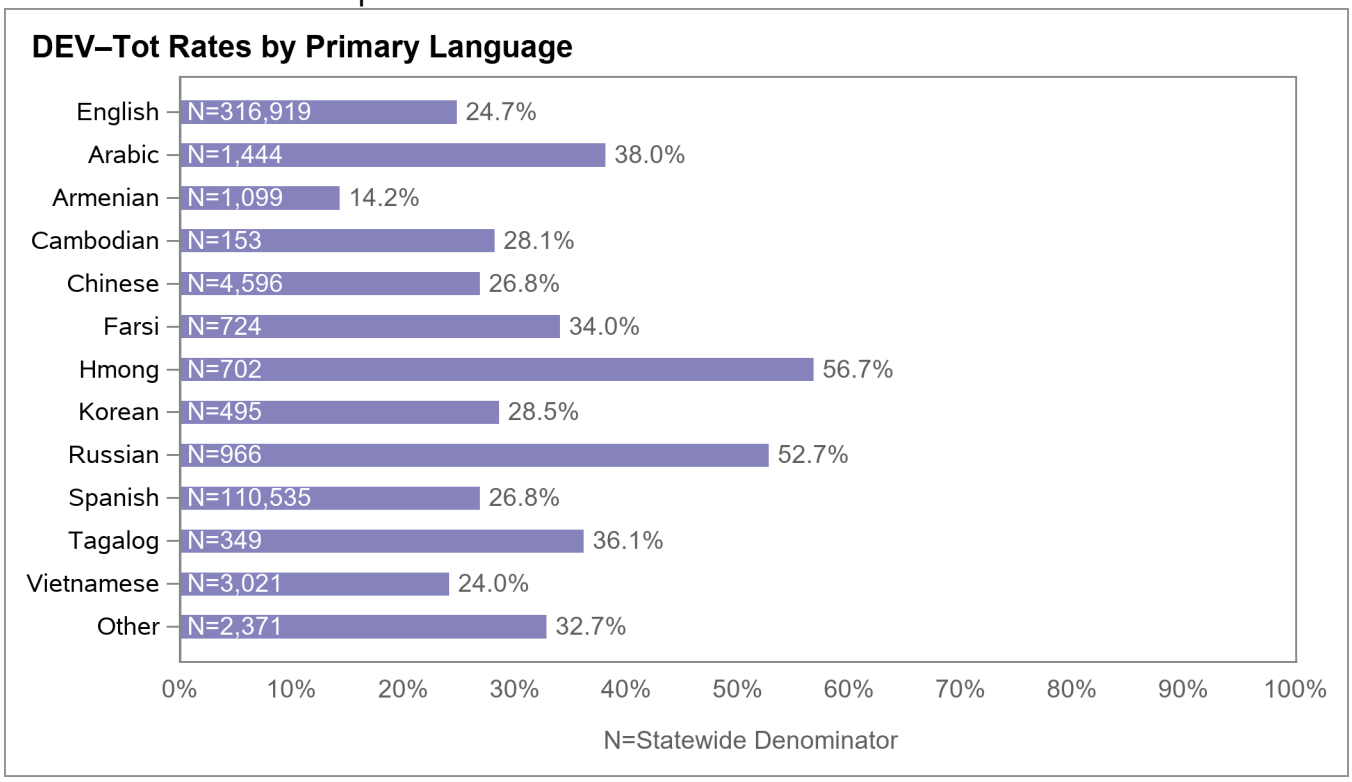
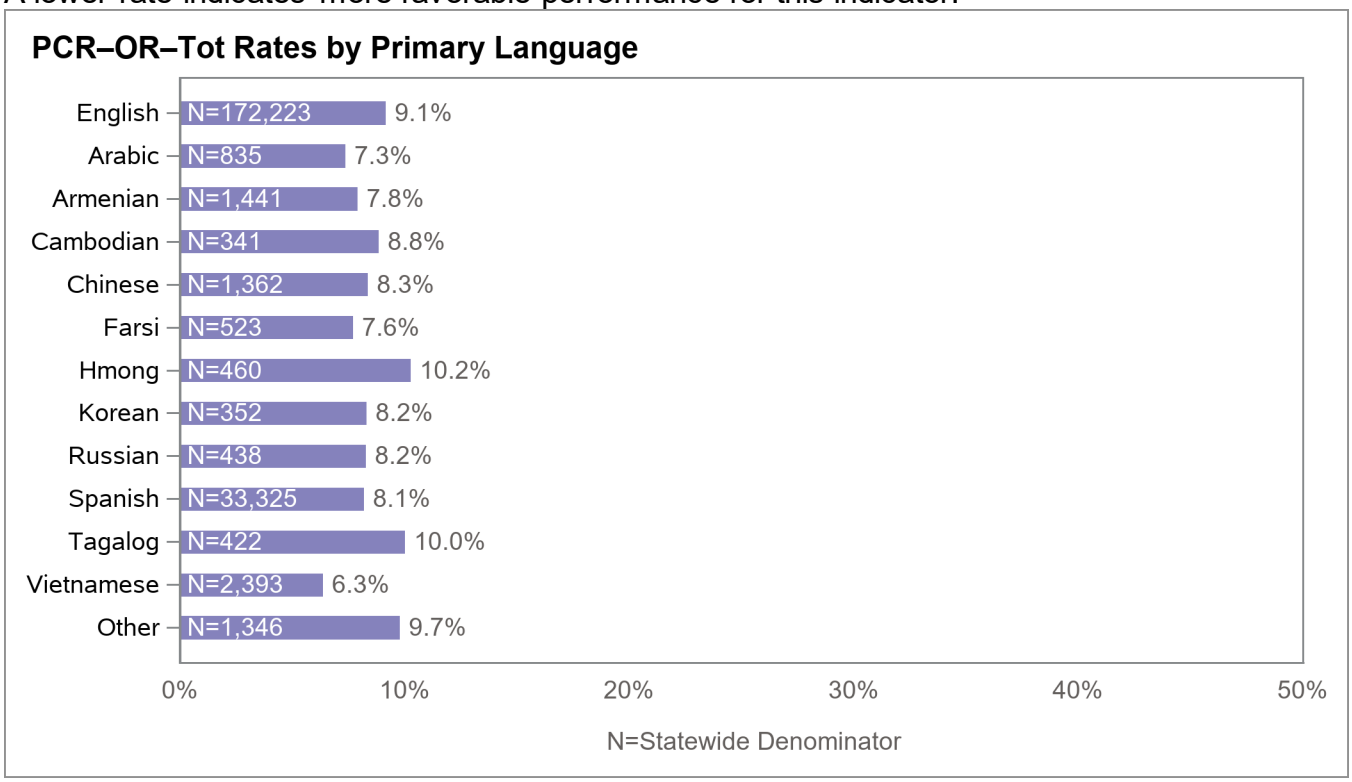


