2016 Health Disparities Report

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

May 2019

Table of Contents

Table of Figures

Table of Tables

Commonly Used Abbreviations and Acronyms

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

- **AAB**—*Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- **ACE**—angiotensin converting enzyme
- **ACR**—*All-Cause Readmissions*
- **AMB–ED**—*Ambulatory Care—Emergency Department Visits*
- **AMB–OP**—*Ambulatory Care— Outpatient Visits*
- **AMR**—*Asthma Medication Ratio*
- **ARBs**—angiotensin receptor blockers
- **BCS**—*Breast Cancer Screening*
- **CAP–1219**—*Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*
- **CAP–1224**—*Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*
- **CAP–256**—*Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- **CAP–711**—*Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- **CBP**—*Controlling High Blood Pressure*
- **CCS**—*Cervical Cancer Screening*
- **CDC–BP**—*Comprehensive Diabetes Care—Blood Pressure Control*
- **CDC–E**—*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- **CDC–H8**—*Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*
- **CDC–H9**—*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- **CDC–HT**—*Comprehensive Diabetes Care—HbA1c Testing*
- **CDC–N**—*Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- **CIS–3**—*Childhood Immunization Status—Combination 3*
- **CMS**—Centers for Medicare & Medicaid Services
- **DHCS**—California Department of Health Care Services
- **EAS**—external accountability set
- **ED**—emergency department
- **HbA1c**—hemoglobin A1c

♦ **HEDIS**®—Healthcare Effectiveness Data and Information Set[1]

♦ **HMO**—health maintenance organization

♦ **HSAG**—Health Services Advisory Group, Inc.

♦ **IDSS**—Interactive Data Submission System

♦ ***IMA–2**—Immunizations for Adolescents—Combination 2*

♦ ***LBP**—Use of Imaging Studies for Low Back Pain*

♦ **MCP**—managed care health plan

♦ **MPL**—minimum performance level

♦ ***MPM–ACE**—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*

♦ ***MPM–Diu**—Annual Monitoring for Patients on Persistent Medications—Diuretics*

♦ **N**—number

♦ **NCQA**—National Committee for Quality Assurance

♦ **OB/GYN**—obstetrician-gynecologist

♦ **PCP**—primary care provider

♦ **PLD**—patient-level detail

♦ ***PPC–Pre**—Prenatal and Postpartum Care—Timeliness of Prenatal Care*

♦ ***PPC–Pst**—Prenatal and Postpartum Care—Postpartum Care*

♦ ***W–34**—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

♦ ***WCC–N**—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*

♦ ***WCC–PA**—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*

---

[1] 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 external accountability set (EAS) performance indicators reported by the 23 full-scope Medi-Cal managed care health plans (MCPs) for reporting year 2017 with data derived from calendar year 2016. This report does not include data for fee-for-service (FFS) beneficiaries in Medi-Cal. EAS indicators reflect clinical quality, timeliness, and access to care provided by MCPs to their beneficiaries; and each MCP is required to report audited EAS results to DHCS annually. The goal of the Health Disparities Report is to improve health care for Medi-Cal beneficiaries by evaluating the health care disparities affecting beneficiaries enrolled in Medi-Cal MCPs.

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 2016, the racial/ethnic distribution of the Medi-Cal managed care population consisted of the following racial/ethnic groups: Hispanic or Latino (46 percent), White (21 percent), Asian or Pacific Islanders (14 percent), Other or Unknown (12 percent), and Black or African American (8 percent). In addition, the Medi-Cal managed care program's age distribution in 2016 was 17-year-olds and younger (41 percent), 18-to-64-year-olds (52 percent), and 65 and older (7 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 and 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 2016 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 50 percent and 75 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 38.7 percent and 42.3 percent, respectively, of quality care indicators. Given national

---

[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] Medi-Cal Managed Care Performance Dashboard, June 2017. Available at https://www.dhcs.ca.gov/services/Documents/MMCD/June142017Release.pdf. Accessed on: Apr 19, 2019.

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

[5] 2016 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; October 2017. AHRQ Pub. No. 17-0001.

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 assessment and 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 population.

DHCS requested that HSAG evaluate EAS measure indicator data collected for reporting year 2017 at the statewide level, which evaluated performance during calendar year 2016, also known as Healthcare Effectiveness and Information Data Set (HEDIS®) measurement year 2016. Several EAS measures consist of more than one indicator; therefore, this report will refer to EAS indicators rather than measures. The EAS indicator set for this analysis included 27 HEDIS indicators and one indicator originally developed by DHCS and MCPs (with guidance from HSAG), for a total of 28 EAS indicators. DHCS grouped the EAS indicators into the following domains of care: Preventive Screening and Children's Health, Preventive Screening and Women's Health, Care for Chronic Conditions, and Appropriate Treatment and Utilization. Please note, HSAG did not include the *Screening for Clinical Depression and Follow-Up Plan* (*CDF*) indicators in the health disparities analysis due to unreliable data and inconsistent reporting by MCPs. For each indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined by the applicable technical specification, such as the HEDIS specification for the Medicaid population. HSAG aggregated EAS results from 23 full-scope MCPs to calculate statewide rates for all EAS indicators and then stratified these statewide rates by race/ethnicity, primary language, age, and gender.

Although HSAG stratified all EAS indicators by race/ethnicity, primary language, age, and gender, HSAG only identified health disparities based on statistical analysis for the racial/ethnic stratification. In order to ensure the methodology to identify health disparities aligned with national standards, HSAG utilized the Centers for Medicare & Medicaid Services'

---

[6] DHCS Strategy for Quality Improvement in Health Care. California Department of Healthcare Services, April 2016. Available at http://www.dhcs.ca.gov/services/Documents/DHCS_Quality_Strategy_2016.pdf. Accessed on Feb 19, 2019.

(CMS') *Racial and Ethnic Disparities by Gender in Health Care in Medicare Advantage* in developing the methodology, analysis, and report structure, when possible.[7]

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

Key Findings for Racial/Ethnic Health Disparities

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 EAS indicators (out of 26 possible indicators) for which rates for selected racial/ethnic groups were worse than, similar to, or better than the rates for the White group.

Figure 1.1—Overall Racial/Ethnic Health Disparities for All EAS Indicators
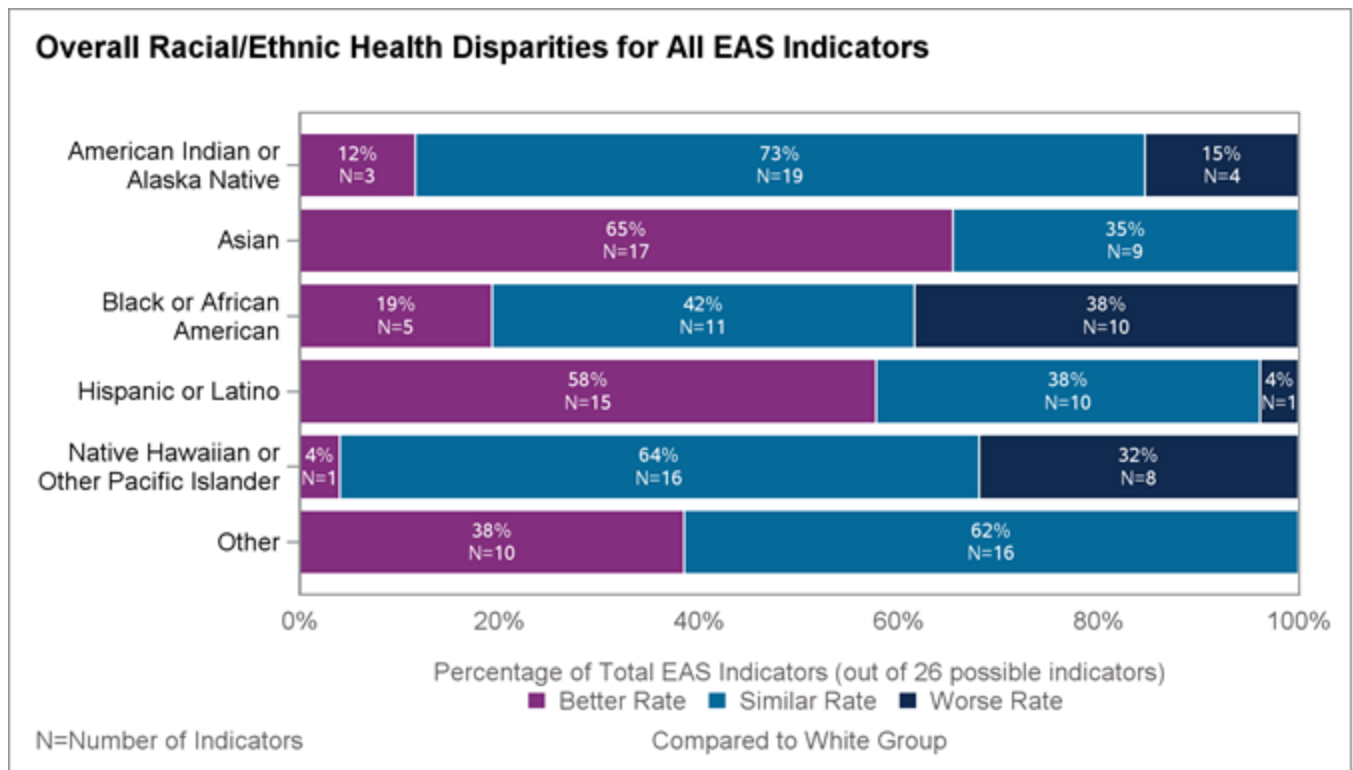
Note: The *Ambulatory Care* indicators were not included in the racial/ethnic health disparities analysis. For the Native Hawaiian or Other Pacific Islander group, one indicator (*Immunizations for Adolescents—Combination 2*) was excluded from the indicator count due to a small numerator (i.e., less than 11).

---

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

American Indian or Alaska Native

♦ For the Appropriate Treatment and Utilization domain, a majority of the indicator rates for the American Indian or Alaska Native group were **better** than the rates for the White group.

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

Asian

♦ For the following domains, a majority of the indicator rates for the Asian group were **better** than the rates for the White group:

  ▪ Preventive Screening and Children's Health

  ▪ Preventive Screening and Women's Health

  ▪ Care for Chronic Conditions

♦ There were no domains where a majority of the indicator rates for the Asian group were **worse** than the rates for the White group.

Black or African American

♦ For the Appropriate Treatment and Utilization domain, a majority of the indicator rates for the Black or African American group were **better** than the rates for the White group.

♦ For the Preventive Screening and Women's Health domain, a majority of the indicator rates for the Black or African American group were **worse** than the rates for the White group.

Hispanic or Latino

♦ For the following domains, a majority of the indicator rates for the Hispanic or Latino group were **better** than the rates for the White group:

  ▪ Preventive Screening and Children's Health

  ▪ Preventive Screening and Women's Health

♦ There were no domains where a majority of the indicator rates for the Hispanic or Latino group were **worse** than the rates for the White group.

Native Hawaiian or Other Pacific Islander

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

♦ For the following domains, a majority of the indicator rates for the Native Hawaiian or Other Pacific Islander group were **worse** than the rates for the White group:

  ▪ Preventive Screening and Children's Health

  ▪ Preventive Screening and Women's Health

Other

♦ For the Preventive Screening and Women's Health domain, a majority of the indicator rates for the Other group were **better** than the rates for the White group.

♦ There were no domains where a majority of the indicator rates for the Other group were **worse** than the rates for the White group.

Overall Conclusions and Items for Consideration

Within the Medi-Cal analysis, the rates for the Black or African American group were worse than those for the White group for 38 percent of indicators in the analysis. All indicators for which the Black or African American group rates were worse than those for the White group were related to health outcomes or access to care. Similarly, the rates for the Native Hawaiian or Other Pacific Islander group and the American Indian or Alaska Native group were worse than those for the White group for 32 percent and 15 percent, respectively, of indicators in the analysis. DHCS should consider opportunities to increase MCP member-level engagement to identify contributors to disparities and strategies to address disparities where possible. Additionally, the rates for the Asian group were better than the rates for the White group for 65 percent of the indicators included in the analysis. DHCS should consider analyzing these health disparities further to determine the additional factors that may be associated with higher rates for the Asian group. Further, although Asian languages were analyzed as part of the primary language analysis, DHCS should consider analyzing the Asian sub-populations that comprise the Asian group in more detail (e.g., at the racial/ethnic level) to determine if findings are consistent across all sub-populations. Lastly, 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 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 every indicator.

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 23 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
Alameda Alliance for Health	Alameda
Anthem Blue Cross Partnership Plan	Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Inyo, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, San Francisco, Sacramento, San Benito, Santa Clara, Sierra, Sutter, Tehama, Tuolumne, Tulare, Yuba
Blue Shield Promise	San Diego
CalOptima	Orange
CalViva	Fresno, Kings, Madera
California Health & Wellness Plan	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba
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
Health Net Community Solutions, Inc.	Kern, Los Angeles, Sacramento, San Diego, San Joaquin, Stanislaus, Tulare
Health Plan of San Joaquin	San Joaquin, Stanislaus

MCP Name	Counties
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 Family Health Care	Kern
LA Care Health Plan	Los Angeles
Molina Healthcare of California Partner Plan, Inc.	Imperial, Riverside, Sacramento, San Bernardino, San Diego
Partnership Health Plan 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

Summary of EAS Performance Measures

DHCS selected 28 EAS indicators reported by the 23 full-scope Medi-Cal MCPs for inclusion in the analysis and report. The indicators were grouped into the following domains of care: Preventive Screening and Children's Health, Preventive Screening and Women's Health, Care for Chronic Conditions, and Appropriate Treatment and Utilization. While health disparities are displayed and discussed primarily at the indicator level in this report, grouping these indicators into domains allows Medi-Cal MCPs and DHCS to consider the results as a whole rather than in isolation when developing strategic changes to improve health care for Medi-Cal beneficiaries.

Table 2.2 displays the selected EAS indicators included in the analysis by domain. The EAS indicator set included 27 HEDIS indicators and one indicator originally developed by DHCS and MCPs (with guidance from HSAG) for a total of 28 EAS indicators.

Table 2.2—EAS Measure Indicators

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

Methodology Overview

For the 2016–2017 contract year, HSAG evaluated EAS indicator data collected for reporting year 2017 at the statewide level, which consists of data collected during calendar year 2016 also known as HEDIS measurement year 2016. HSAG aggregated the results from the 23 full-scope MCPs and then stratified these statewide rates for all EAS indicators by demographic stratifications (i.e., race/ethnicity, primary language, age, and gender).

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

The information below provides a high-level overview of the health disparities analyses conducted on the reporting year 2017 data for DHCS. For the detailed methodology, please see Appendix B.

Data Sources

As required by the National Committee for Quality Assurance (NCQA), each MCP submitted patient-level detail (PLD) files containing beneficiary-level information, including the member ID, date of birth, member months, and gender for beneficiaries included in the audited HEDIS rates. Additionally, the PLD files indicate whether a beneficiary was included in the numerator and/or denominator for each applicable HEDIS indicator. Each MCP also submitted separate PLD files for the *Ambulatory Care* and *All-Cause Readmissions* indicators, which only contained information regarding numerator and denominator criteria for those three indicators. HSAG validated the reporting year 2017 PLD files against the audited HEDIS Interactive Data Submission System (IDSS) files to confirm numerator and denominator counts matched for each EAS indicator. Additionally, DHCS provided supplemental files with demographic data (e.g., date of birth, gender, ZIP code, race/ethnicity, primary language) from DHCS' Management Information System/Decision Support System (MIS/DSS) data system.

Statistical Analysis

HSAG combined the demographic PLD files and the measure PLD 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 a majority of national health disparities reports and has historically been used as a reference point for reporting health care and non-health care disparities.

---

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

HSAG performed the logistic regression using SAS® software.[9] 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, <u>and</u> 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, <u>and</u> the rate for the racial/ethnic group was lower or less favorable than the rate for the reference group. In other words, the racial/ethnic group being evaluated showed a health disparity compared to the reference group.
♦ **Similar Rate** = The absolute difference from the reference group was less than 3 percentage points or the *p*-value of the coefficient of the logistic regression was greater than or equal to 0.05. This means no health disparities were identified when the racial/ethnic group was compared to the reference group.

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

Evaluating Results

Within Section 3 of this report, indicator results are grouped and discussed by domain as shown in Table 2.2, starting with an overall domain-level figure. Following each domain-level figure, the narrative is organized by racial/ethnic group and describes indicators for which the rates for the racial/ethnic group were better than or worse than the rates for the White group. The results of the aggregate health disparity analyses for 26 EAS indicators are presented within horizontal bar graphs in Section 3. Of note, due to limitations with the data, HSAG did not perform statistical analyses to identify health disparities for the *Ambulatory Care* indicators; therefore, these indicators are not included in Section 3 and are only presented in Appendix A. Within Appendix A, HSAG also presents indicator rates for the primary language, age, and

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

gender 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 four EAS indicators (*Childhood Immunization Status—Combination 3*, *Prenatal and Postpartum Care—Postpartum Care*, *Comprehensive Diabetes Care—HbA1c Testing*, *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*).

Figure Interpretation

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

Figure 2.1—Sample Domain-Level Horizontal Stacked Bar Graph

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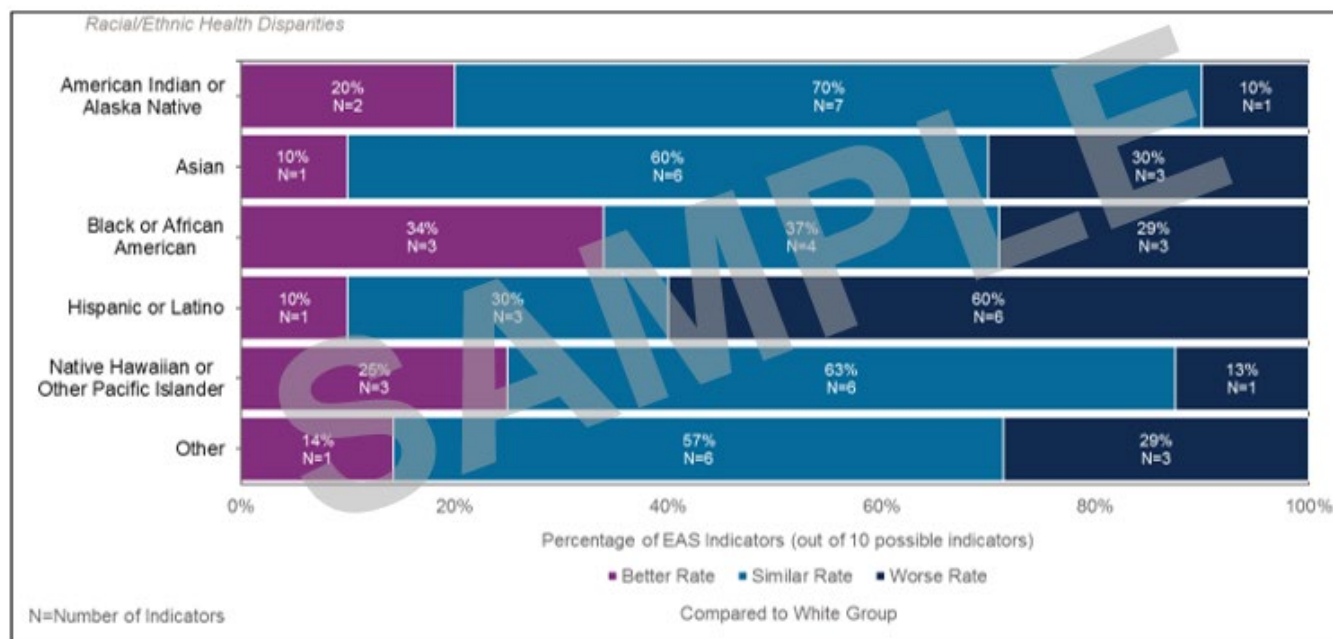
Additionally, the "Executive Summary" includes a similar overall horizontal stacked bar graph that displays the percentage of EAS indicators that had a better rate, worse rate, or similar rate to the White group for each racial/ethnic group across all indicators.

For each EAS indicator presented within Section 3 of this report, horizontal bar graphs display the rates for each racial/ethnic group. 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 below 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 (HMO) 25th percentile for HEDIS 2017.[10] 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 EAS 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). An example of the horizontal bar graph figure is shown in Figure 2.2. All data in the sample figure are mock data.

Figure 2.2—Sample Indicator-Level Horizontal Bar Graph Figure

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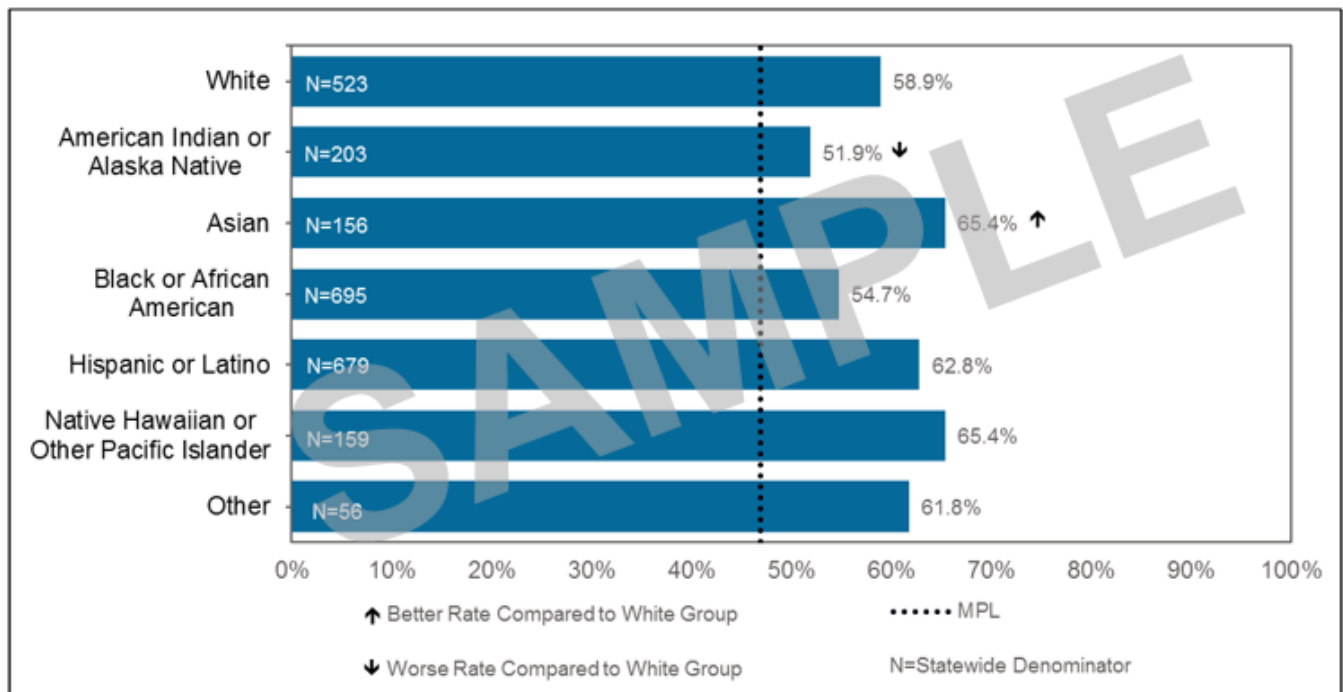
Note: The rate for the Unknown/Missing group was 60.9 percent (N=75).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

---

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

Within Appendix A, horizontal bar graphs display the EAS indicator rates by demographic stratification (primary language, age, and gender). Statistical analysis was not performed on these demographic stratifications to identify health disparities; therefore, these rates are for information purposes only. When available, the figures also display the minimum performance level for the corresponding EAS indicator that represents the national Medicaid 25th 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 EAS indicator. "N" represents the total statewide denominator for an indicator for a particular group. A "Note" is included below 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 age is shown in Figure 2.3. All data in the sample figure are mock data.

Figure 2.3—Sample Horizontal Stacked Bar Graph by Demographic Stratification Figure

FIGURE CONTAINS MOCK DATA

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

Choropleth Map Interpretation

The choropleth maps highlight regional performance differences for the select EAS indicators. HSAG first assigned a county to each beneficiary based on the county code provided in the DHCS demographic file. If the county code was missing for a beneficiary in the demographic

data file, HSAG 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 beneficiaries within a county. For each indicator, HSAG and DHCS determined cut points (e.g., 60.00%, 65.00%, 70.00%, 80.00%) based on the distribution of county-level rates to display the variation of county performance. HSAG then created performance levels (Lowest Performance [dark blue], Low Performance [light blue], Middle/Average Performance [gray], High Performance [light magenta], and Highest Performance [magenta]) based on the cut points for each indicator. Once the performance levels were set for each indicator, each county was shaded the corresponding color of the performance level.

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

Table 2.3—Performance Level and Corresponding Colors

Indicator	Performance Level and Corresponding Colors
Childhood Immunization Status—Combination 3	Below 60.00%
	60.00% to 64.99%
	65.00% to 69.99%
	70.00% to 79.99%
	80.00%+
Prenatal and Postpartum Care—Postpartum Care	Below 55.00%
	55.00% to 63.99%
	64.00% to 67.99%
	68.00% to 71.99%
	72.00%+
Comprehensive Diabetes Care—HbA1c Testing	Below 83.00%
	83.00% to 85.49%
	85.50% to 87.49%
	87.50% to 89.99%
	90.00%+

Indicator	Performance Level and Corresponding Colors
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Below 25.00%
	25.00% to 29.99%
	30.00% to 34.99%
	35.00% to 39.99%
	40.00%+

Cautions and Limitations

Hybrid Indicators

For hybrid measures/indicators, NCQA recommends the submission of a sample of 411 beneficiaries per reporting unit to limit bias and to allow for results from the sample to be generalizable to the entire eligible population. As the rates for individual strata will be based on fewer than 411 beneficiaries, it should be noted that the stratified rates may not be generalizable to the total eligible population. Due to this caveat, the stratified rates produced for hybrid measures should be interpreted with caution. Of note, HSAG pulled a random sample of 411 beneficiaries for each Kaiser reporting unit for hybrid measures since Kaiser reported all measures that allowed for the hybrid option using administrative data only (except *Controlling High Blood Pressure*). HSAG pulled a random sample for the Kaiser reporting units to limit the overrepresentation of Kaiser beneficiaries toward the statewide average for hybrid measures. Additionally, HSAG did not weight the statewide rates for hybrid measures by the total eligible population; so, all MCPs, regardless of size, count equally toward the statewide rates. As such, performance may not be representative of actual statewide performance.

Limiting Beneficiaries

To match the age parameters for each indicator, HSAG limited the analysis to beneficiaries whose age was in one of the valid age groups for each indicator. For indicators in the Preventive Screening and Women's Health domain, HSAG only kept beneficiaries who were identified as female in the demographic file. Further, for the *Breast Cancer Screening* indicator and *Cervical Cancer Screening* indicator, the age groups were limited to women 52 to 74 years of age and 24 to 64 years of age, respectively. Additionally, HSAG included the "Unknown/Missing" group for race/ethnicity, primary language, and gender in the formal report as a footnote beneath the figures. Please note that for gender, "Unknown/Missing" data was only available for *All-Cause Readmissions* and *Ambulatory Care*; therefore, a footnote for "Unknown/Missing" is only included on the gender figures for those measures.

Geographic Variability

The results of the geographic variability analysis should be interpreted with caution because HSAG did not weight the county rates for hybrid indicators by the total eligible population. Due to this, all MCPs, regardless of size, count equally toward the county rates.

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

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

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

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

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

Group	Better Rate	Similar Rate	Worse Rate
American Indian or Alaska Native		100% N=9	
Asian	78% N=7	22% N=2	
Black or African American	22% N=2	44% N=4	33% N=3
Hispanic or Latino	100% N=9		
Native Hawaiian or Other Pacific Islander		50% N=4	50% N=4
Other	44% N=4	56% N=5	

Percentage of Total EAS Indicators (out of 9 possible indicators)
■ Better Rate ■ Similar Rate ■ Worse Rate

N=Number of Indicators   Compared to White Group

American Indian or Alaska Native

♦ No rates for the American Indian or Alaska Native group were **better** than or **worse** than the rates for the White group.

Asian

♦ For the following indicators, the rates for the Asian group were **better** than the rates for the White group:

- *Childhood Immunization Status—Combination 3*
- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Immunizations for Adolescents—Combination 2*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

♦ No rates for the Asian group were **worse** than the rates for the White group.

Black or African American

♦ For the following indicators, the rates for the Black or African American group were **better** than the rates for the White group:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*

♦ For the following indicators, the rates for the Black or African American group were **worse** than the rates for the White group:

- *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*
- *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Hispanic or Latino

♦ All nine indicator rates for the Hispanic or Latino group were **better** than the rates for the White group.

Native Hawaiian or Other Pacific Islander

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

♦ For the following indicators, the rates for the Native Hawaiian or Other Pacific Islander group were **worse** than the rates for the White group:

■ *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months*

■ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years*

■ *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years*

■ *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years*

Other

♦ For the following indicators, the rates for the Other group were **better** than the rates for the White group:

■ *Childhood Immunization Status—Combination 3*

■ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total*

■ *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total*

■ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

♦ No rates for the Other group were **worse** than the rates for the White group.

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

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

Childhood Immunization Status—Combination 3 (CIS–3)

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

Figure 3.2—Childhood Immunization Status—Combination 3 (CIS–3) Rates by Race/Ethnicity
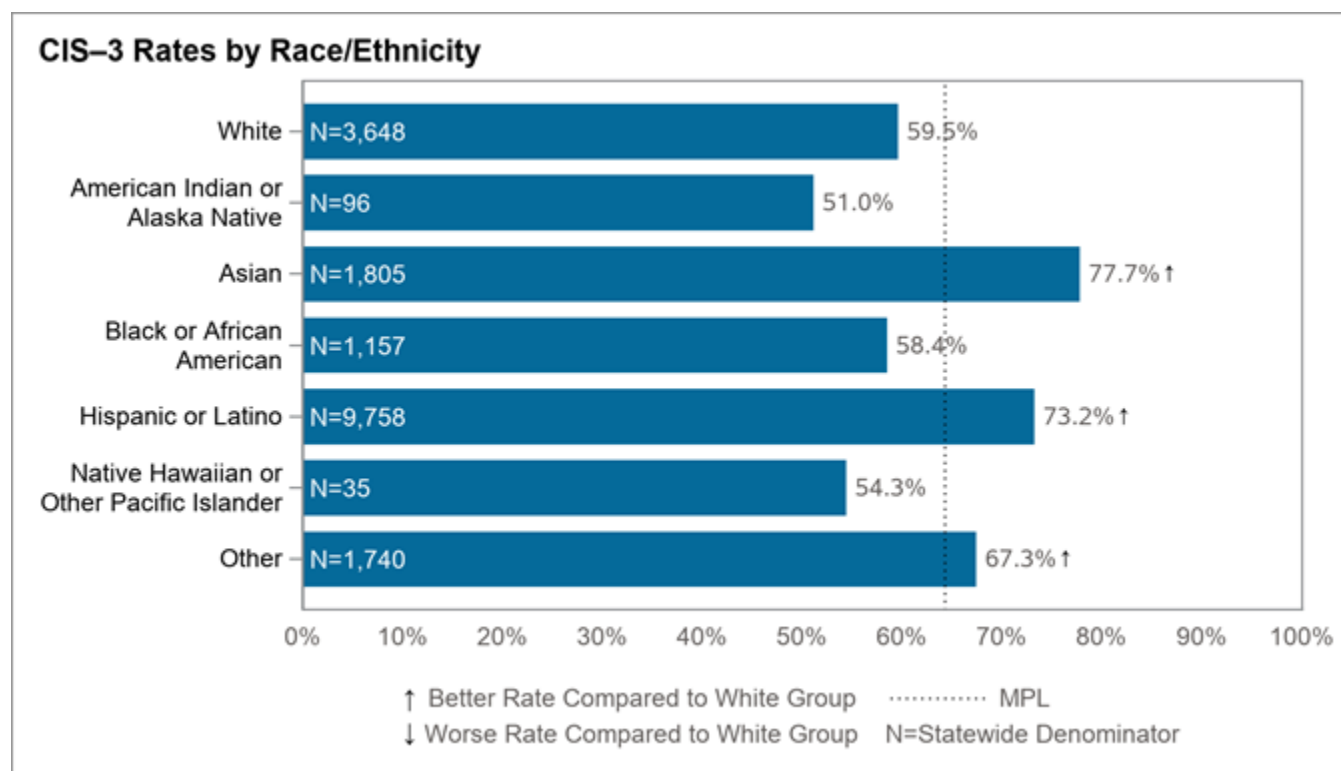
Note: The rate for the Unknown/Missing group was 64.5 percent (N=1,746).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 51.0 percent for the American Indian or Alaska Native group to 77.7 percent for the Asian group.

♦ Three health disparities were identified for the *Childhood Immunization Status—Combination 3* indicator:

   ■ The rate for the Asian group was **better** than the rate for the White group.

   ■ The rate for the Hispanic or Latino group was **better** than the rate for the White group.

   ■ The rate for the Other group was **better** than the rate for the White group.

♦ The 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

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

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

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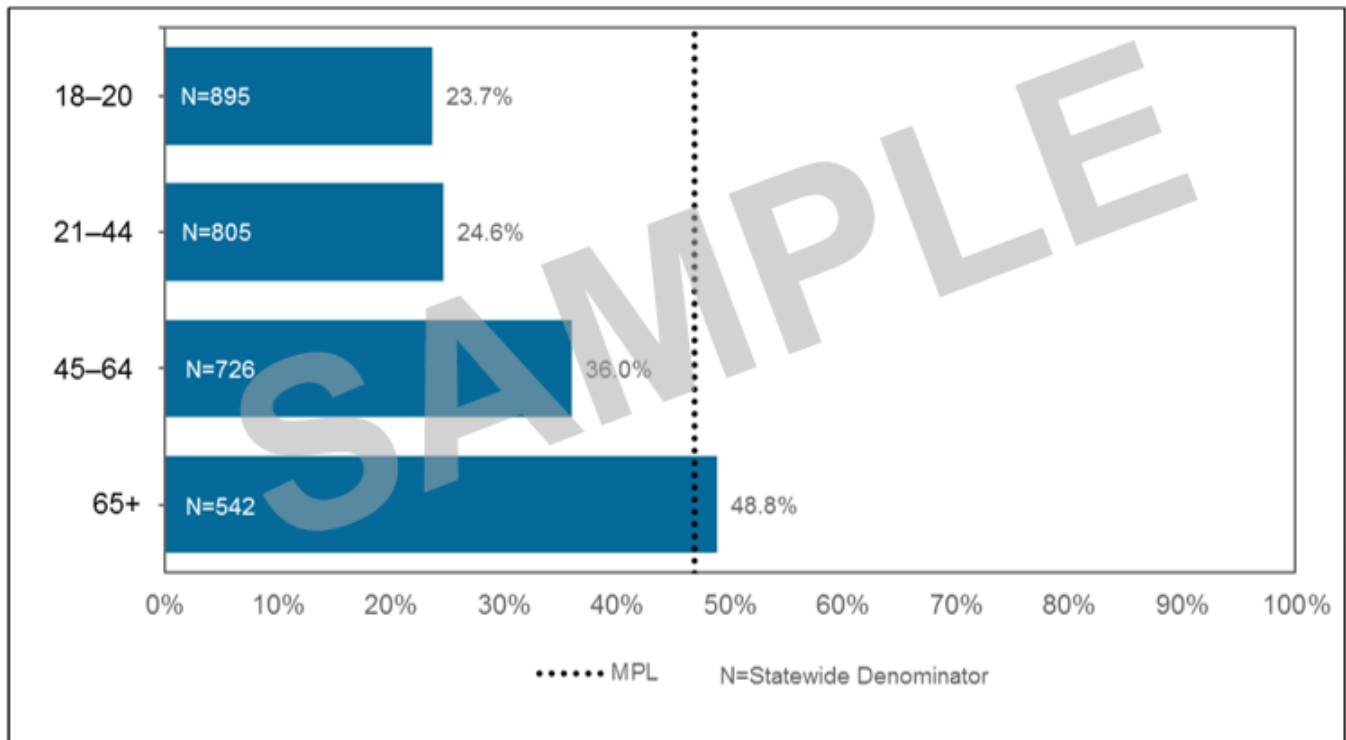

Note: The rate for the Unknown/Missing group was 92.1 percent (N=15,085).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 87.4 percent for the Native Hawaiian or Other Pacific Islander group to 94.5 percent for the Hispanic or Latino group.

♦ Two health disparities were identified for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months* indicator:

■ The rate for the Hispanic or Latino group was **better** than the rate for the White group.

■ The rate for the Native Hawaiian or Other Pacific Islander group was **worse** than the rate for the White group.

♦ The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:

  ■ White

  ■ American Indian or Alaska Native

  ■ Black or African American

  ■ Native Hawaiian or Other Pacific Islander

  ■ Other

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

The *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* (*CAP–256*) indicator measures the percentage of beneficiaries 25 months to 6 years of age who had a visit with a PCP. Figure 3.4 displays the statewide *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* (*CAP–256*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

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

Note: The rate for the Unknown/Missing group was 81.3 percent (N=51,627).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 75.1 percent for the Native Hawaiian or Other Pacific Islander group to 86.4 percent for the Hispanic or Latino group.

♦ Four health disparities were identified for the *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years* indicator:

- The rate for the Asian group was **better** than the rate for the White group.
- The rate for the Hispanic or Latino group was **better** than the rate for the White group.
- The rate for the Black or African American group was **worse** than the rate for the White group.

■ The rate for the Native Hawaiian or Other Pacific Islander group was **worse** than the rate for the White group.

♦ The rates for the following racial/ethnic groups were below the minimum performance level for this indicator:

■ White

■ American Indian or Alaska Native

■ Asian

■ Black or African American

■ Native Hawaiian or Other Pacific Islander

■ Other

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

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

Figure 3.5—Children and Adolescents' Access to Primary Care Practitioners— 7 to 11 Years (CAP–711) Rates by Race/Ethnicity
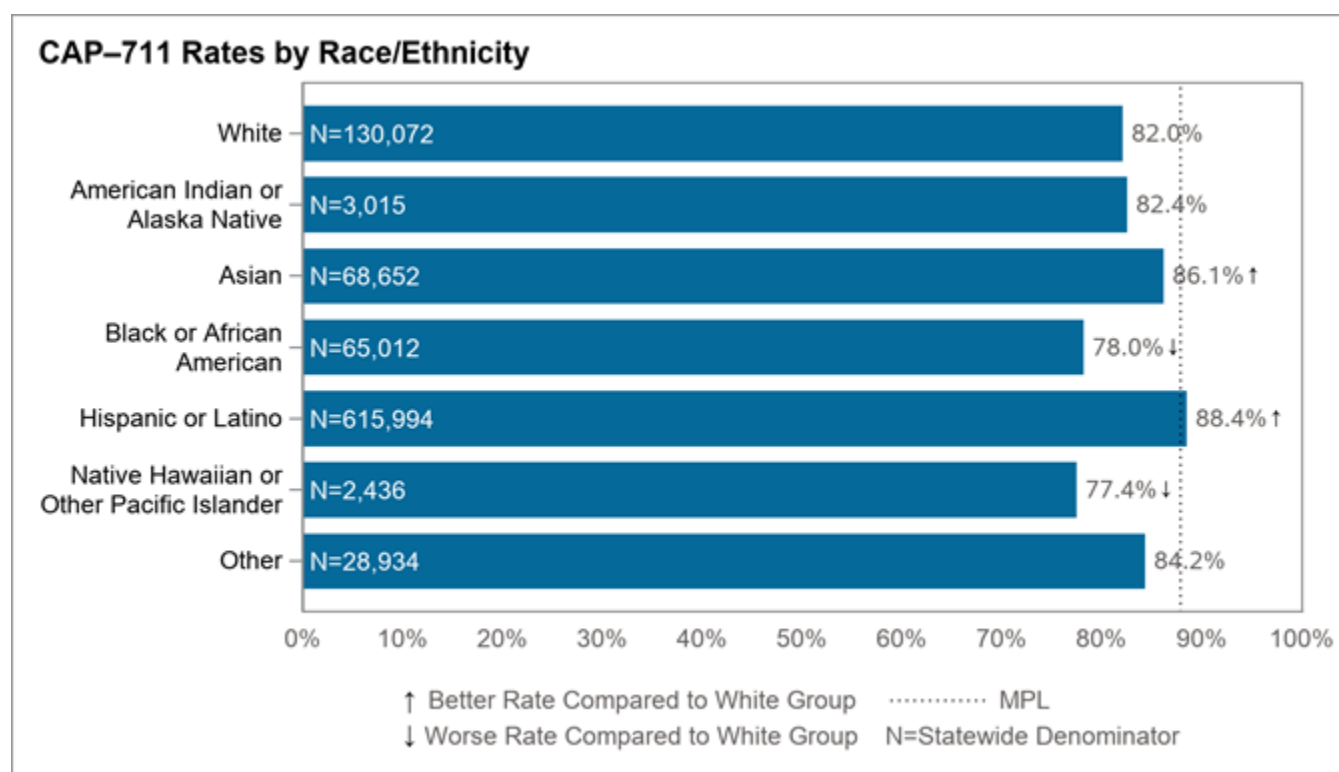
Note: The rate for the Unknown/Missing group was 82.7 percent (N=22,671).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 77.4 percent for the Native Hawaiian or Other Pacific Islander group to 88.4 percent for the Hispanic or Latino group.

♦ Four health disparities were identified for the *Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years* indicator:

  ▪ The rate for the Asian group was **better** than the rate for the White group.

  ▪ The rate for the Hispanic or Latino group was **better** than the rate for the White group.

  ▪ The rate for the Black or African American group was **worse** than the rate for the White group.

- ■ The rate for the Native Hawaiian or Other Pacific Islander group was **worse** than the rate for the White group.
- ♦ The rate for the following racial/ethnic groups were below the minimum performance level for this indicator:
  - ■ White
  - ■ American Indian or Alaska Native
  - ■ Asian
  - ■ Black or African American
  - ■ Native Hawaiian or Other Pacific Islander
  - ■ Other

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

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

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

CAP–1219 Rates by Race/Ethnicity

Race/Ethnicity	Denominator	Rate
White	N=178,355	80.3%
American Indian or Alaska Native	N=4,410	81.9%
Asian	N=117,244	82.1%
Black or African American	N=87,506	76.9% ↓
Hispanic or Latino	N=768,761	85.5% ↑
Native Hawaiian or Other Pacific Islander	N=3,066	75.9% ↓
Other	N=41,399	82.2%

↑ Better Rate Compared to White Group ⋯⋯⋯ MPL
↓ Worse Rate Compared to White Group N=Statewide Denominator
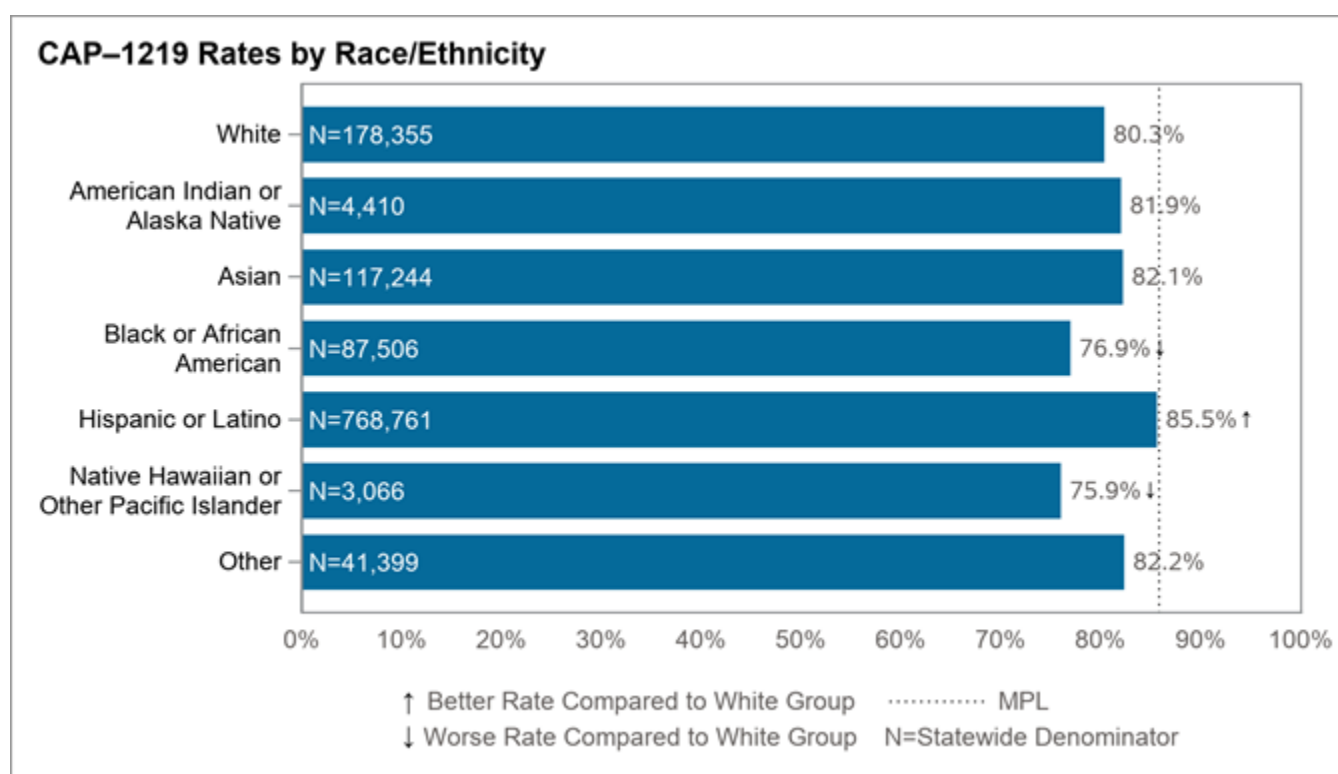
Note: The rate for the Unknown/Missing group was 78.9 percent (N=28,837).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 75.9 percent for the Native Hawaiian or Other Pacific Islander group to 85.5 percent for the Hispanic or Latino group.

♦ Three health disparities were identified for the *Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years* indicator:

  ■ The rate for the Hispanic or Latino group was **better** than the rate for the White group.

  ■ The rate for the Black or African American group was **worse** than the rate for the White group.

  ■ The rate for the Native Hawaiian or Other Pacific Islander group was **worse** than the rate for the White group.

♦ The rates for all racial/ethnic groups were below the minimum performance level for this indicator.

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 conjugate vaccine; one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine; and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. Figure 3.7 displays the statewide *Immunizations for Adolescents—Combination 2* (*IMA–2*) rates and denominator for each racial/ethnic group in addition to identified health disparities.

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

Note: The rate for the Unknown/Missing group was 20.3 percent (N=503).
Immunizations for Adolescents—Combination 2 is a first-year indicator for reporting year 2017; therefore, the indicator does not have an applicable minimum performance level.
S indicates fewer than 11 cases exist in the numerator for this race/ethnicity group; therefore, HSAG suppresses displaying the rate in this report to satisfy the Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

♦ The reportable rates for all racial/ethnic groups ranged from 13.2 percent for the American Indian or Alaska Native group to 33.8 percent for the Asian group.
♦ Two health disparities were identified for the *Immunizations for Adolescents—Combination 2* indicator:
  ■ The rate for the Asian group was **better** than the rate for the White group.
  ■ The rate for the Hispanic or Latino group was **better** than the rate for the White group.

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

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

Figure 3.8—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total (WCC–N) Rates by Race/Ethnicity
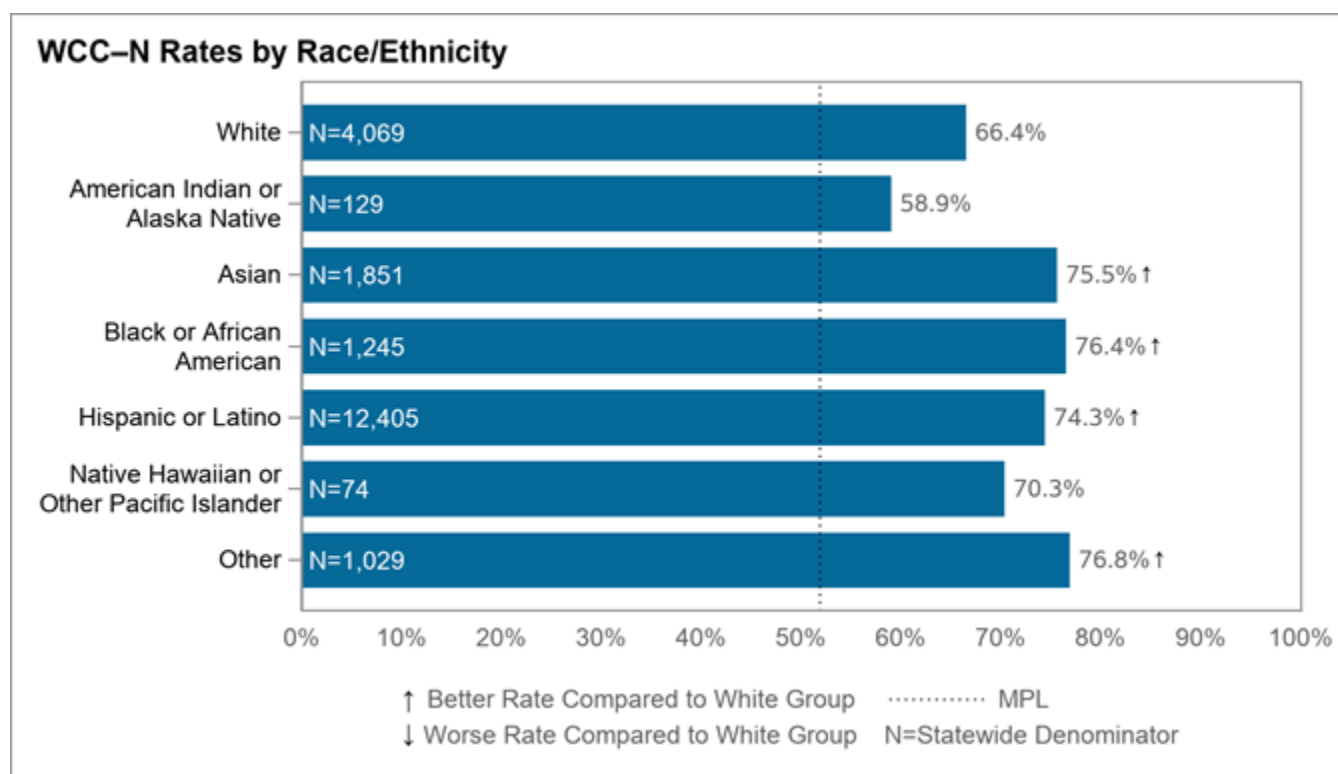
Note: The rate for the Unknown/Missing group was 75.4 percent (N=633).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 58.9 percent for the American Indian or Alaska Native group to 76.8 percent for the Other group.

♦ Four health disparities were identified for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total* indicator:

  ▪ The rate for the Asian group was **better** than the rate for the White group.

- ■ The rate for the Black or African American group was **better** than the rate for the White group.
- ■ The rate for the Hispanic or Latino group was **better** than the rate for the White group.
- ■ The rate for the Other group was **better** than the rate for the White group.
- ♦ No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

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

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

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

WCC–PA Rates by Race/Ethnicity

Race/Ethnicity	Denominator	Rate
White	N=4,069	59.8%
American Indian or Alaska Native	N=129	59.7%
Asian	N=1,851	68.4% ↑
Black or African American	N=1,245	69.4% ↑
Hispanic or Latino	N=12,405	68.0% ↑
Native Hawaiian or Other Pacific Islander	N=74	66.2%
Other	N=1,029	70.1% ↑

↑ Better Rate Compared to White Group ·········· MPL
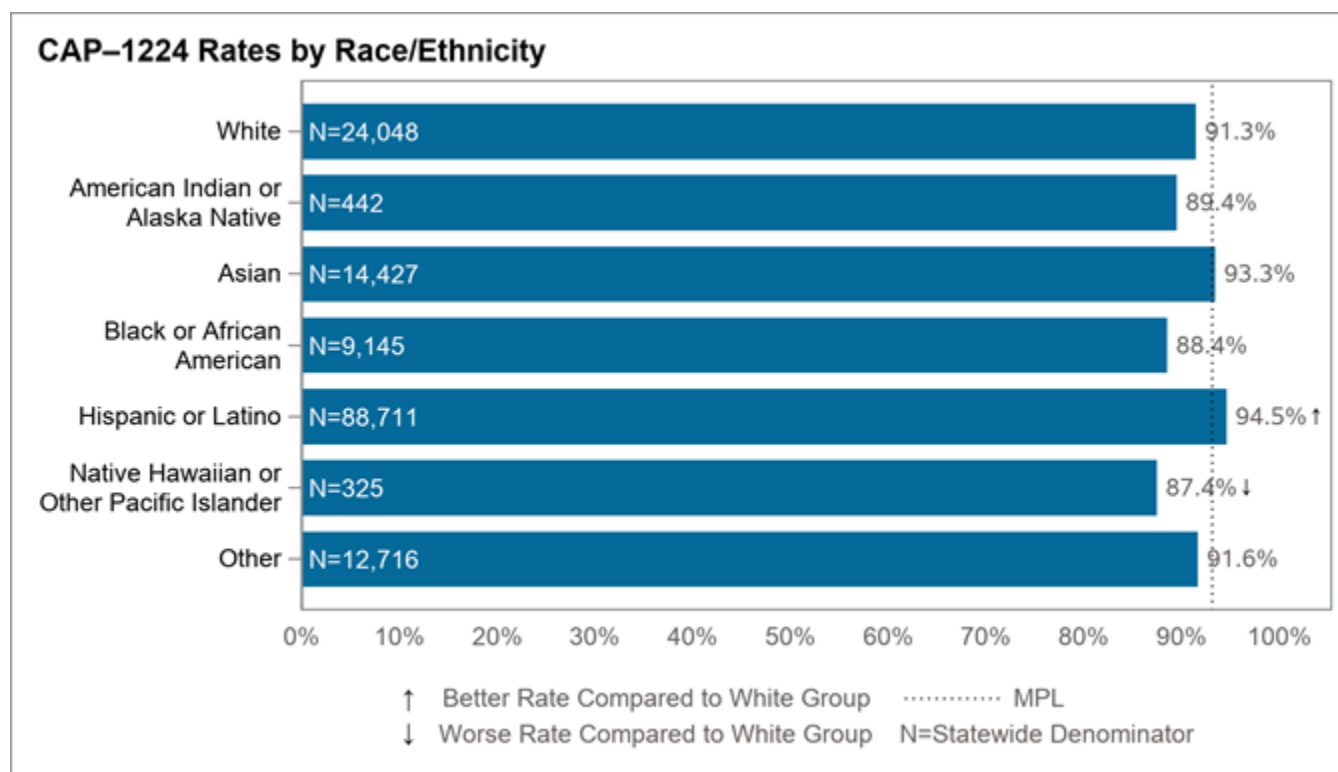↓ Worse Rate Compared to White Group N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 65.6 percent (N=633).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all race/ethnicity groups ranged from 59.7 percent for the American Indian or Alaska Native group to 70.1 percent for the Other group.

♦ Four health disparities were identified for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Physical Activity—Total* indicator:

- ■ The rate for the Asian group was **better** than the rate for the White group.
- ■ The rate for the Black or African American group was **better** than the rate for the White group.
- ■ The rate for the Hispanic or Latino group was **better** than the rate for the White group.
- ■ The rate for the Other group was **better** than the rate for the White group.
- ♦ No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

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

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

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

W–34 Rates by Race/Ethnicity

Race/Ethnicity	N	Rate
White	N=3,947	65.0%
American Indian or Alaska Native	N=114	68.4%
Asian	N=1,506	74.5% ↑
Black or African American	N=1,309	66.8%
Hispanic or Latino	N=11,201	75.0% ↑
Native Hawaiian or Other Pacific Islander	N=56	67.9%
Other	N=1,298	69.0% ↑

↑ Better Rate Compared to White Group   ⋯⋯⋯ MPL
↓ Worse Rate Compared to White Group   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 67.3 percent (N=938).
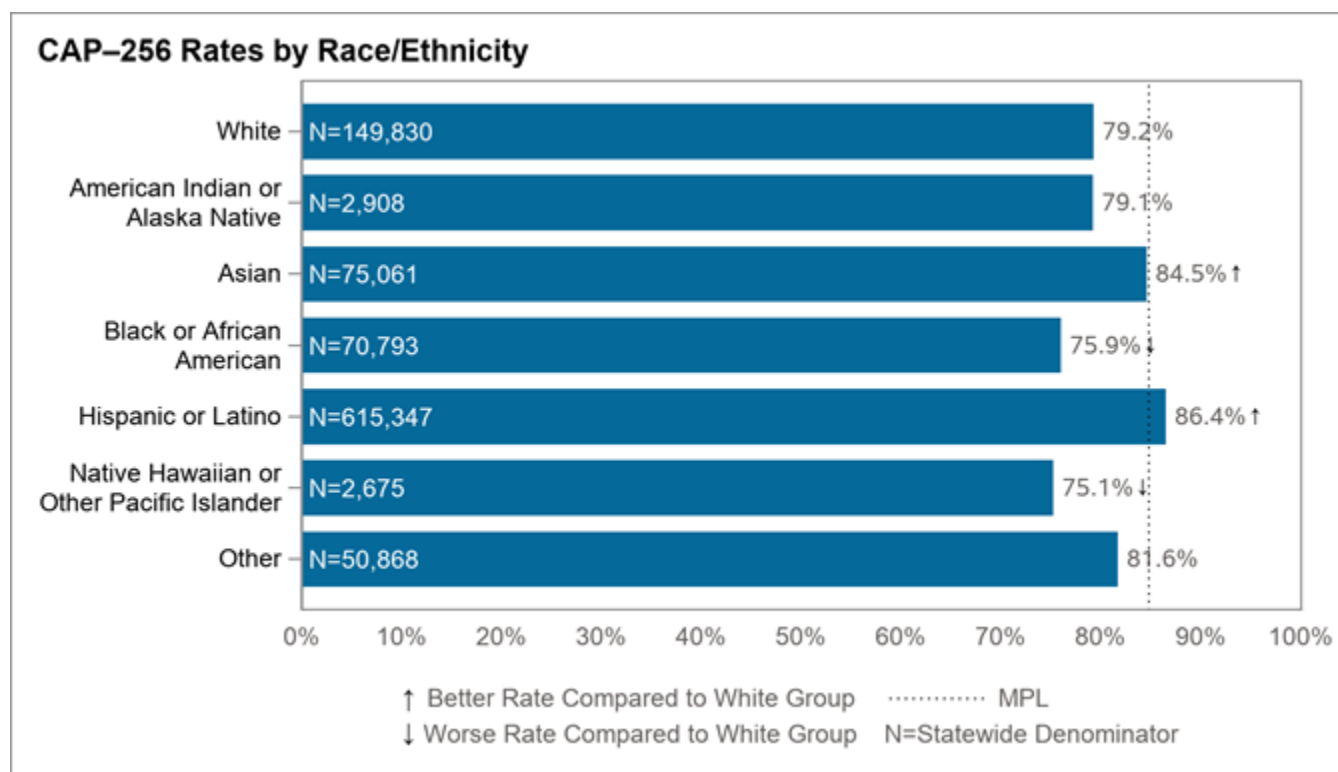The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 65.0 percent for the White group to 75.0 percent for the Hispanic or Latino group.

♦ Three health disparities were identified for the W*ell-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* indicator:
  ▪ The rate for the Asian group was **better** than the rate for the White group.
  ▪ The rate for the Hispanic or Latino group was **better** than the rate for the White group.
  ▪ The rate for the Other group was **better** than the rate for the White group.

♦ No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

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

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

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

American Indian or Alaska Native

♦ No rates for the American Indian or Alaska Native group were **better** than the rates for the White group.

♦ For the following indicators, the rates for the American Indian or Alaska Native group were **worse** than the rates for the White group:

  ■ *Breast Cancer Screening*

  ■ *Prenatal and Postpartum Care—Postpartum Care*

  ■ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Asian

♦ For the following indicators, the rates for the Asian group were **better** than the rates for the White group:

  ■ *Breast Cancer Screening*
  ■ *Cervical Cancer Screening*
  ■ *Prenatal and Postpartum Care—Postpartum Care*

♦ No rates for the Asian group were **worse** than the rates for the White group.

Black or African American

♦ For *Cervical Cancer Screening*, the rate for the Black or African American group was **better** than the rate for the White group.

♦ For the following indicators, the rates for the Black or African American group were **worse** than the rates for the White group:

  ■ *Prenatal and Postpartum Care—Postpartum Care*
  ■ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Hispanic or Latino

♦ For the following indicators, the rates for the Hispanic or Latino group were **better** than the rates for the White group:

  ■ *Breast Cancer Screening*
  ■ *Cervical Cancer Screening*

♦ No rates for the Hispanic or Latino group were **worse** than the rates for the White group.

Native Hawaiian or Other Pacific Islander

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

♦ For the following indicators, the rates for the Native Hawaiian or Other Pacific Islander group were **worse** than the rates for the White group:

  ■ *Prenatal and Postpartum Care—Postpartum Care*
  ■ *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Other

♦ For the following indicators, the rates for the Other group were **better** than the rates for the White group:

  ■ *Breast Cancer Screening*
  ■ *Cervical Cancer Screening*

♦ No rates for the Other group were **worse** than the rates for the White group.

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

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

Breast Cancer Screening (BCS)

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

Figure 3.12—Breast Cancer Screening (BCS) Rates by Race/Ethnicity
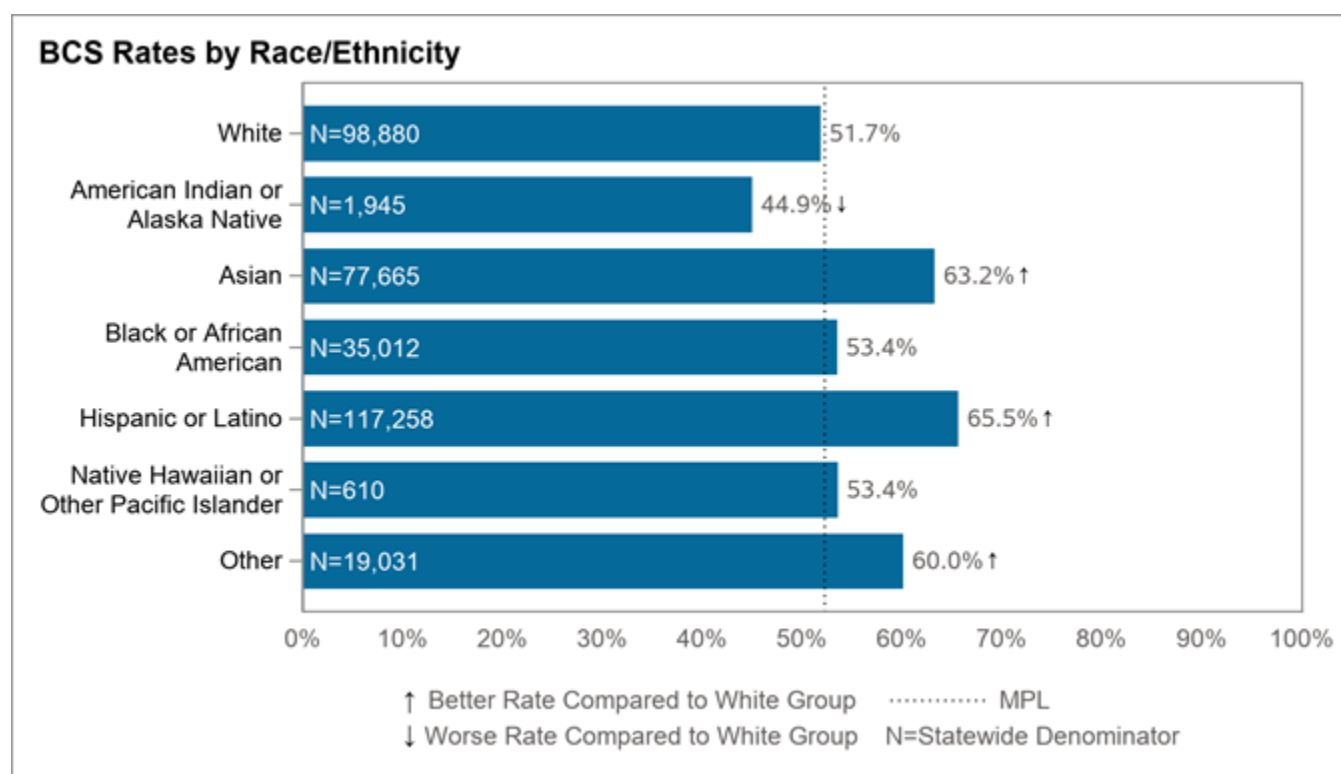
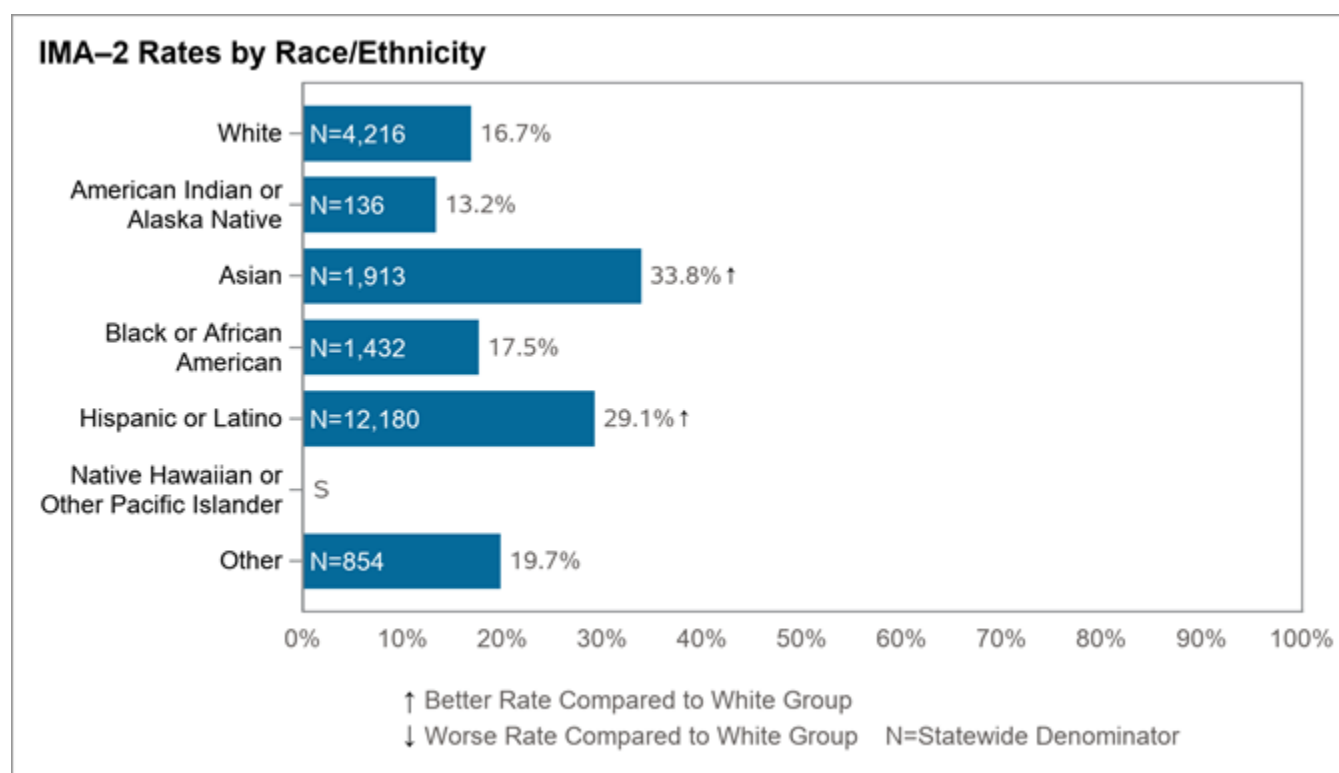Note: The rate for the Unknown/Missing group was 54.0 percent (N=18,973).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 44.9 percent for the American Indian or Alaska Native group to 65.5 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

Cervical Cancer Screening (CCS)

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

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

CCS Rates by Race/Ethnicity

Race/Ethnicity	N	Rate
White	N=7,047	51.7%
American Indian or Alaska Native	N=195	50.3%
Asian	N=3,304	56.1% ↑
Black or African American	N=1,776	55.0% ↑
Hispanic or Latino	N=7,469	58.5% ↑
Native Hawaiian or Other Pacific Islander	N=55	41.8%
Other	N=1,572	57.8% ↑

↑ Better Rate Compared to White Group .... MPL
↓ Worse Rate Compared to White Group N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 50.5 percent (N=655).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 41.8 percent for the Native Hawaiian or Other Pacific Islander group to 58.5 percent for the Hispanic or Latino group.
♦ Four health disparities were identified for the *Cervical Cancer Screening* indicator:
  ▪ The rate for the Asian group was **better** than the rate for the White group.
  ▪ The rate for the Black or African American group was **better** than the rate for the White group.
  ▪ The rate for the Hispanic or Latino group was **better** than the rate for the White group.
  ▪ The rate for the Other group was **better** than the rate for the White group.
♦ The rate for the Native Hawaiian or Other Pacific Islander group was below the minimum performance level for this indicator.

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

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

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

PPC–Pst Rates by Race/Ethnicity

Race/Ethnicity	Denominator	Rate
White	N=4,769	63.2%
American Indian or Alaska Native	N=186	53.2% ↓
Asian	N=2,591	74.1% ↑
Black or African American	N=1,577	49.8% ↓
Hispanic or Latino	N=8,631	65.6%
Native Hawaiian or Other Pacific Islander	N=75	44.0% ↓
Other	N=1,641	65.2%

↑ Better Rate Compared to White Group   ·········· MPL
↓ Worse Rate Compared to White Group   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 68.8 percent (N=282).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.
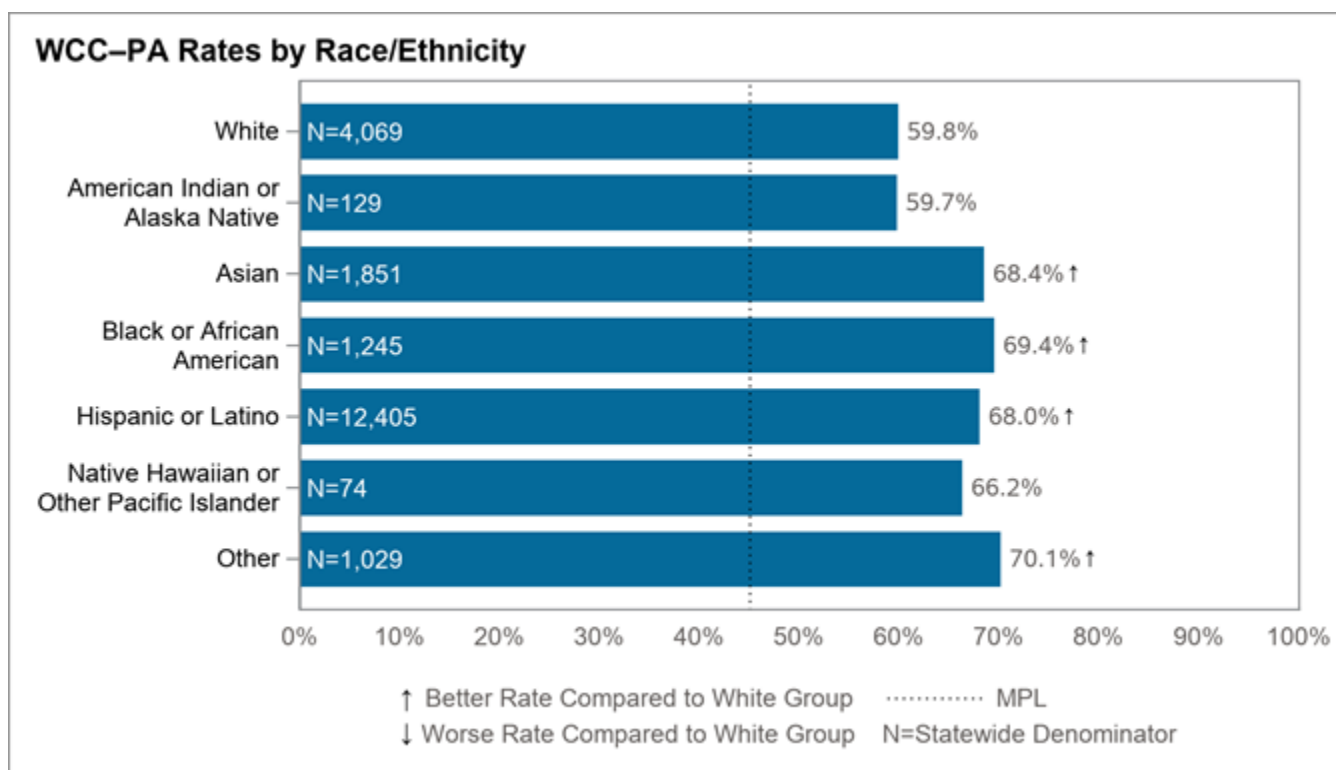
♦ The rates for all racial/ethnic groups ranged from 44.0 percent for the Native Hawaiian or Other Pacific Islander group to 74.1 percent for the Asian group.

♦ Four health disparities were identified for the *Prenatal and Postpartum Care—Postpartum Care* indicator:

■ The rate for the Asian group was **better** than the rate for the White group.

■ The rate for the 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 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:

■ American Indian or Alaska Native

■ Black or African American

■ Native Hawaiian or Other Pacific Islander

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

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

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

PPC–Pre Rates by Race/Ethnicity

Race/Ethnicity	Denominator	Rate
White	N=4,769	83.6%
American Indian or Alaska Native	N=186	76.3%↓
Asian	N=2,591	85.7%
Black or African American	N=1,577	77.2%↓
Hispanic or Latino	N=8,631	82.9%
Native Hawaiian or Other Pacific Islander	N=75	74.7%↓
Other	N=1,641	83.5%

↑ Better Rate Compared to White Group ·········· MPL
↓ Worse Rate Compared to White Group   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 84.8 percent (N=282).

The minimum performance level represents the national Medicaid 25th percentile for this indicator.
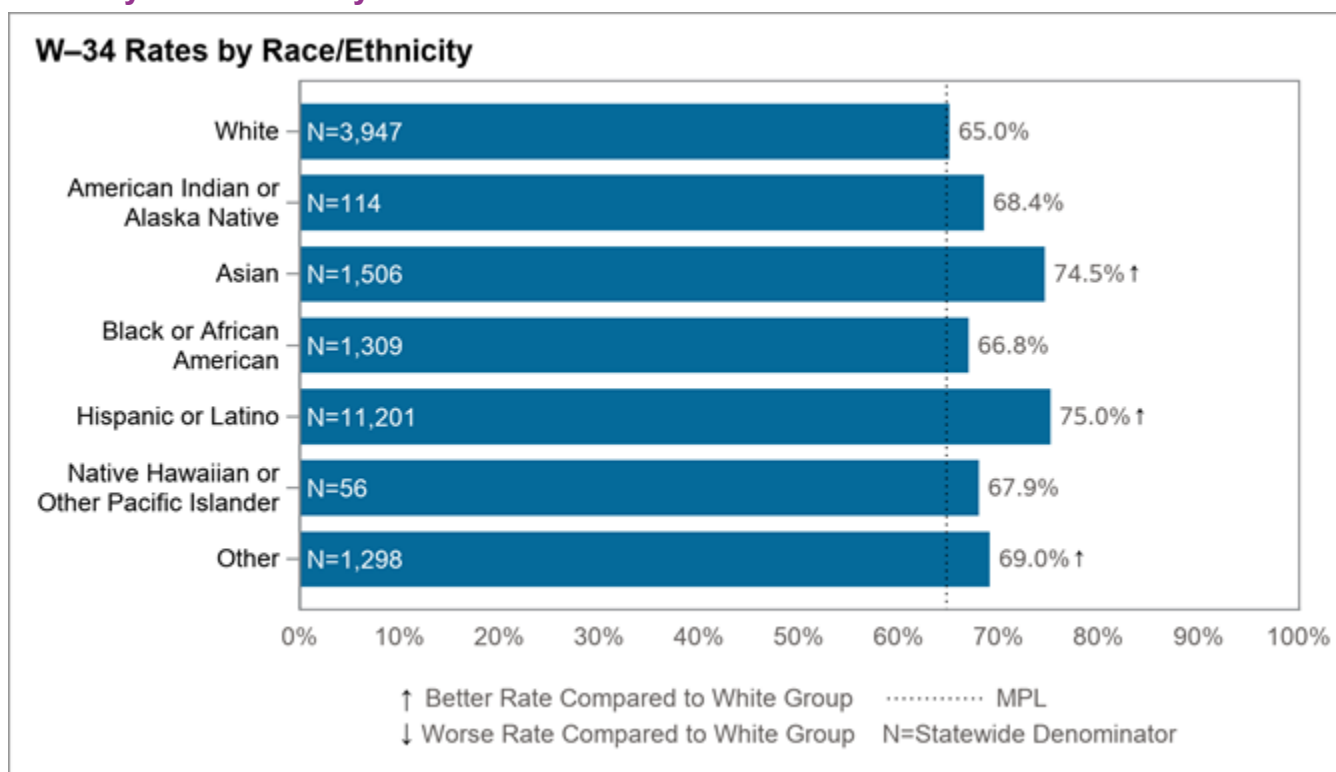
♦ The rates for all racial/ethnic groups ranged from 74.7 percent for the Native Hawaiian or Other Pacific Islander group to 85.7 percent for the Asian group.

♦ Three health disparities were identified for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator:

  ▪ The rate for the American Indian or Alaska Native group was **worse** than the rate for the White group.

  ▪ The rate for the Black or African American group was **worse** than the rate for the White group.

  ▪ The rate for the Native Hawaiian or Other Pacific Islander group was **worse** than the rate for the White group.

♦ No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Racial/Ethnic Health Disparities: Care for Chronic Conditions Domain

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

Figure 3.16—Racial/Ethnic Health Disparities Summary: Care for Chronic Conditions Domain
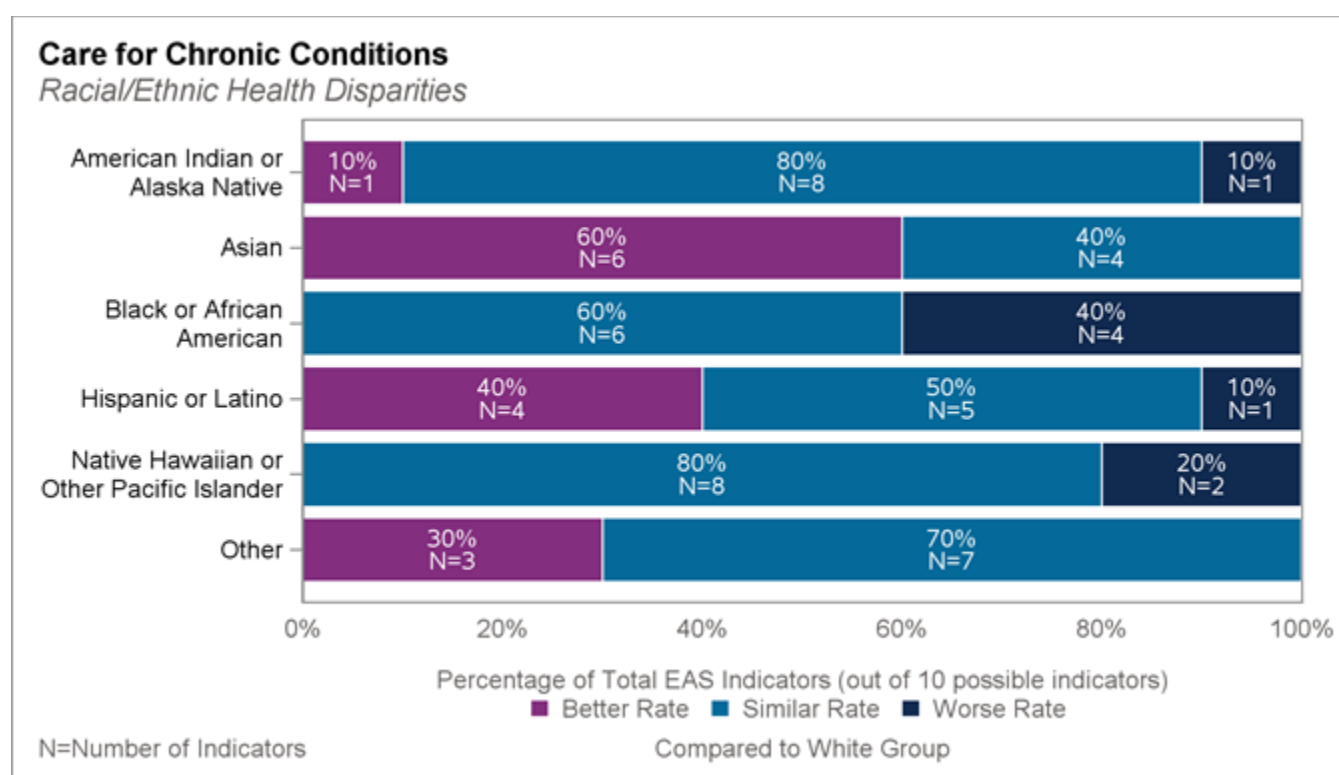
American Indian or Alaska Native

♦ For *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, the rate for the American Indian or Alaska Native group was **better** than the rate for the White group.

♦ For *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*, the rate for the American Indian or Alaska Native group was **worse** than the rate for the White group.

Asian

♦ For the following indicators, the rates for the Asian group were **better** than the rates for the White group:

■ *Asthma Medication Ratio*

■ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

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

■ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

■ *Comprehensive Diabetes Care—HbA1c Testing*

■ *Controlling High Blood Pressure*

♦ No rates for the Asian group were **worse** than the rates for the White group.

Black or African American

♦ No rates for the Black or African American group were **better** than the rates for the White group.

♦ For the following indicators, the rates for the Black or African American group were **worse** than the rates for the White group:

■ *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

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

■ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

■ *Controlling High Blood Pressure*

Hispanic or Latino

♦ For the following indicators, the rates for the Hispanic or Latino group were **better** than the rates for the White group:

■ *Asthma Medication Ratio*

■ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

■ *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*

■ *Annual Monitoring for Patients on Persistent Medications—Diuretics*

♦ *For Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)*, the rate for the Hispanic or Latino group was **worse** than the rate for the White group.

Native Hawaiian or Other Pacific Islander

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

♦ For the following indicators, the rates for the Native Hawaiian or Other Pacific Islander group were **worse** than the rates for the White group:

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

■ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

Other

♦ For the following indicators, the rates for the Other group were **better** than the rates for the White group:

  ■ *Asthma Medication Ratio*

  ■ *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*

  ■ *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*

♦ No rates for the Other group were **worse** than the rates for the White group.

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

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

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

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

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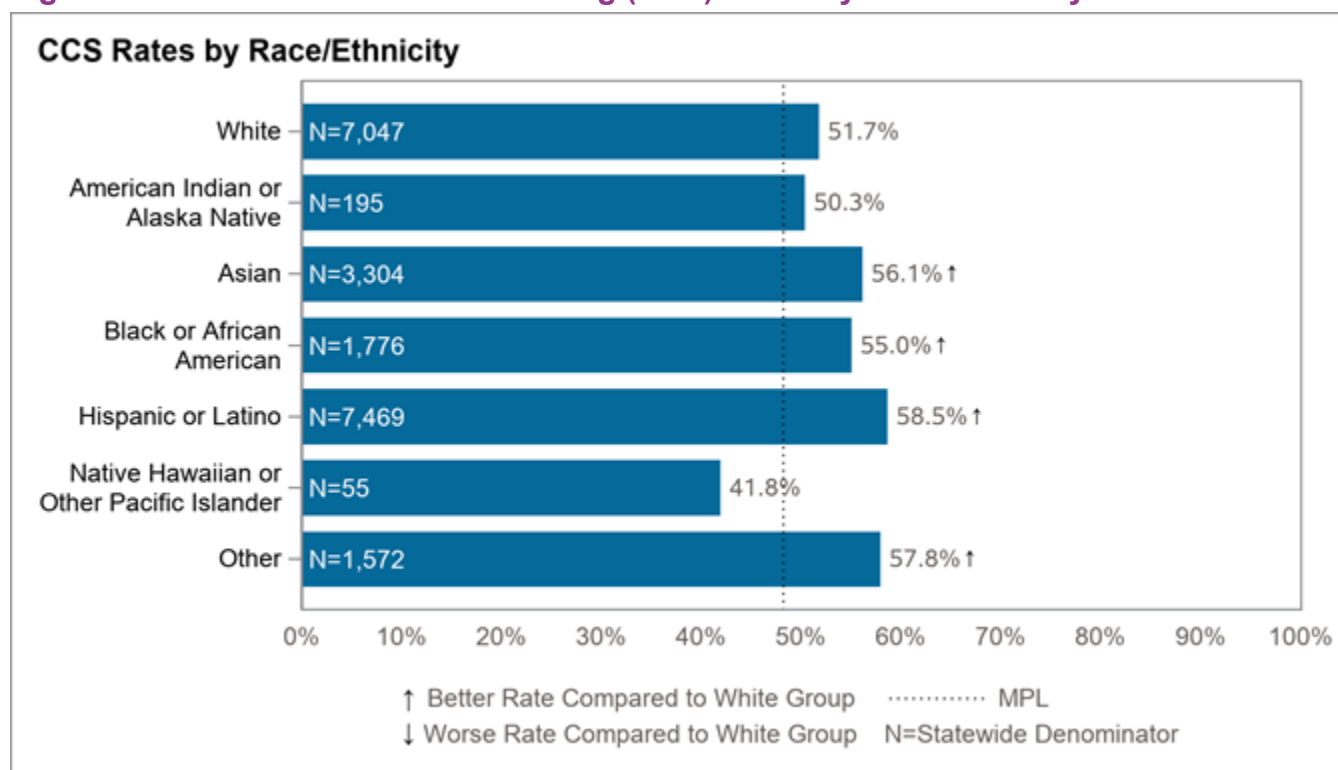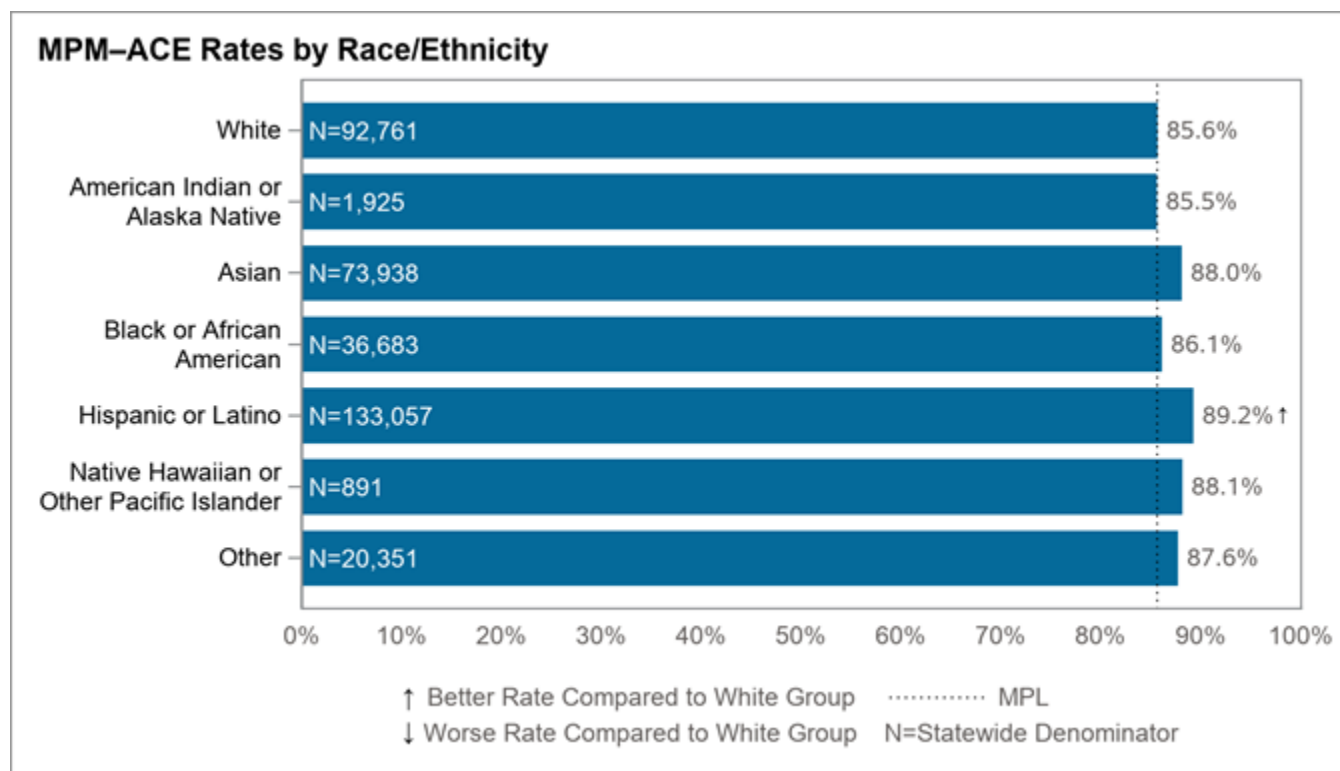

Note: The rate for the Unknown/Missing group was 88.0 percent (N=17,468).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 85.5 percent for the American Indian or Alaska Native group to 89.2 percent for the Hispanic or Latino group.

♦ One health disparity was identified for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* indicator as the rate for the Hispanic or Latino 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

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

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

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

MPM–Diu Rates by Race/Ethnicity

Race/Ethnicity	N	Rate
White	N=56,357	85.8%
American Indian or Alaska Native	N=1,133	87.3%
Asian	N=30,638	87.5%
Black or African American	N=32,450	85.0%
Hispanic or Latino	N=65,007	89.0% ↑
Native Hawaiian or Other Pacific Islander	N=467	86.3%
Other	N=11,161	87.2%

↑ Better Rate Compared to White Group   ┈┈┈┈ MPL
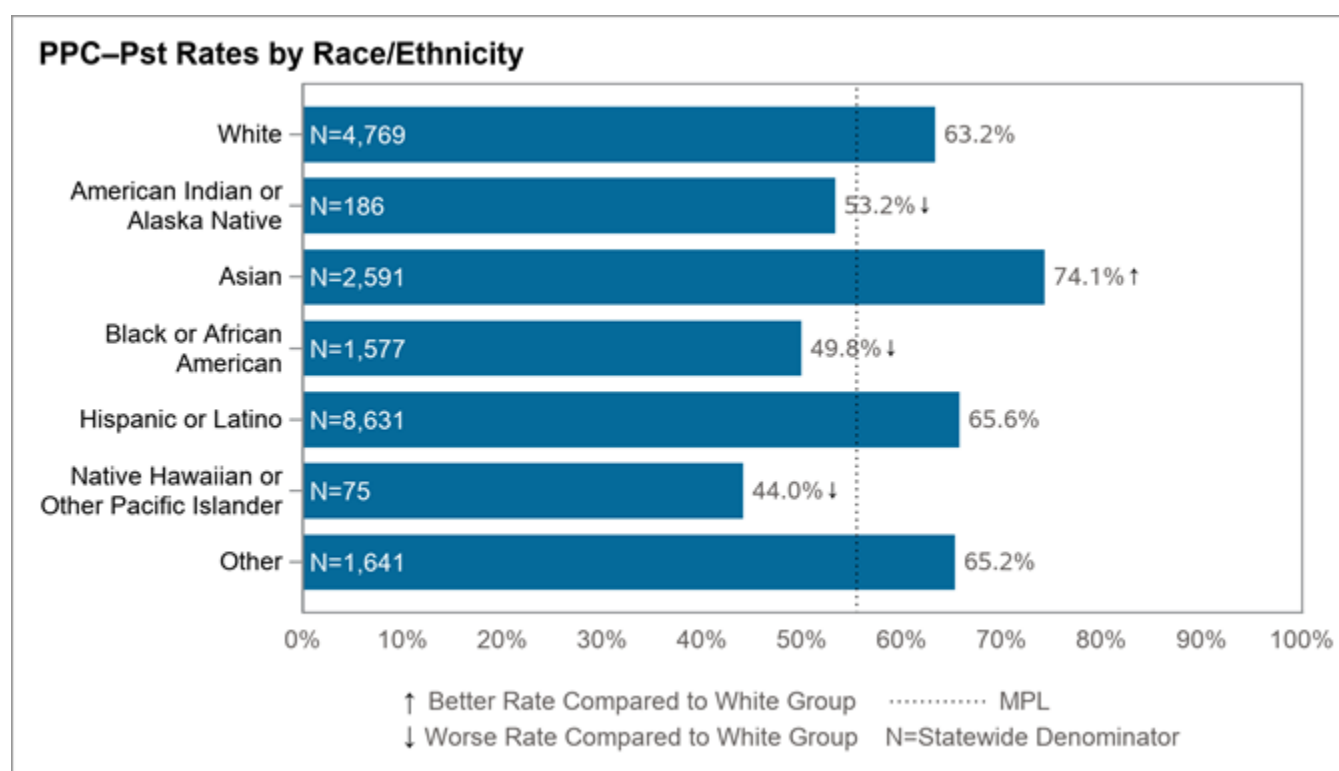↓ Worse Rate Compared to White Group   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 87.6 percent (N=9,711).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 85.0 percent for the Black or African American group to 89.0 percent for the Hispanic or Latino group.

♦ One health disparity was identified for the *Annual Monitoring for Patients on Persistent Medications—Diuretics* indicator as the rate for the Hispanic or Latino group was **better** than the rate for the White group.

♦ The rate for the Black or African American group was below the minimum performance level for this indicator.

Asthma Medication Ratio (AMR)

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

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

AMR Rates by Race/Ethnicity

Race/Ethnicity	N	Rate
White	N=22,320	57.1%
American Indian or Alaska Native	N=571	55.2%
Asian	N=9,022	66.3% ↑
Black or African American	N=13,803	54.7%
Hispanic or Latino	N=42,505	61.9% ↑
Native Hawaiian or Other Pacific Islander	N=237	54.4%
Other	N=3,984	62.6% ↑

↑ Better Rate Compared to White Group   ·········· MPL
↓ Worse Rate Compared to White Group   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 62.1 percent (N=3,701).
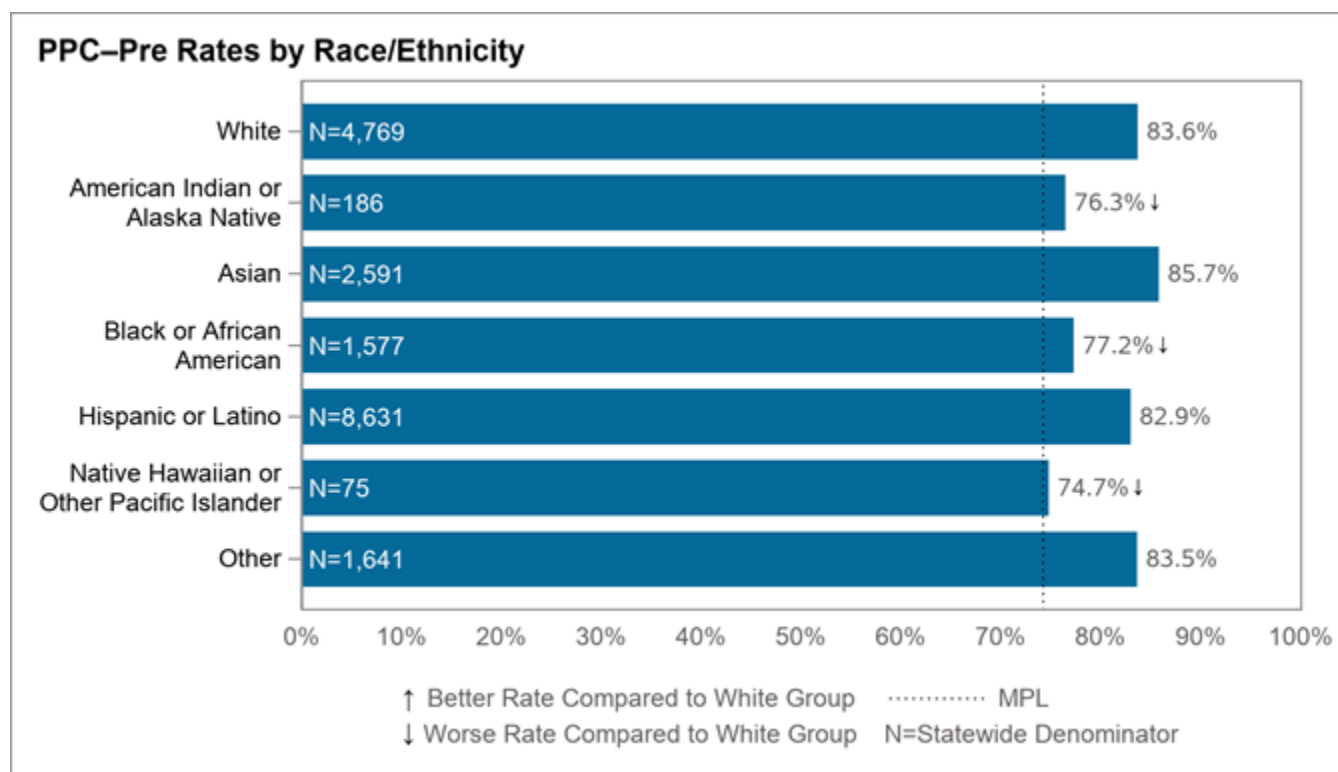The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 54.4 percent for the Native Hawaiian or Other Pacific Islander group to 66.3 percent for the Asian group.
♦ Three health disparities were identified for the *Asthma Medication Ratio* indicator:
 ▪ The rate for the Asian group was **better** than the rate for the White group.
 ▪ The rate for the Hispanic or Latino group was **better** than the rate for the White group.
 ▪ The rate for the Other group was **better** than the rate for the White group.
♦ The rate for the Native Hawaiian or Other Pacific Islander group was below the minimum performance level for this indicator.

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

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

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

Note: The rate for the Unknown/Missing group was 61.5 percent (N=945).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 52.8 percent for the Native Hawaiian or Other Pacific Islander group to 65.7 percent for the American Indian or Alaska Native group.

♦ One health disparity was identified for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* indicator as the rate for the Black or African American group was **worse** than the rate for the White group.

♦ No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

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

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

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

Note: The rate for the Unknown/Missing group was 55.7 percent (N=945).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 44.4 percent for the Native Hawaiian or Other Pacific Islander group to 62.3 percent for the Asian group.

♦ Four health disparities were identified for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* indicator:

▪ The rate for the American Indian or Alaska Native group was **better** than the rate for the White group.

▪ 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 Native Hawaiian or Other Pacific Islander group was below the minimum performance level for this indicator.

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

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

Figure 3.22—Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) (CDC–H8) Rates by Race/Ethnicity
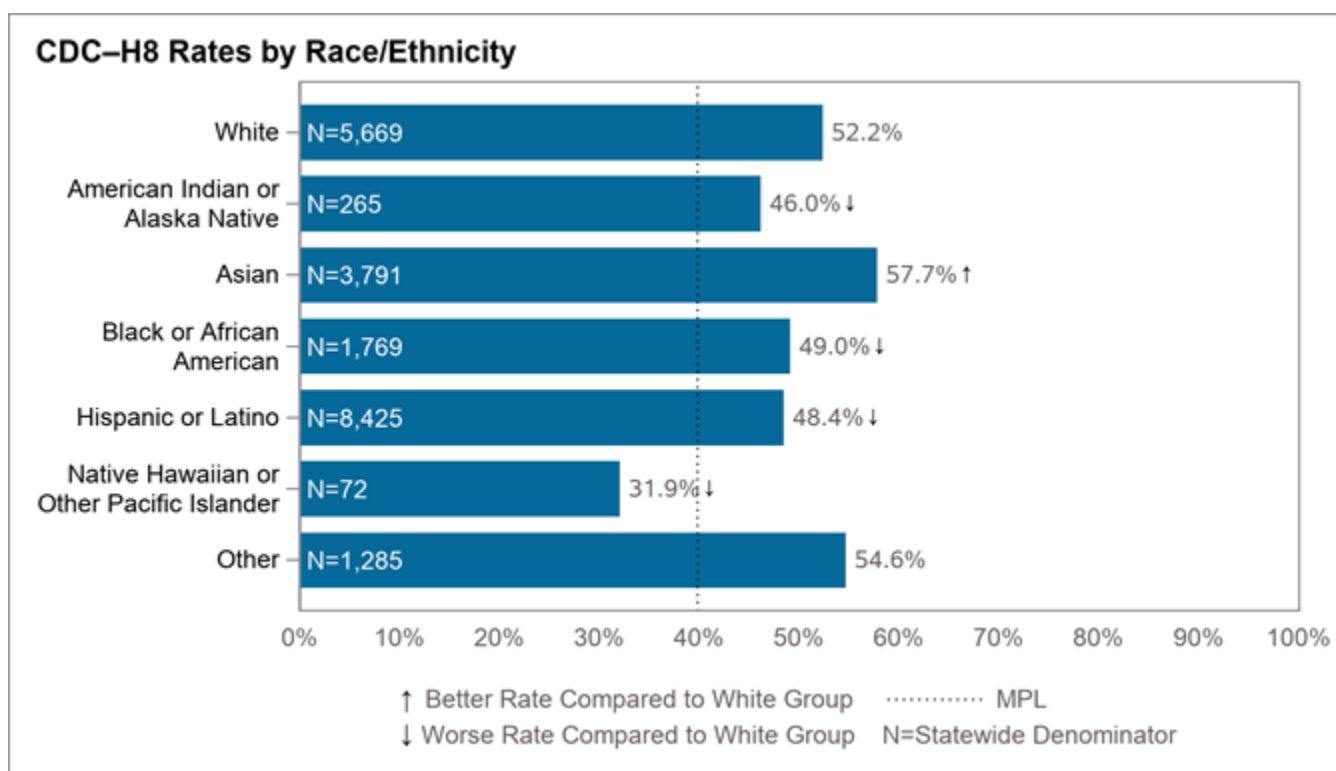
Note: The rate for the Unknown/Missing group was 54.5 percent (N=945).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 31.9 percent for the Native Hawaiian or Other Pacific Islander group to 57.7 percent for the Asian group.

♦ Five health disparities were identified for the *Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)* indicator:

  ▪ The rate for the Asian group was **better** than the rate for the White group.

  ▪ The rate for the American Indian or Alaska Native group was **worse** than the rate for the White group.

  ▪ The rate for the 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 Native Hawaiian or Other Pacific Islander group was below the minimum performance level for this indicator.