Figure A.10—Plan All-Cause Readmissions—Observed Readmission Rate—Total (PCR–OR–Tot) Rates by Primary Language

Note: The rate for the Unknown/Missing group was 10.3 percent (N=1,329).
The *Plan All-Cause Readmissions—Observed Readmission Rate—Total* indicator does not have an established minimum performance level.
A lower rate indicates more favorable performance for this indicator.



Appendix B. Methodology

A health disparity is the difference in health outcomes between groups within a population.[20] To assess and improve health disparities, the California Department of Health Care Services (DHCS) contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a health disparities study using the managed care accountability set (MCAS) measures reported by the 25 full-scope Medi-Cal managed care health plans (MCPs) for reporting year 2020 with data that are derived from calendar year 2019. 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 beneficiaries in Medi-Cal.

For the 2019–20 contract year, HSAG evaluated measure data collected for reporting year 2020 at the statewide level, which consists of data collected during calendar year 2019 also known as Healthcare Effectiveness Data and Information Set (HEDIS®)[21] measurement year 2019. Several measures include more than one indicator; therefore, this report will refer to indicators rather than measures.

Due to the impacts of the coronavirus disease 2019 (COVID-19) on MCPs' abilities to collect medical records, DHCS allowed the MCPs three options for hybrid measure reporting for reporting year 2020, consistent with similar National Committee for Quality Assurance (NCQA) allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.
- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Due to some MCPs electing to rotate hybrid measures, not all MCPs provided member-level information in the patient-level detail files for reporting year 2020. Given the differences in how MCPs reported hybrid measures for reporting year 2020 and the missing member-level information in the patient-level detail files, the 2019–20 Health Disparities analysis was limited to 10 administrative MCAS indicators. For each indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined either by the HEDIS specifications for the Medicaid population or by the Centers for Medicare & Medicaid Services'

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

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

(CMS') Core Set of Adult Health Care Quality Measures for Medicaid and Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Adult and Child Core Set) specifications. HSAG aggregated results from 25 full-scope MCPs and then stratified the statewide rates for the 10 MCAS indicators by the following demographic stratifications:

- Race/ethnicity
- Primary language

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

Data Sources

HSAG received a CA-required patient-level detail file from each MCP for each HEDIS reporting unit. The reporting year 2020 patient-level detail files followed HSAG's patient-level detail file instructions and included the Medi-Cal client identification number, date of birth, and member months 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 Excel reporting files. Please note, it is possible that non-certified eligible members were included by some or all MCPs in the reporting year 2020 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 demographic file from DHCS' Management Information System/Decision Support System data system:

- CA-required demographic file
  - Member's Medi-Cal client identification number
  - Date of birth
  - ZIP Code
  - Gender
  - Race/Ethnicity
  - Primary language
  - County

Combining Data

To calculate indicator rates for the demographic stratifications, HSAG first had to combine the indicator files provided by MCPs with the demographic file provided by DHCS. The following outlines HSAG's process for matching 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, or county), HSAG obtained the demographic values from another record in the demographic file using the following logic:

- HSAG prioritized records from the same reporting unit 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 calendar year 2019.
  - If HSAG could not recover the missing demographic values from a record within calendar year 2019, then the most recent non-missing observation from calendar year 2018 was used.
- 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 contains the same client identification number, HSAG only considered a client identification number to match if the date of birth in the demographic file was within 10 years of the date of birth recorded in the indicator file. If 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."

Statistical Analysis

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 logistic regression. To facilitate this, HSAG performed the procedures described below.

Pre-Analysis

Based on the methodology for combining data described above, HSAG created separate 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.

One of the indicators (i.e., *Plan All-Cause Readmissions*) was event-based rather than member-based, which allowed for denominators greater than one. In order to satisfy the requirements for performing a logistic regression, HSAG altered the indicator files to convert all observations to have dichotomous values for the numerator and denominator (e.g., if an observation had a denominator value of three and a numerator value of two, HSAG created three separate observations that each had a denominator value of one; two of which had a numerator value of one and one of which had a numerator value of zero).

Statewide-Level Health Disparity Analysis

HSAG performed a statewide-level health disparity analysis for the racial/ethnic demographic stratification. Specifically, HSAG compared each racial/ethnic group to the White group (i.e., the reference group) for each indicator. The White racial/ethnic group was chosen as the reference group because it is used in a majority of national health disparities reports and has historically been used a reference point for reporting health care and non-health care disparities.

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

For each indicator, HSAG calculated an absolute difference by taking the absolute value of the difference between the rate for a racial/ethnic group and the rate for the reference group. For this report, a health disparity was defined as a rate for a racial/ethnic group with an absolute difference greater than or equal to 3 percentage points ***and*** a *p*-value of the coefficient of the

logistic regression that is less than 0.05. When analyzing the rate for a racial/ethnic group, HSAG classified the rate in one of the following three categories based on the preceding analyses:

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

Indicators and Stratifications

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

Table B.1—Demographic Stratification Groups

*Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of June 2017. 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 B.2 for more detail)
Primary language*	English, Spanish, Arabic, Armenian, Cambodian, Chinese (Mandarin or Cantonese), Farsi, Hmong, Korean, Russian, Tagalog, Vietnamese, Other, and Unknown/Missing

Table B.2 displays the individual racial/ethnic groups that comprise the racial/ethnic demographic stratifications. Please note that for the analyses, the stratifications were collapsed into more meaningful comparison groups, as displayed in Table B.1. Racial/ethnic stratifications were based on data collection guidance from the federal Office of Management and Budget as well as the U.S. Department of Health and Human Services.

Table B.2—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, Laotian, Vietnamese, and Other Asian or Pacific Islander*
American Indian or Alaska Native	American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander	Hawaiian, Guamanian, and Samoan
Other	Other
Unknown/Missing	Unknown/Missing

Table B.3 displays the indicators included in the analysis and the allowable age groups for each indicator.

Table B.3—Indicators and Age Groups

Indicators	Age Groups
Antidepressant Medication Management—Effective Acute Phase Treatment and *Effective Continuation Phase Treatment*	18+ Years
Asthma Medication Ratio—Total	5–64 Years
Breast Cancer Screening	50–74 Years
Chlamydia Screening in Women—Total	16–24 Years
Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years and *Ages 21–44 Years*	15–44 Years

Indicators	Age Groups
Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception—60 Days—Ages 21–44 Years	21–44 Years
Developmental Screening in the First Three Years of Life—Total	0–3 Years
Plan All-Cause Readmissions—Observed Readmission Rate—Total	18–64 Years

Rate Spreadsheets

After performing the analyses, HSAG compiled and produced indicator rate spreadsheets in an Excel format that provided all indicator data for all stratifications (race/ethnicity, primary language, age, gender).[22] HSAG produced a statewide and 25 MCP-specific rate spreadsheets that contain applicable numerator, denominator, eligible population, demographic, and rate data for each reporting unit. HSAG did not suppress any data in the rate spreadsheets.