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

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

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

CDC–H9 Rates by Race/Ethnicity

Race/Ethnicity	N	Rate
White	N=5,669	37.6%
American Indian or Alaska Native	N=265	43.0%
Asian	N=3,791	30.5% ↑
Black or African American	N=1,769	42.7% ↓
Hispanic or Latino	N=8,425	40.6%
Native Hawaiian or Other Pacific Islander	N=72	59.7% ↓
Other	N=1,285	34.3% ↑

↑ Better Rate Compared to White Group ·········· MPL
↓ Worse Rate Compared to White Group N=Statewide Denominator
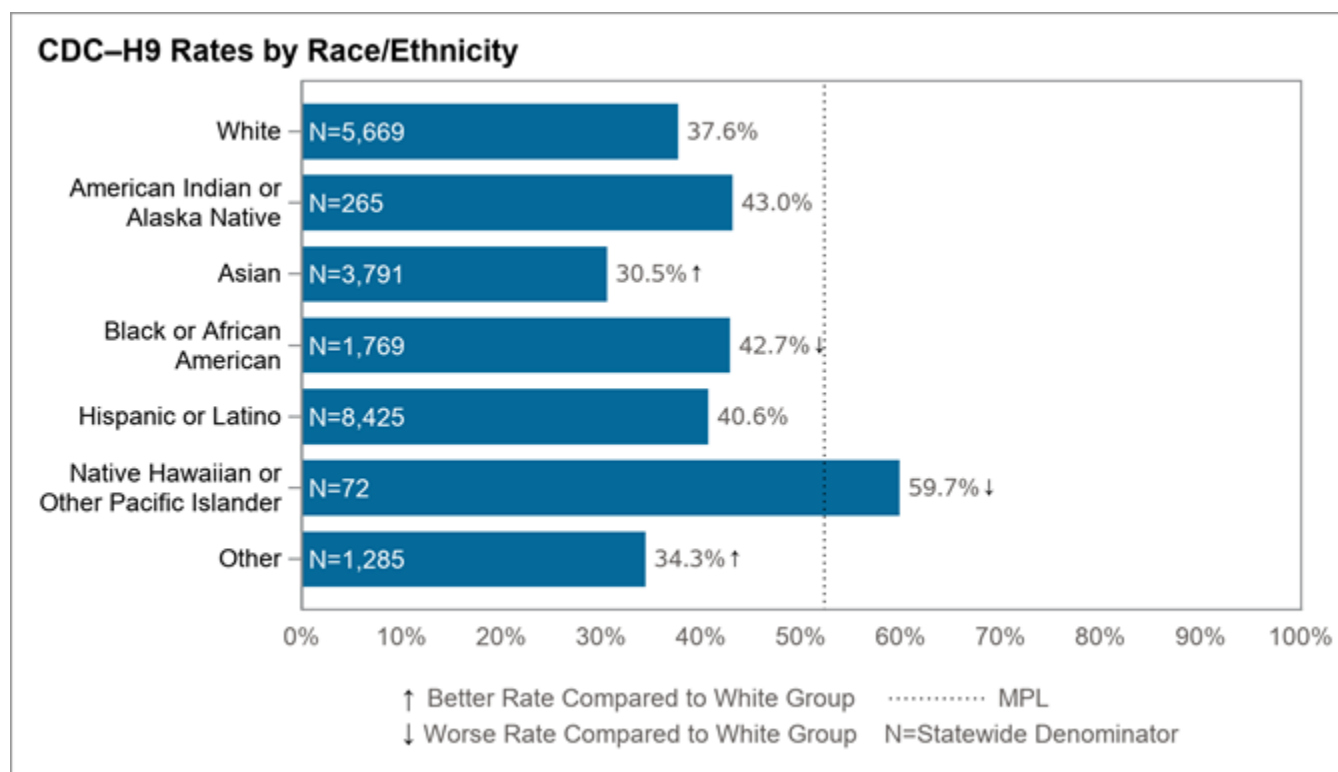
Note: The rate for the Unknown/Missing group was 35.8 percent (N=945).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.
A lower rate indicates more favorable performance for this indicator.

♦ The rates for all racial/ethnic groups ranged from 59.7 percent for the Native Hawaiian or Other Pacific Islander group to 30.5 percent for the Asian group.

♦ Four health disparities were identified for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)* indicator:

■ The rate for the Asian group was **better** than the rate for the White group.
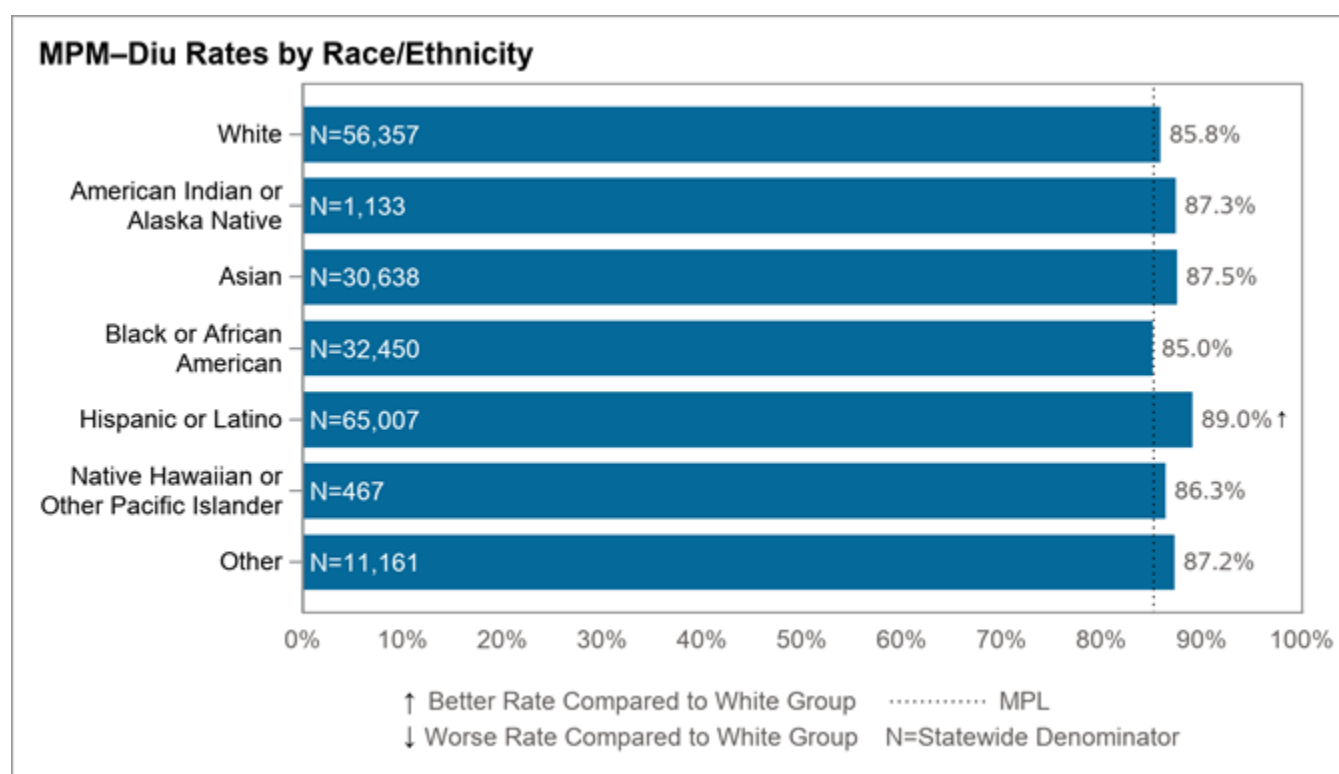
■ The rate for the Other group was **better** than the rate for the White group.

- ■ The rate for the Black or African American group was **worse** than the rate for the White group.
- ■ The rate for the Native Hawaiian or Other Pacific Islander group was **worse** than the rate for the White group.
♦ The rate for the Native Hawaiian or Other Pacific Islander group was above the minimum performance level for this indicator, indicating less favorable performance.

Comprehensive Diabetes Care—HbA1c Testing (CDC–HT)

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

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

CDC–HT Rates by Race/Ethnicity

Race/Ethnicity	Denominator	Rate
White	N=5,669	84.6%
American Indian or Alaska Native	N=265	89.1%
Asian	N=3,791	88.6% ↑
Black or African American	N=1,769	82.5%
Hispanic or Latino	N=8,425	87.6%
Native Hawaiian or Other Pacific Islander	N=72	77.8%
Other	N=1,285	87.5%

↑ Better Rate Compared to White Group .... MPL
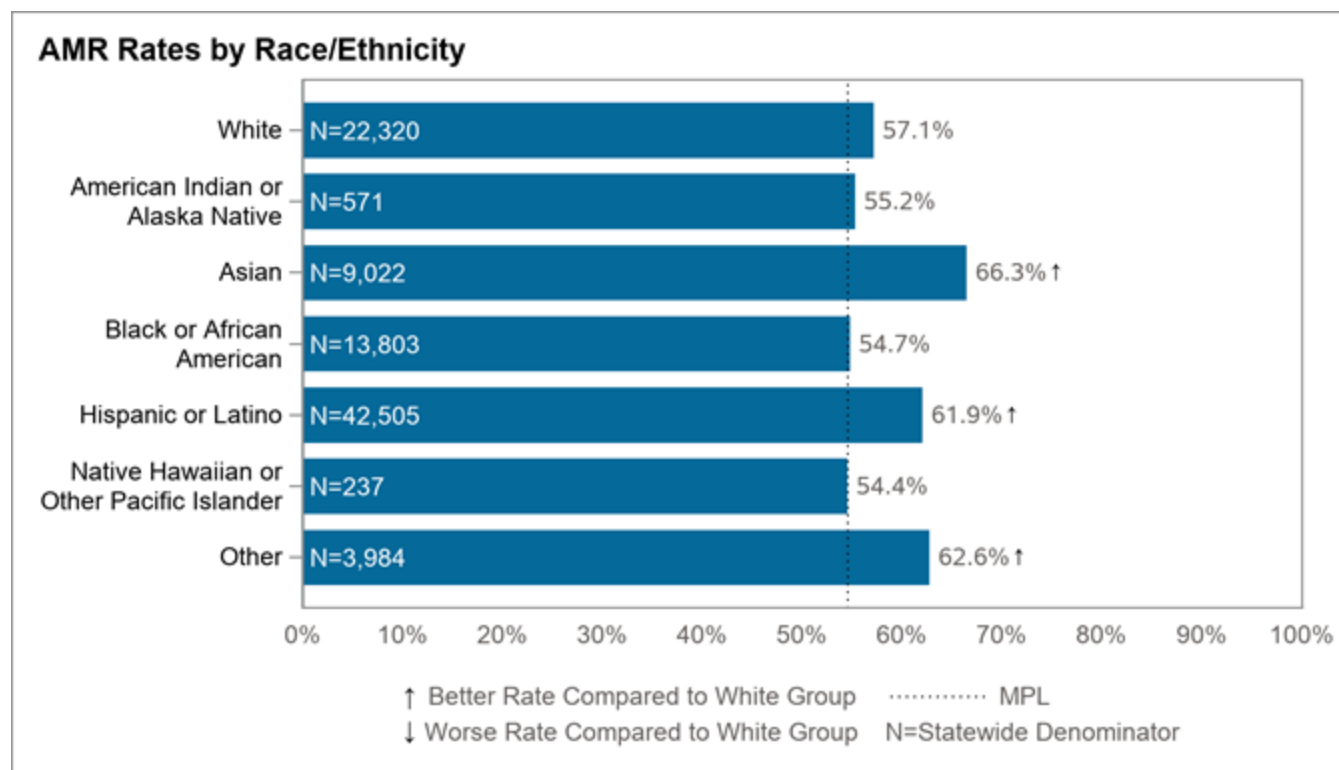↓ Worse Rate Compared to White Group N=Statewide Denominator
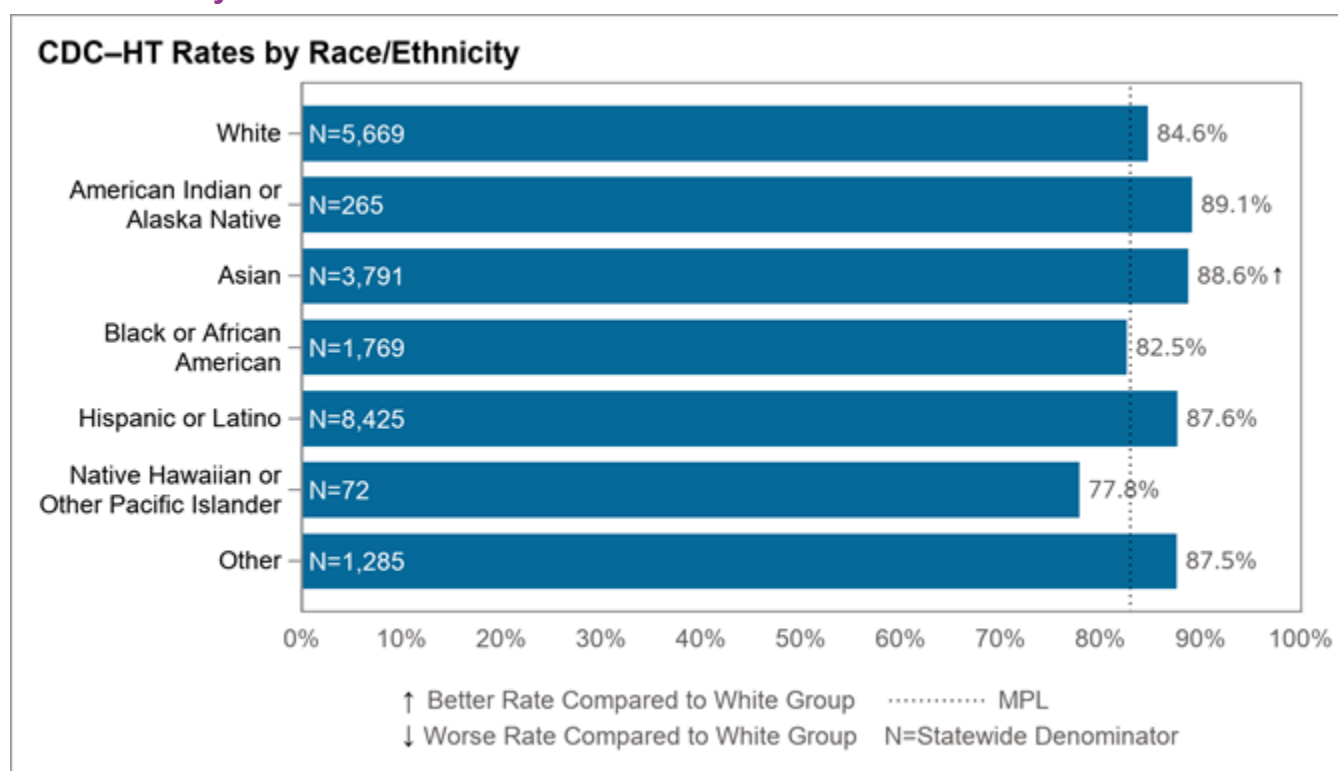
Note: The rate for the Unknown/Missing group was 85.9 percent (N=945).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 77.8 percent for the Native Hawaiian or Other Pacific Islander group to 89.1 percent for the American Indian or Alaska Native group.

♦ One health disparity was identified for the *Comprehensive Diabetes Care—HbA1c Testing* indicator as the rate for the Asian group was **better** than the rate for the White group.

♦ The following racial/ethnic group rates were below the minimum performance level for this indicator:

   ▪ Black or African American
   ▪ Native Hawaiian or Other Pacific Islander

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

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

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

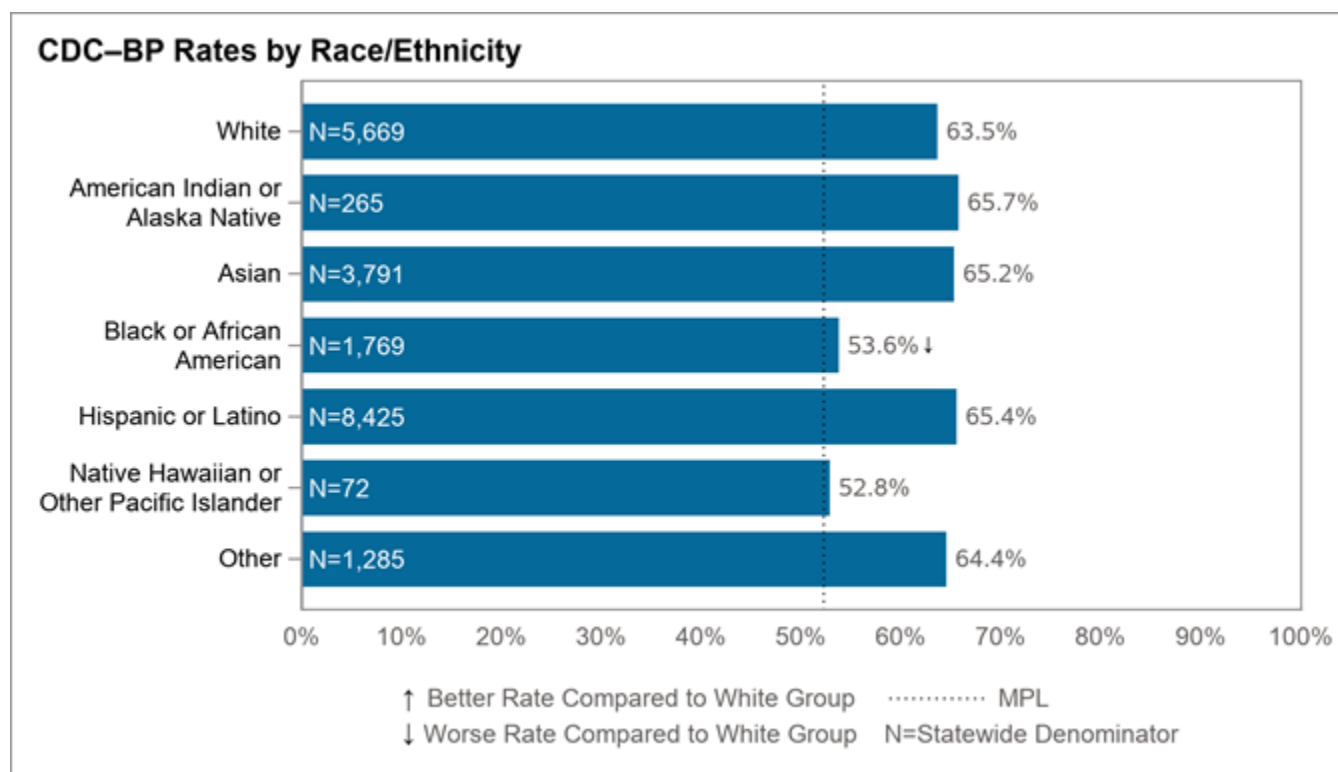Note: The rate for the Unknown/Missing group was 87.7 percent (N=945).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 83.3 percent for the Native Hawaiian or Other Pacific Islander group to 91.7 percent for the American Indian or Alaska Native group.

♦ No health disparities were identified for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* indicator.

♦ The rate for the Native Hawaiian or Other Pacific Islander group was below the minimum performance level for this indicator.

Controlling High Blood Pressure (CBP)

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

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

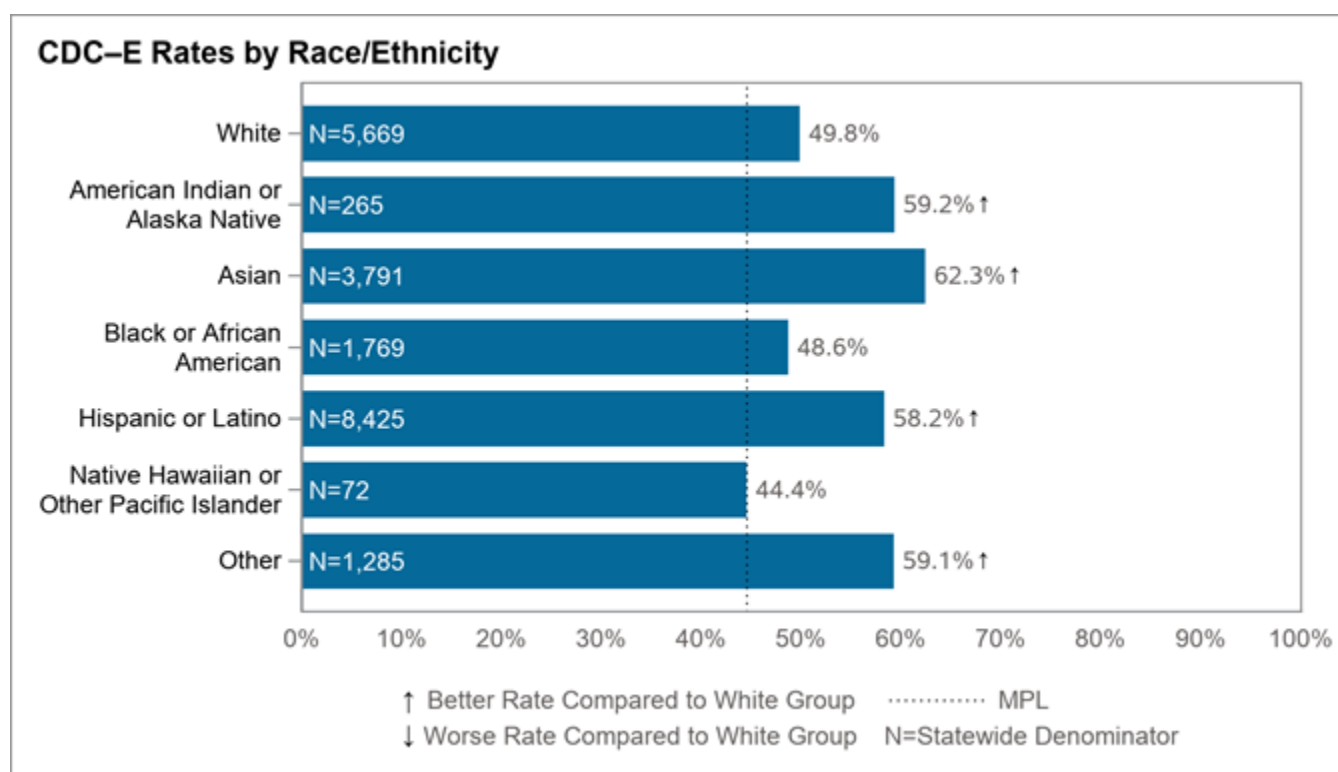Note: The rate for the Unknown/Missing group was 61.4 percent (N=911).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 53.1 percent for the Black or African American group to 69.7 percent for the Native Hawaiian or Other Pacific Islander group.
♦ Two health disparities were identified for the *Controlling High Blood Pressure* indicator:
   ▪ The rate for the Asian group was **better** than the rate for the White group.
   ▪ The rate for the Black or African American group was **worse** than the rate for the White group.
♦ No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Racial/Ethnic Health Disparities: Appropriate Treatment and Utilization Domain

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

Figure 3.27—Racial/Ethnic Health Disparities Summary: Appropriate Treatment and Utilization Domain
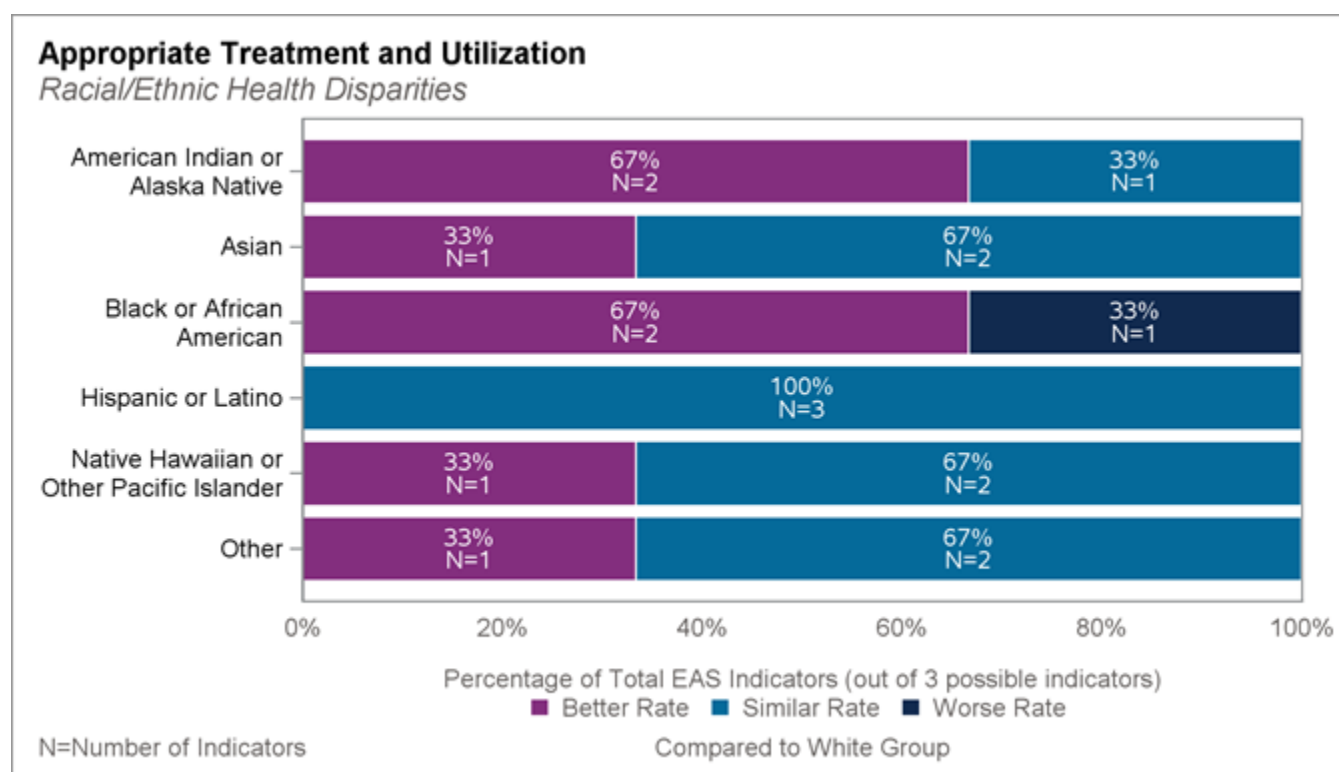
American Indian or Alaska Native

♦ For the following indicators, the rates for the American Indian or Alaska Native group were **better** than the rates for the White group:

- *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*
- *Use of Imaging Studies for Low Back Pain*

♦ No rates for the American Indian or Alaska Native group were **worse** than the rates for the White group.

Asian

♦ For *All-Cause Readmissions*, the rate for the Asian group was **better** than the rate for the White group.

♦ No rates for the Asian group were **worse** than the rates for the White group.

Black or African American

♦ For the following indicators, the rates for the Black or African American group were **better** than the rates for the White group:

  ■ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

  ■ *Use of Imaging Studies for Low Back Pain*

♦ For *All-Cause Readmissions*, the rate for the Black or African American group was **worse** than the rate for the White group.

Hispanic or Latino

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

Native Hawaiian or Other Pacific Islander

♦ For *All-Cause Readmissions*, the rate for the Native Hawaiian or Other Pacific Islander group was **better** than the rate for the White group.

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

Other

♦ For *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*, the rate for the Other group was **better** than the rate for the White group.

♦ No rates for the Other group were **worse** than the rates for the White group.

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

Figure 3.28 through Figure 3.30 display the racial/ethnic health disparities for each indicator included in the Appropriate Treatment and Utilization domain, except for the *Ambulatory Care* indicators. To see the *Ambulatory Care* statewide rates stratified by race/ethnicity, see Appendix A. 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.

All-Cause Readmissions (ACR)

The *All-Cause Readmissions* (*ACR*) indicator measures the percentage of acute inpatient hospital stays for beneficiaries 21 years of age and older that were followed by an unplanned acute inpatient readmission for any diagnosis within 30 days. Figure 3.28 displays the statewide *All-Cause Readmissions* (*ACR*) rates and denominator for each racial/ethnic group in addition to identified health disparities. A lower rate indicates more favorable performance for this indicator.

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

ACR Rates by Race/Ethnicity

Race/Ethnicity	Denominator	Rate
White	N=91,014	15.9%
American Indian or Alaska Native	N=2,347	17.4%
Asian	N=24,287	12.5% ↑
Black or African American	N=38,329	20.2% ↓
Hispanic or Latino	N=81,726	14.2%
Native Hawaiian or Other Pacific Islander	N=673	12.0% ↑
Other	N=13,393	14.2%

↑ Better Rate Compared to White Group
↓ Worse Rate Compared to White Group   N=Statewide Denominator
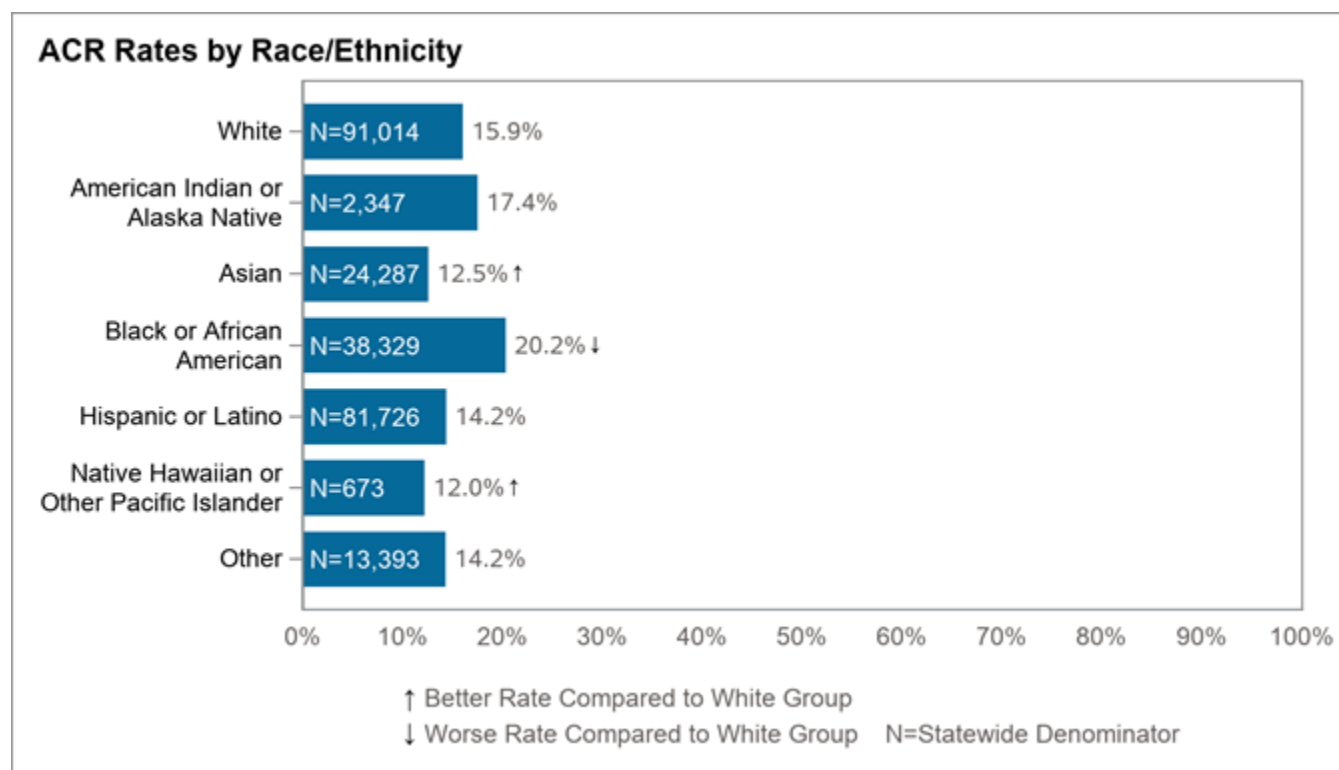
Note: The rate for the Unknown/Missing group was 16.5 percent (N=10,879).
A lower rate indicates more favorable performance for this indicator.

The *All-Cause Readmissions* indicator was originally developed for the ACR Collaborative Quality Improvement Project; therefore, no minimum performance level was established for this indicator.

♦ The rates for all racial/ethnic groups ranged from 20.2 percent for the Black or African American group to 12.0 percent for the Native Hawaiian or Other Pacific Islander group.

♦ Three health disparities were identified for the *All-Cause Readmissions* 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 Black or African American group was **worse** than the rate for the White group.

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

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

Figure 3.29—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) Rates by Race/Ethnicity
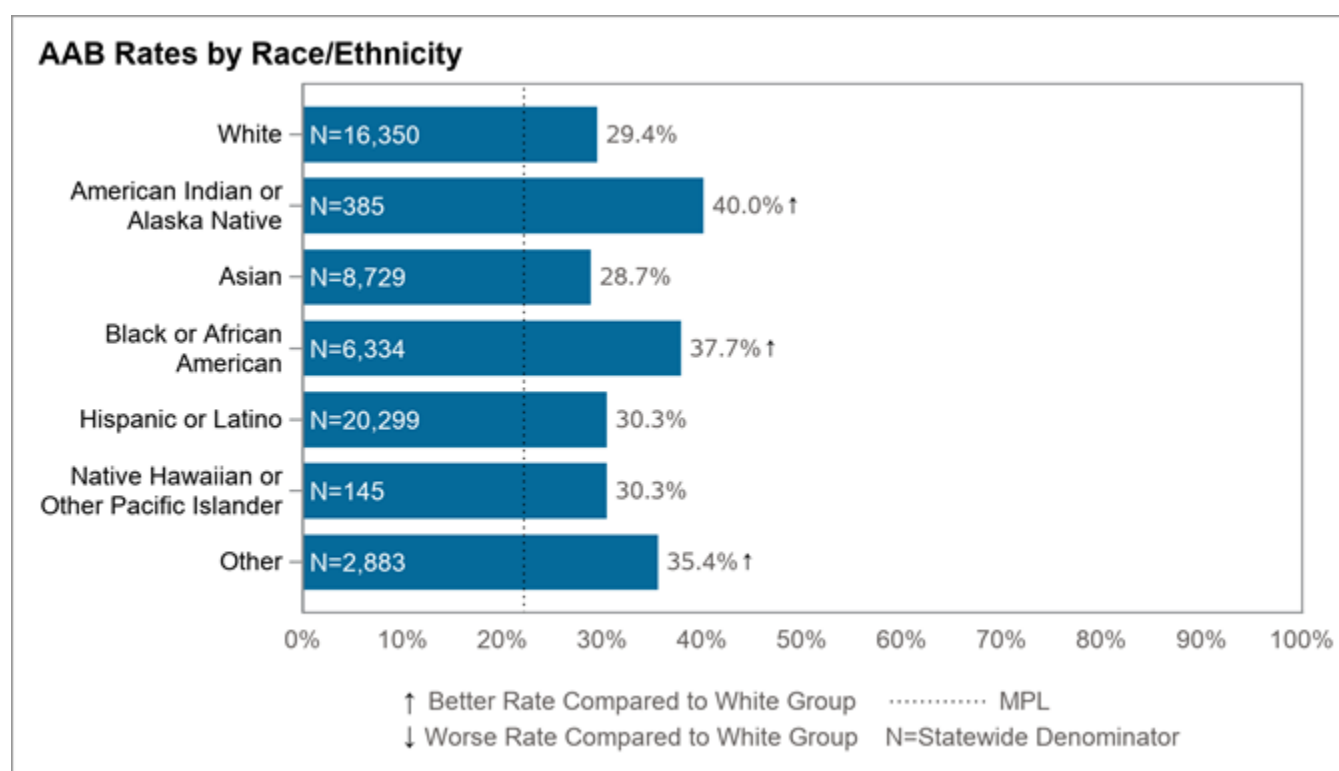
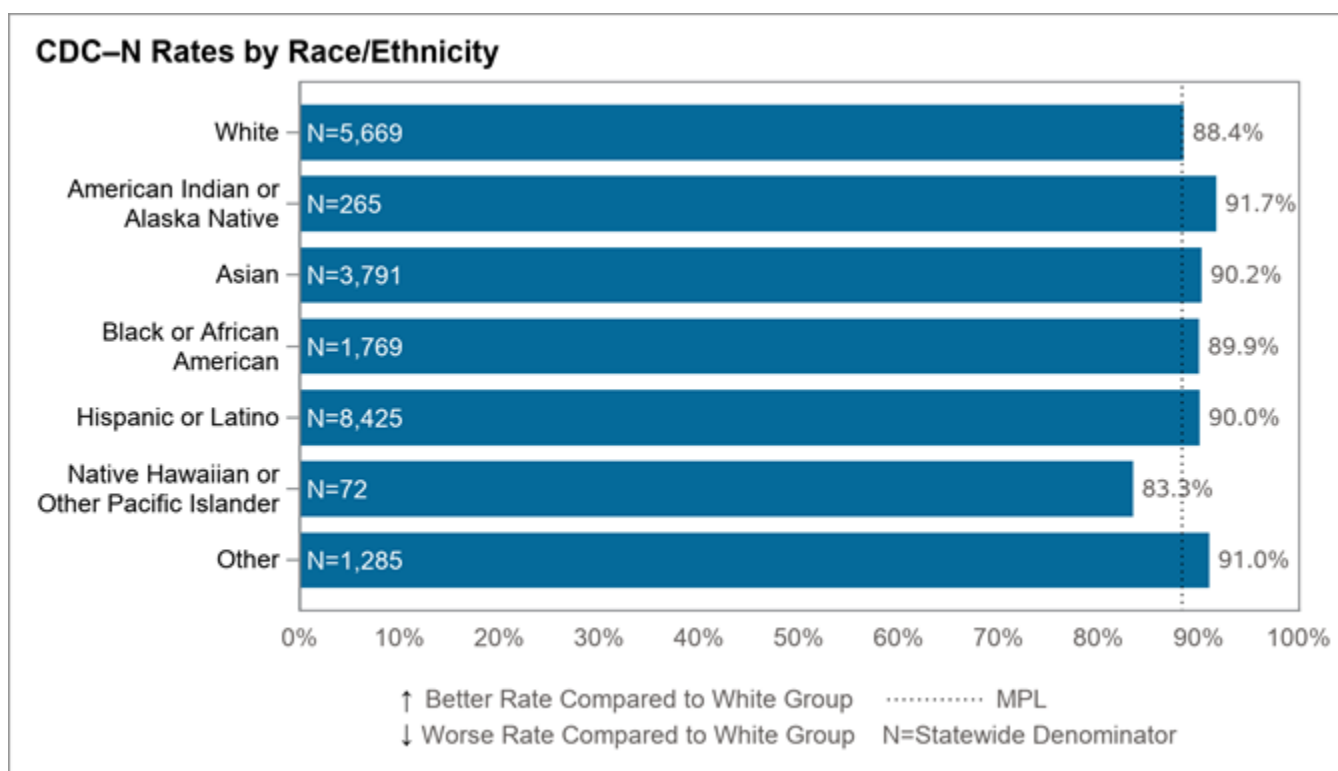Note: The rate for the Unknown/Missing group was 31.6 percent (N=1,856).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 28.7 percent for the Asian group to 40.0 percent for the American Indian or Alaska Native group.

♦ Three health disparities were identified for the *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis* indicator:

  ■ The rate for the American Indian or Alaska Native group was **better** than the rate for the White group.

  ■ The rate for the Black or African American group was **better** than the rate for the White group.

  ■ The rate for the Other group was **better** than the rate for the White group.

♦ No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

Use of Imaging Studies for Low Back Pain (LBP)

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

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

LBP Rates by Race/Ethnicity

Race/Ethnicity	Denominator	Rate
White	N=26,805	72.2%
American Indian or Alaska Native	N=773	78.0% ↑
Asian	N=10,279	74.5%
Black or African American	N=12,422	76.2% ↑
Hispanic or Latino	N=42,039	71.8%
Native Hawaiian or Other Pacific Islander	N=235	76.6%
Other	N=6,635	72.7%

↑ Better Rate Compared to White Group ·········· MPL
↓ Worse Rate Compared to White Group   N=Statewide Denominator
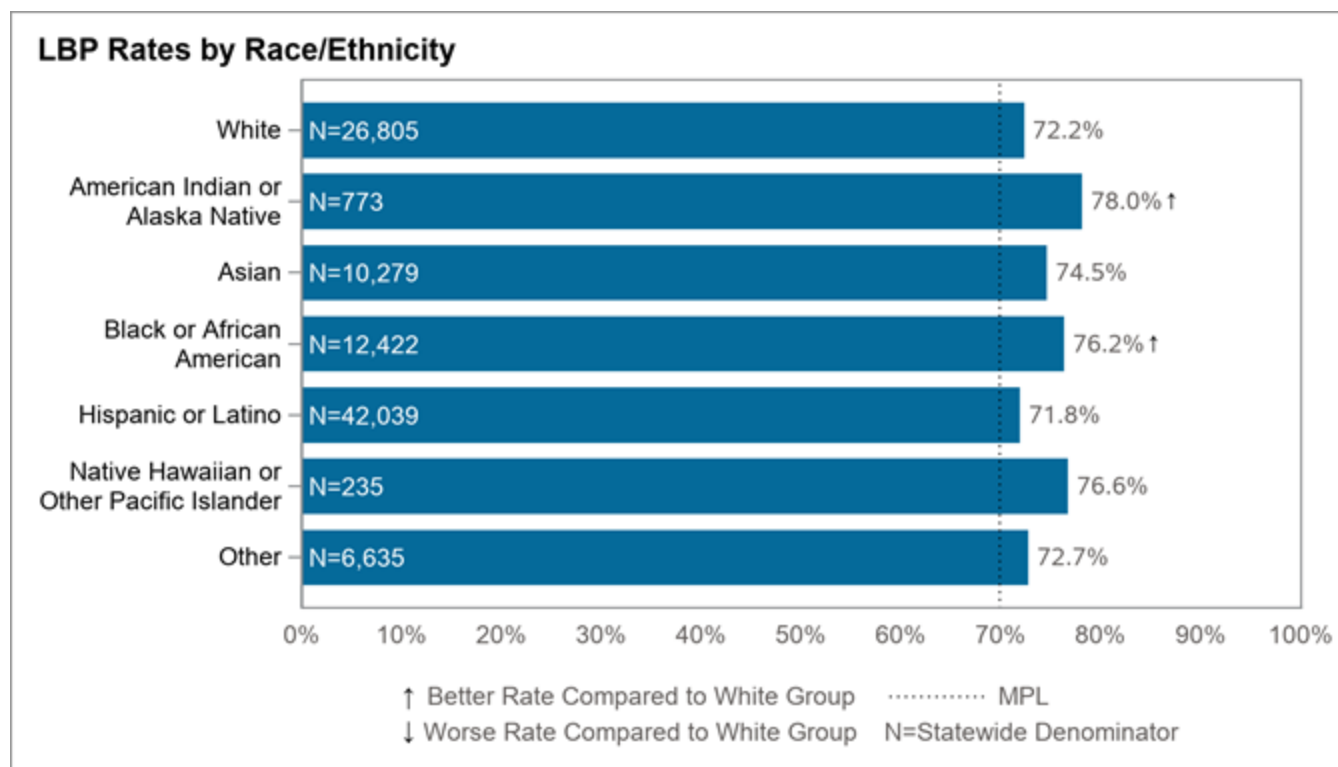
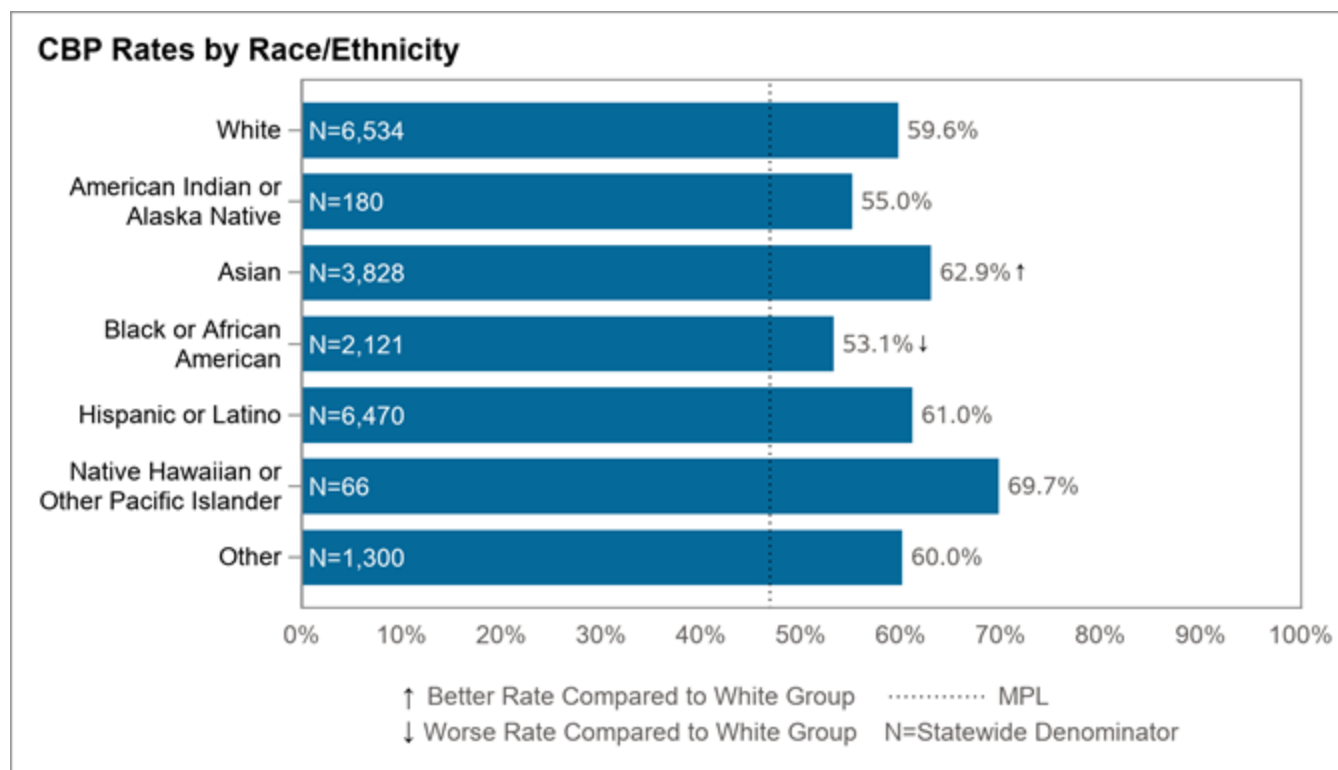Note: The rate for the Unknown/Missing group was 73.3 percent (N=2,554).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

♦ The rates for all racial/ethnic groups ranged from 71.8 percent for the Hispanic or Latino group to 78.0 percent for the American Indian or Alaska Native group.

♦ Two health disparities were identified for the *Use of Imaging Studies for Low Back Pain* indicator:

  ▪ The rate for the American Indian or Alaska Native group was **better** than the rate for the White group.

  ▪ The rate for the Black or African American group was **better** than the rate for the White group.

♦ No rates for the racial/ethnic groups were below the minimum performance level for this indicator.

4. 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 (*Childhood Immunization Status— Combination 3*, *Prenatal and Postpartum Care—Postpartum Care*, *Comprehensive Diabetes Care—HbA1c Testing*, and *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*).