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. To highlight identified health disparities, HSAG displayed arrows next to the rate on the bar graph to indicate whether the rate for the racial/ethnic group being evaluated was a better rate (indicated by an upward arrow) or worse rate (indicated by a downward arrow) than the rate for the reference group. No arrow represents similar rates compared to the reference group, which means no health disparities were identified. "N" represents the total statewide denominator for an indicator for a particular group.

In addition, HSAG produced a horizontal stacked bar graph that displays for each racial/ethnic group the percentage of all 10 MCAS indicators analyzed in this study that had a better rate, worse rate, or similar rate when compared to the reference group.

[22] Please note, gender and age demographic stratifications were excluded from the 2019–20 Health Disparities Report; however, the stratifications were provided in the rate spreadsheets for informational purposes.

Within the appendix of the Health Disparities Report, HSAG also calculated indicator rates for the primary language demographic stratification; however, statistical analysis was not performed on this demographic stratification to identify health disparities. For each indicator, HSAG created horizontal bar graphs and indicated the minimum performance level for the corresponding indicator as established by DHCS, if applicable. The minimum performance levels for each indicator are based on NCQA's Quality Compass national Medicaid Health Maintenance Organization 50th percentiles. The minimum performance level is displayed not as a statistical benchmark for health disparities but to provide more information about overall performance for a specific indicator. "N" represents the total statewide denominator for an indicator for a particular group.

Geographic Variability by County for Select Indicators

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

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Antidepressant Medication Management—Effective Continuation Phase Treatment*
- *Asthma Medication Ratio—Total*
- *Breast Cancer Screening*
- *Chlamydia Screening in Women—Total*

To highlight regional performance differences, HSAG first assigned a county to each member based on the county code provided in the DHCS demographic file. If the county code was missing for a member in the demographic data file, HSAG utilized the ZIP Code to determine the appropriate county. HSAG then calculated county-level rates for each indicator listed previously by summing the numerators and denominators for all members within a county. For each indicator, HSAG calculated performance quintiles based on county performance (i.e., 20th percentile, 40th percentile, 60th percentile, and 80th percentile). HSAG then determined which quintile each county fell into (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 B.4. Please note, HSAG shaded counties with numerators less than 11 or denominators less than 30 white to indicate the rate was suppressed.

Table B.4—Statewide Performance Quintile Thresholds and Corresponding Colors

Statewide Performance 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

Caveats

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 B.3. For the *Chlamydia Screening in Women—Total* and *Breast Cancer Screening* indicators, HSAG only kept members who were identified as female in the demographic file. Additionally, HSAG included the "Unknown/Missing" group for race/ethnicity and primary language 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.

COVID-19 Impacts on Reporting

Due to the impacts of COVID-19 on MCPs' abilities to collect medical records, DHCS allowed the MCPs three options for hybrid measure reporting for reporting year 2020, consistent with similar NCQA allowances:

- Using the applicable hybrid technical specifications, report the hybrid rates using measurement year 2019 data.

- Report the measurement year 2018 audited hybrid rates, if available (i.e., the MCP reported the rates to DHCS or reported the rates to NCQA as part of the health plan accreditation process).
- Report the hybrid rates using measurement year 2019 administrative data only.

Due to some MCPs electing to rotate hybrid measures, not all MCPs provided member-level information in the patient-level detail files for reporting year 2020. Given the differences in how MCPs reported hybrid measures for reporting year 2020 and the missing member-level information in the patient-level detail files, the 2019–20 Health Disparities analysis was limited to 10 administrative MCAS indicators. According to NCQA, COVID-19 did not have an impact on the MCPs' abilities to report measures that only require administrative data.[23] Future iterations of the Health Disparities Report will include additional indicators reported by MCPs.

Electronic Health Record Data

Due to inconsistent reporting of electronic health record (EHR) data by MCPs, differences in rates for the *Developmental Screening in the First Three Years of Life—Total* indicator may be indicative of data completeness rather than performance.

[23] National Committee for Quality Assurance. Coronavirus and NCQA. Available at: https://www.ncqa.org/covid/ Accessed on: Oct 21, 2020.