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—Childhood Immunization Status—Combination 3 (CIS–3)
Geographic Variability by County**
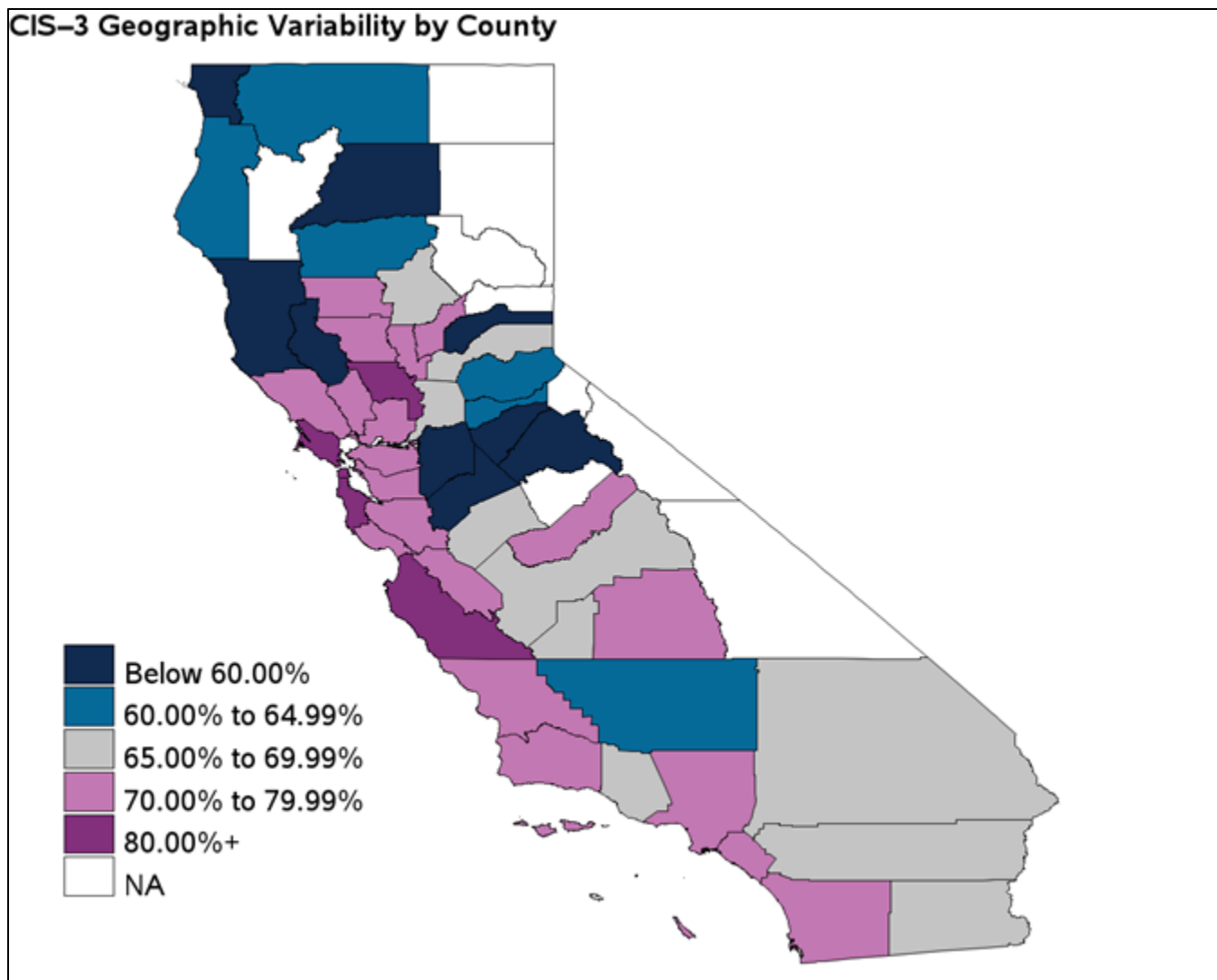
NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Figure 4.3—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Geographic Variability by County
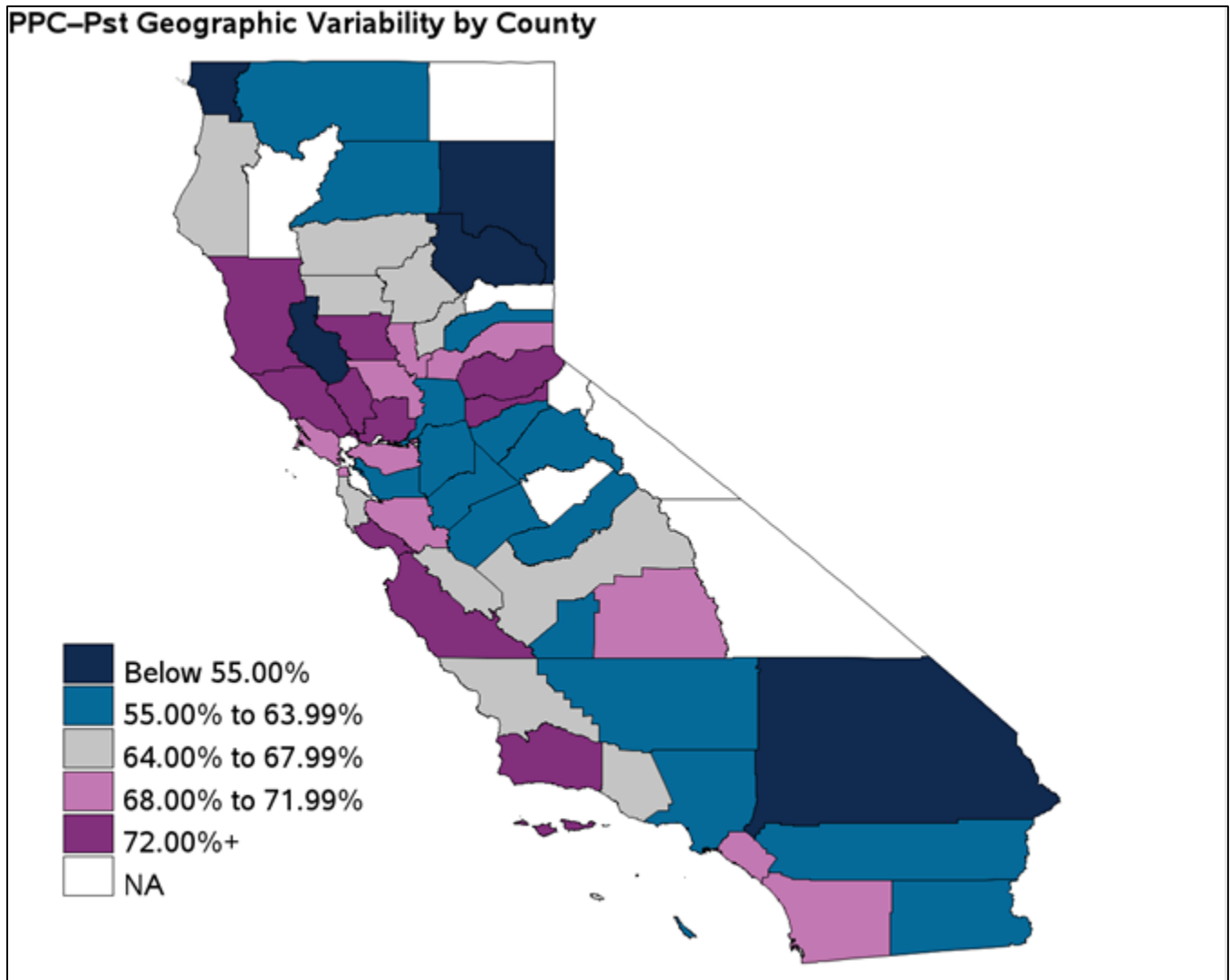
PPC–Pst Geographic Variability by County

Legend:
- Below 55.00%
- 55.00% to 63.99%
- 64.00% to 67.99%
- 68.00% to 71.99%
- 72.00%+
- NA

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

Figure 4.4—Comprehensive Diabetes Care—HbA1c Testing (CDC–HT) Geographic Variability by County
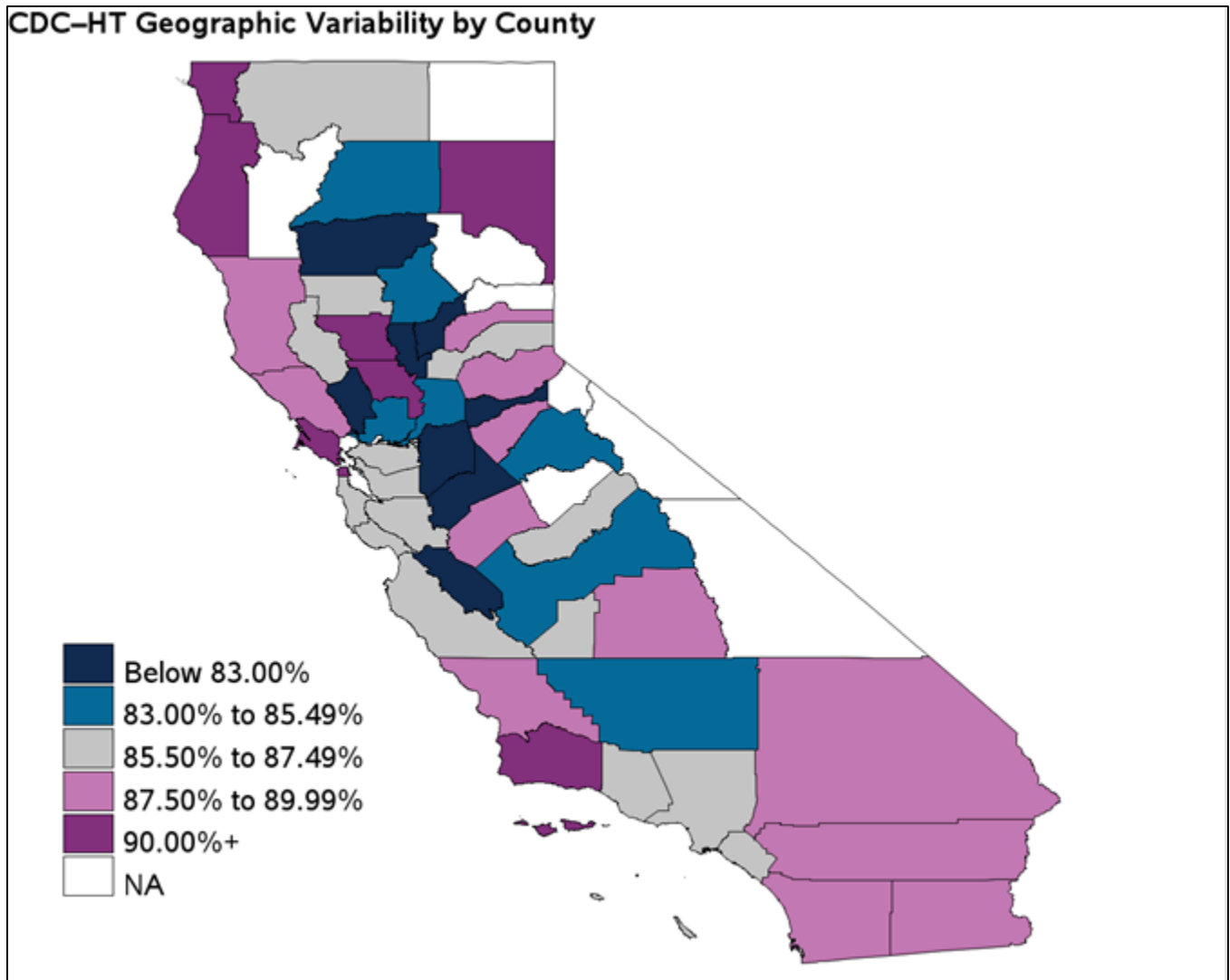
NA indicates the rate had a small denominator (i.e., less than 30) or small numerator (i.e., less than 11).

Figure 4.5—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) Geographic Variability by County
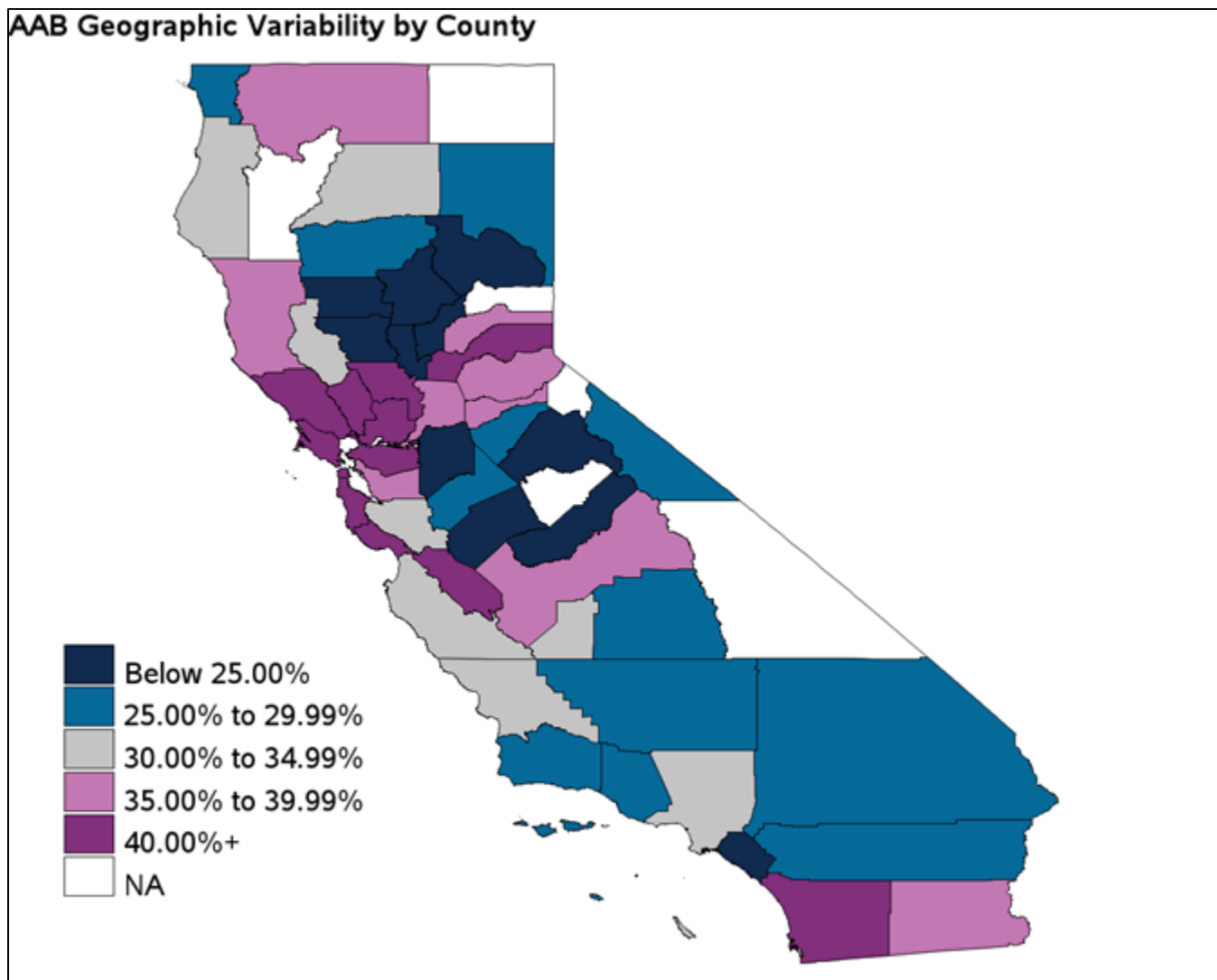
AAB Geographic Variability by County

Legend:
- Below 25.00%
- 25.00% to 29.99%
- 30.00% to 34.99%
- 35.00% to 39.99%
- 40.00%+
- NA

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

Appendix A. Demographic Stratification Results

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

Race/Ethnicity

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

Appropriate Treatment and Utilization Domain

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

Ambulatory Care (AMB)

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

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

AMB–ED Rates by Race/Ethnicity

Race/Ethnicity	Denominator	Rate
White	N=24,055,160	51.9
American Indian or Alaska Native	N=514,471	63.9
Asian	N=14,280,689	21.3
Black or African American	N=9,529,882	66.4
Hispanic or Latino	N=56,341,692	41.3
Native Hawaiian or Other Pacific Islander	N=302,747	45.6
Other	N=6,353,327	41.7

ED visits per 1,000 Member Months

N=Statewide Denominator
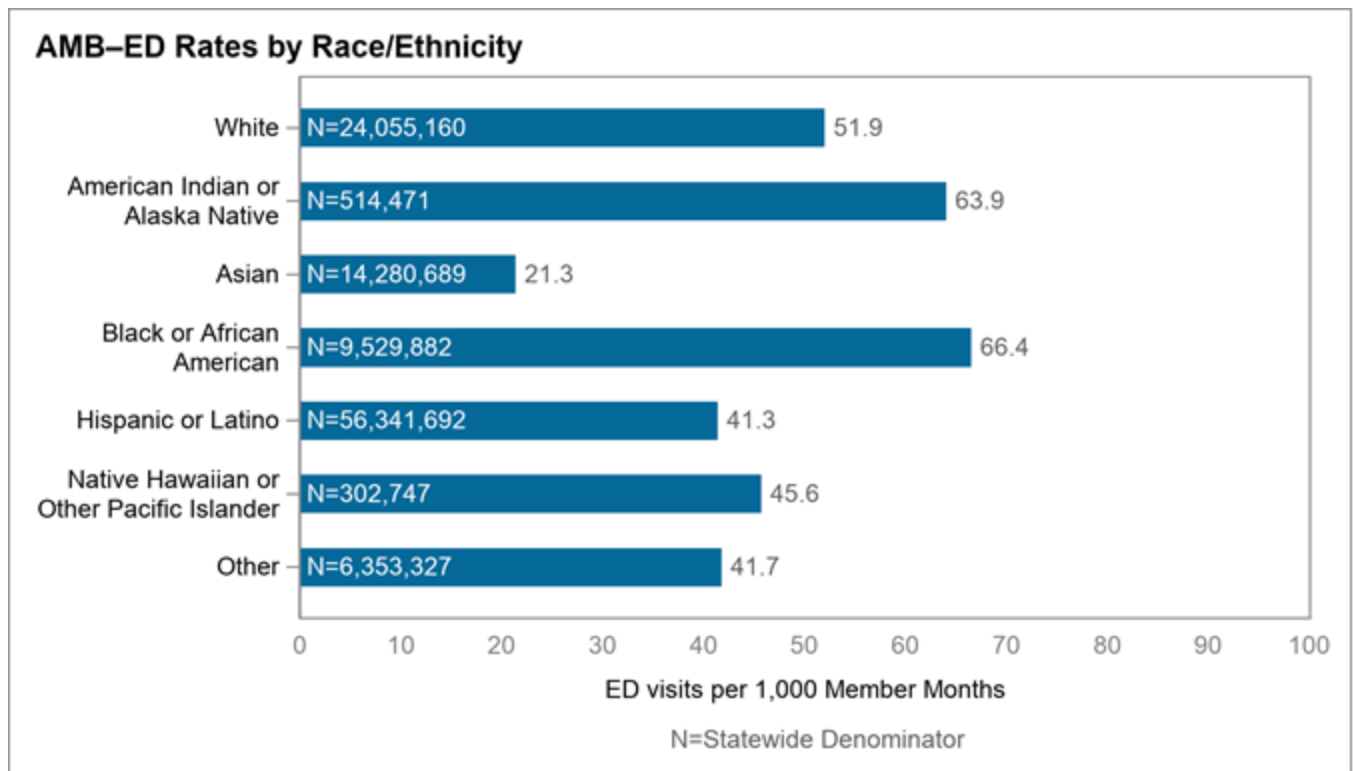
Note: The rate for the Unknown/Missing group rate was 43.8 emergency department visits per 1,000 member months (N=4,206,291).

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

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

AMB–OP Rates by Race/Ethnicity

Race/Ethnicity	Rate
White (N=24,055,160)	280.2
American Indian or Alaska Native (N=514,471)	274.0
Asian (N=14,280,689)	260.8
Black or African American (N=9,529,882)	257.6
Hispanic or Latino (N=56,341,692)	266.5
Native Hawaiian or Other Pacific Islander (N=302,747)	203.0
Other (N=6,353,327)	272.4

OP visits per 1,000 Member Months

N=Statewide Denominator
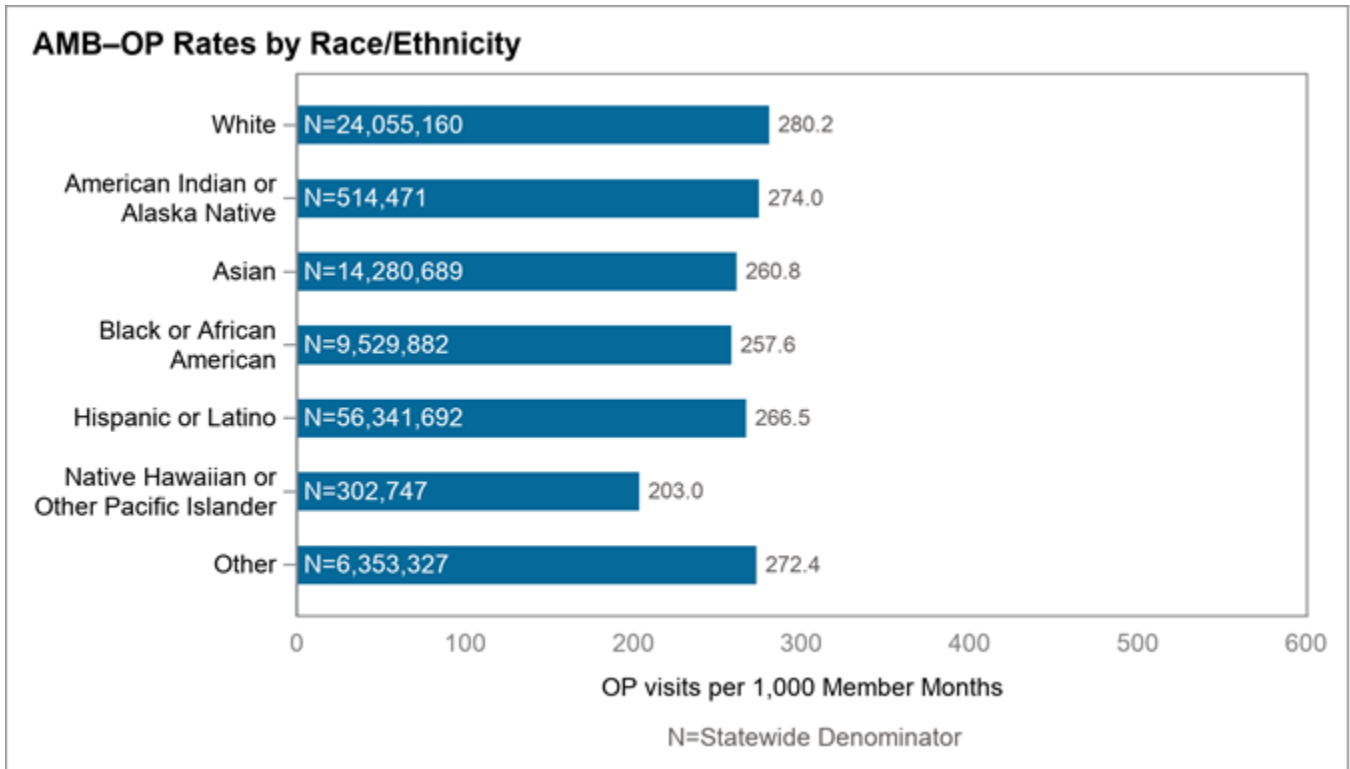
Note: The rate for the Unknown/Missing group was 278.6 OP visits per 1,000 member months (N=4,206,291).

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

Primary Language

Figure A.3 through Figure A.30 display the statewide rates by each primary language group for each EAS indicator. Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of July 2016. Please note, the rate for the Unknown/Missing group is only included as a footnote if the rate met the minimum denominator (i.e., 30 or more) and minimum numerator (i.e., 11 or more) requirements.

Preventive Screening and Children's Health Domain

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

Figure A.3—Childhood Immunization Status—Combination 3 (CIS–3) Rates by Primary Language
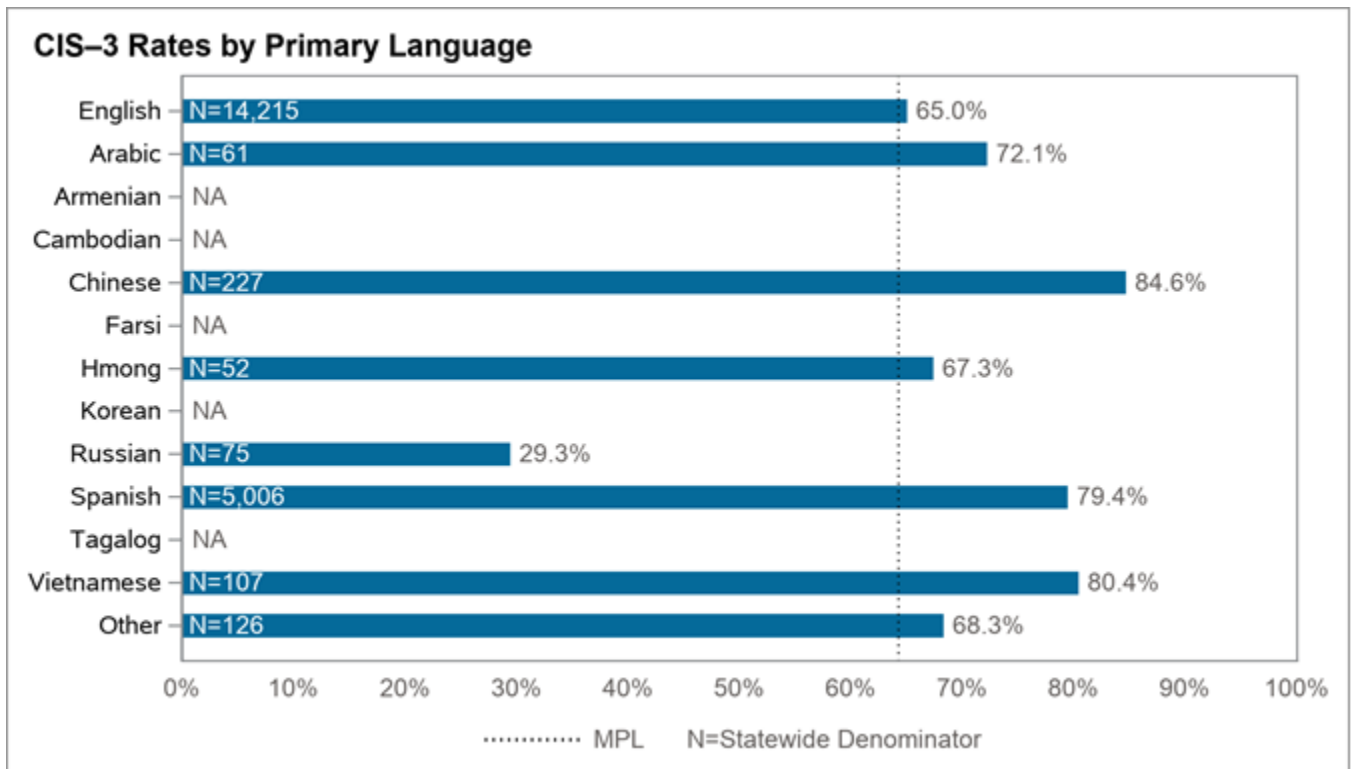
NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CAP–1224 Rates by Primary Language

Primary Language	N (Statewide Denominator)	Rate
English	N=114,222	92.6%
Arabic	N=458	92.6%
Armenian	N=349	95.1%
Cambodian	N=82	93.9%
Chinese	N=1,750	90.7%
Farsi	N=161	91.9%
Hmong	N=340	90.9%
Korean	N=349	94.6%
Russian	N=343	90.4%
Spanish	N=44,308	94.7%
Tagalog	N=181	90.1%
Vietnamese	N=1,245	96.3%
Other	N=836	92.3%

············· MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 75.6 percent (N=275).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

Note: The rate for the Unknown/Missing group was 66.4 percent (N=1,361).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CAP–711 Rates by Primary Language

Primary Language	N (Statewide Denominator)	Rate
English	N=523,833	82.8%
Arabic	N=2,884	91.1%
Armenian	N=2,112	90.7%
Cambodian	N=673	83.8%
Chinese	N=7,643	91.1%
Farsi	N=793	91.7%
Hmong	N=2,230	70.7%
Korean	N=1,696	85.6%
Russian	N=2,327	72.6%
Spanish	N=375,745	90.9%
Tagalog	N=1,248	84.1%
Vietnamese	N=10,381	93.3%
Other	N=4,772	86.4%

·········· MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 65.5 percent (N=449).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CAP–1219 Rates by Primary Language

Primary Language	N (Statewide Denominator)	Rate
English	N=659,328	80.7%
Arabic	N=4,173	85.9%
Armenian	N=3,547	85.3%
Cambodian	N=1,549	79.3%
Chinese	N=13,805	85.9%
Farsi	N=1,519	89.3%
Hmong	N=4,730	71.2%
Korean	N=3,272	75.9%
Russian	N=3,736	72.1%
Spanish	N=502,626	87.2%
Tagalog	N=2,485	77.9%
Vietnamese	N=20,578	88.8%
Other	N=7,559	82.4%

·········· MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 63.9 percent (N=671).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

IMA–2 Rates by Primary Language

Language	N	Rate
English	N=12,430	19.4%
Arabic	N=90	24.4%
Armenian	NA	
Cambodian	NA	
Chinese	N=243	51.4%
Farsi	NA	
Hmong	N=76	23.7%
Korean	NA	
Russian	S	
Spanish	N=7,863	34.3%
Tagalog	N=61	26.2%
Vietnamese	N=243	37.9%
Other	N=135	25.9%

N=Statewide Denominator

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

Immunizations for Adolescents—Combination 2 is a first-year indicator for reporting year 2017; therefore, the indicator does not have an applicable minimum performance level.

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 Privacy Rule's de-identification standard.

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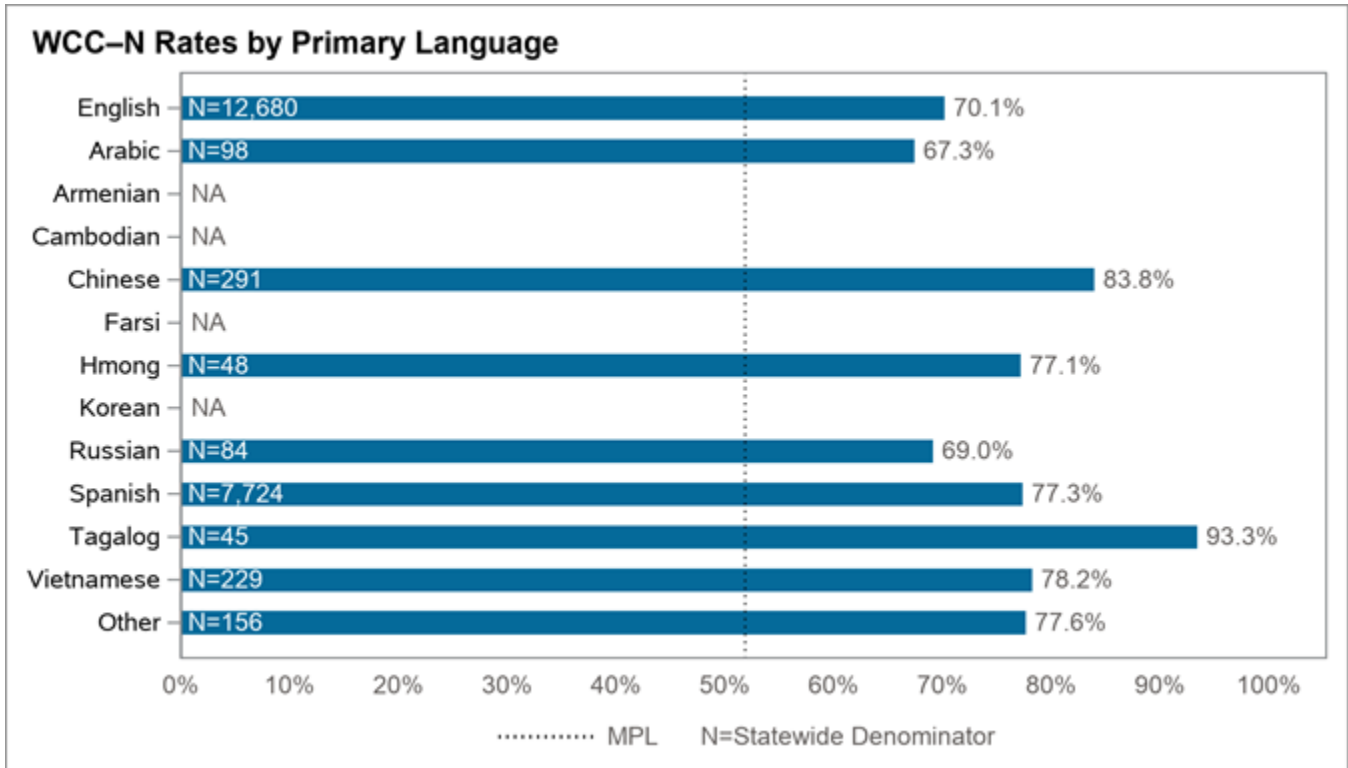
WCC–N Rates by Primary Language

Primary Language	N	Rate
English	N=12,680	70.1%
Arabic	N=98	67.3%
Armenian	NA	
Cambodian	NA	
Chinese	N=291	83.8%
Farsi	NA	
Hmong	N=48	77.1%
Korean	NA	
Russian	N=84	69.0%
Spanish	N=7,724	77.3%
Tagalog	N=45	93.3%
Vietnamese	N=229	78.2%
Other	N=156	77.6%

·············· MPL   N=Statewide Denominator

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

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

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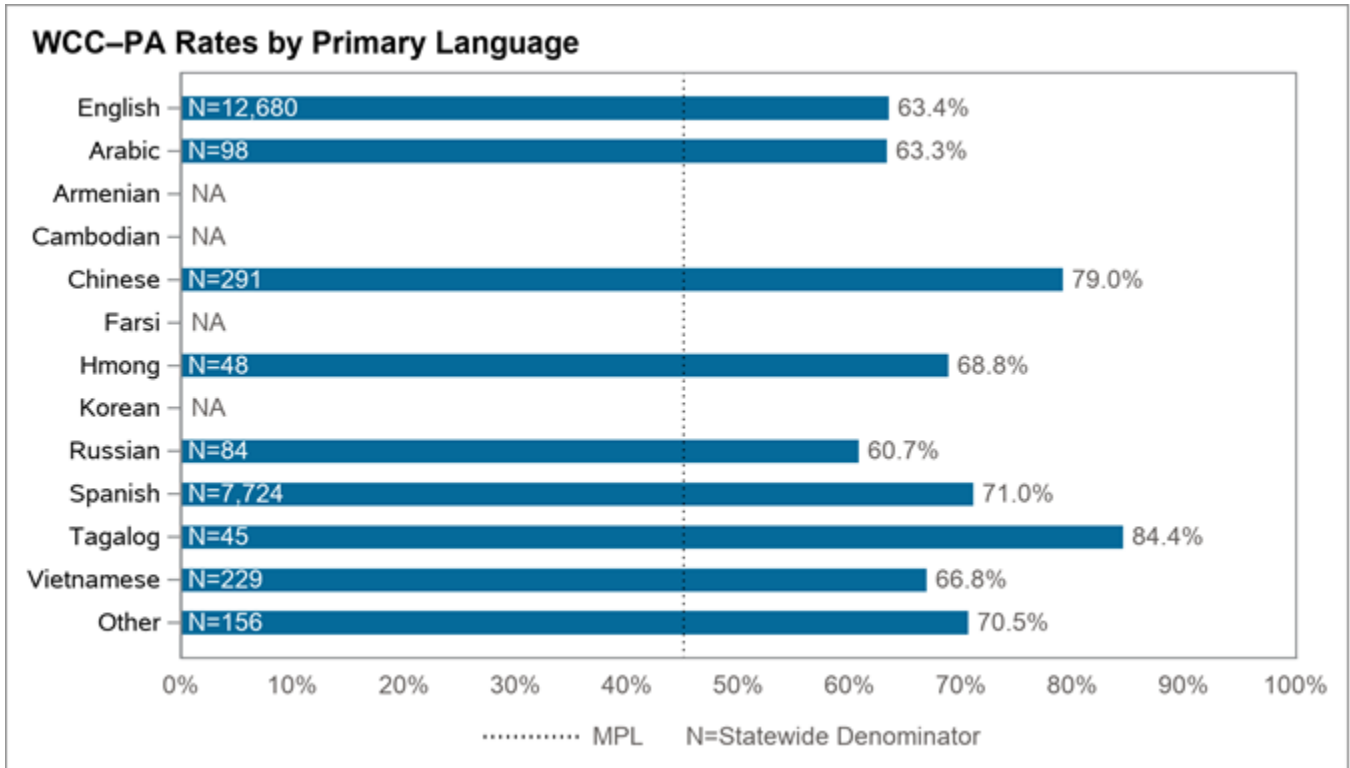
WCC–PA Rates by Primary Language

Primary Language	N	Rate
English	N=12,680	63.4%
Arabic	N=98	63.3%
Armenian		NA
Cambodian		NA
Chinese	N=291	79.0%
Farsi		NA
Hmong	N=48	68.8%
Korean		NA
Russian	N=84	60.7%
Spanish	N=7,724	71.0%
Tagalog	N=45	84.4%
Vietnamese	N=229	66.8%
Other	N=156	70.5%

·········· MPL   N=Statewide Denominator

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

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

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

W–34 Rates by Primary Language

Primary Language	N	Rate
English	N=13,611	68.3%
Arabic	N=67	65.7%
Armenian	NA	
Cambodian	NA	
Chinese	N=214	89.3%
Farsi	NA	
Hmong	N=54	59.3%
Korean	NA	
Russian	N=89	67.4%
Spanish	N=5,926	79.0%
Tagalog	N=33	72.7%
Vietnamese	N=142	85.9%
Other	N=151	74.2%

·········· MPL   N=Statewide Denominator
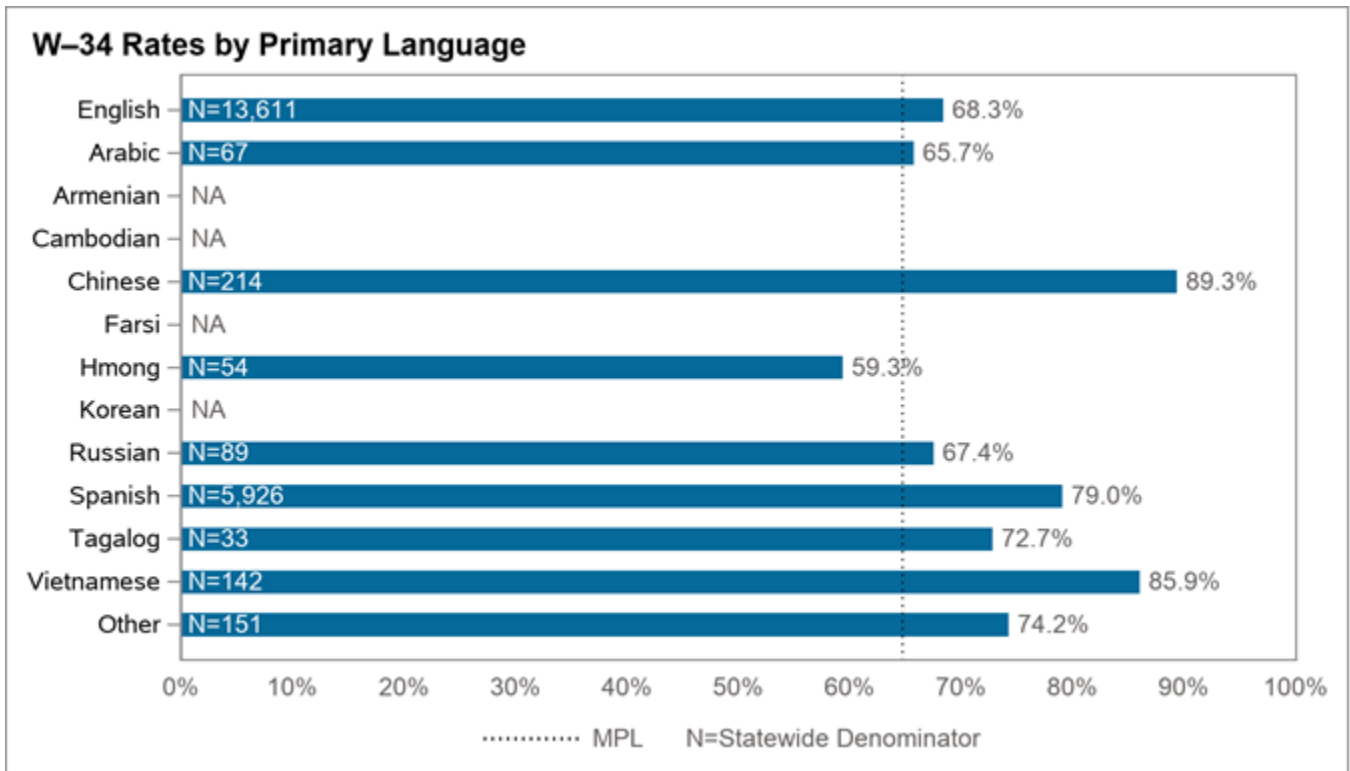
Note: The rate for the Unknown/Missing group was 46.7 percent (N=30).
NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

Preventive Screening and Women's Health Domain

Figure A.12 through Figure A.15 display the statewide Preventive Screening and Women's Health indicator rates and denominator for each primary language group.
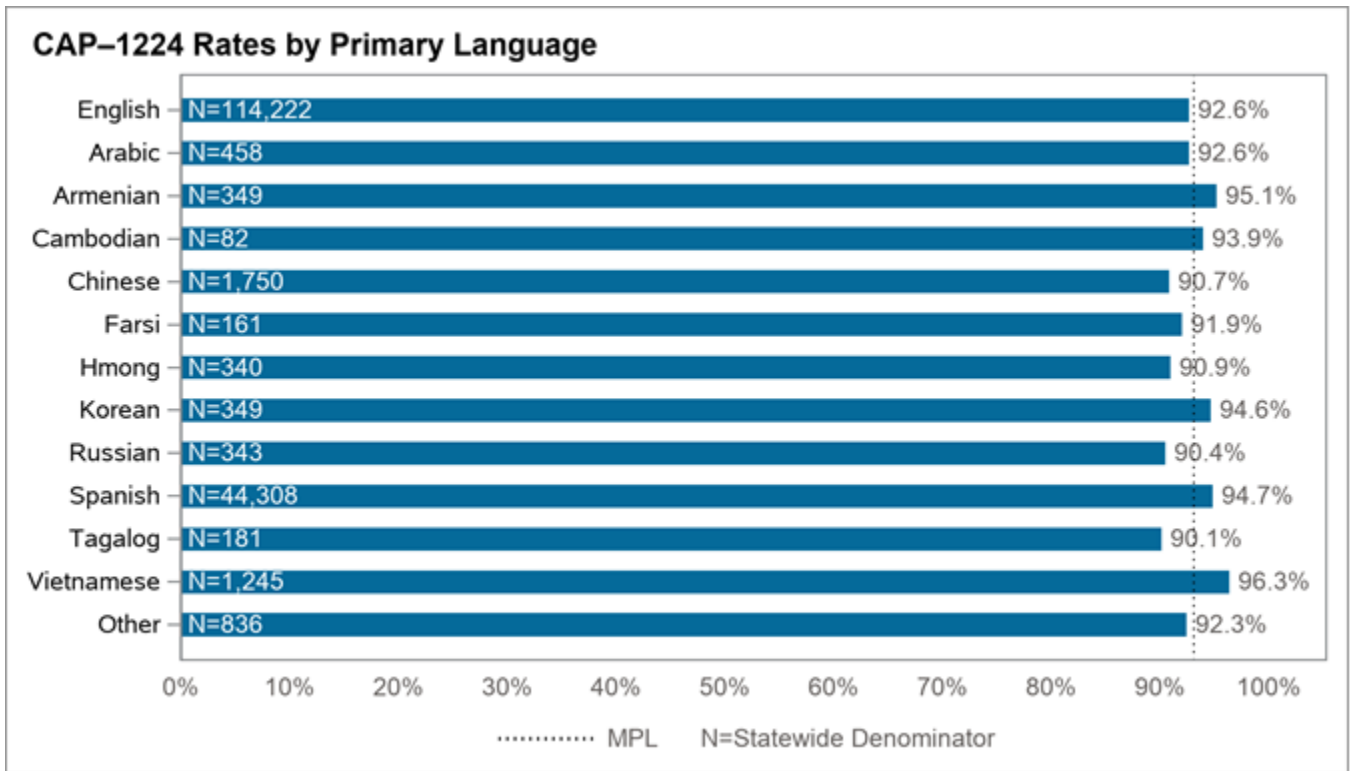
Figure A.12—Breast Cancer Screening (BCS) Rates by Primary Language

BCS Rates by Primary Language

Primary Language	N	Rate
English	N=208,555	53.7%
Arabic	N=2,457	67.2%
Armenian	N=5,186	62.0%
Cambodian	N=2,643	51.9%
Chinese	N=15,945	64.0%
Farsi	N=2,456	69.1%
Hmong	N=1,569	34.7%
Korean	N=2,899	56.5%
Russian	N=1,977	52.4%
Spanish	N=90,995	69.9%
Tagalog	N=2,969	61.8%
Vietnamese	N=17,186	71.8%
Other	N=7,055	55.5%

.... MPL   N=Statewide Denominator
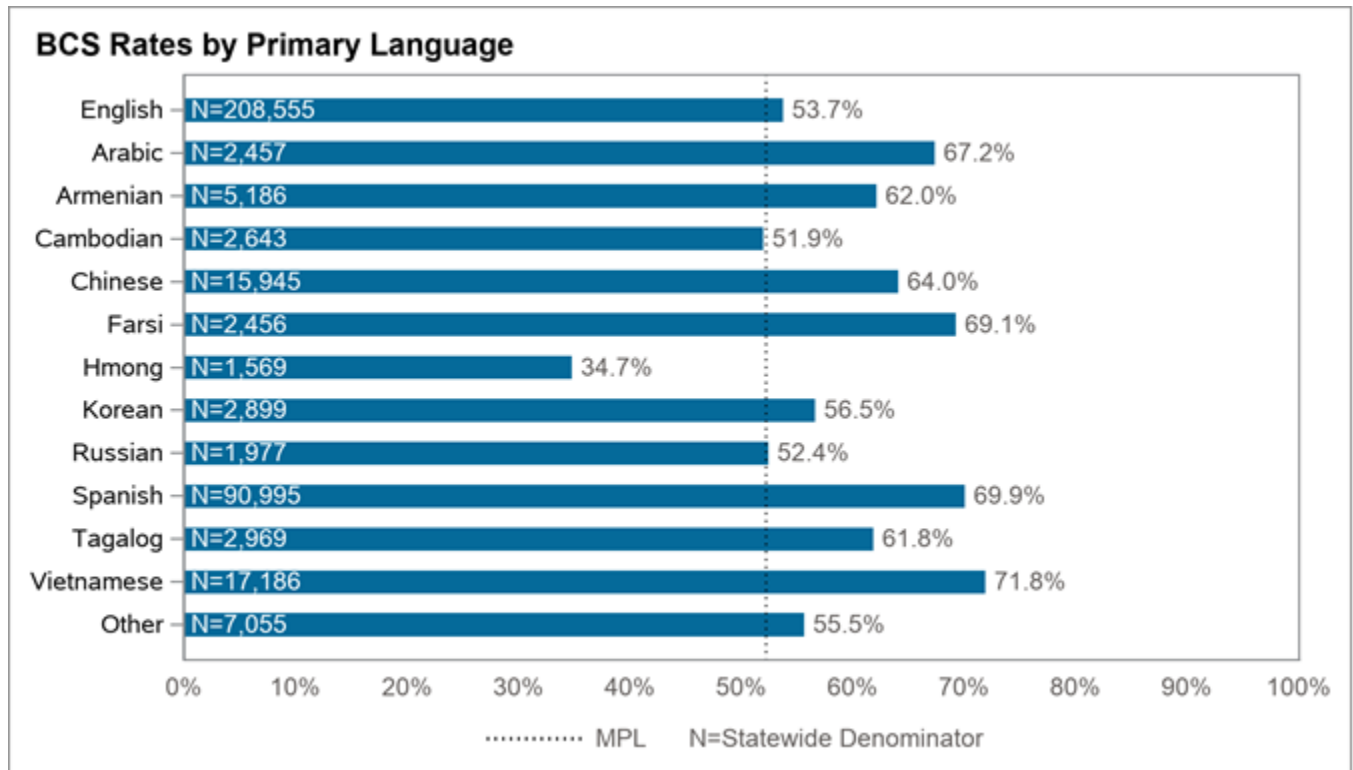
Note: The rate for the Unknown/Missing group was 48.0 percent (N=7,482).
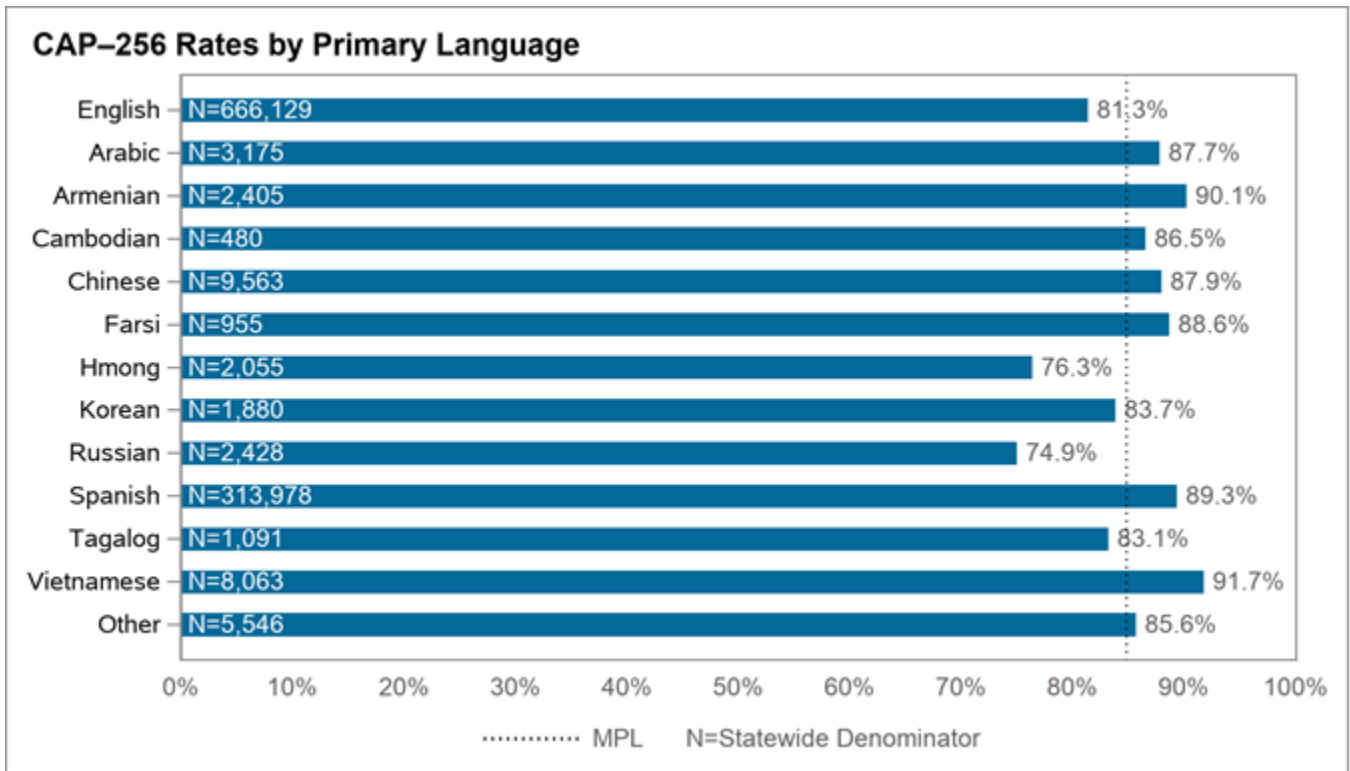The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CCS Rates by Primary Language

Primary Language	N	Rate
English	N=16,841	53.3%
Arabic	N=93	61.3%
Armenian	N=31	64.5%
Cambodian	N=44	43.2%
Chinese	N=377	64.5%
Farsi	N=47	57.4%
Hmong	N=76	30.3%
Korean	N=47	44.7%
Russian	N=97	40.2%
Spanish	N=3,572	64.2%
Tagalog	N=73	56.2%
Vietnamese	N=404	68.1%
Other	N=209	55.0%

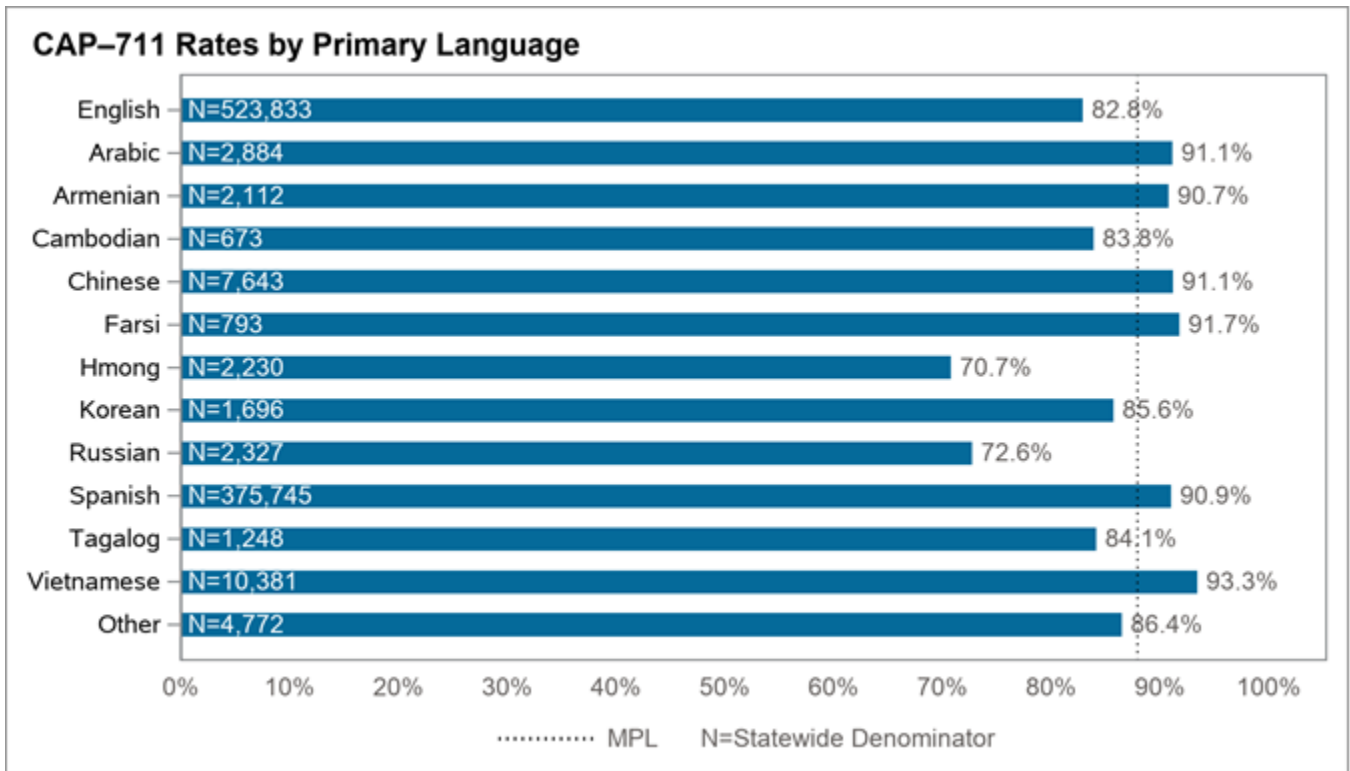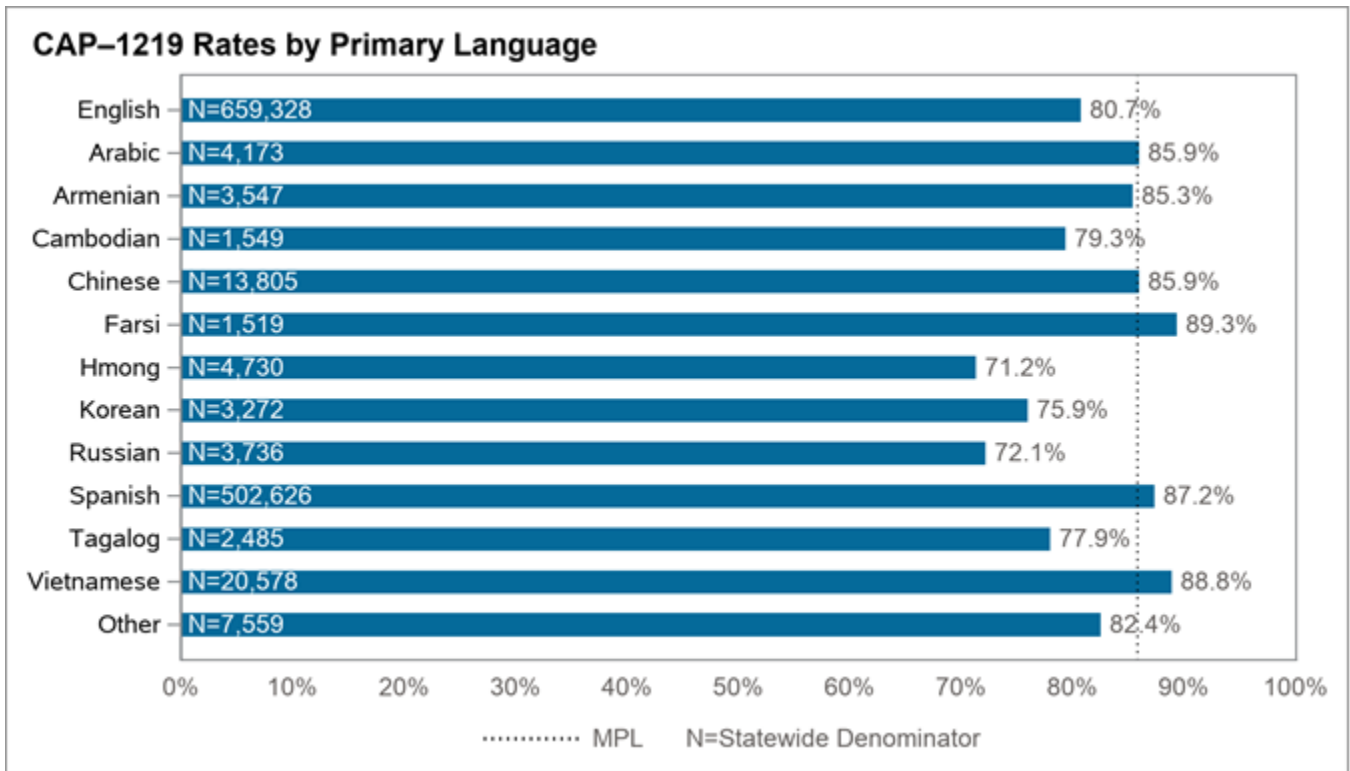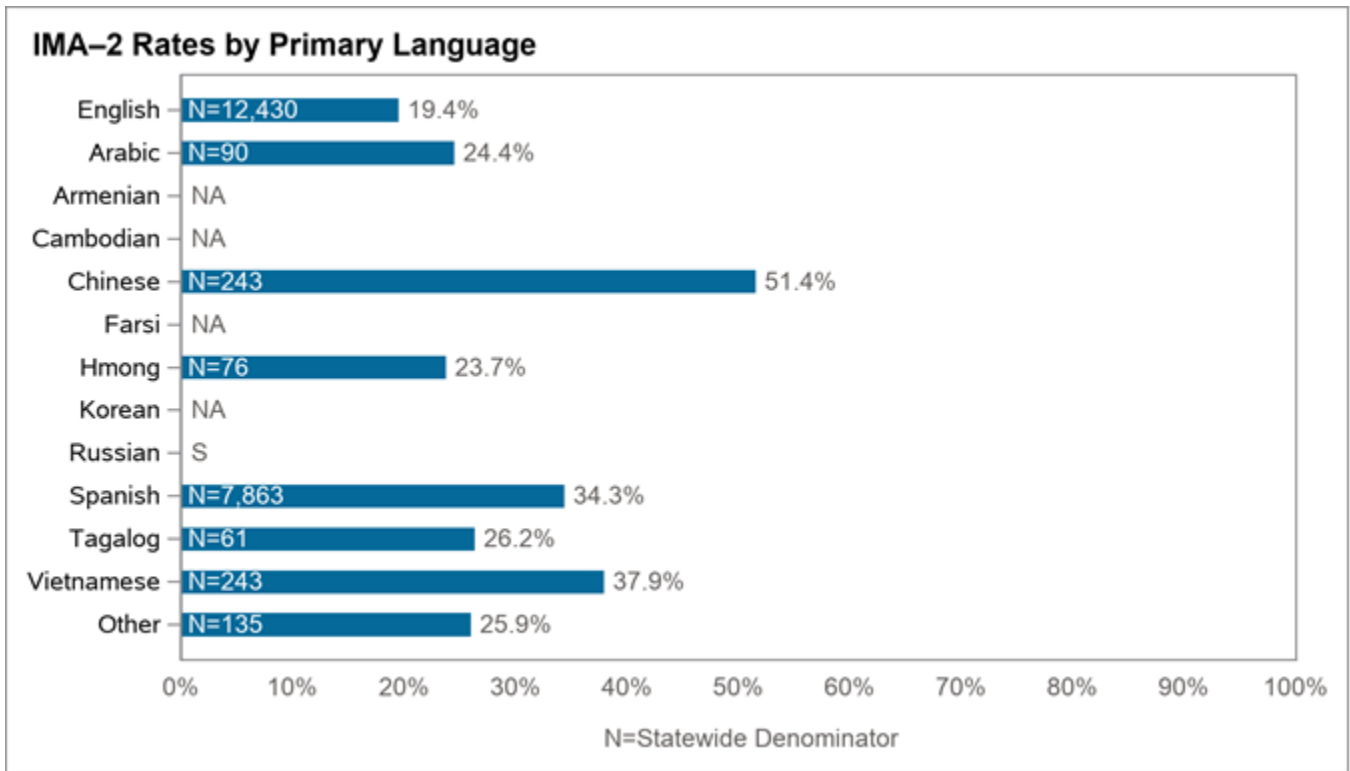············ MPL   N=Statewide Denominator
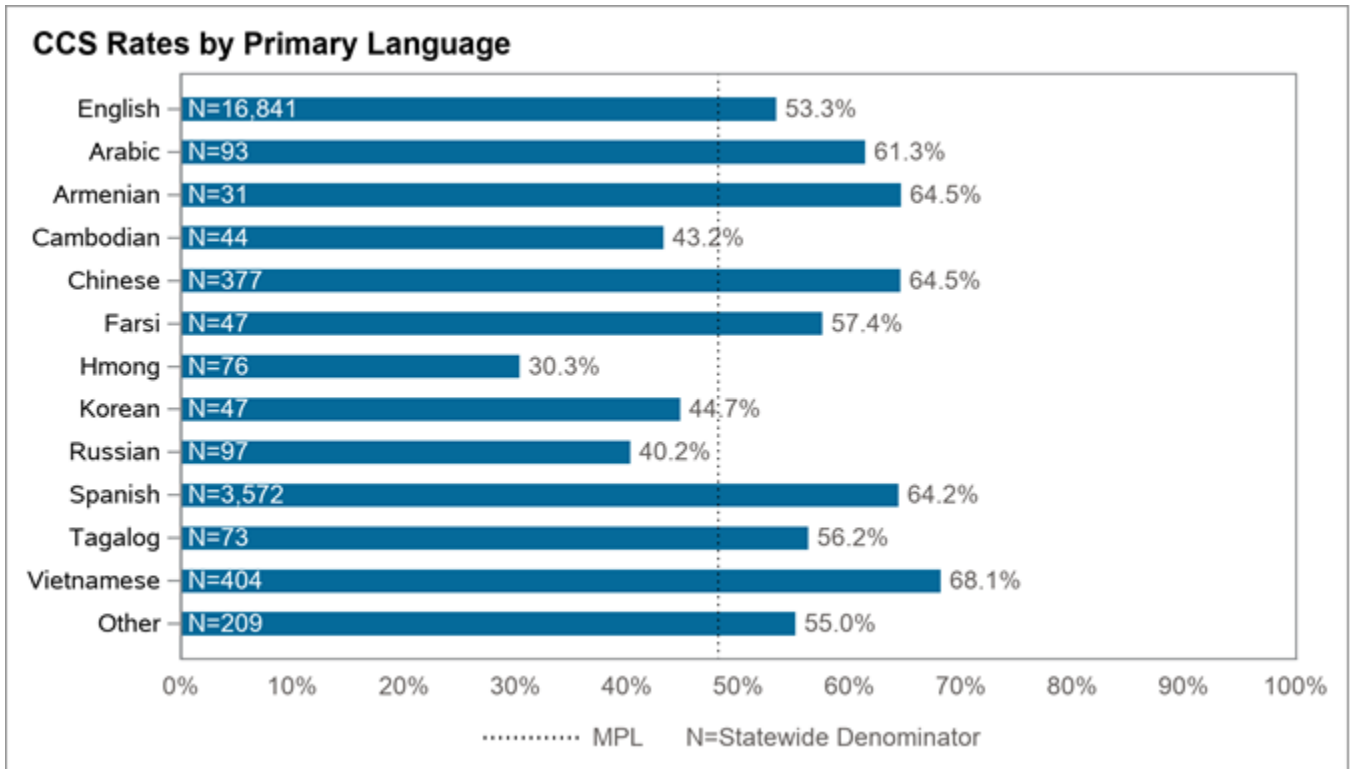
Note: The rate for the Unknown/Missing group was 32.7 percent (N=162).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

PPC–Pst Rates by Primary Language

Primary Language	N	Rate
English	N=15,988	62.1%
Arabic	N=92	71.7%
Armenian	NA	
Cambodian	NA	
Chinese	N=235	89.8%
Farsi	N=39	82.1%
Hmong	N=51	56.9%
Korean	NA	
Russian	N=72	66.7%
Spanish	N=2,867	74.9%
Tagalog	N=31	77.4%
Vietnamese	N=175	84.6%
Other	N=165	75.8%

············ MPL   N=Statewide Denominator

NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

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

Figure A.15—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Primary Language
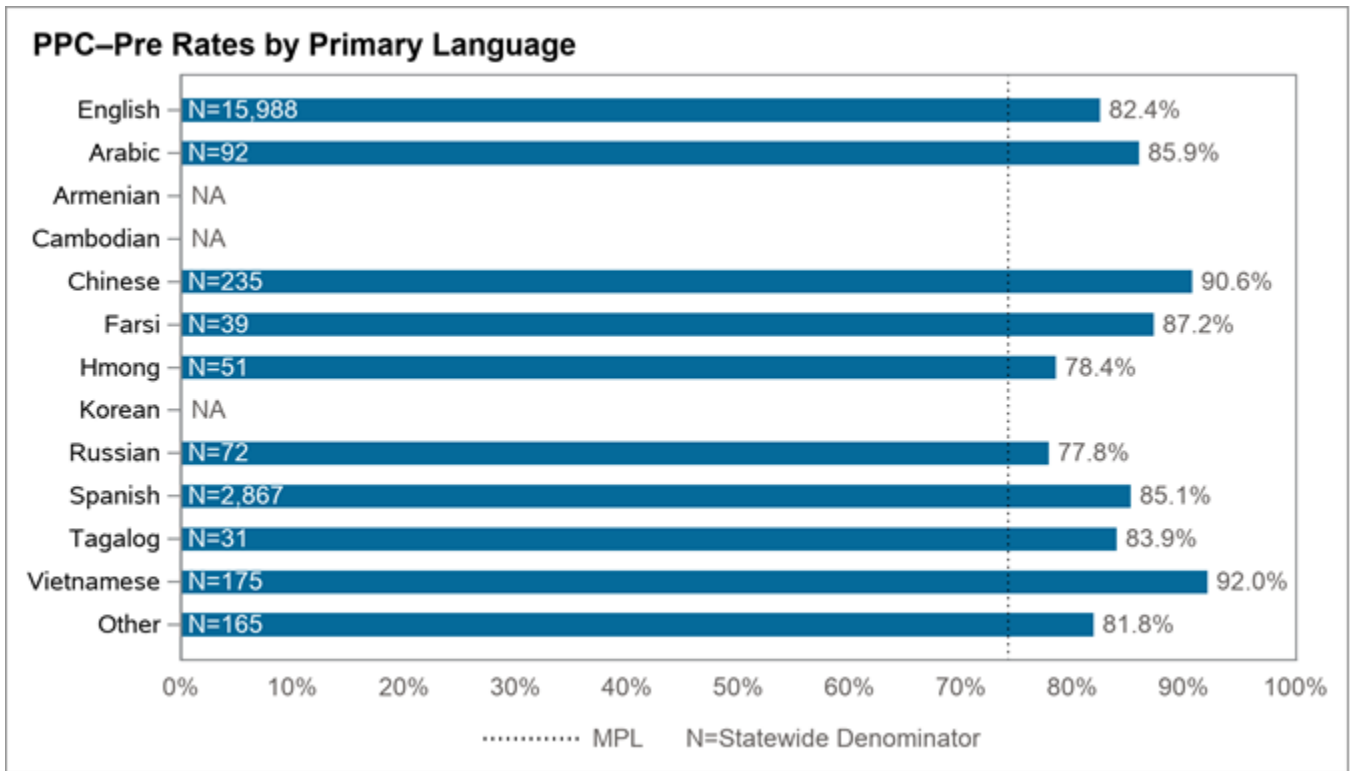
NA indicates the rate for the primary language group had a small denominator (i.e., less than 30).

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

Care for Chronic Conditions Domain

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

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

MPM–ACE Rates by Primary Language

Primary Language	N	Rate
English	N=222,845	86.1%
Arabic	N=3,464	92.5%
Armenian	N=5,782	90.2%
Cambodian	N=1,835	83.5%
Chinese	N=9,268	89.3%
Farsi	N=1,835	89.2%
Hmong	N=931	86.9%
Korean	N=1,837	84.2%
Russian	N=2,100	87.4%
Spanish	N=96,165	90.4%
Tagalog	N=4,870	89.0%
Vietnamese	N=12,492	89.0%
Other	N=7,081	87.9%

·········· MPL   N=Statewide Denominator
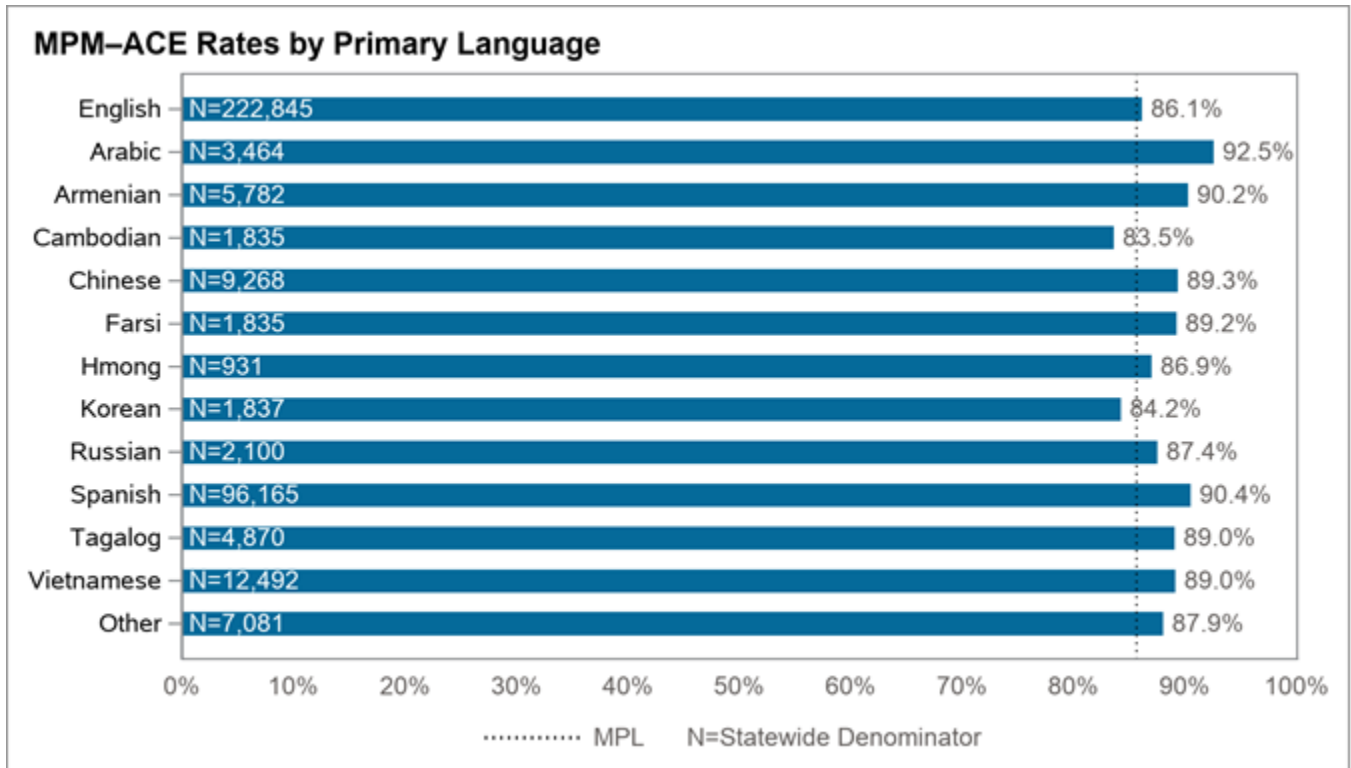
Note: The rate for the Unknown/Missing group was 88.4 percent (N=6,569).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

MPM–Diu Rates by Primary Language

Primary Language	N	Rate
English	N=137,273	85.7%
Arabic	N=1,752	92.8%
Armenian	N=2,686	91.1%
Cambodian	N=881	82.9%
Chinese	N=3,723	88.0%
Farsi	N=858	89.0%
Hmong	N=349	88.0%
Korean	N=759	82.1%
Russian	N=1,168	87.4%
Spanish	N=44,389	90.5%
Tagalog	N=1,935	89.1%
Vietnamese	N=4,129	87.9%
Other	N=3,348	88.2%

·········· MPL   N=Statewide Denominator
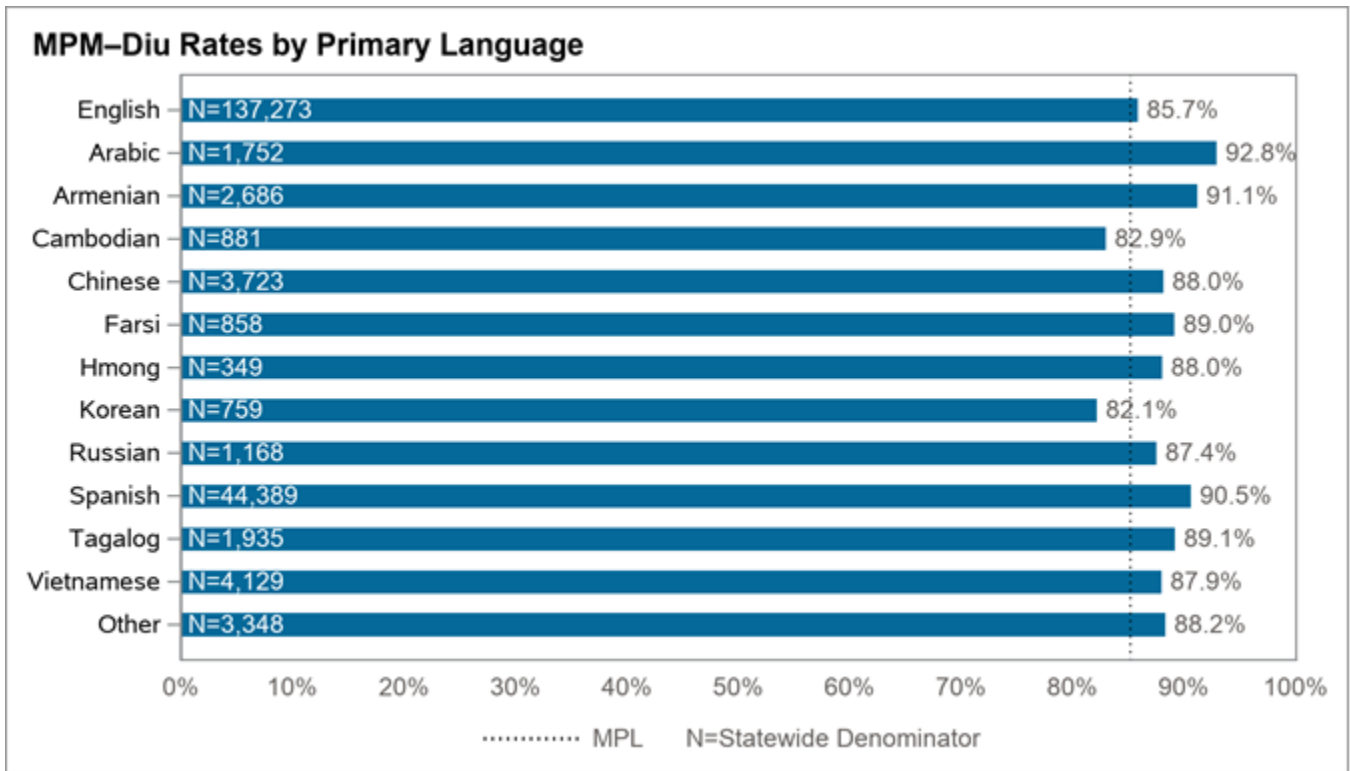
Note: The rate for the Unknown/Missing group was 87.9 percent (N=3,674).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

AMR Rates by Primary Language

Primary Language	N (Statewide Denominator)	Rate
English	N=68,346	57.9%
Arabic	N=293	69.6%
Armenian	N=552	56.7%
Cambodian	N=485	63.9%
Chinese	N=543	75.1%
Farsi	N=157	59.9%
Hmong	N=258	55.4%
Korean	N=53	58.5%
Russian	N=124	65.3%
Spanish	N=21,946	65.7%
Tagalog	N=166	59.6%
Vietnamese	N=1,746	70.4%
Other	N=717	66.5%

.... MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 62.4 percent (N=757).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CDC–BP Rates by Primary Language

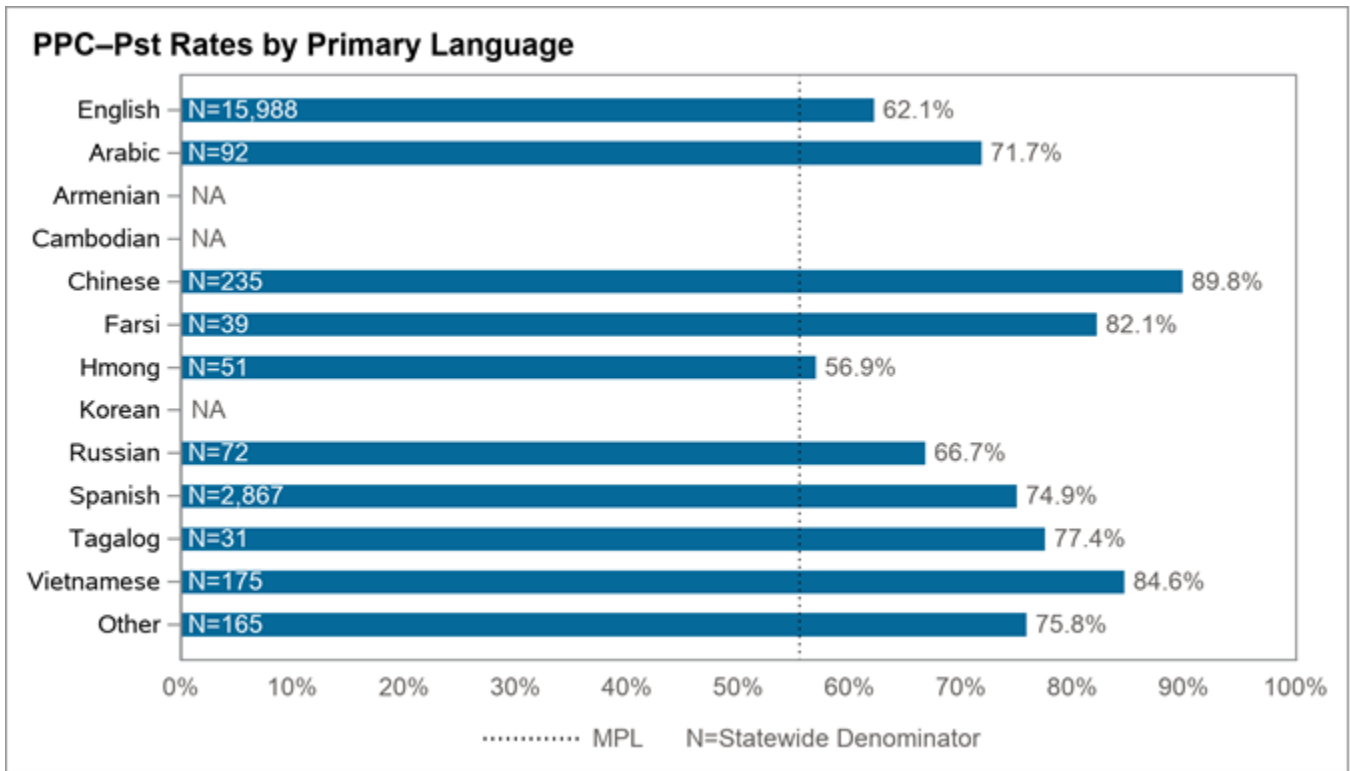| Primary Language	N (Statewide Denominator)	Rate
English	N=14,332	61.8%
Arabic	N=134	67.2%
Armenian	N=53	62.3%
Cambodian	N=77	57.1%
Chinese	N=345	76.2%
Farsi	N=73	67.1%
Hmong	N=101	67.3%
Korean	N=44	61.4%
Russian	N=98	55.1%
Spanish	N=5,545	67.9%
Tagalog	N=212	68.9%
Vietnamese	N=378	64.6%
Other	N=501	61.3%

·········· MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 64.0 percent (N=328).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CDC–E Rates by Primary Language

Primary Language	N (Statewide Denominator)	Rate
English	N=14,332	52.2%
Arabic	N=134	67.2%
Armenian	N=53	56.6%
Cambodian	N=77	49.4%
Chinese	N=345	69.6%
Farsi	N=73	65.8%
Hmong	N=101	40.6%
Korean	N=44	61.4%
Russian	N=98	51.0%
Spanish	N=5,545	63.9%
Tagalog	N=212	70.3%
Vietnamese	N=378	64.3%
Other	N=501	55.7%

·········· MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 51.2 percent (N=328).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CDC–H8 Rates by Primary Language

Primary Language	N (Statewide Denominator)	Rate
English	N=14,332	49.6%
Arabic	N=134	68.7%
Armenian	N=53	54.7%
Cambodian	N=77	58.4%
Chinese	N=345	71.3%
Farsi	N=73	58.9%
Hmong	N=101	49.5%
Korean	N=44	70.5%
Russian	N=98	56.1%
Spanish	N=5,545	52.0%
Tagalog	N=212	63.2%
Vietnamese	N=378	64.8%
Other	N=501	56.1%

············ MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 61.3 percent (N=328).
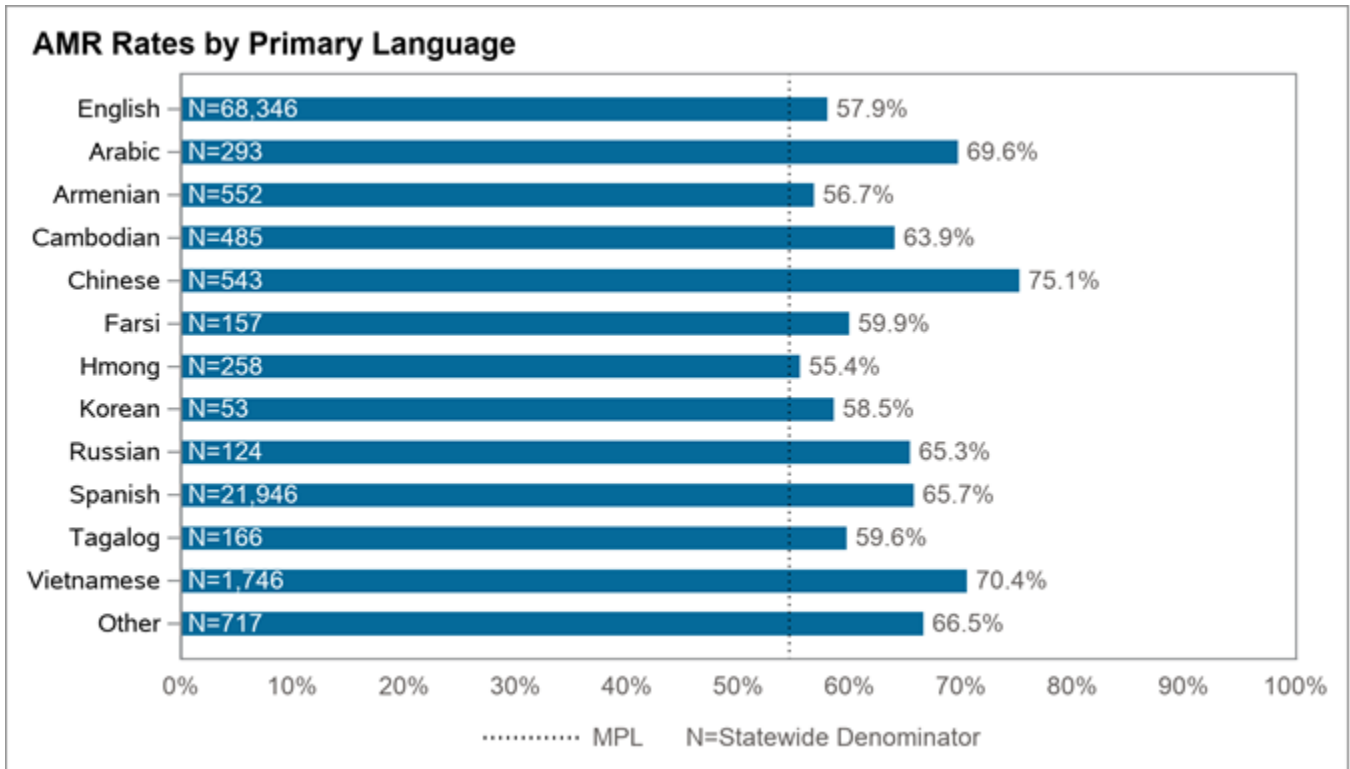The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CDC–H9 Rates by Primary Language

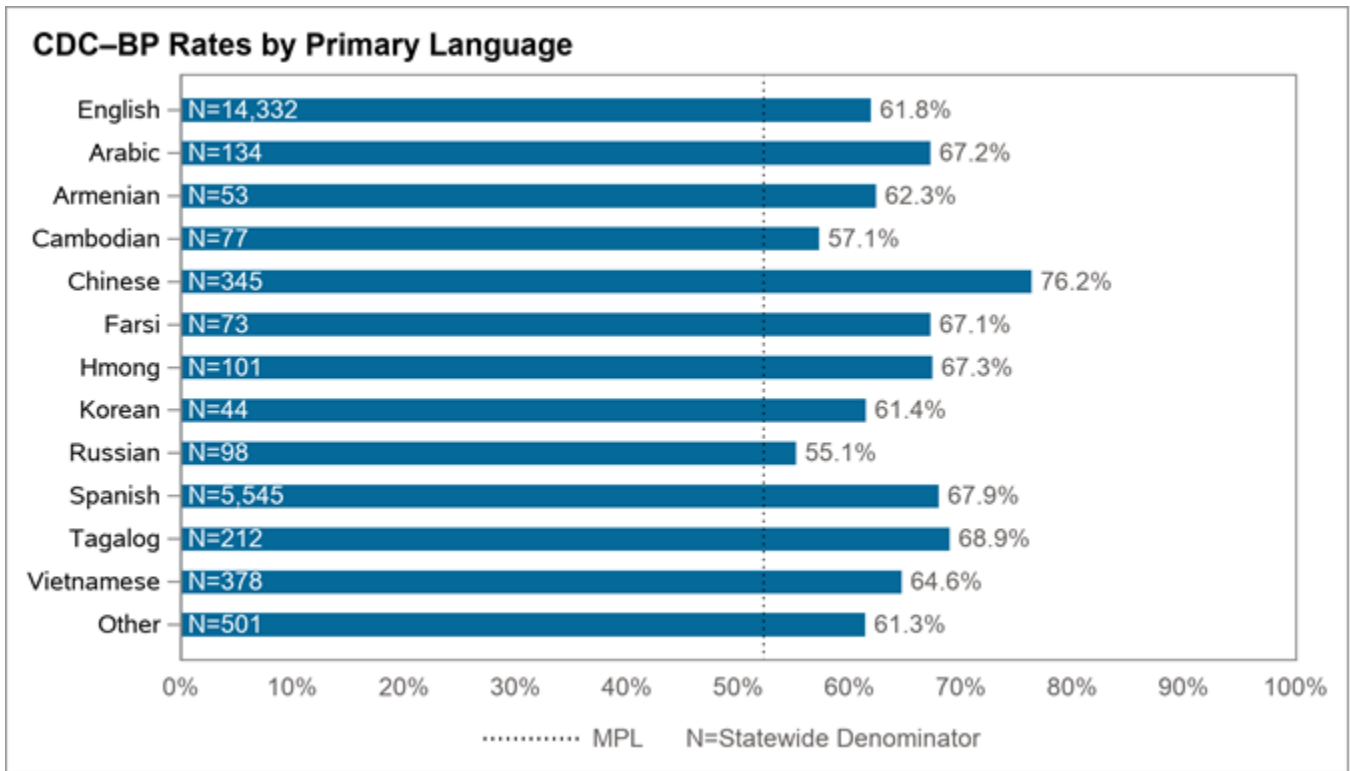| Primary Language	N (Statewide Denominator)	Rate
English	N=14,332	40.2%
Arabic	N=134	20.9%
Armenian	N=53	34.0%
Cambodian	N=77	31.2%
Chinese	N=345	20.9%
Farsi	N=73	31.5%
Hmong	N=101	40.6%
Korean	S	
Russian	N=98	26.5%
Spanish	N=5,545	36.0%
Tagalog	N=212	24.1%
Vietnamese	N=378	24.3%
Other	N=501	30.1%

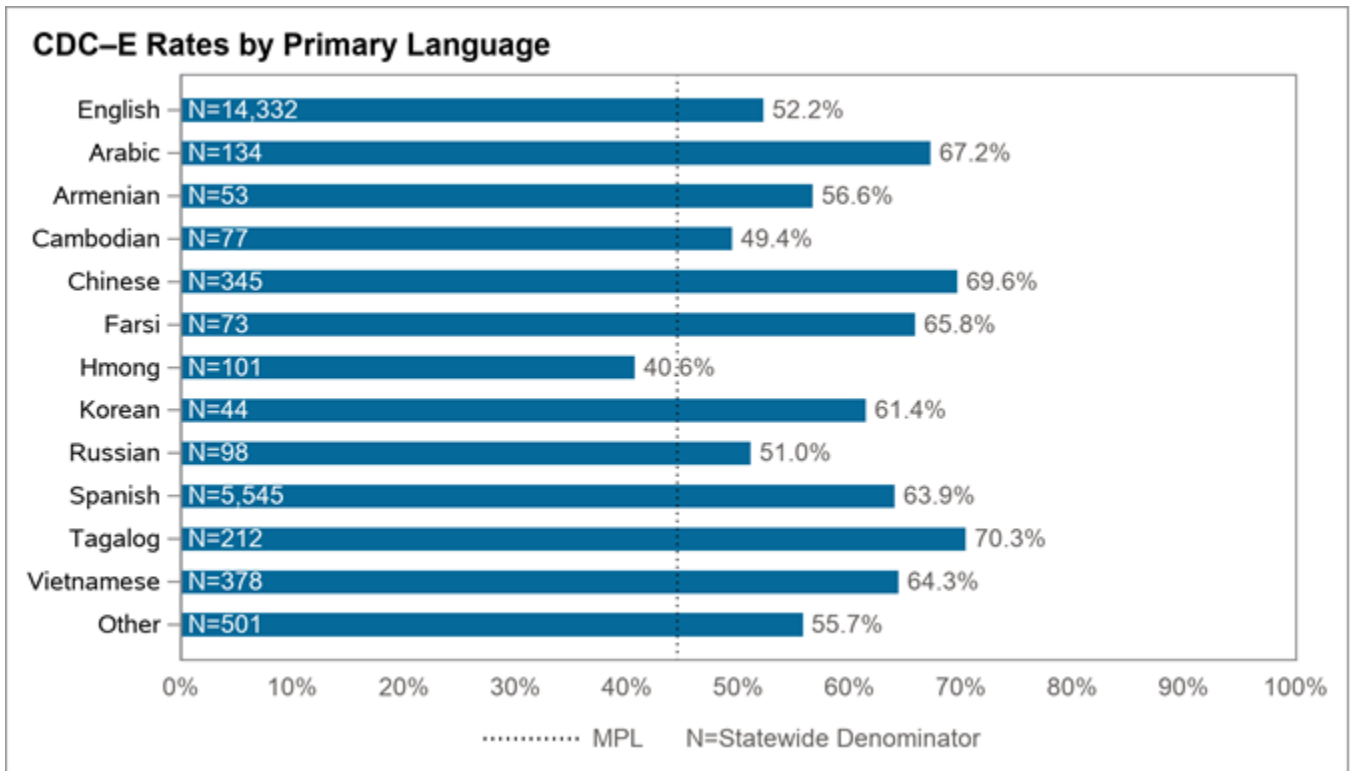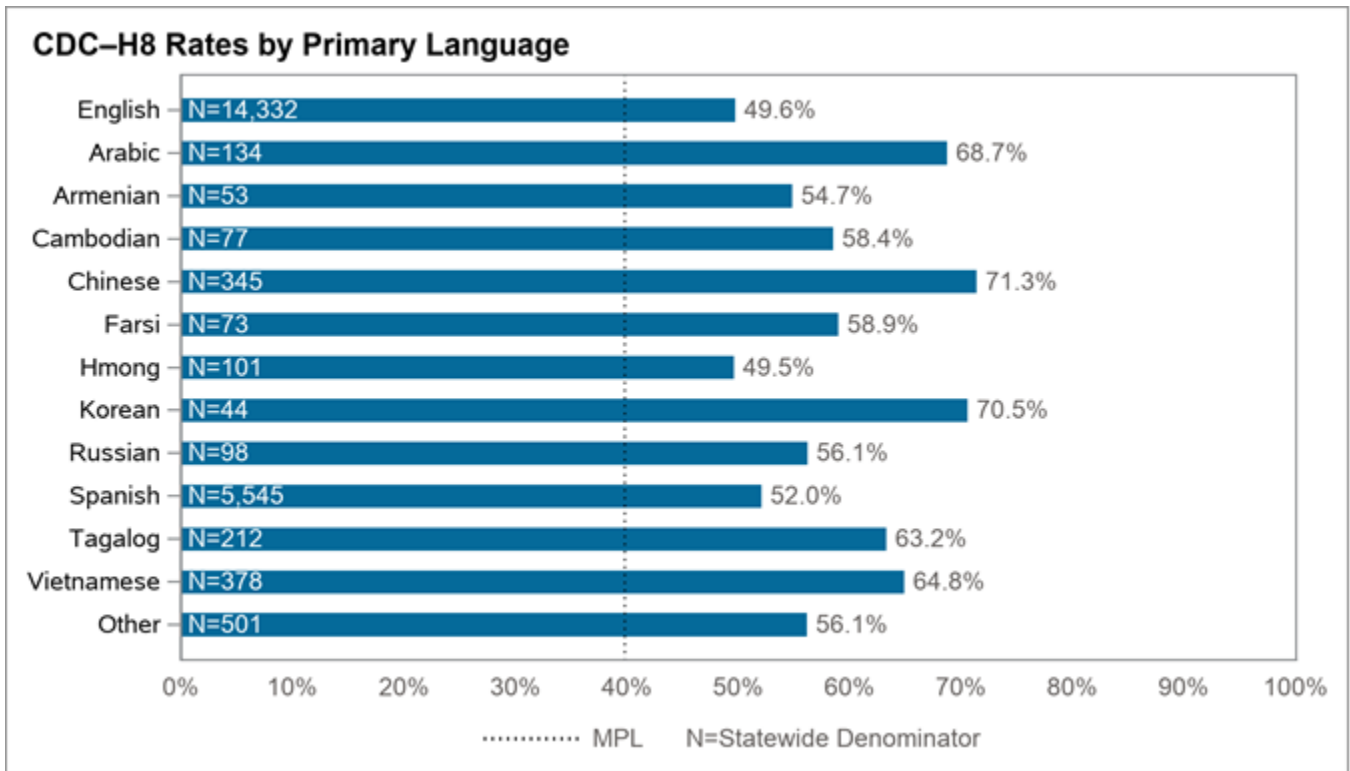·········· MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 30.2 percent (N=328).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.
A lower rate indicates more favorable performance 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 Health Insurance Portability and Accountability Act of 1996 Privacy Rule's de-identification standard.

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

CDC–HT Rates by Primary Language

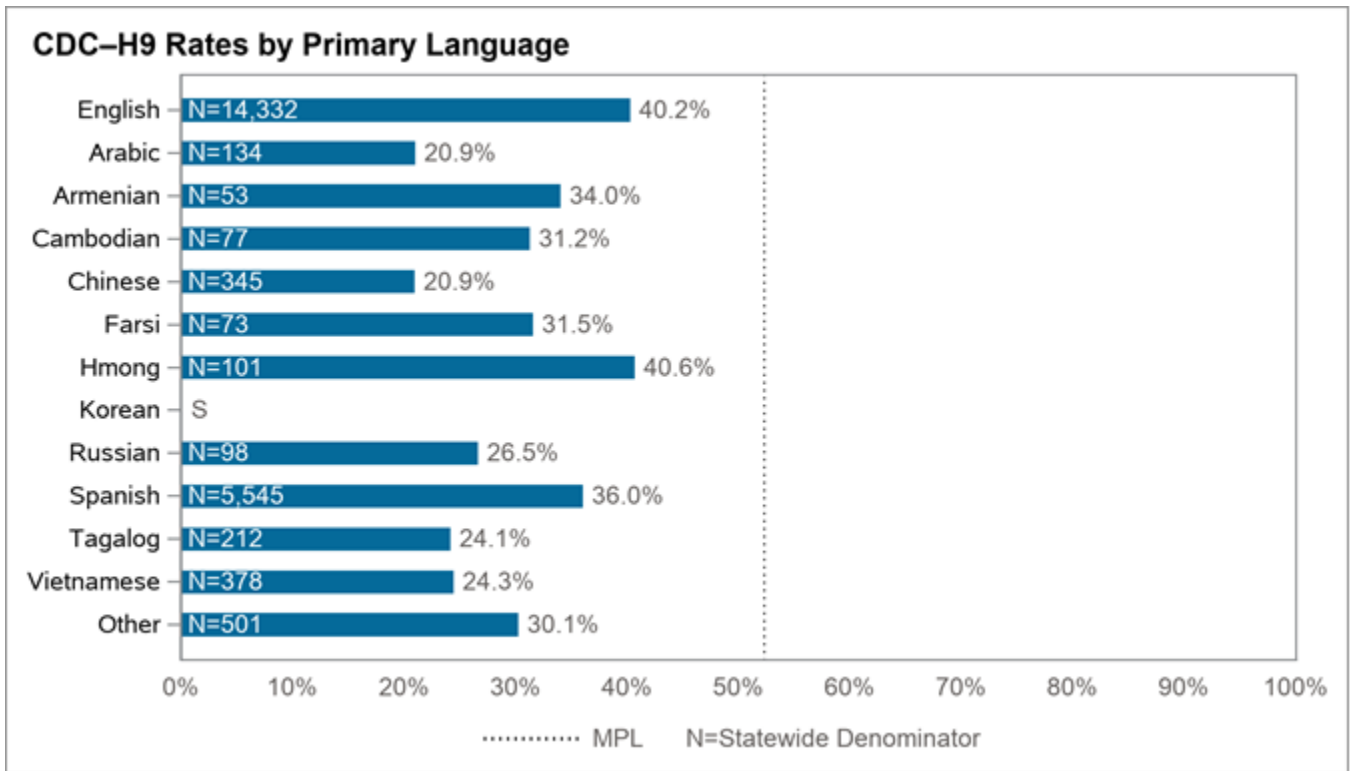| Primary Language	N	Rate
English	N=14,332	84.4%
Arabic	N=134	91.8%
Armenian	N=53	83.0%
Cambodian	N=77	89.6%
Chinese	N=345	90.7%
Farsi	N=73	90.4%
Hmong	N=101	87.1%
Korean	N=44	95.5%
Russian	N=98	85.7%
Spanish	N=5,545	90.9%
Tagalog	N=212	92.0%
Vietnamese	N=378	88.1%
Other	N=501	88.2%

.... MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 85.7 percent (N=328).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CDC–N Rates by Primary Language

Primary Language	N	Rate
English	N=14,332	88.5%
Arabic	N=134	93.3%
Armenian	N=53	96.2%
Cambodian	N=77	92.2%
Chinese	N=345	86.4%
Farsi	N=73	93.2%
Hmong	N=101	85.1%
Korean	N=44	88.6%
Russian	N=98	94.9%
Spanish	N=5,545	92.0%
Tagalog	N=212	95.3%
Vietnamese	N=378	90.2%
Other	N=501	90.2%

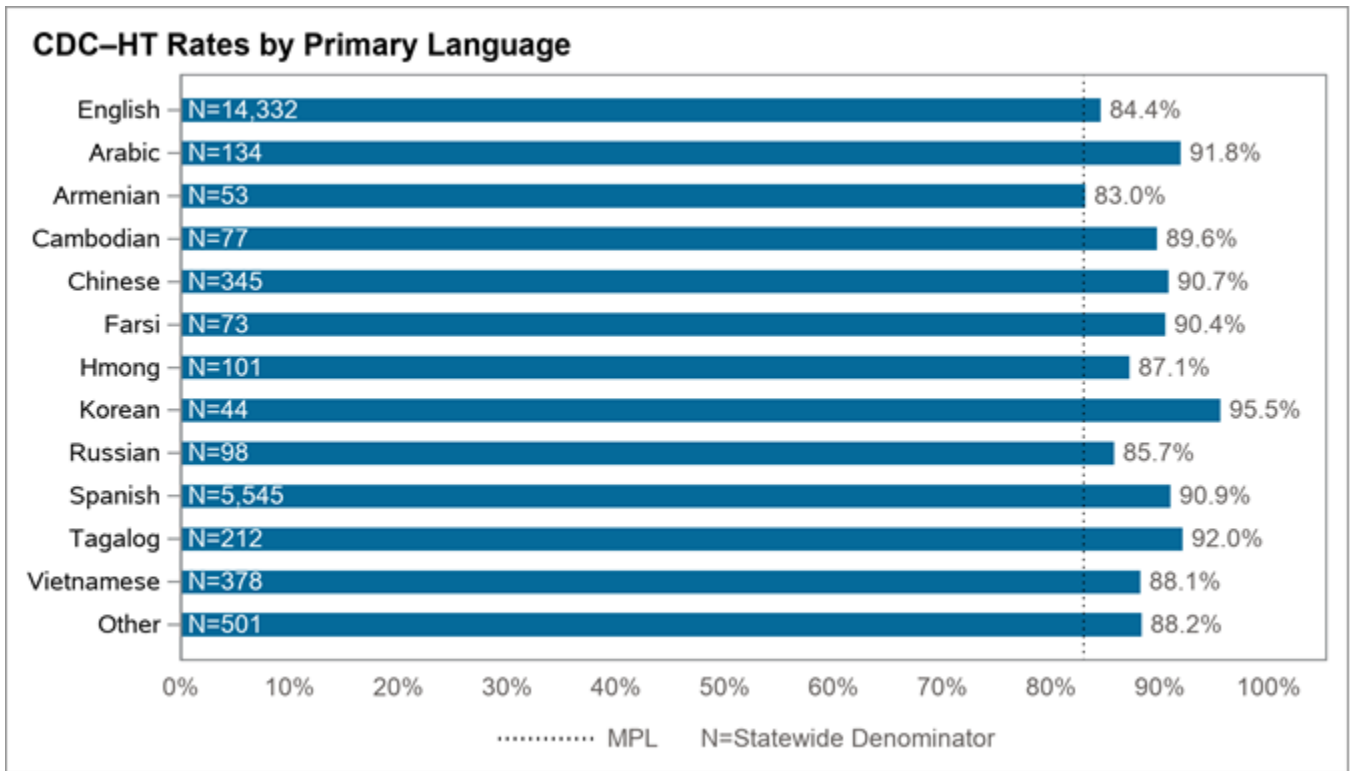............. MPL   N=Statewide Denominator
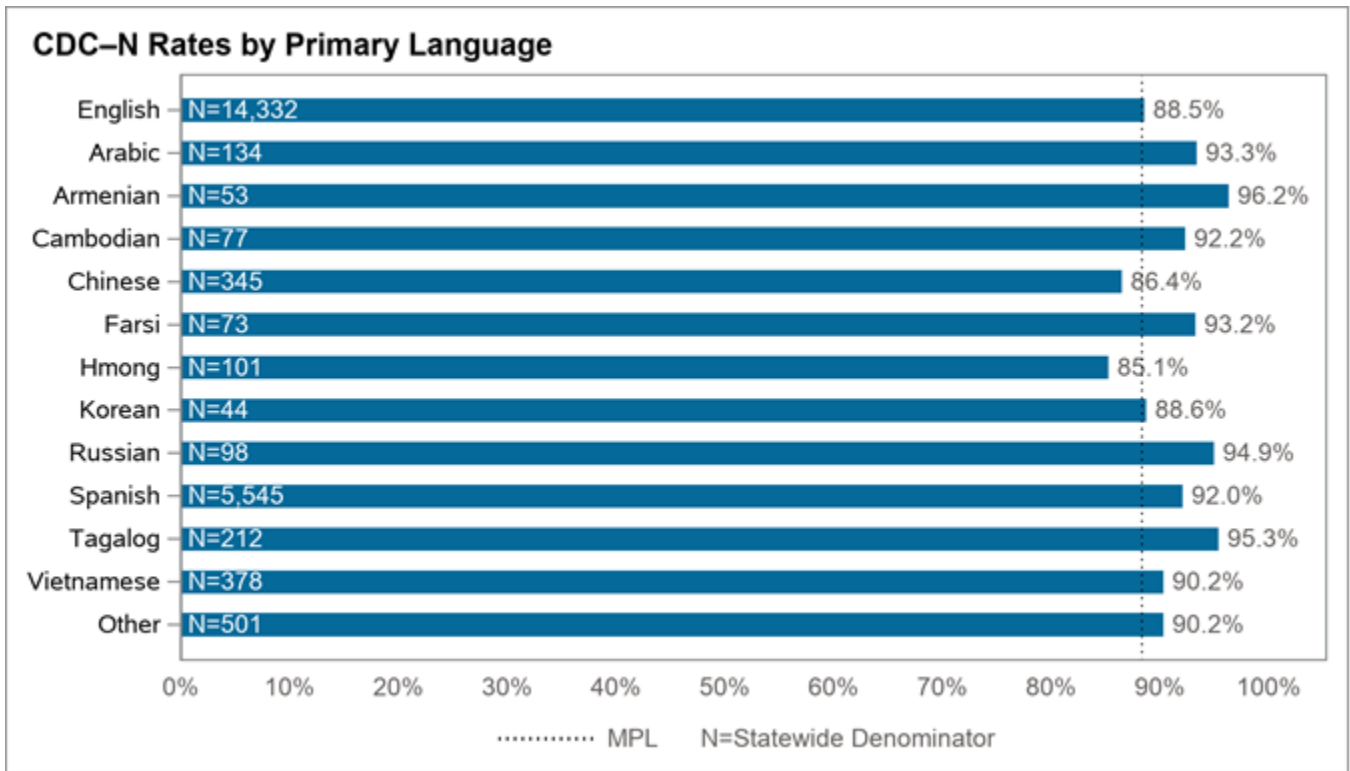
Note: The rate for the Unknown/Missing group was 90.9 percent (N=328).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CBP Rates by Primary Language

Primary Language	N	Rate
English	N=14,324	58.0%
Arabic	N=164	62.2%
Armenian	N=41	65.9%
Cambodian	N=87	56.3%
Chinese	N=466	74.2%
Farsi	N=71	70.4%
Hmong	N=94	44.7%
Korean	N=61	59.0%
Russian	N=189	57.1%
Spanish	N=4,368	63.7%
Tagalog	N=262	66.8%
Vietnamese	N=476	65.8%
Other	N=445	58.7%

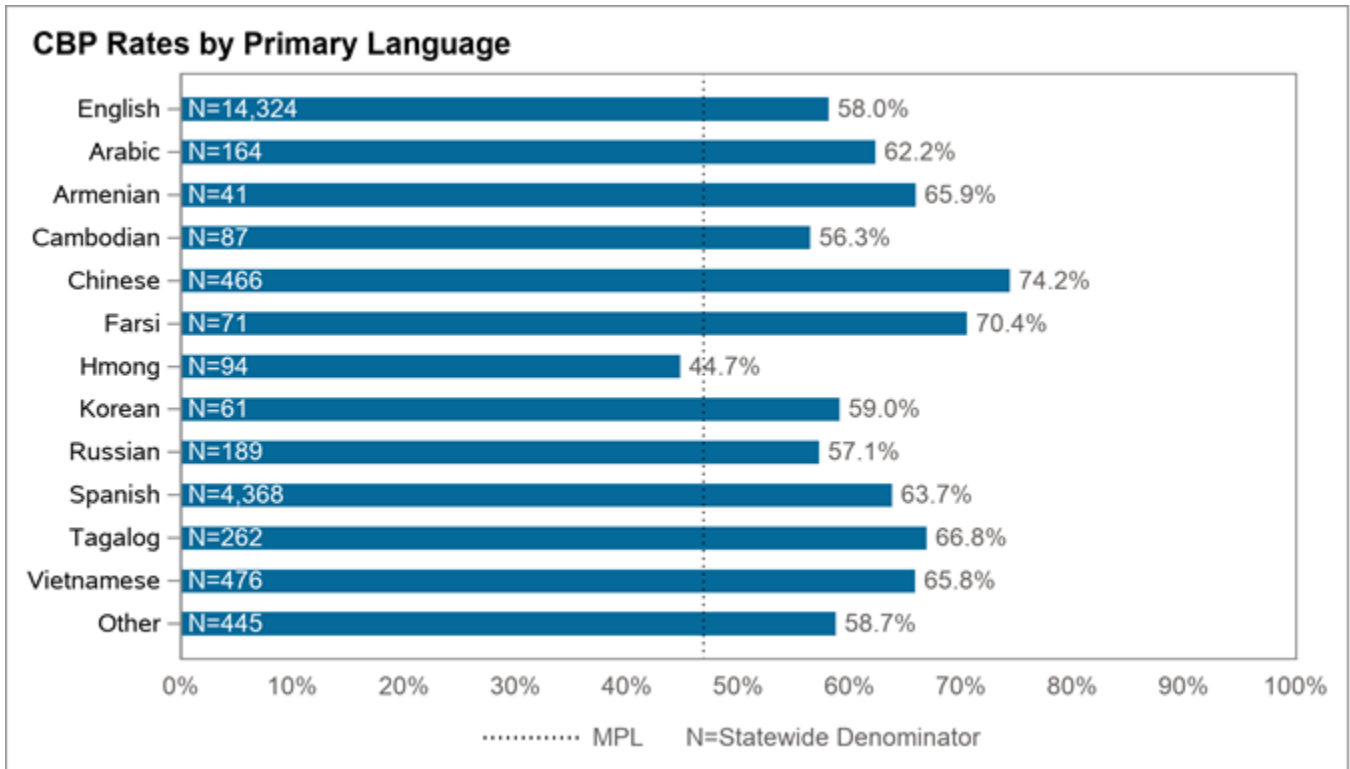............. MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 72.1 percent (N=362).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

Appropriate Treatment and Utilization Domain

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

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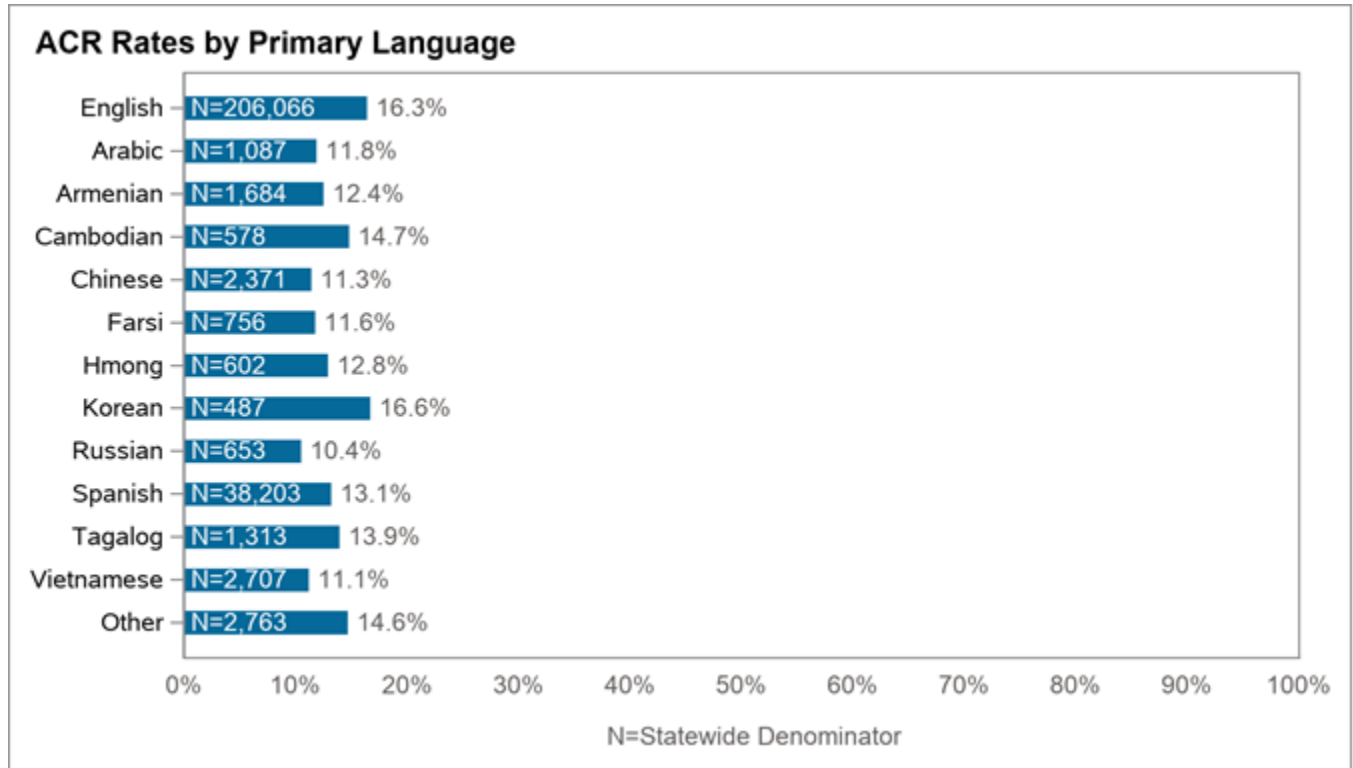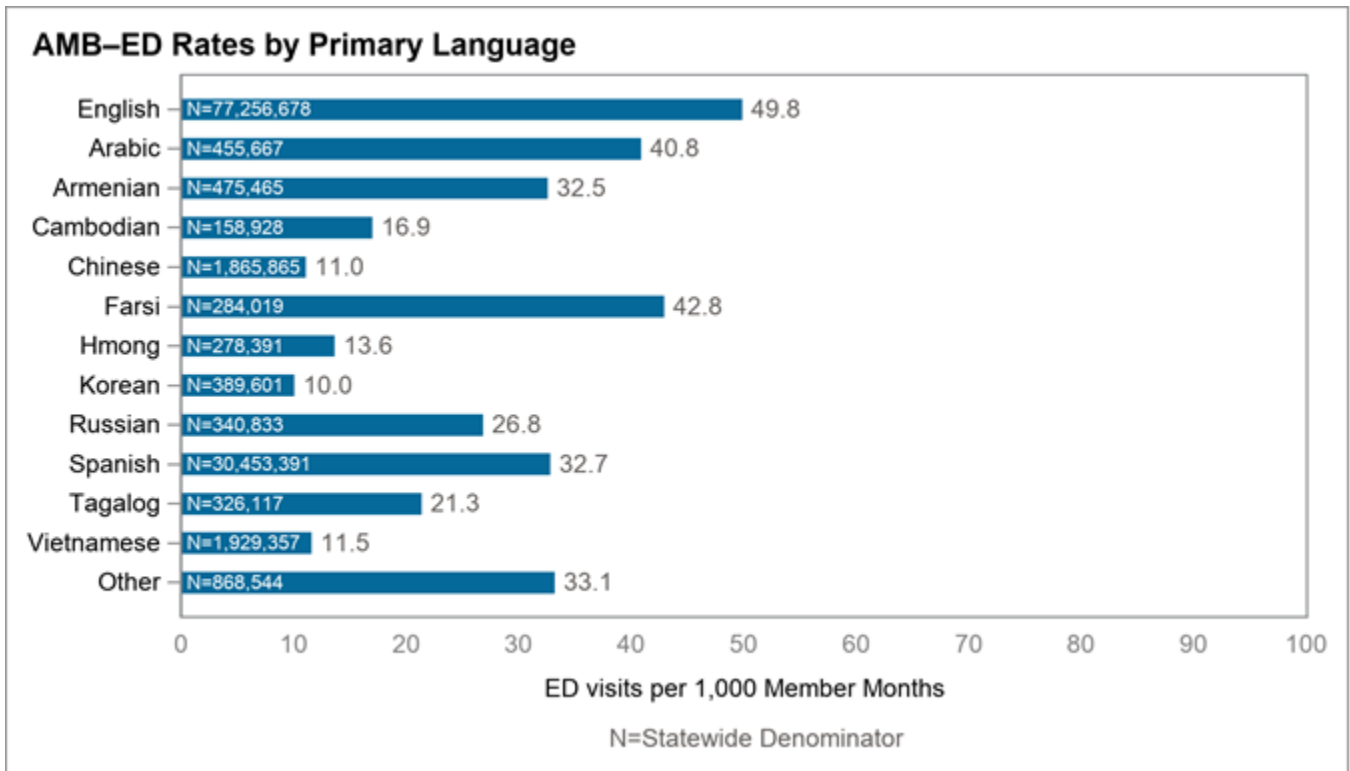

Note: The rate for the Unknown/Missing group was 16.0 percent (N=3,378).
A lower rate indicates more favorable performance for this indicator.
The *All-Cause Readmissions* indicator was originally developed for the ACR Collaborative Quality Improvement Project; therefore, no minimum performance level was established for this indicator.
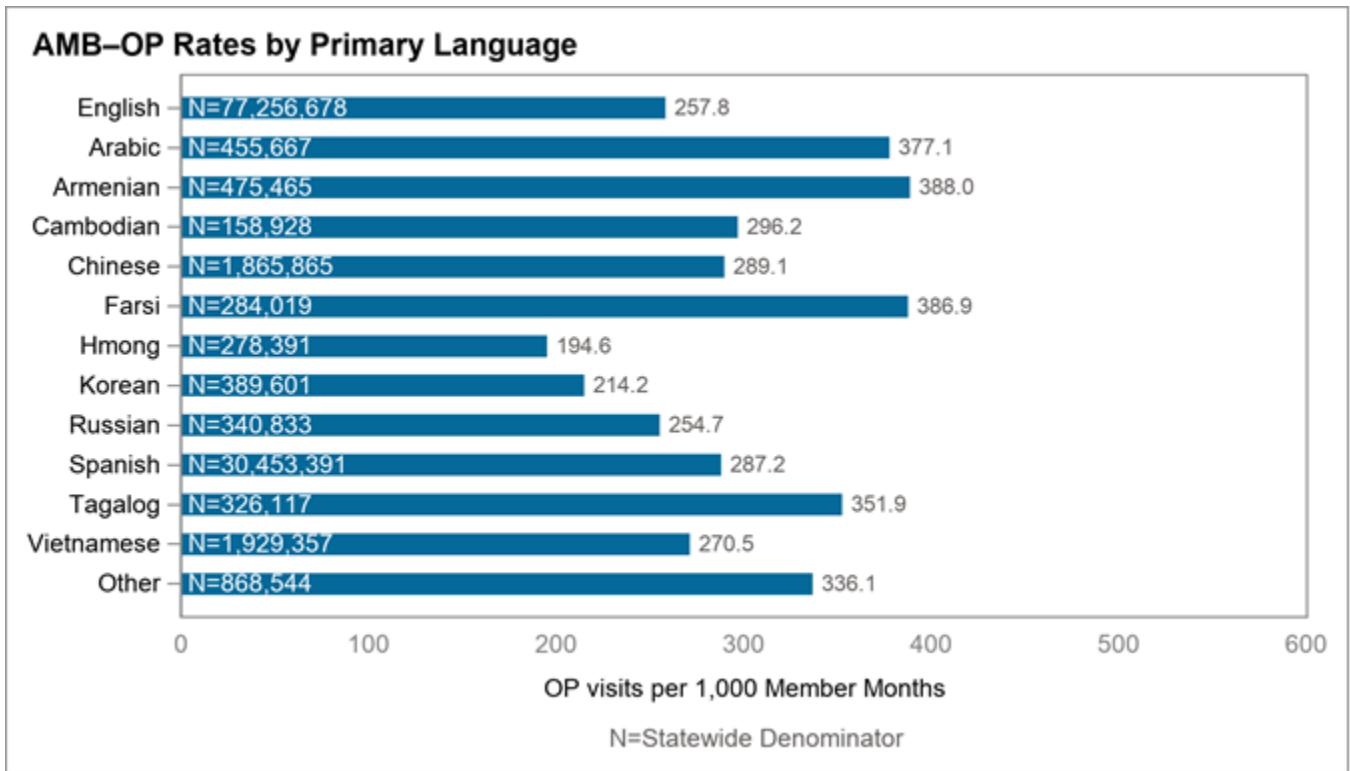
Figure A.27—Ambulatory Care—Emergency Department Visits (AMB–ED) Rates by Primary Language

AMB–ED Rates by Primary Language

Primary Language	N=Statewide Denominator	ED visits per 1,000 Member Months
English	N=77,256,678	49.8
Arabic	N=455,667	40.8
Armenian	N=475,465	32.5
Cambodian	N=158,928	16.9
Chinese	N=1,865,865	11.0
Farsi	N=284,019	42.8
Hmong	N=278,391	13.6
Korean	N=389,601	10.0
Russian	N=340,833	26.8
Spanish	N=30,453,391	32.7
Tagalog	N=326,117	21.3
Vietnamese	N=1,929,357	11.5
Other	N=868,544	33.1

Note: The rate for the Unknown/Missing group was 43.7 emergency department visits per 1,000 member months (N=501,403).

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

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

AMB–OP Rates by Primary Language

Primary Language	N (Statewide Denominator)	Rate
English	N=77,256,678	257.8
Arabic	N=455,667	377.1
Armenian	N=475,465	388.0
Cambodian	N=158,928	296.2
Chinese	N=1,865,865	289.1
Farsi	N=284,019	386.9
Hmong	N=278,391	194.6
Korean	N=389,601	214.2
Russian	N=340,833	254.7
Spanish	N=30,453,391	287.2
Tagalog	N=326,117	351.9
Vietnamese	N=1,929,357	270.5
Other	N=868,544	336.1

OP visits per 1,000 Member Months

N=Statewide Denominator

Note: The rate for the Unknown/Missing was 341.6 OP visits per 1,000 member months (N=501,403).

The *Ambulatory Care—Outpatient Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.
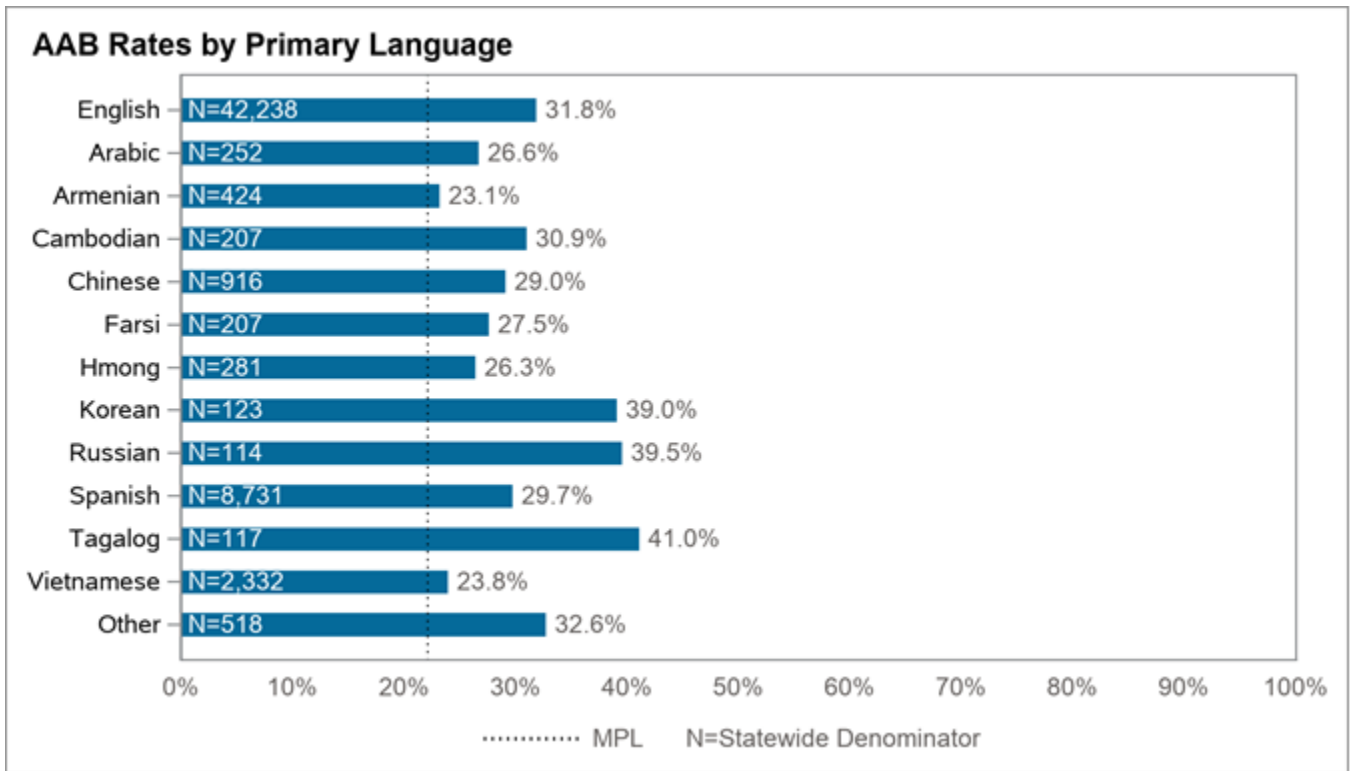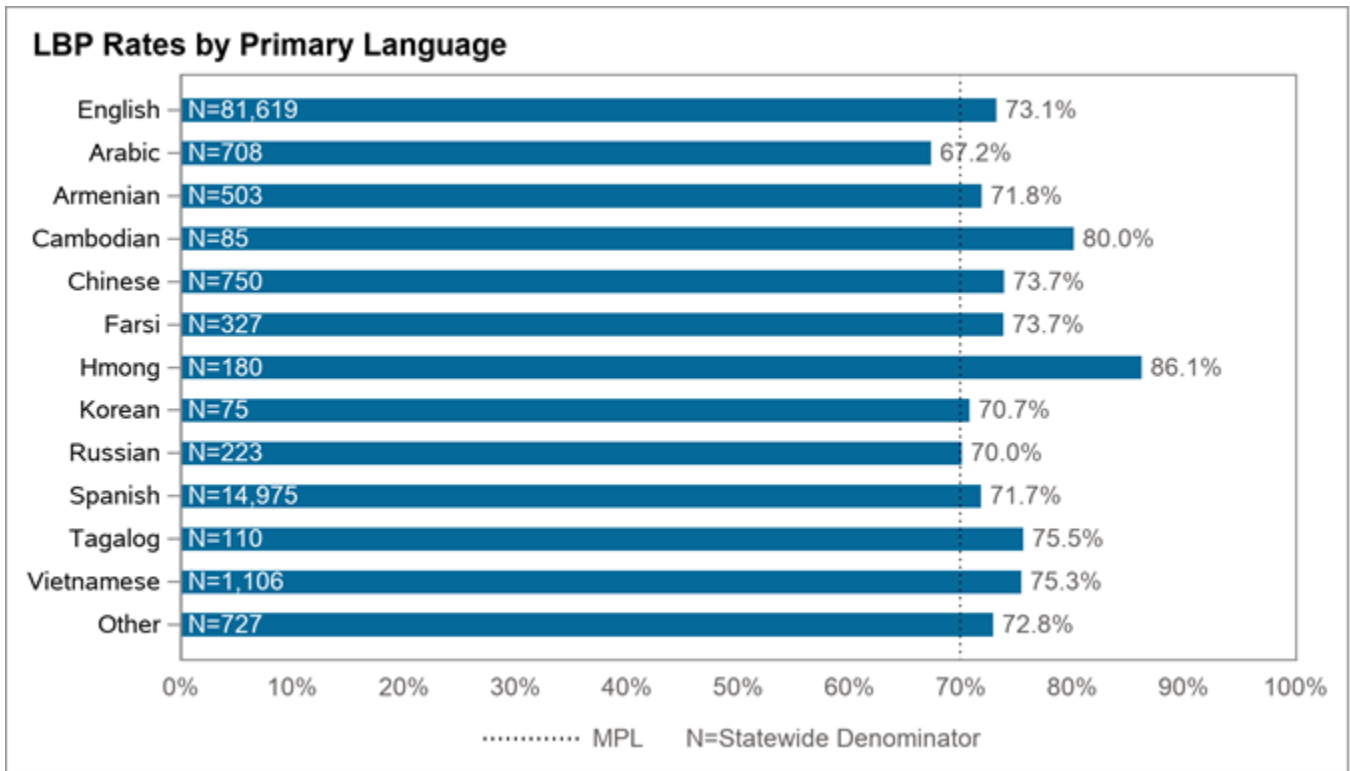
Figure A.29—Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB) Rates by Primary Language

AAB Rates by Primary Language

Primary Language	N	Rate
English	N=42,238	31.8%
Arabic	N=252	26.6%
Armenian	N=424	23.1%
Cambodian	N=207	30.9%
Chinese	N=916	29.0%
Farsi	N=207	27.5%
Hmong	N=281	26.3%
Korean	N=123	39.0%
Russian	N=114	39.5%
Spanish	N=8,731	29.7%
Tagalog	N=117	41.0%
Vietnamese	N=2,332	23.8%
Other	N=518	32.6%

·········· MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 31.9 percent (N=521).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.
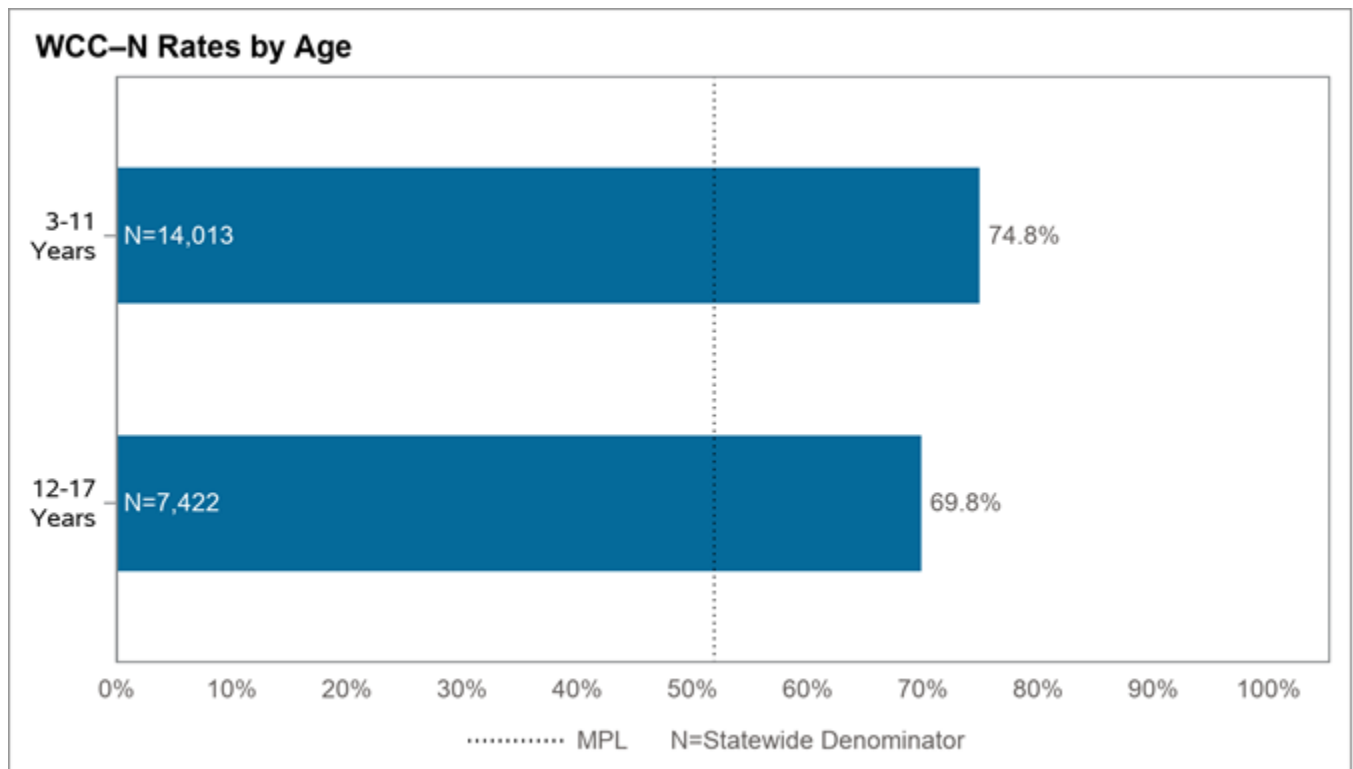
Figure A.30—Use of Imaging Studies for Low Back Pain (LBP) Rates by Primary Language

LBP Rates by Primary Language

Primary Language	N (Statewide Denominator)	Rate
English	N=81,619	73.1%
Arabic	N=708	67.2%
Armenian	N=503	71.8%
Cambodian	N=85	80.0%
Chinese	N=750	73.7%
Farsi	N=327	73.7%
Hmong	N=180	86.1%
Korean	N=75	70.7%
Russian	N=223	70.0%
Spanish	N=14,975	71.7%
Tagalog	N=110	75.5%
Vietnamese	N=1,106	75.3%
Other	N=727	72.8%

·········· MPL   N=Statewide Denominator

Note: The rate for the Unknown/Missing group was 74.6 percent (N=354).
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

Age

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

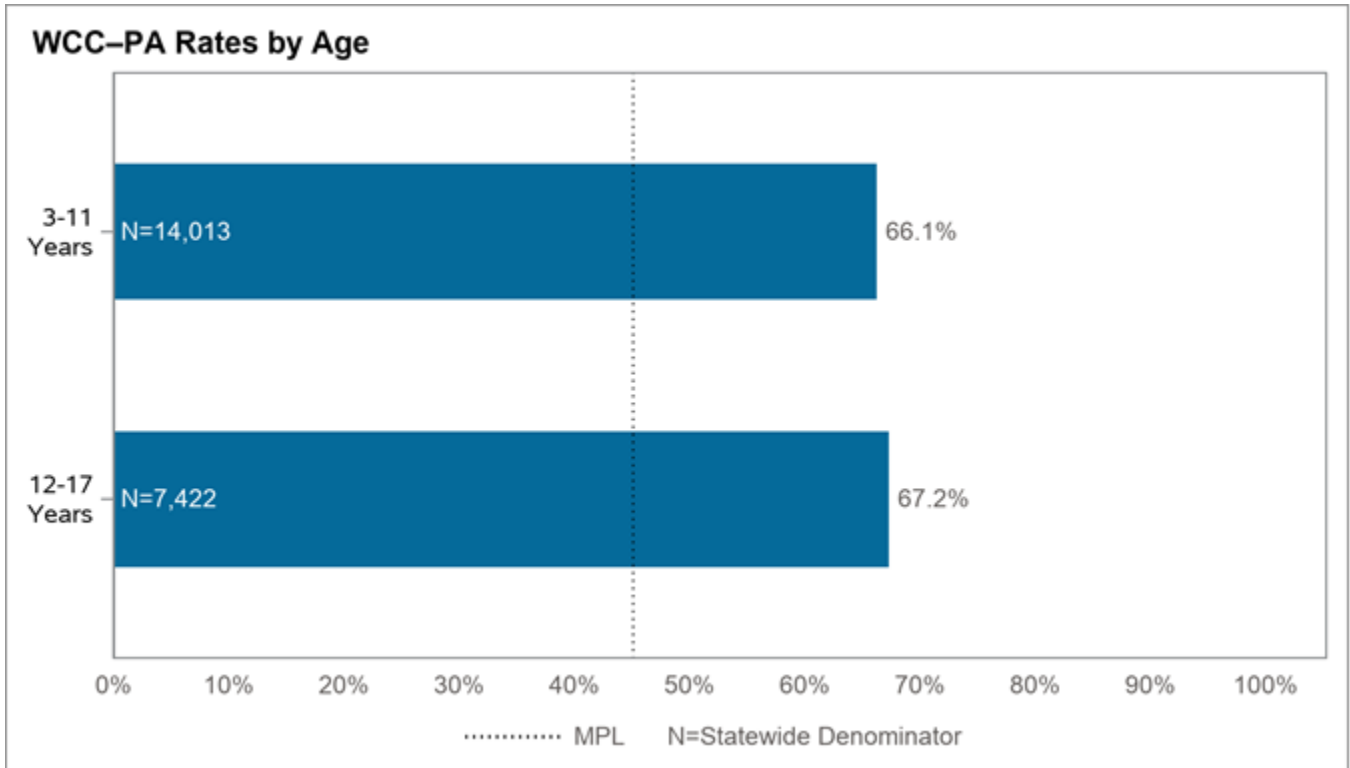## *Preventive Screening and Children's Health Domain*

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

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

WCC–N Rates by Age

Age	Rate
3-11 Years	N=14,013 — 74.8%
12-17 Years	N=7,422 — 69.8%

············ MPL   N=Statewide Denominator

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

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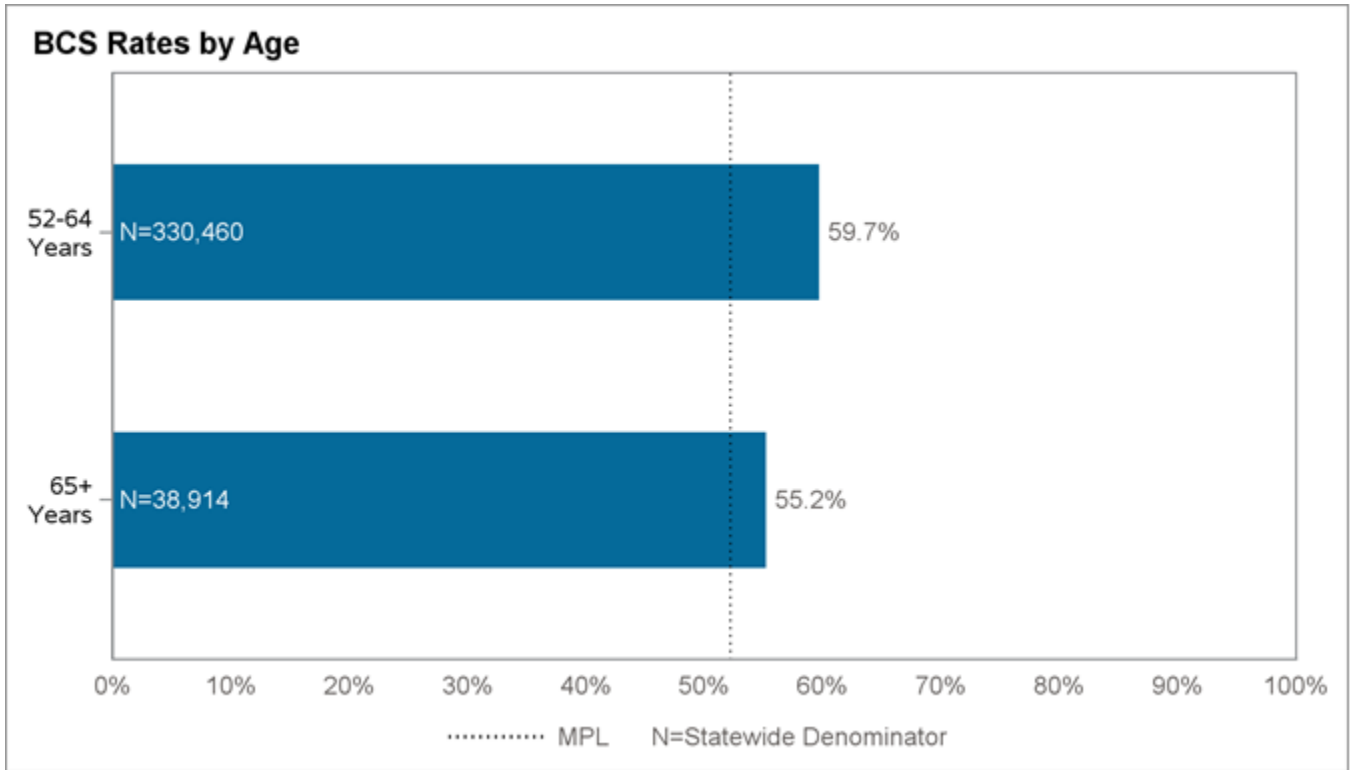

WCC–PA Rates by Age

Age	N	Rate
3-11 Years	N=14,013	66.1%
12-17 Years	N=7,422	67.2%

············ MPL   N=Statewide Denominator

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

Preventive Screening and Women's Health

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

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

BCS Rates by Age

Age Group	N	Rate
52-64 Years	N=330,460	59.7%
65+ Years	N=38,914	55.2%

.... MPL   N=Statewide Denominator

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

Figure A.34—Cervical Cancer Screening (CCS) Rates by Age
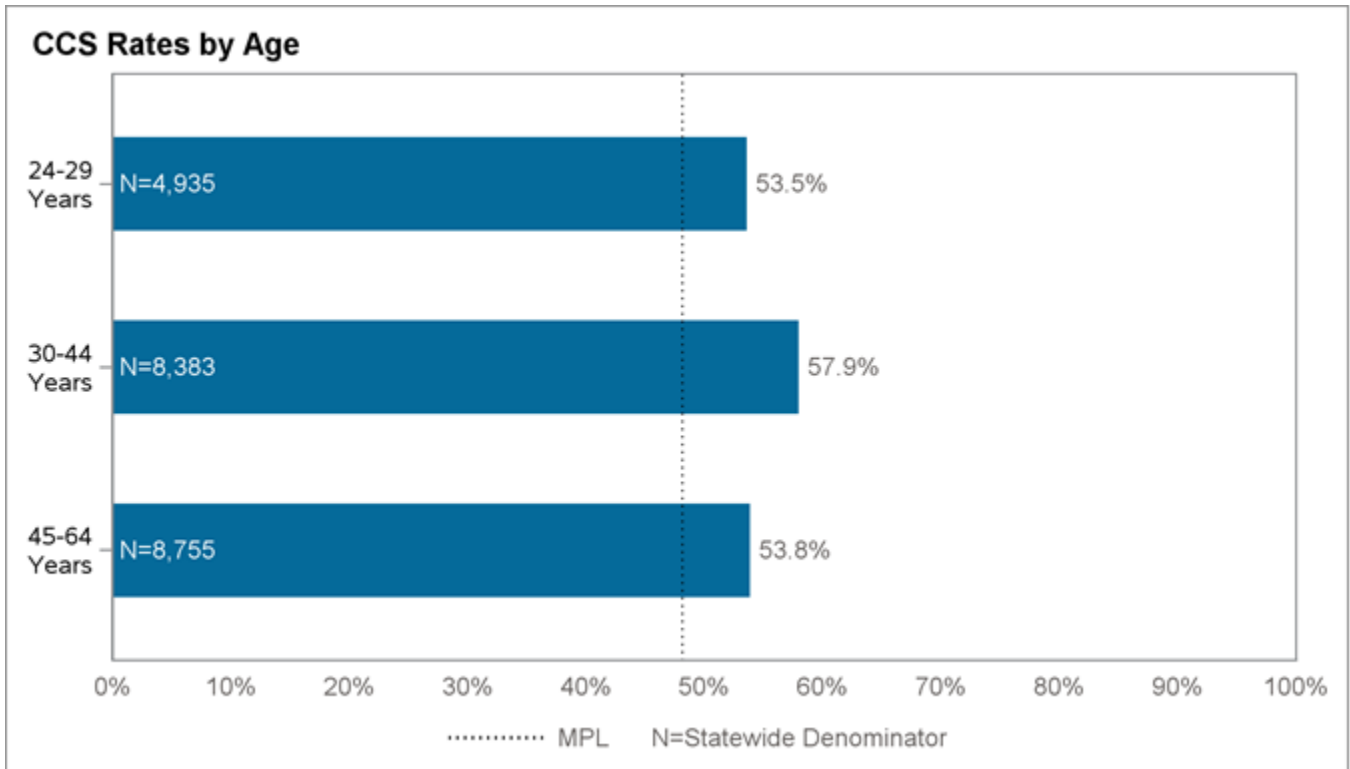
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

Figure A.35—Prenatal and Postpartum Care—Postpartum Care (PPC–Pst) Rates by Age
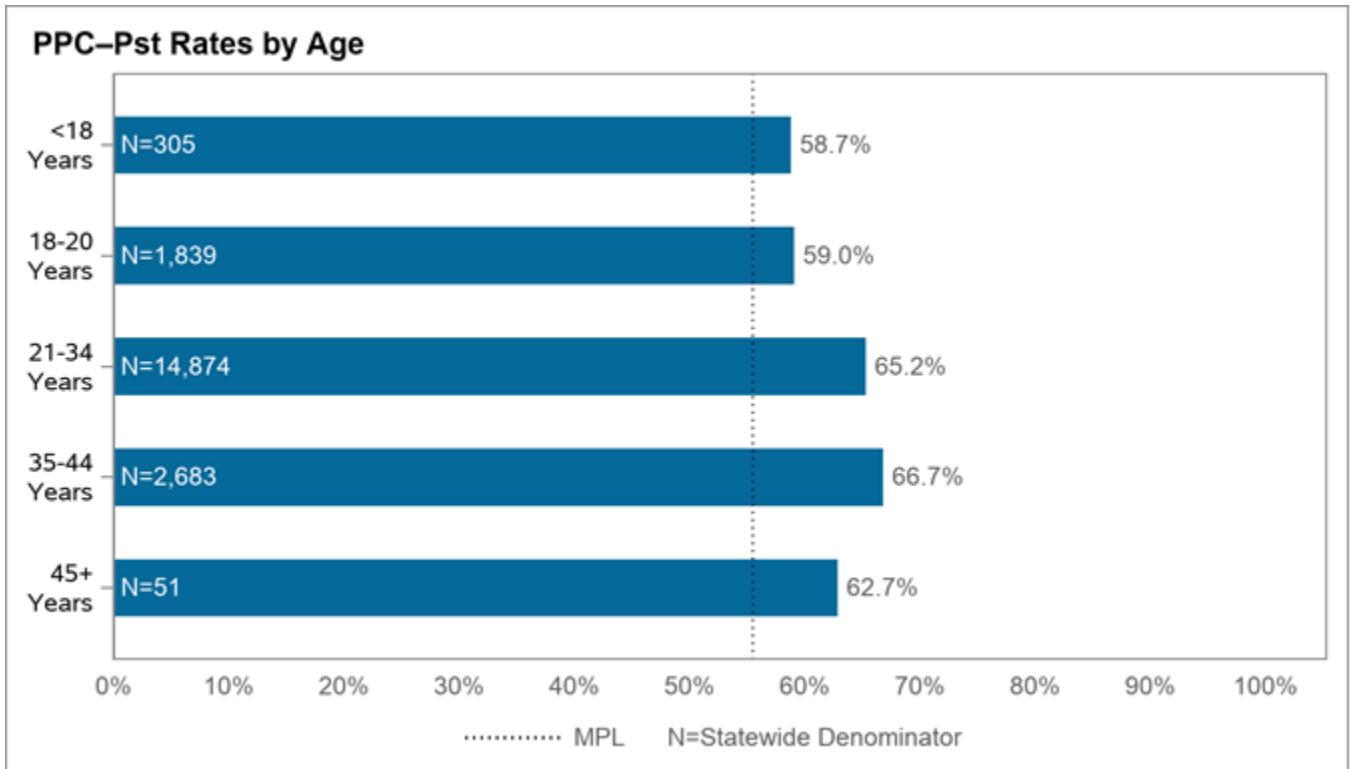
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

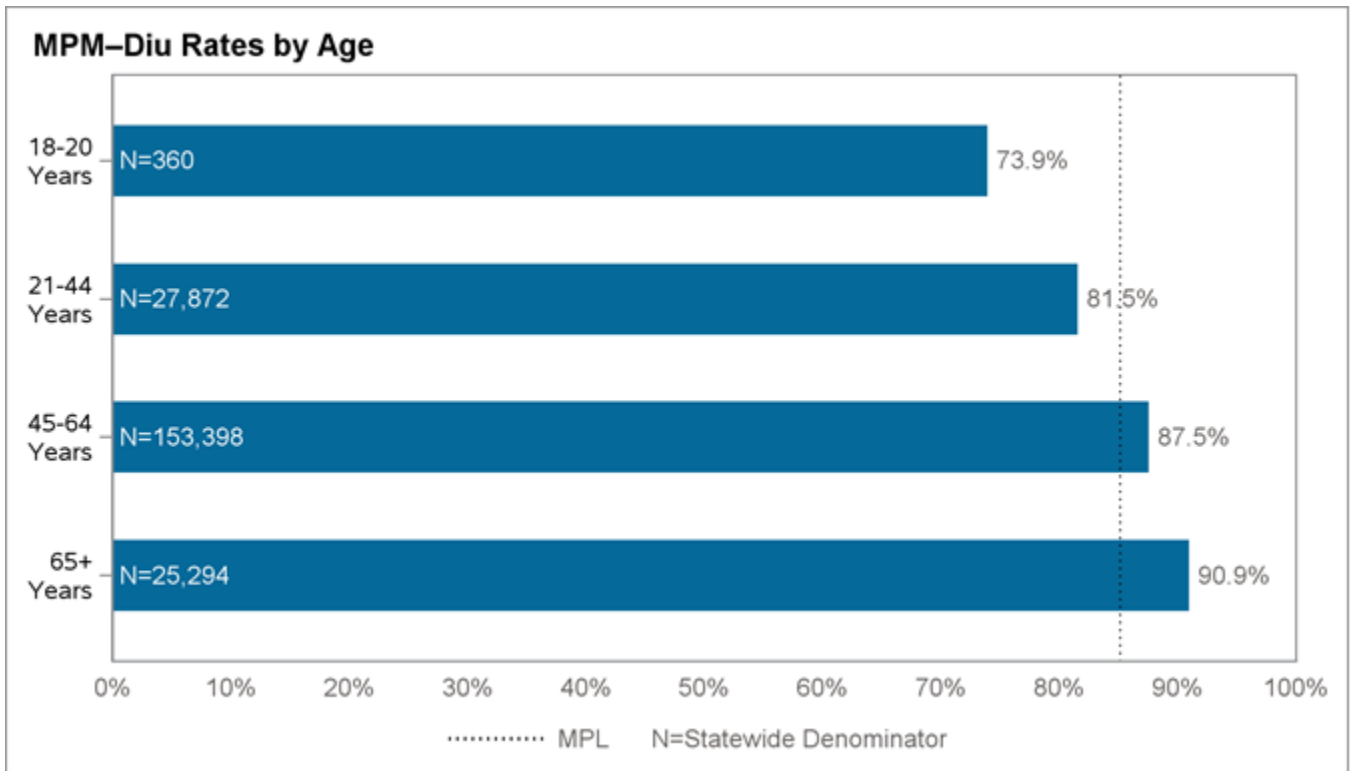**Figure A.36—Prenatal and Postpartum Care—Timeliness of Prenatal Care (PPC–Pre) Rates by Age**
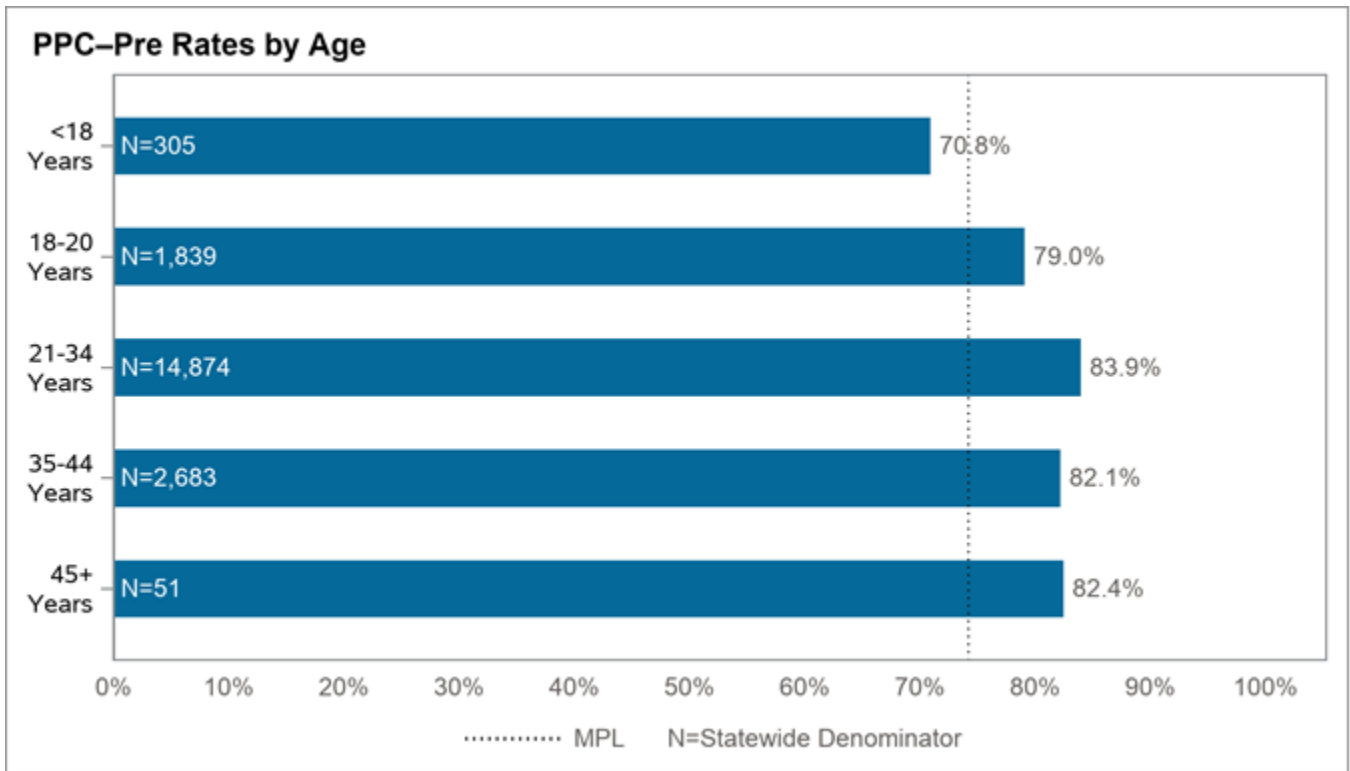
PPC–Pre Rates by Age

Age	N	Rate
<18 Years	N=305	70.8%
18-20 Years	N=1,839	79.0%
21-34 Years	N=14,874	83.9%
35-44 Years	N=2,683	82.1%
45+ Years	N=51	82.4%

.... MPL   N=Statewide Denominator

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

Care for Chronic Conditions

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

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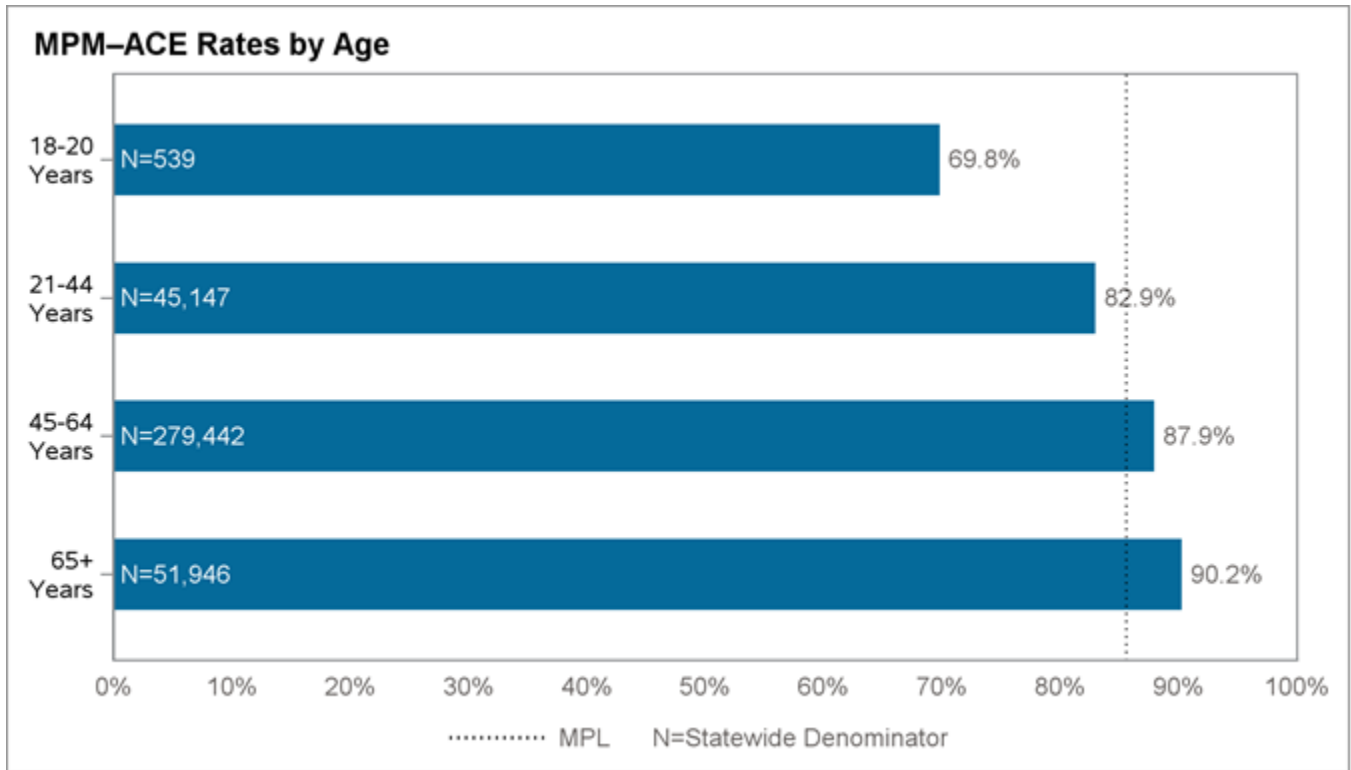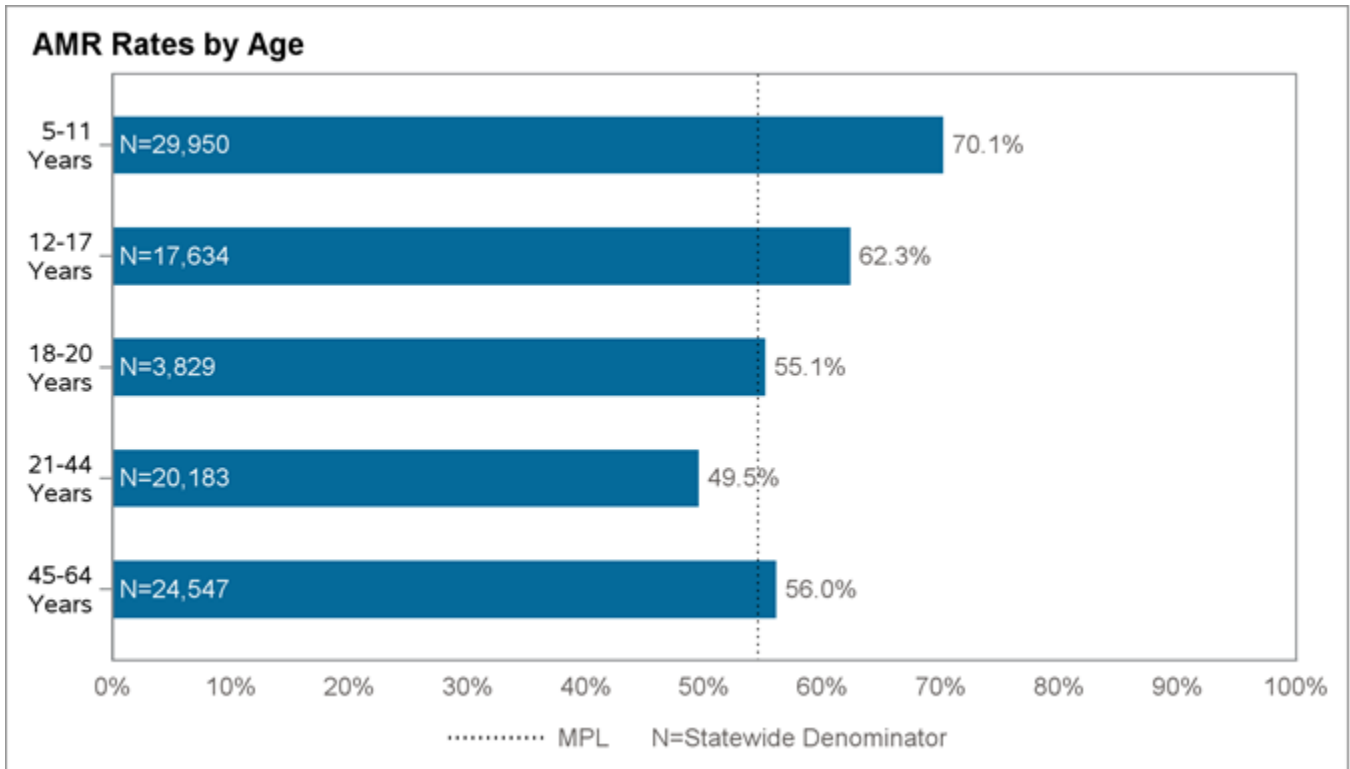

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

MPM–Diu Rates by Age

Age	N	Rate
18-20 Years	N=360	73.9%
21-44 Years	N=27,872	81.5%
45-64 Years	N=153,398	87.5%
65+ Years	N=25,294	90.9%

·········· MPL   N=Statewide Denominator

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

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

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

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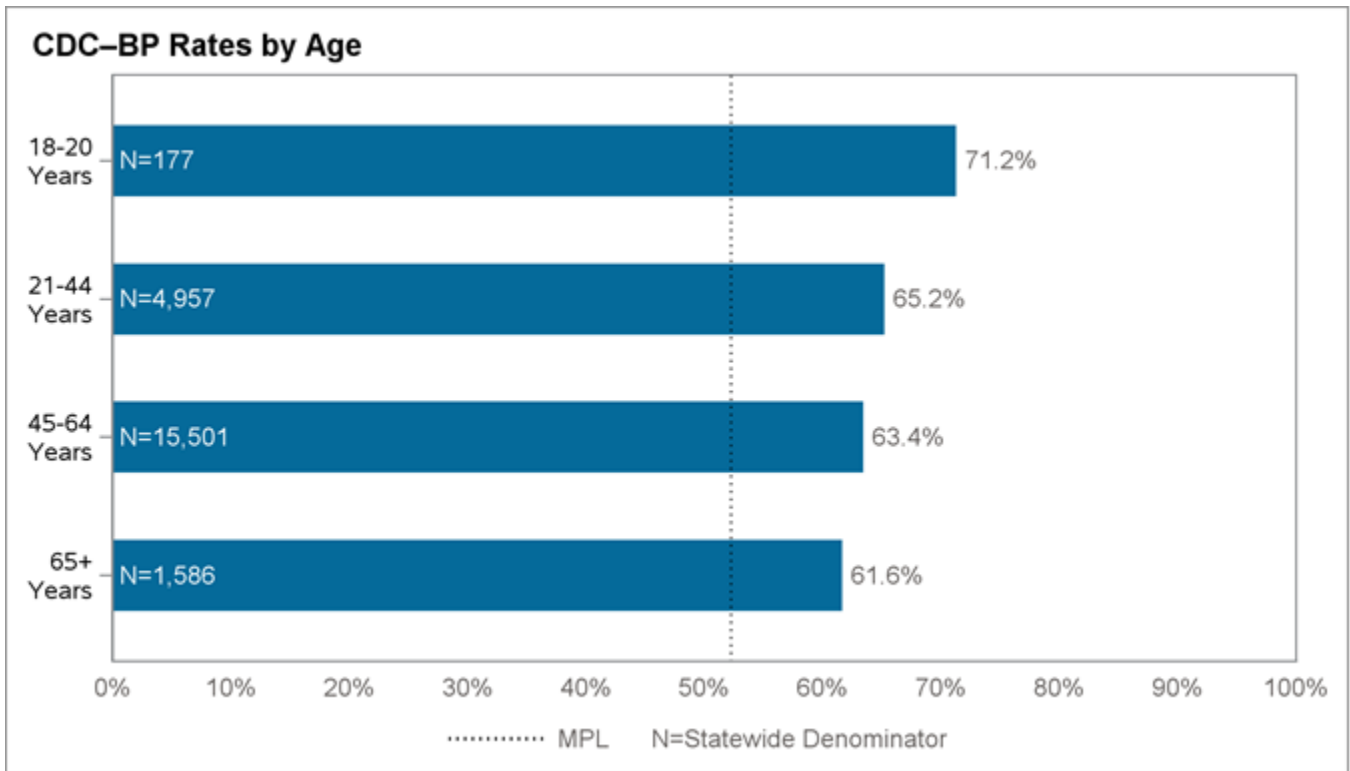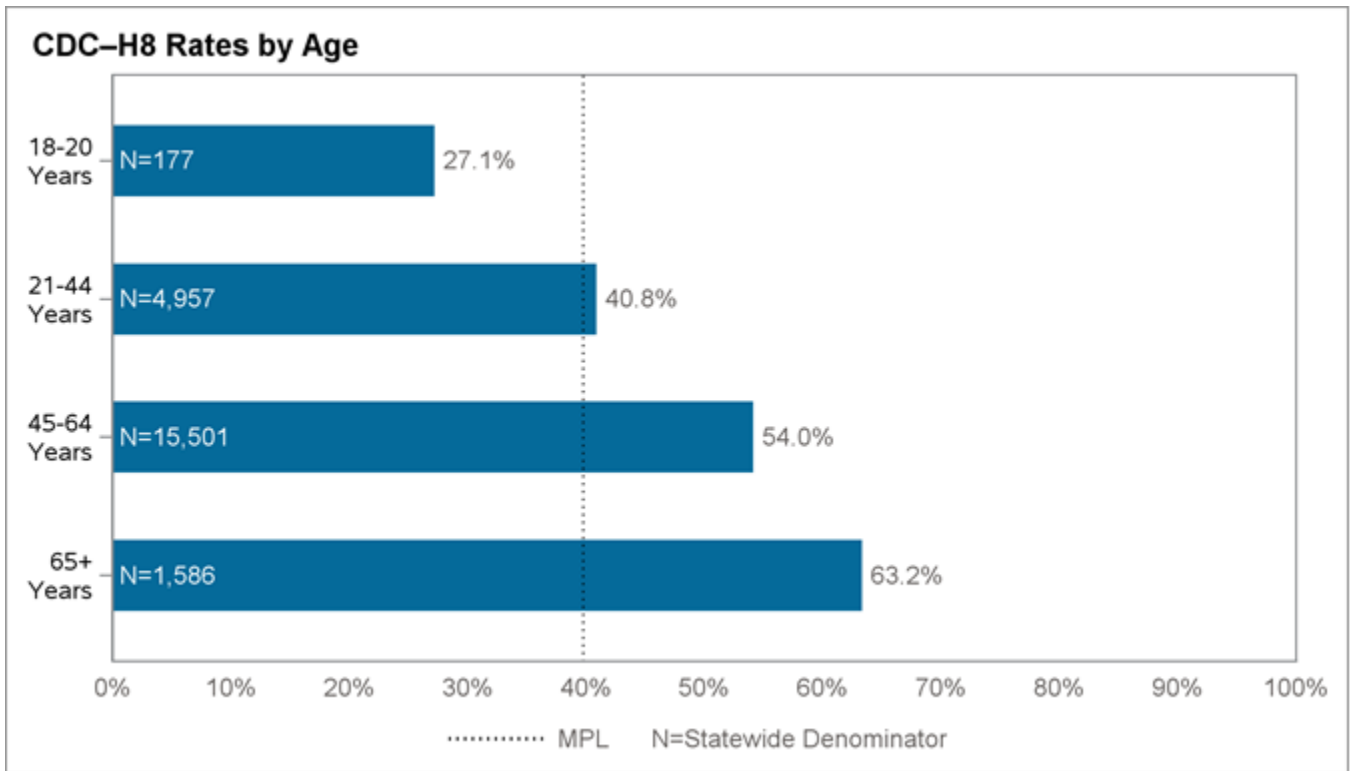

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

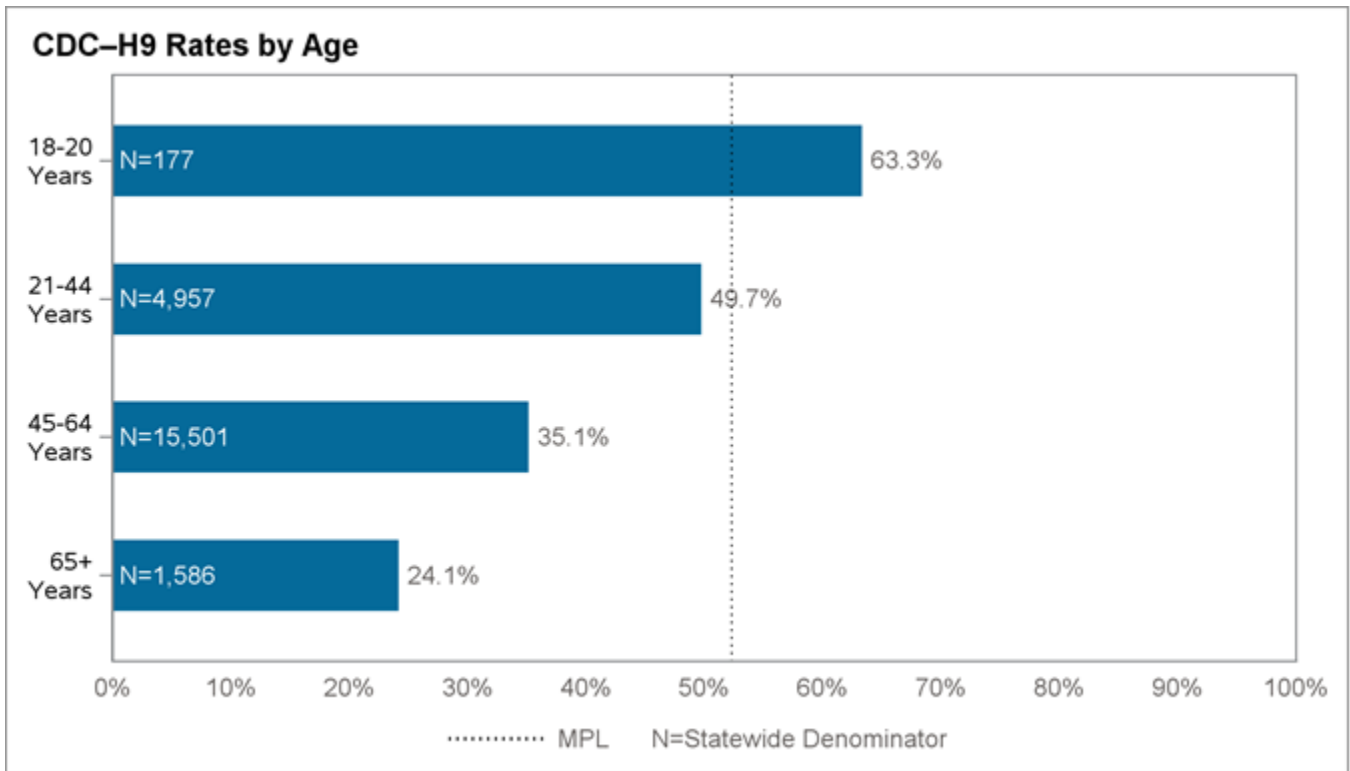**Figure A.41—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E) Rates by Age**
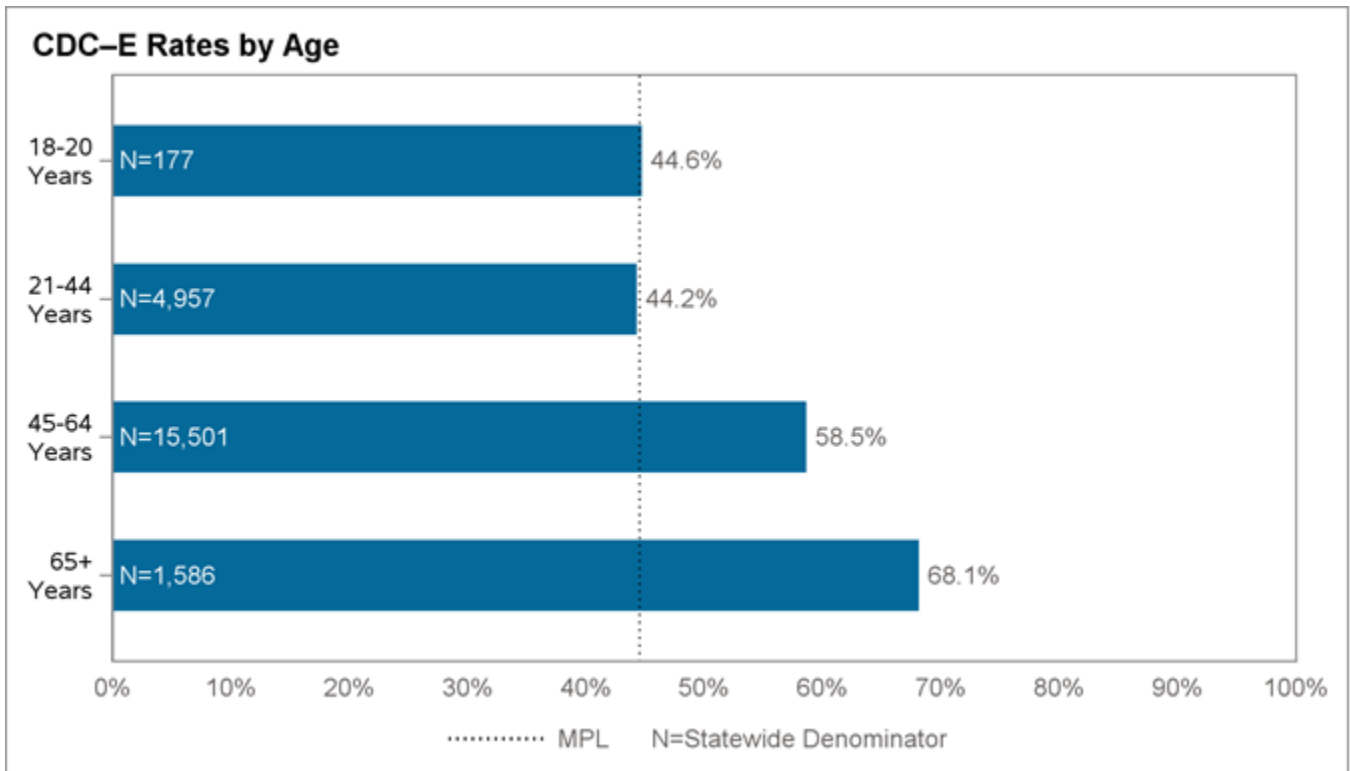
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

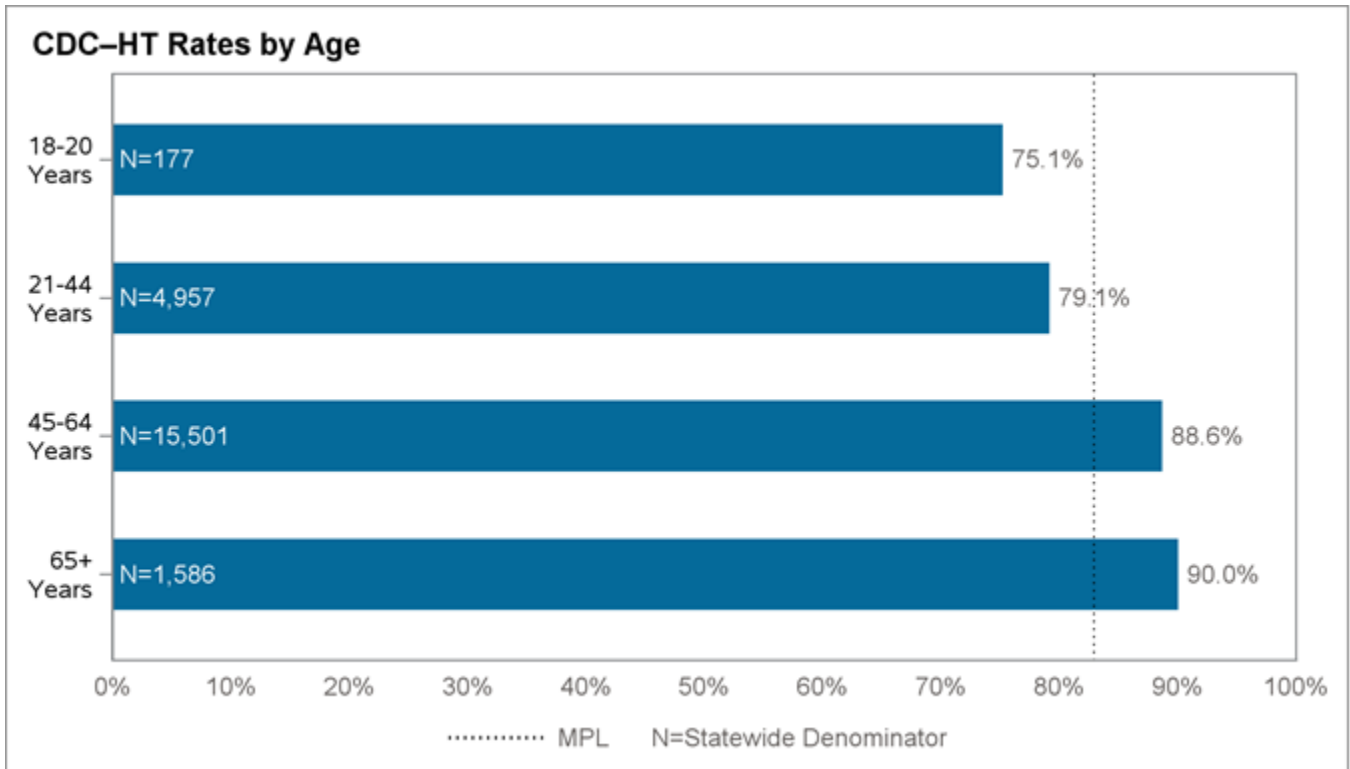**Figure A.42—Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent) (CDC–H8) Rates by Age**

CDC–H8 Rates by Age

Age	Rate
18-20 Years	N=177 — 27.1%
21-44 Years	N=4,957 — 40.8%
45-64 Years	N=15,501 — 54.0%
65+ Years	N=1,586 — 63.2%

·········· MPL   N=Statewide Denominator

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

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

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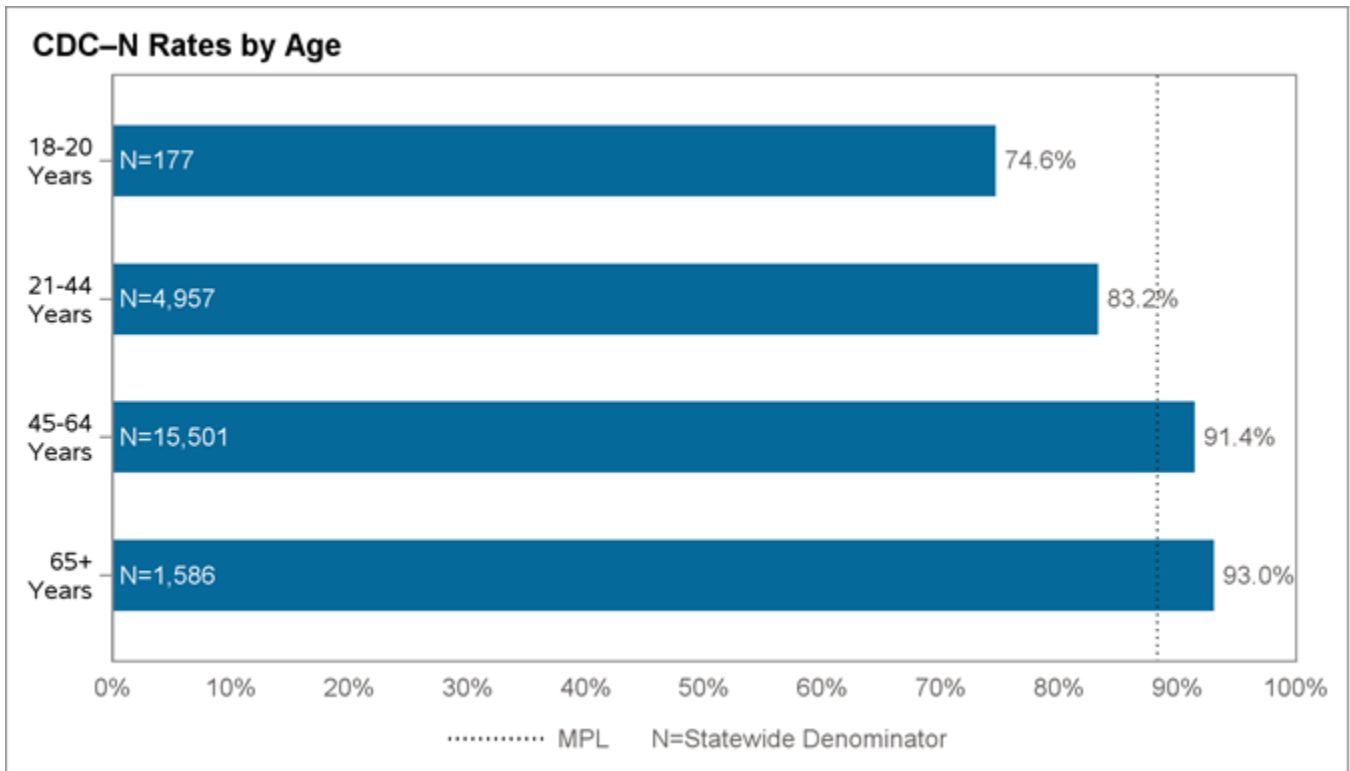
A lower rate indicates more favorable performance for this indicator.

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

CDC–HT Rates by Age

Age	N	Rate
18-20 Years	N=177	75.1%
21-44 Years	N=4,957	79.1%
45-64 Years	N=15,501	88.6%
65+ Years	N=1,586	90.0%

·············· MPL   N=Statewide Denominator

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

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

CDC–N Rates by Age

Age	N	Rate
18-20 Years	N=177	74.6%
21-44 Years	N=4,957	83.2%
45-64 Years	N=15,501	91.4%
65+ Years	N=1,586	93.0%

.... MPL   N=Statewide Denominator

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

Figure A.46—Controlling Blood Pressure (CBP) Rates by Age
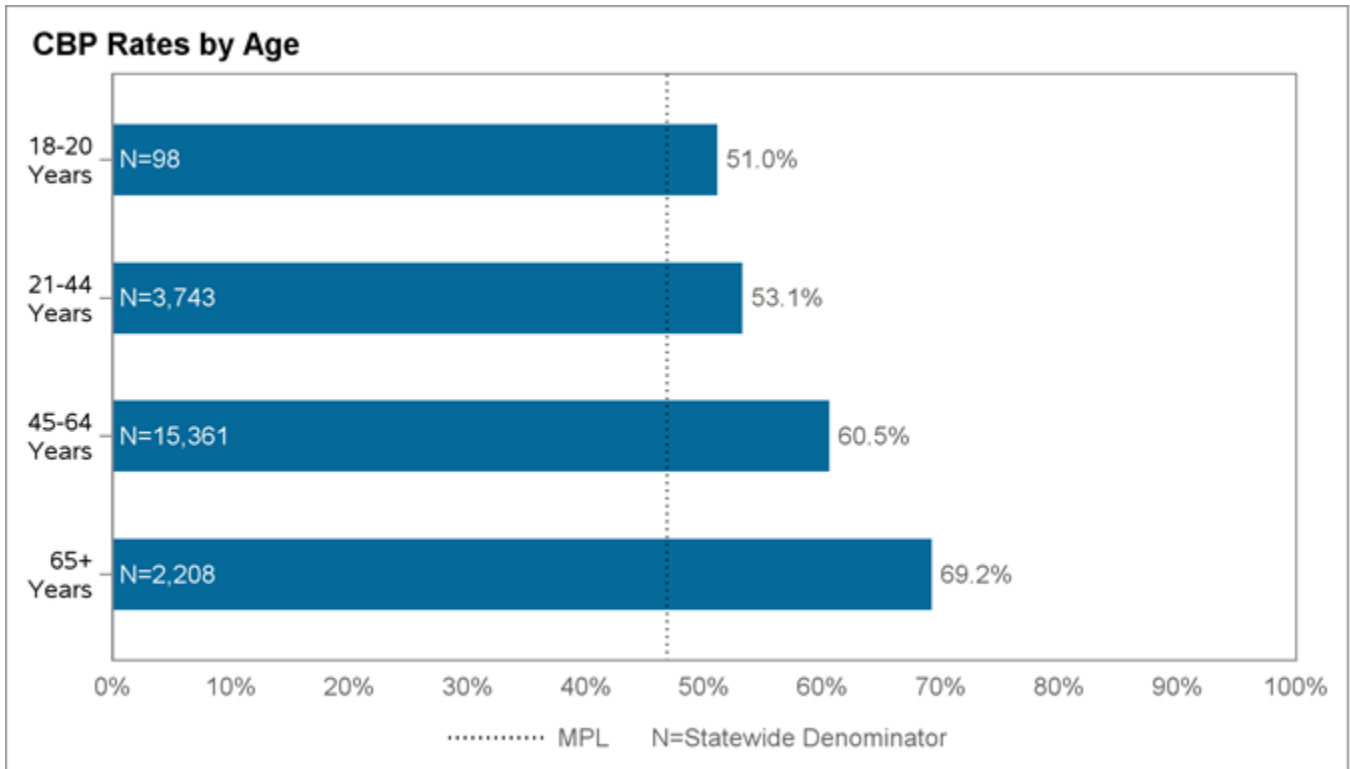
The minimum performance level represents the national Medicaid 25th percentile for this indicator.


Appropriate Treatment and Utilization

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

### Figure A.47—All-Cause Readmissions (ACR) Rates by Age
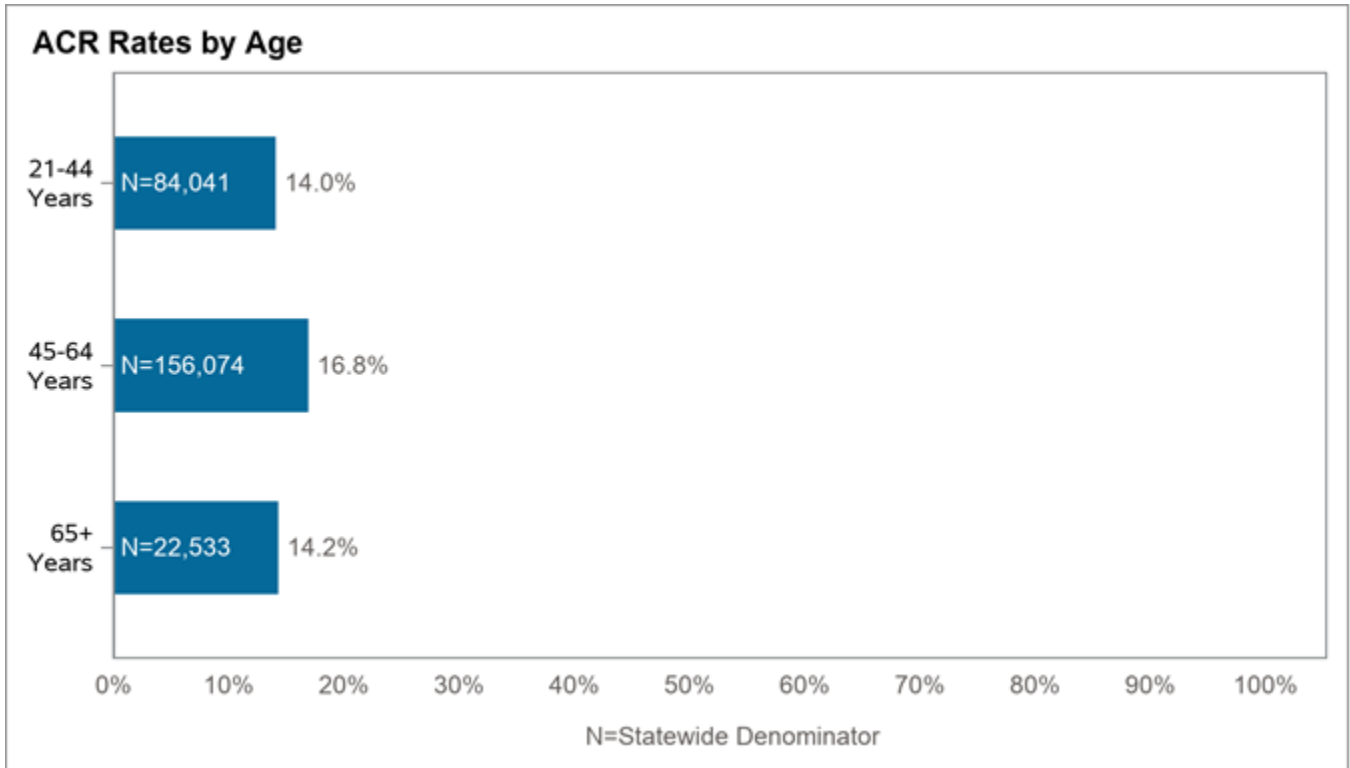
A lower rate indicates more favorable performance for this indicator.
The *All-Cause Readmissions* indicator was originally developed for the ACR Collaborative Quality Improvement Project; therefore, no minimum performance level was established for this indicator.

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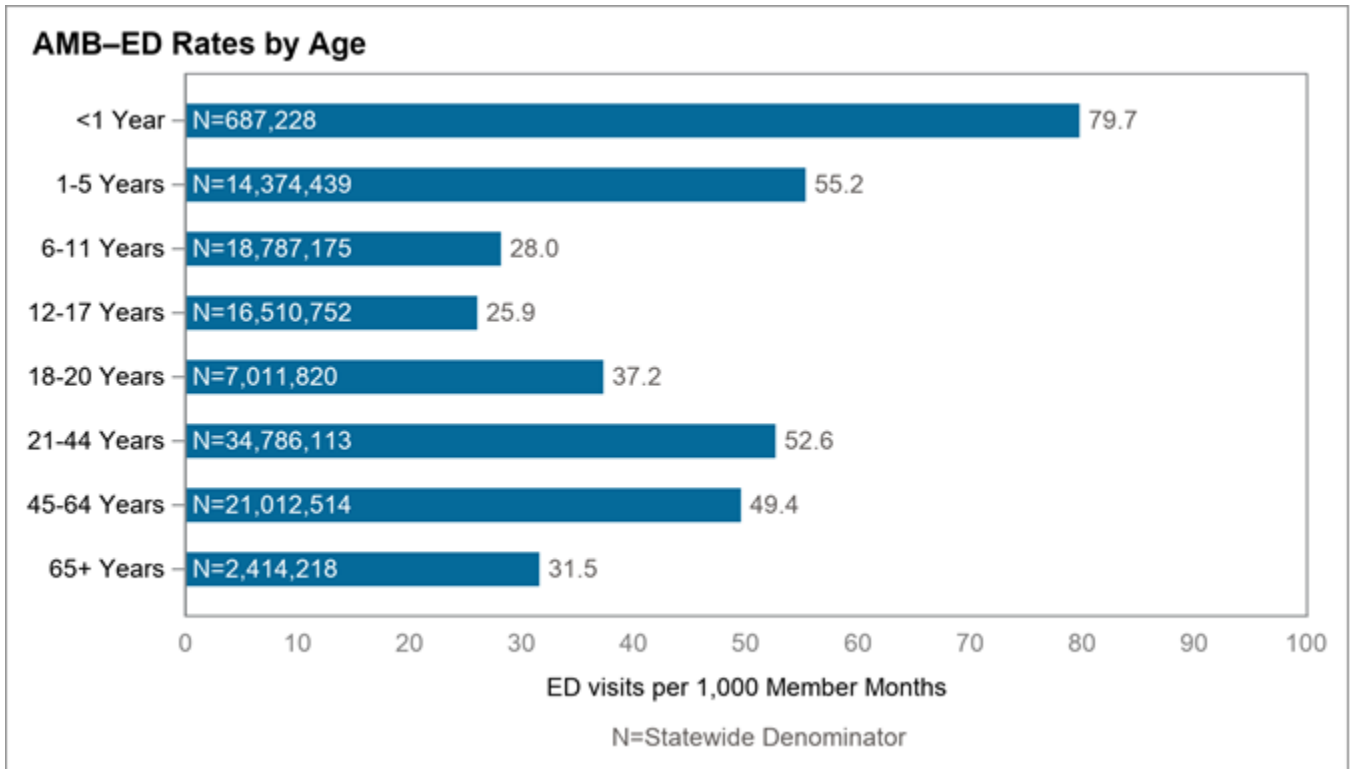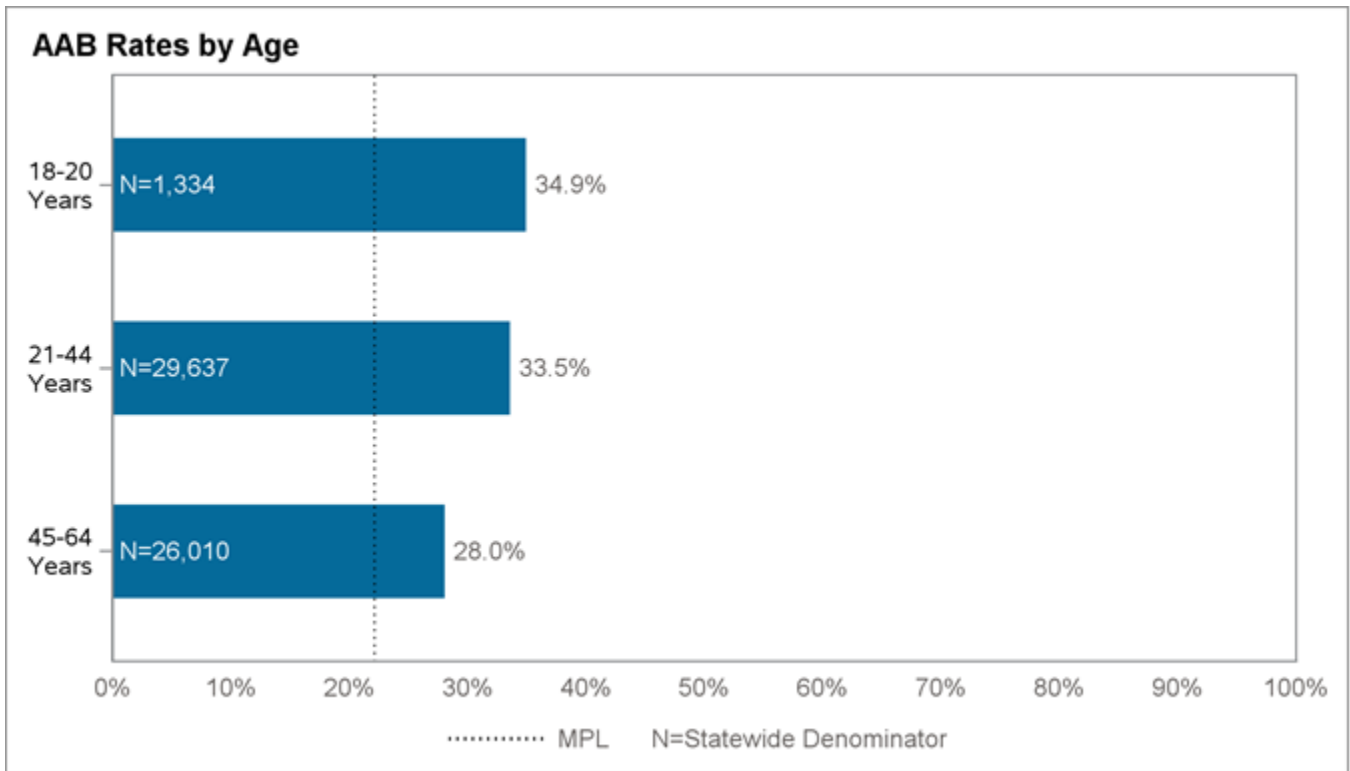

The *Ambulatory Care—Emergency Department Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

**Figure A.49—Ambulatory Care—Outpatient Visits (AMB–OP) Rates by Age**
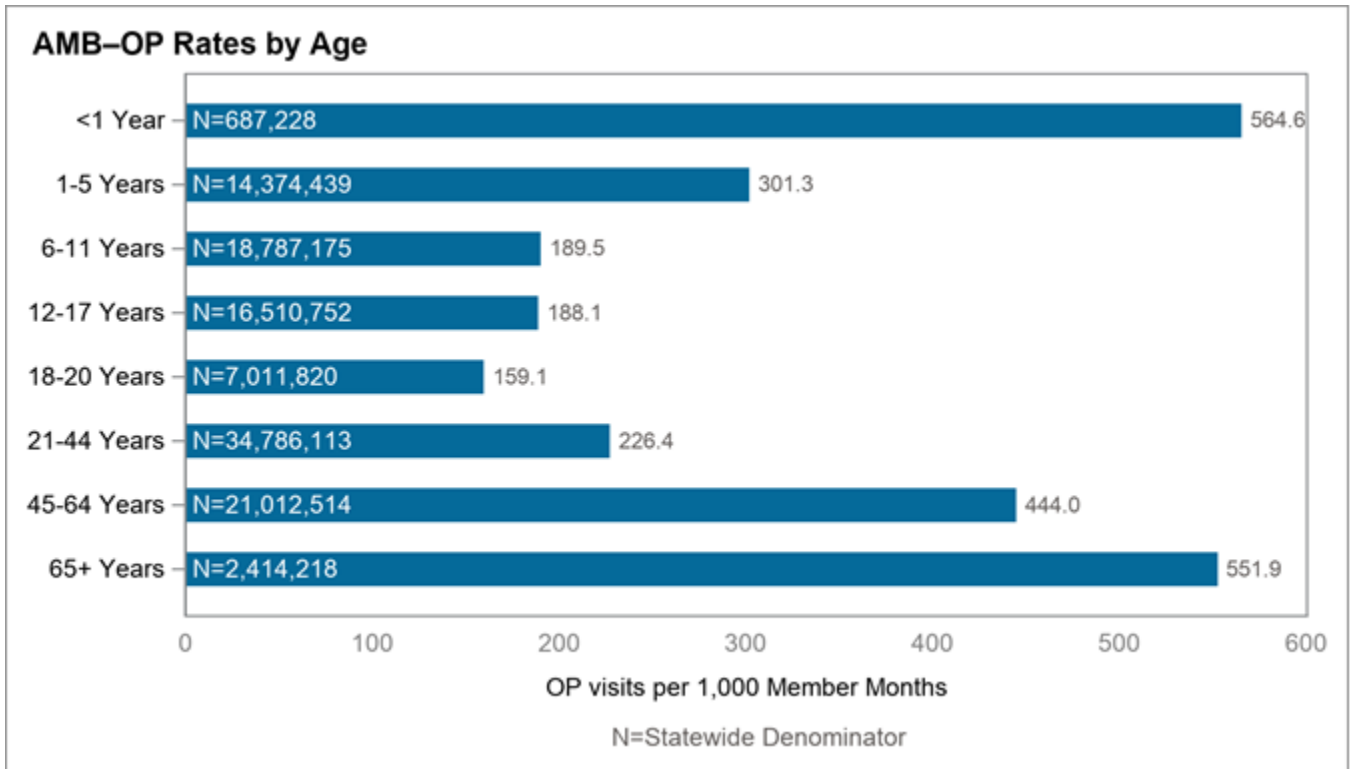
The *Ambulatory Care—Outpatient Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

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

AAB Rates by Age

Age	N	Rate
18-20 Years	N=1,334	34.9%
21-44 Years	N=29,637	33.5%
45-64 Years	N=26,010	28.0%

············· MPL   N=Statewide Denominator

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

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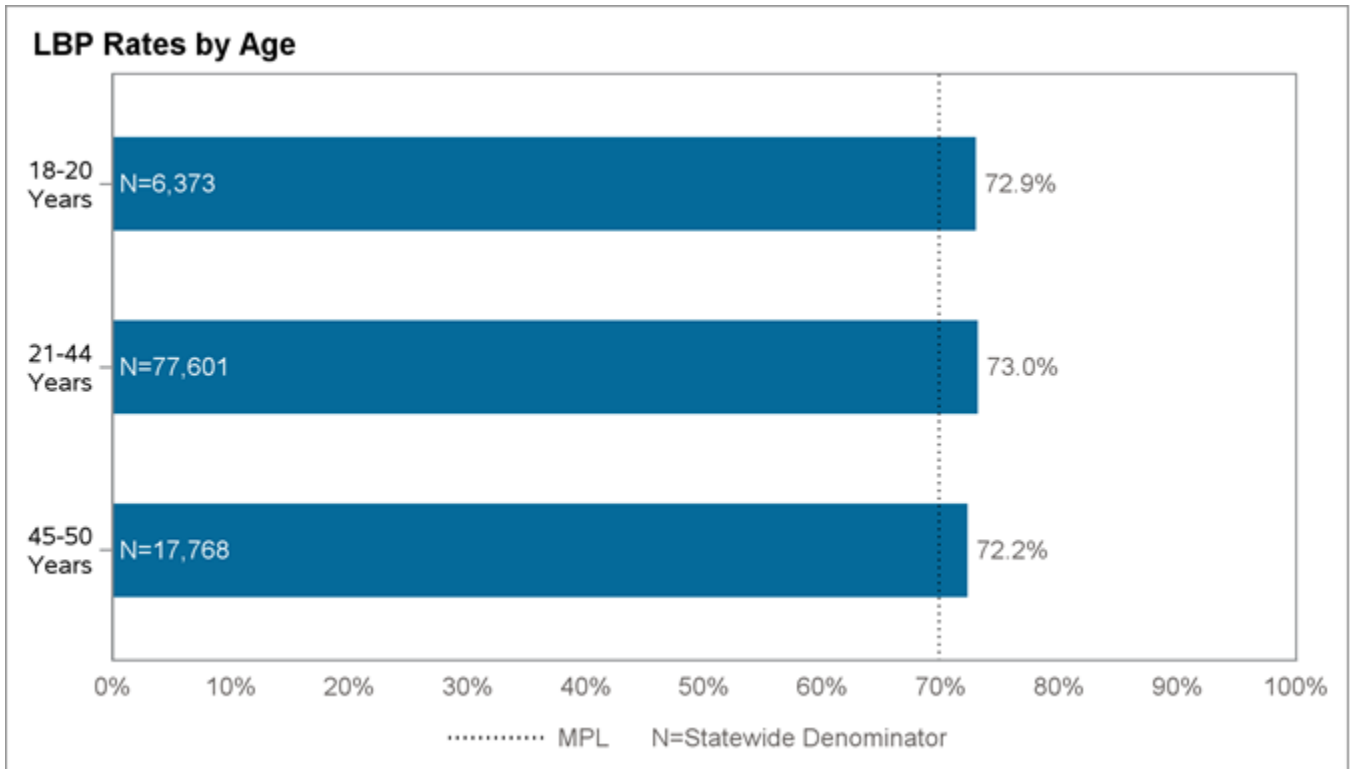
LBP Rates by Age

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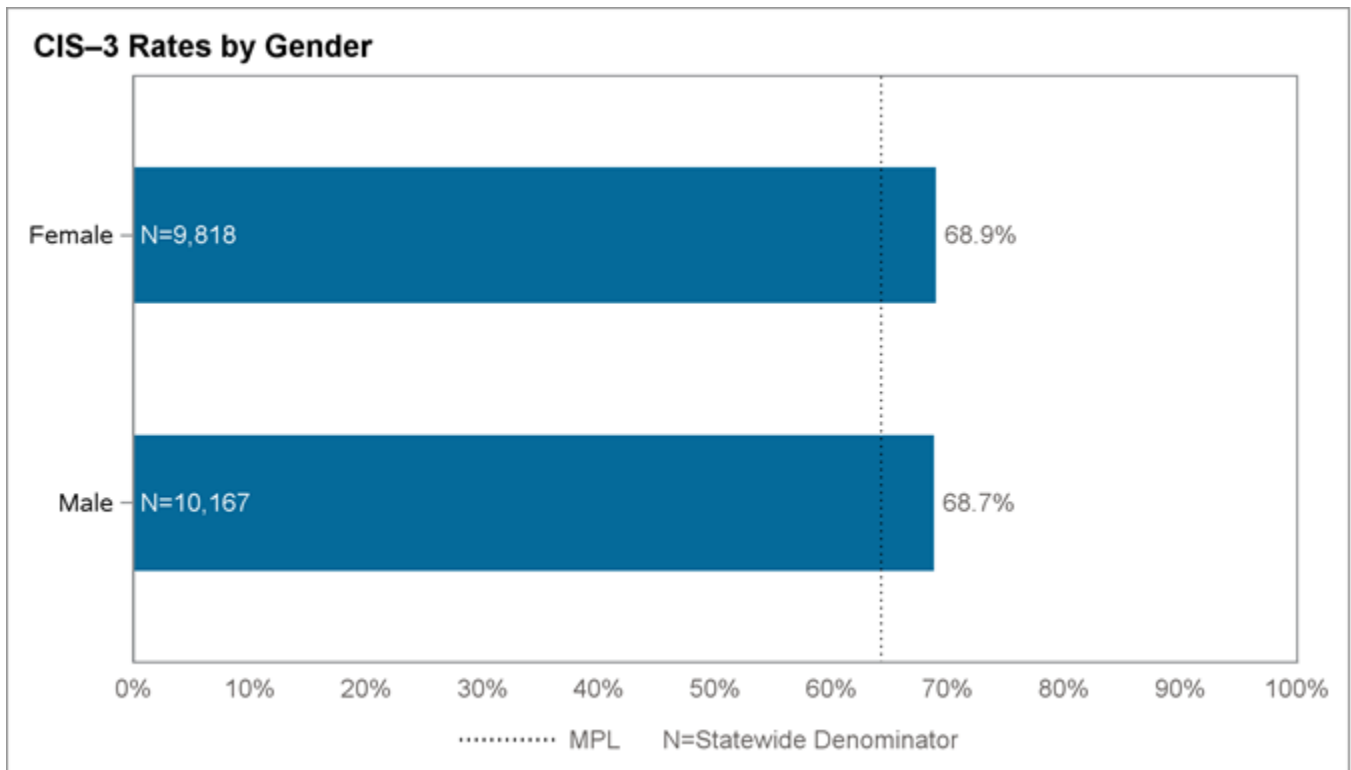
Gender

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

## *Preventive Screening and Children's Health*

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

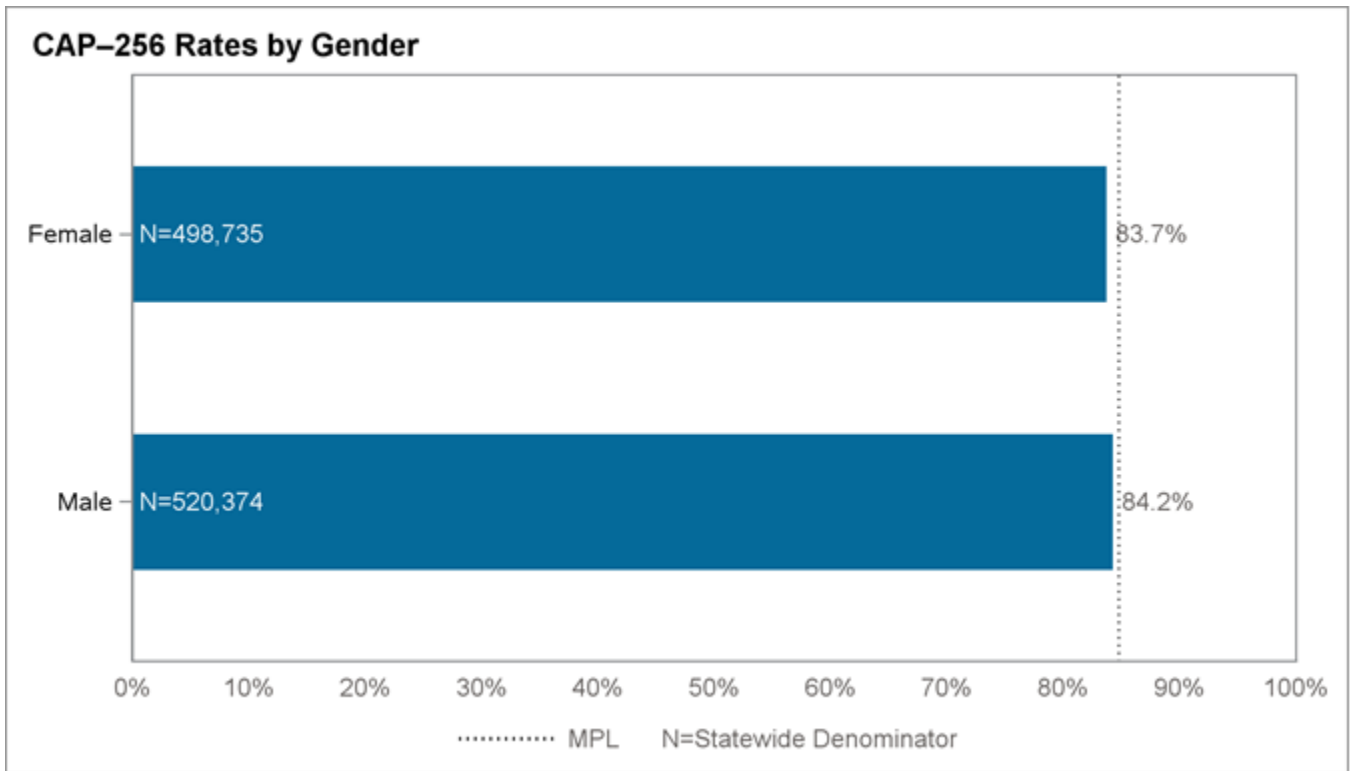**Figure A.52—Childhood Immunization Status—Combination 3 (CIS–3) Rates by Gender**

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

Figure A.53—Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months (CAP–1224) Rates by Gender
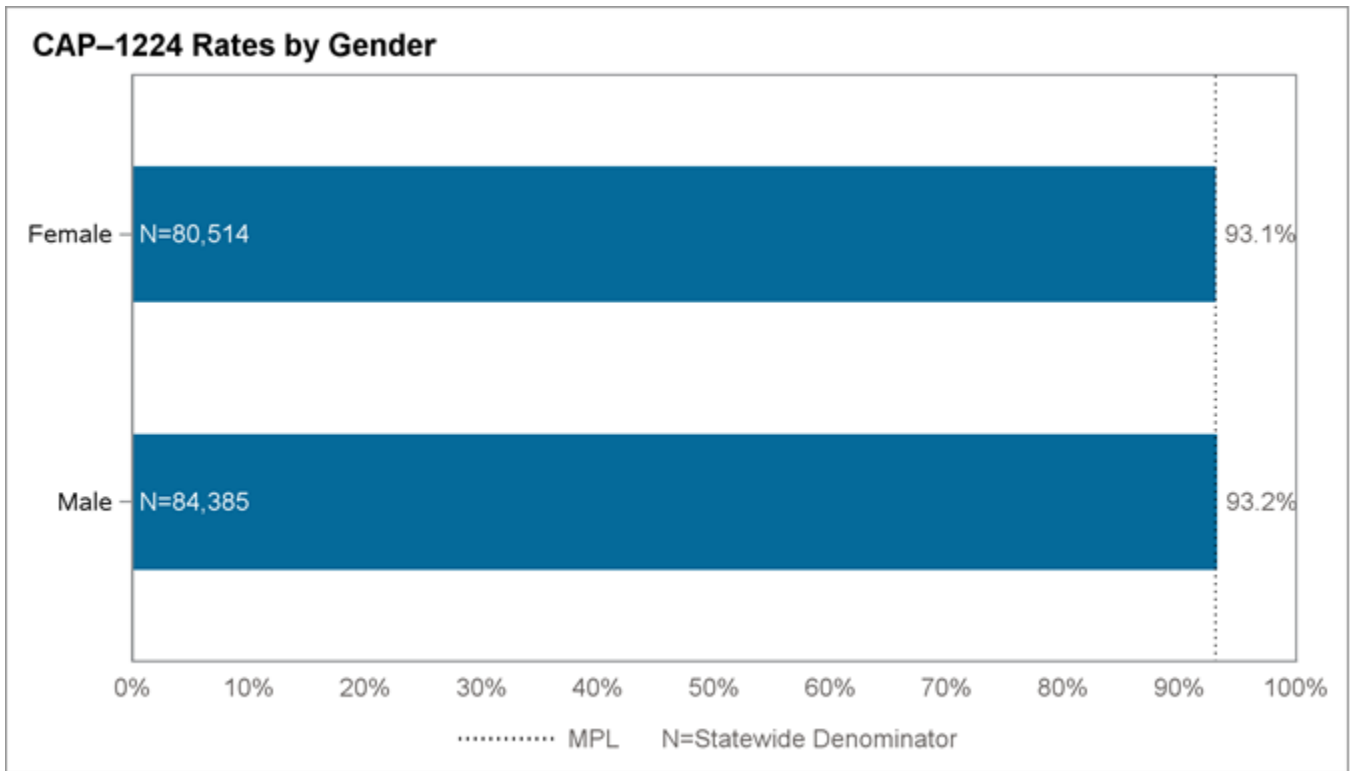
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

CAP–256 Rates by Gender

Female – N=498,735 — 83.7%

Male – N=520,374 — 84.2%
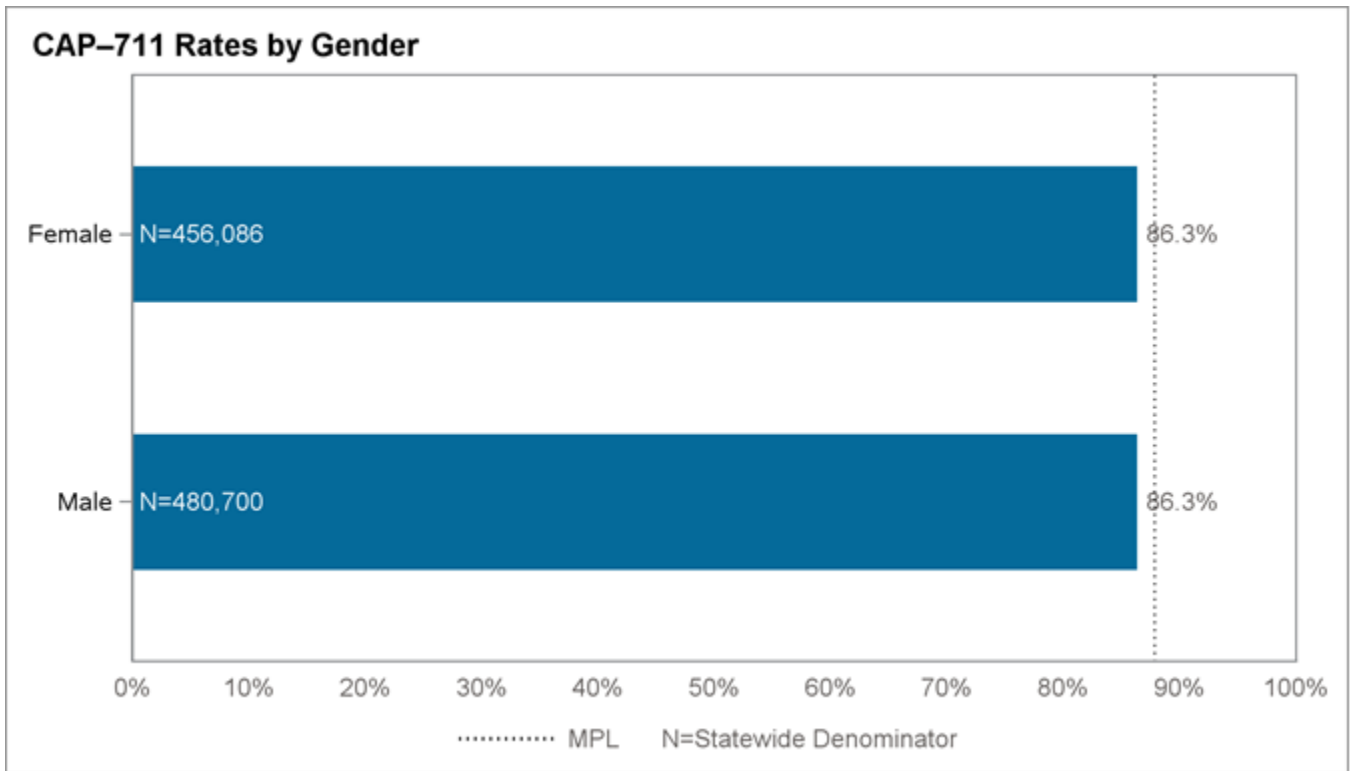
·········· MPL   N=Statewide Denominator

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

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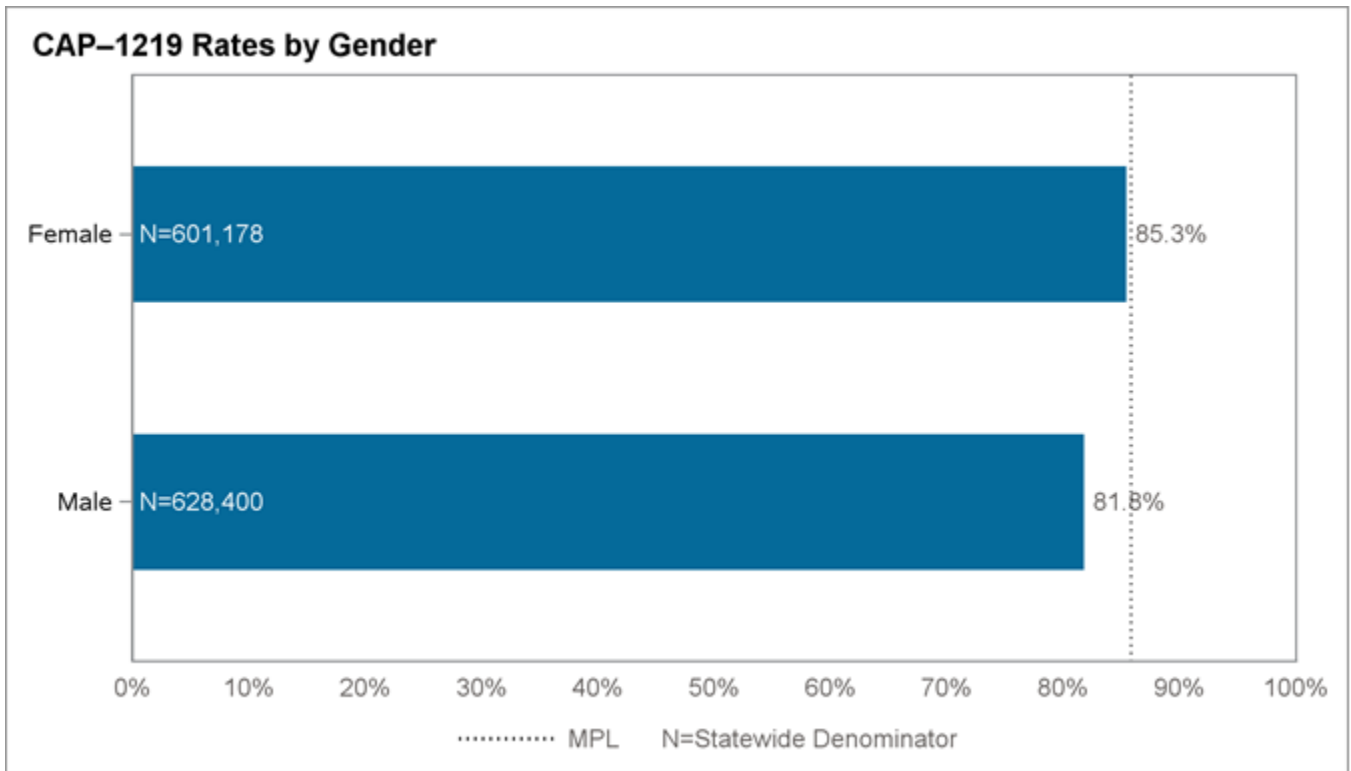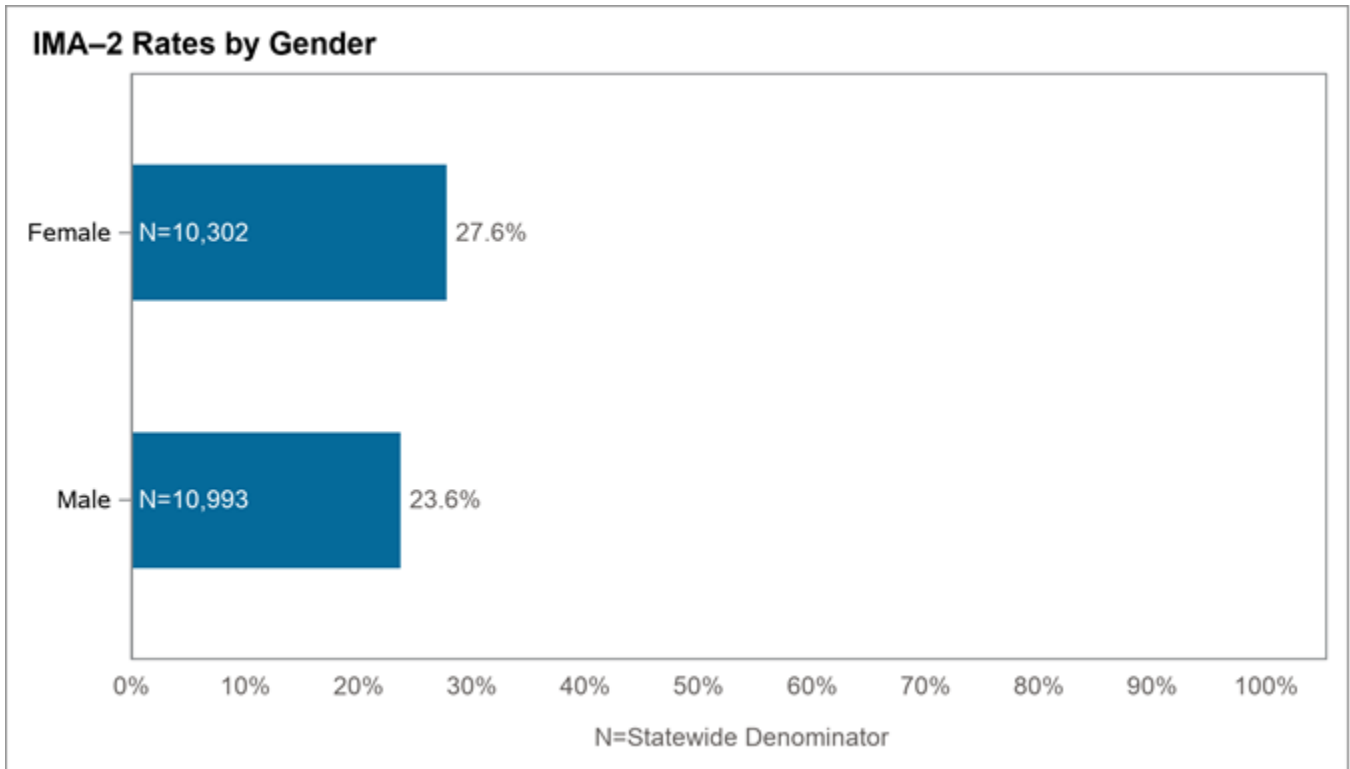

The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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

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

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

Immunizations for Adolescents—Combination 2 is a first-year indicator for reporting year2017; therefore, the indicator does not have an applicable minimum performance level.

Figure A.58—Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total (WCC–N) Rates by Gender
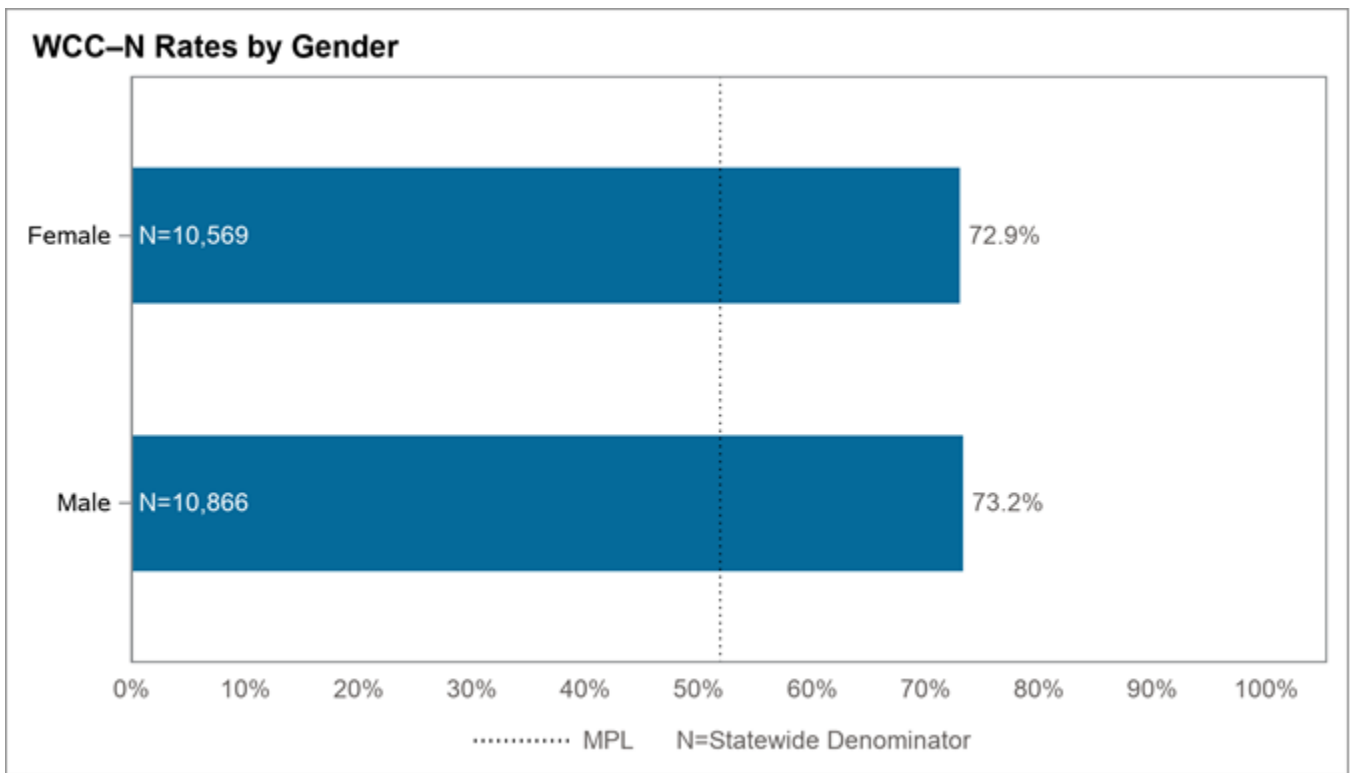
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

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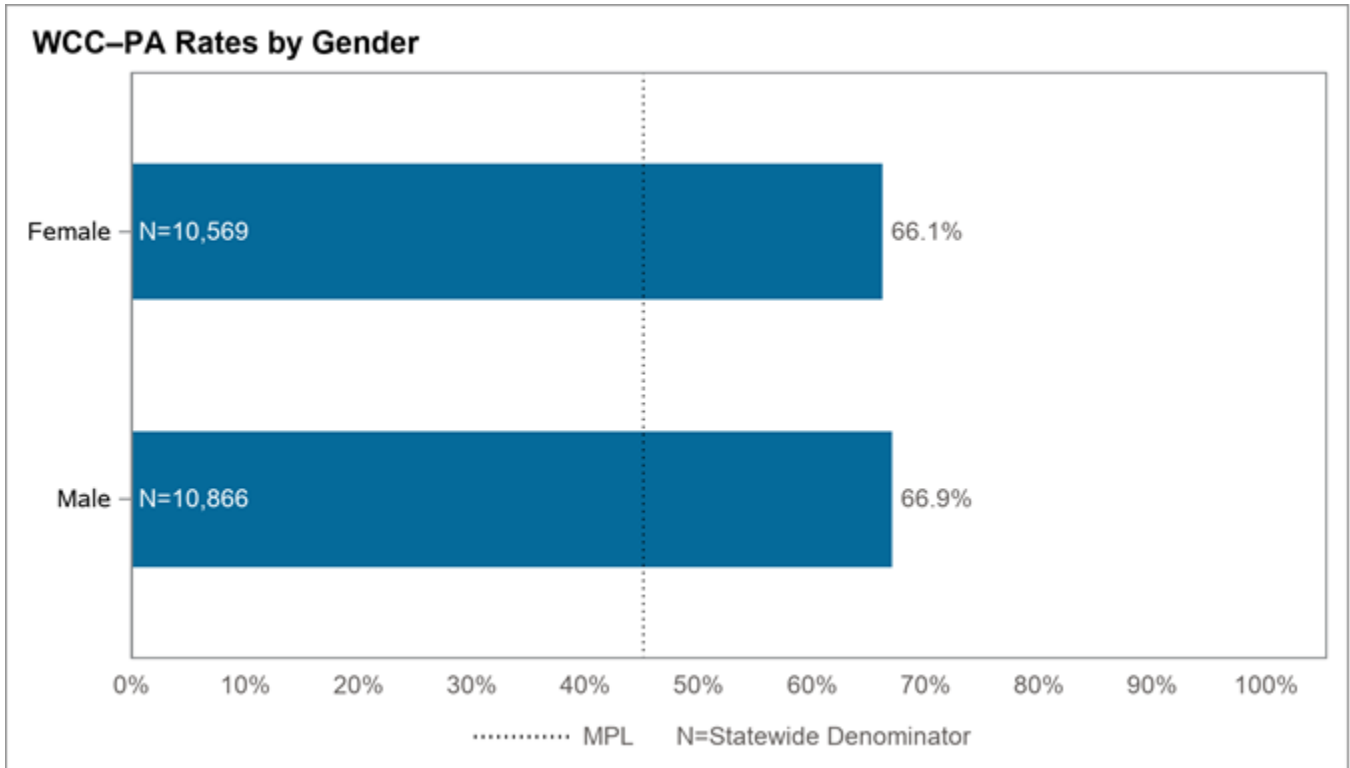
WCC–PA Rates by Gender

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

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

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

Care for Chronic Conditions

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

Figure A.61—Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs (MPM–ACE) Rates by Gender
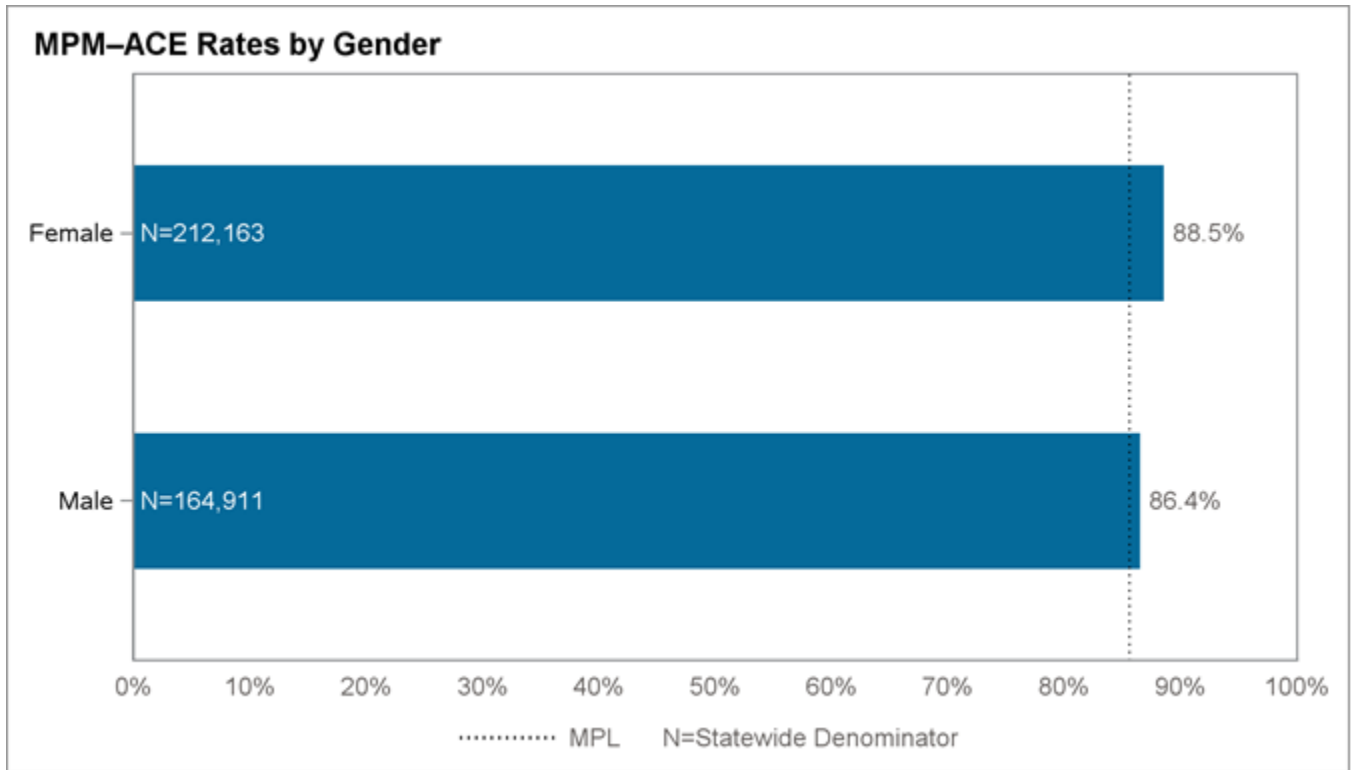
The minimum performance level represents the national Medicaid 25th percentile for this indicator.
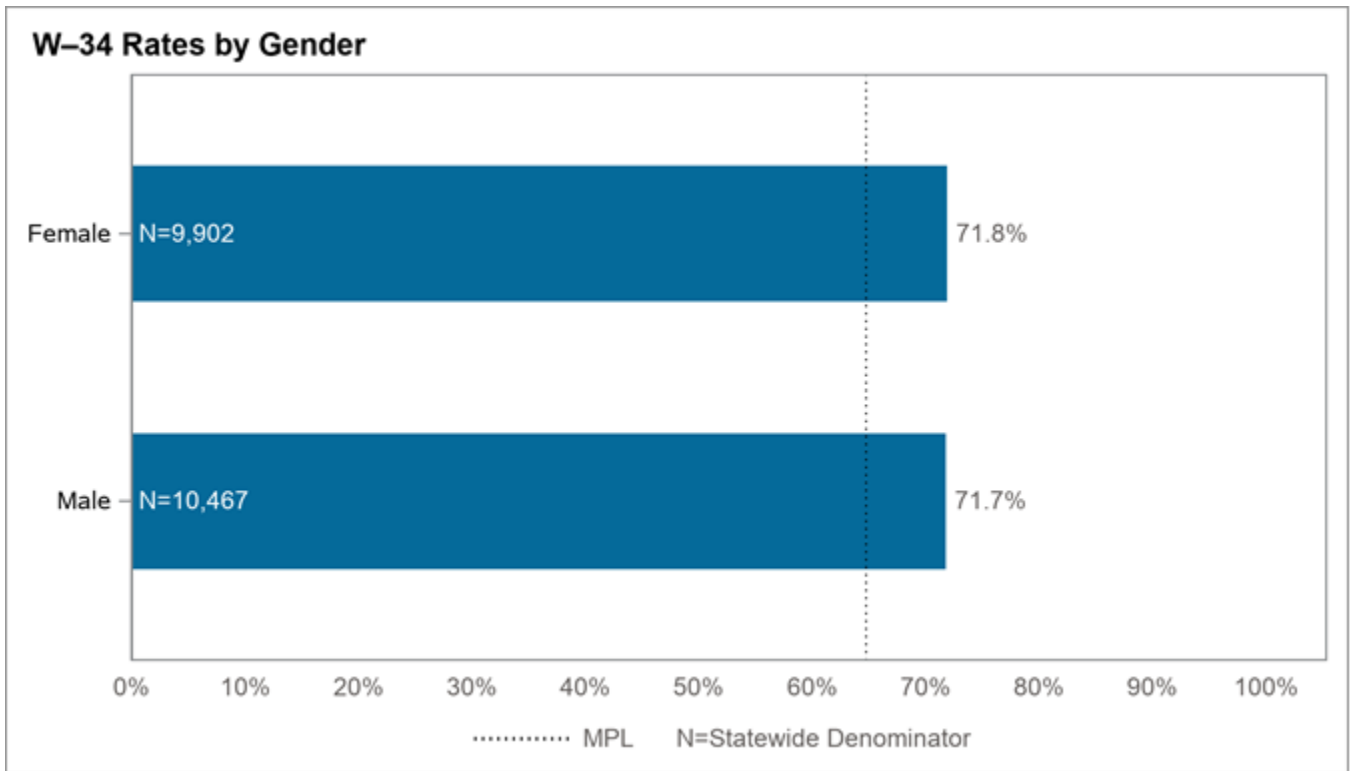
Figure A.62—Annual Monitoring for Patients on Persistent Medications—Diuretics (MPM–Diu) Rates by Gender

MPM–Diu Rates by Gender

Female – N=126,916 — 87.5%

Male – N=80,008 — 86.5%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

·········· MPL   N=Statewide Denominator

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

Figure A.63—Asthma Medication Ratio (AMR) Rates by Gender
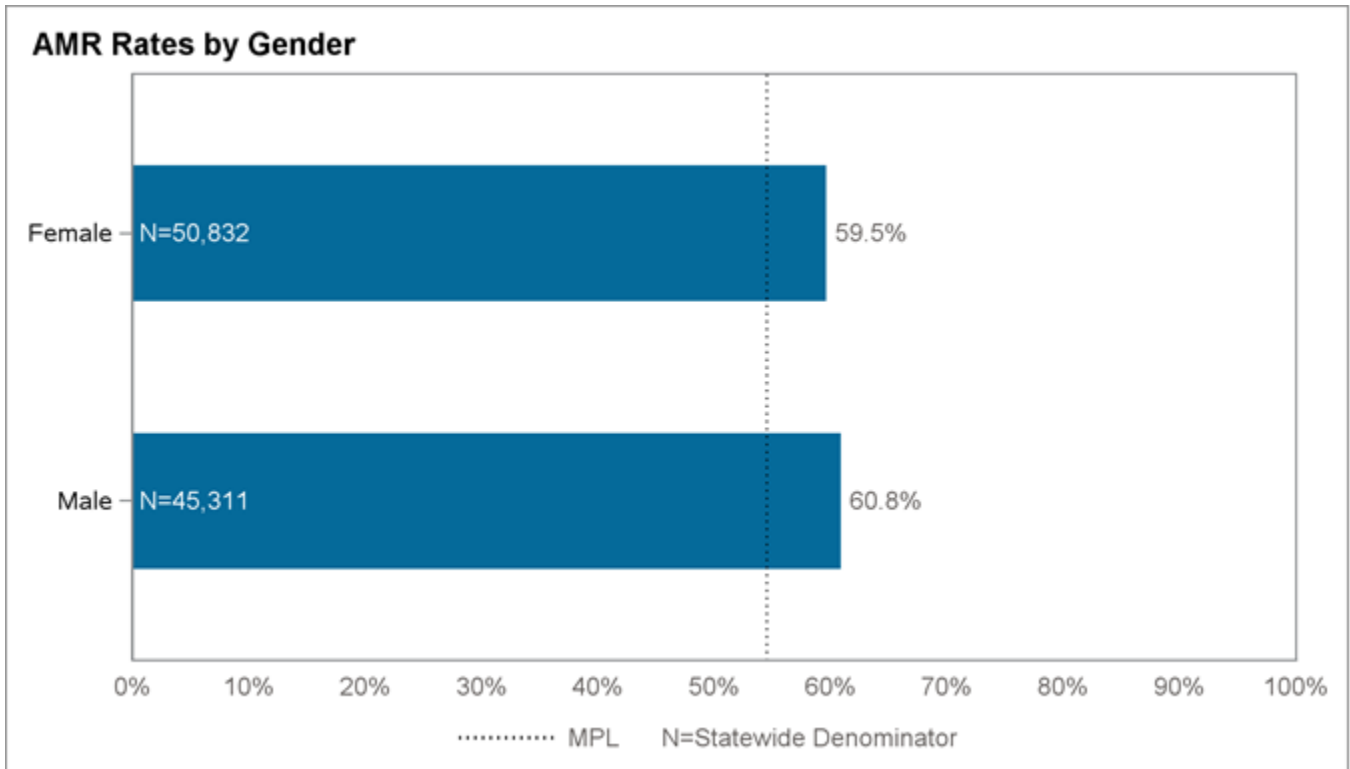
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

Figure A.64—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) (CDC–BP) Rates by Gender
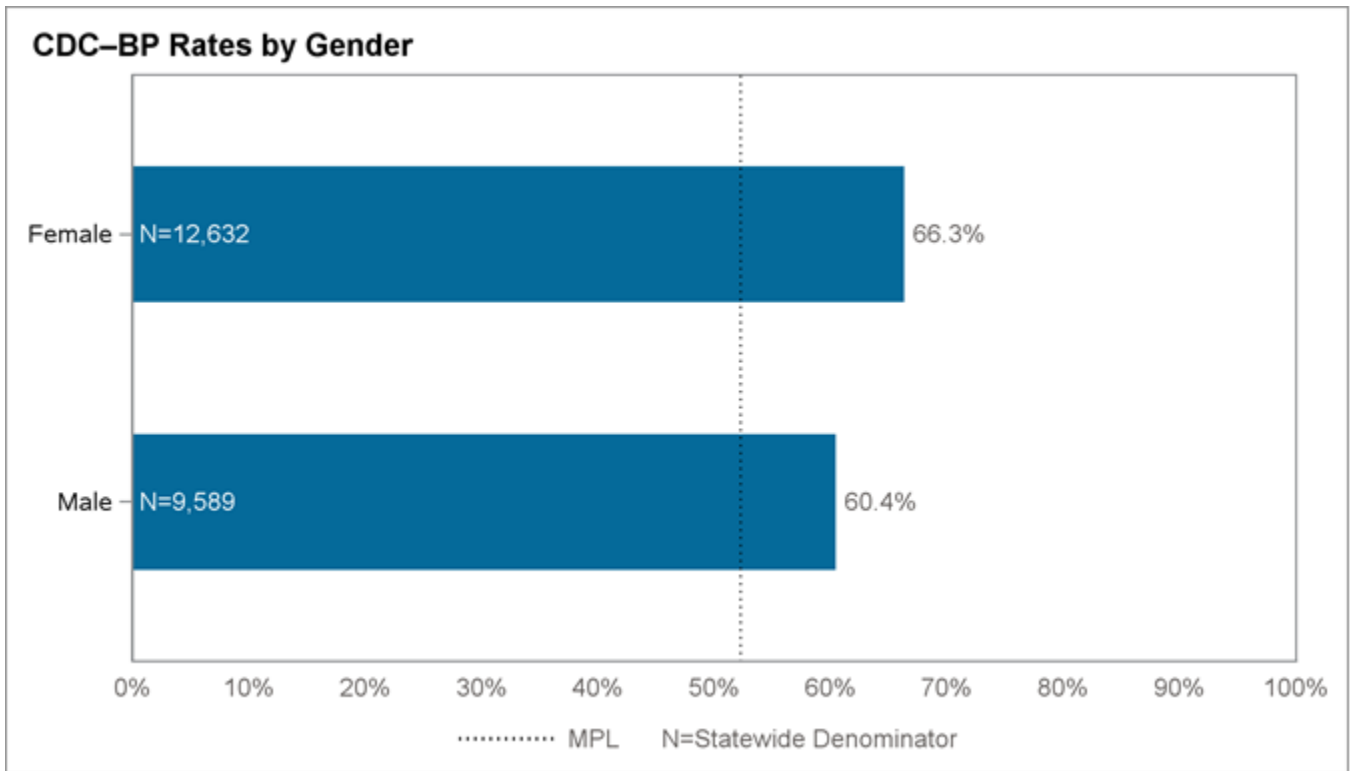
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

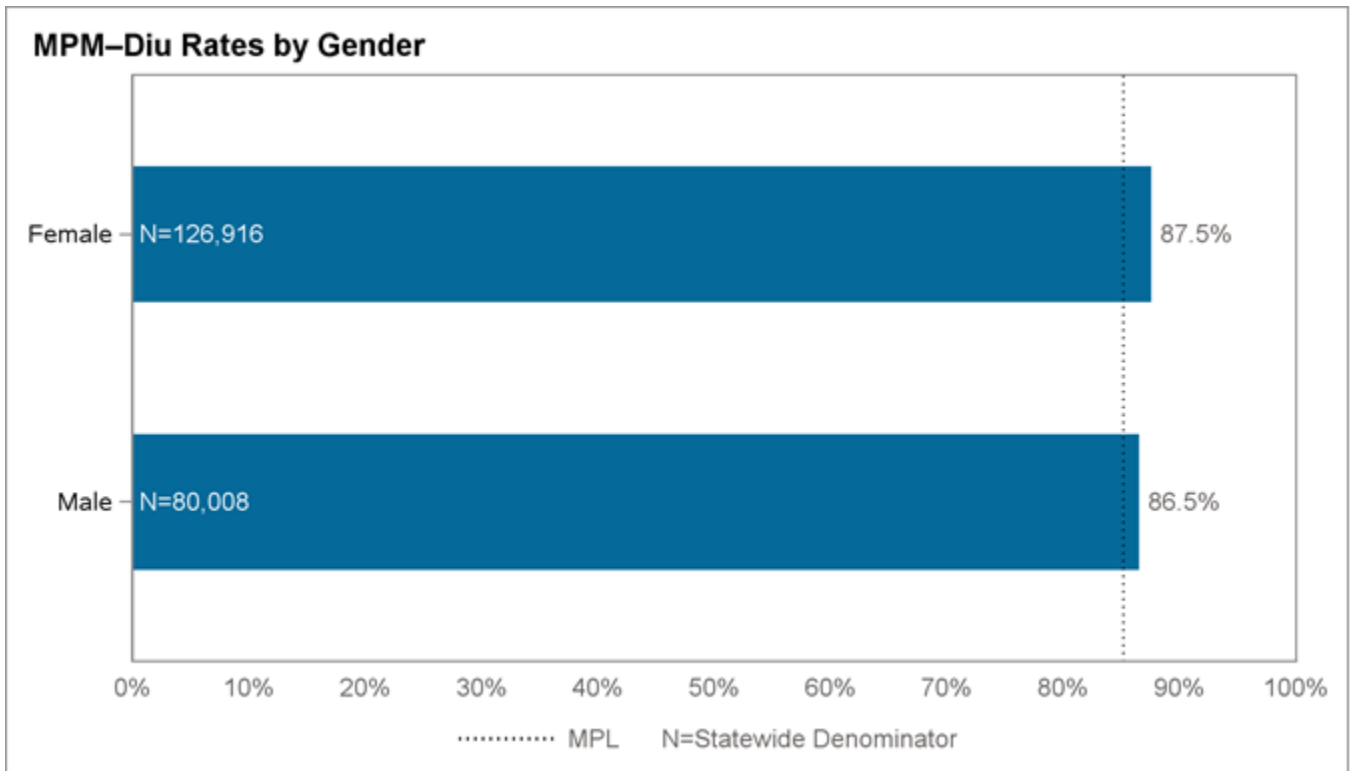**Figure A.65—Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (CDC–E) Rates by Gender**

CDC–E Rates by Gender

Female – N=12,632   58.1%

Male – N=9,589   53.0%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

·········· MPL   N=Statewide Denominator

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

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

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

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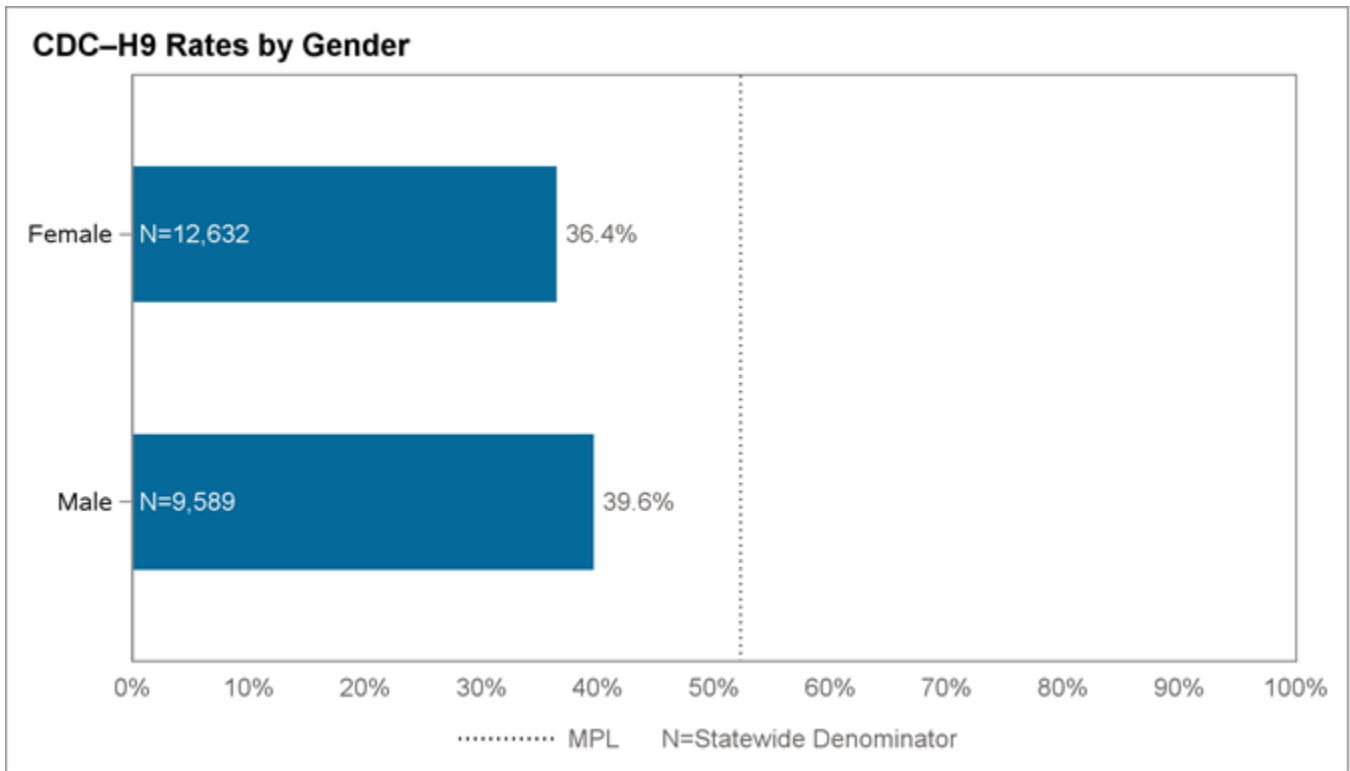
CDC–H9 Rates by Gender

Female – N=12,632 — 36.4%

Male – N=9,589 — 39.6%

.... MPL   N=Statewide Denominator

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

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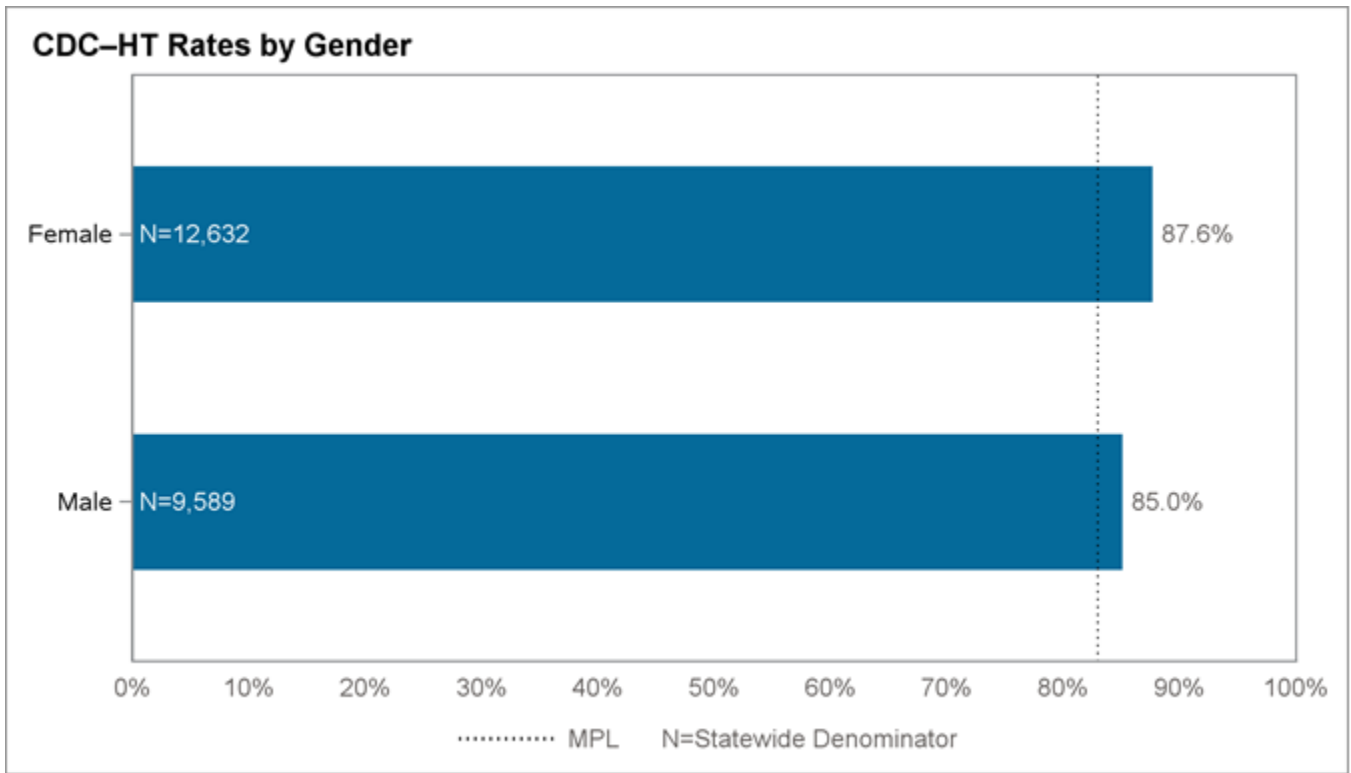
CDC–HT Rates by Gender

Female – N=12,632 — 87.6%
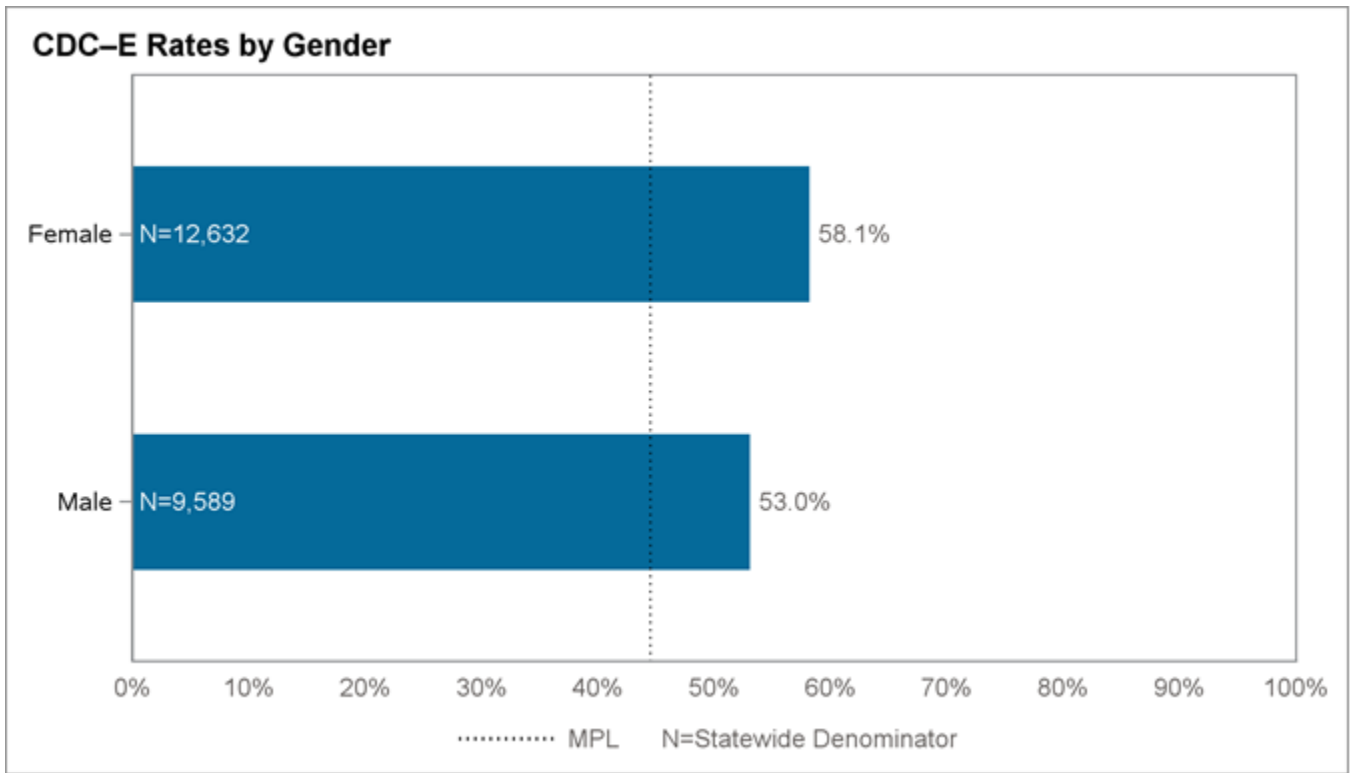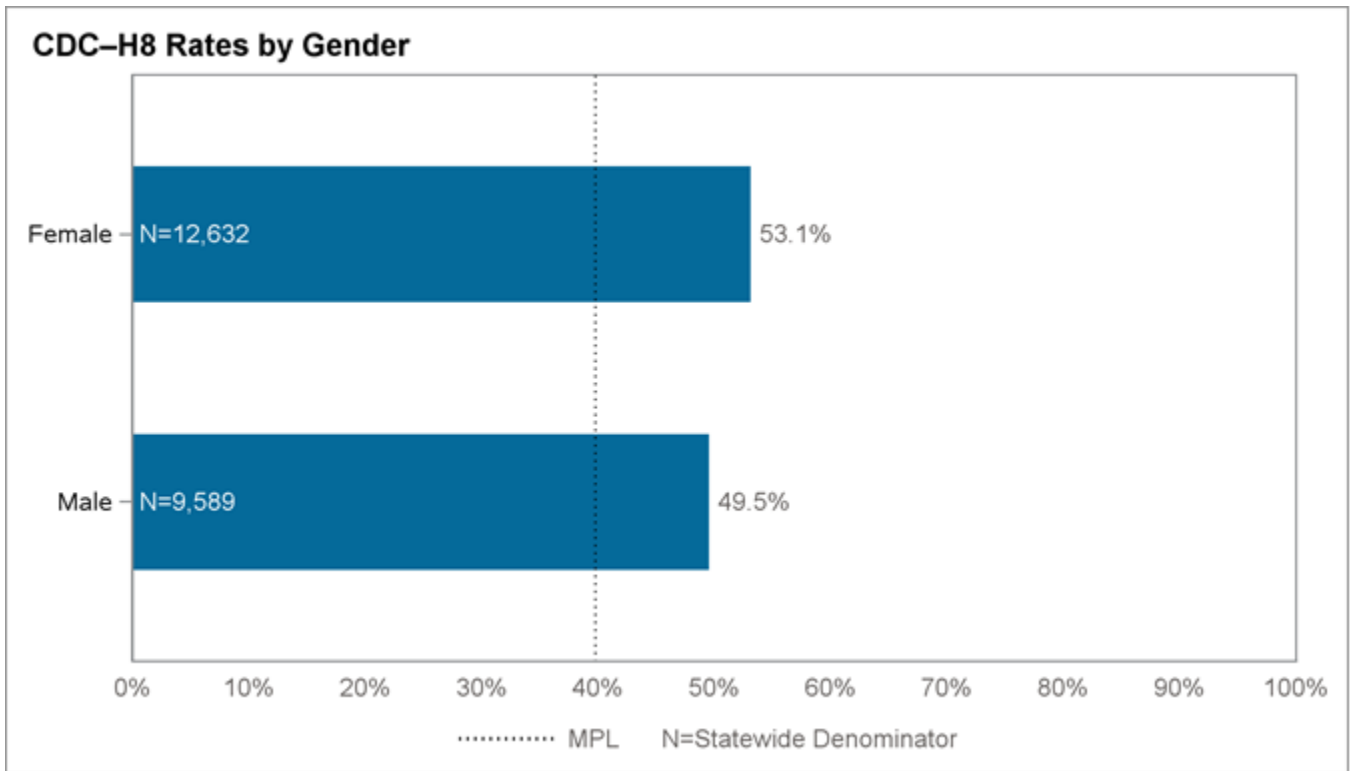
Male – N=9,589 — 85.0%

MPL   N=Statewide Denominator

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

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

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

Figure A.70—Controlling Blood Pressure (CBP) Rates by Gender
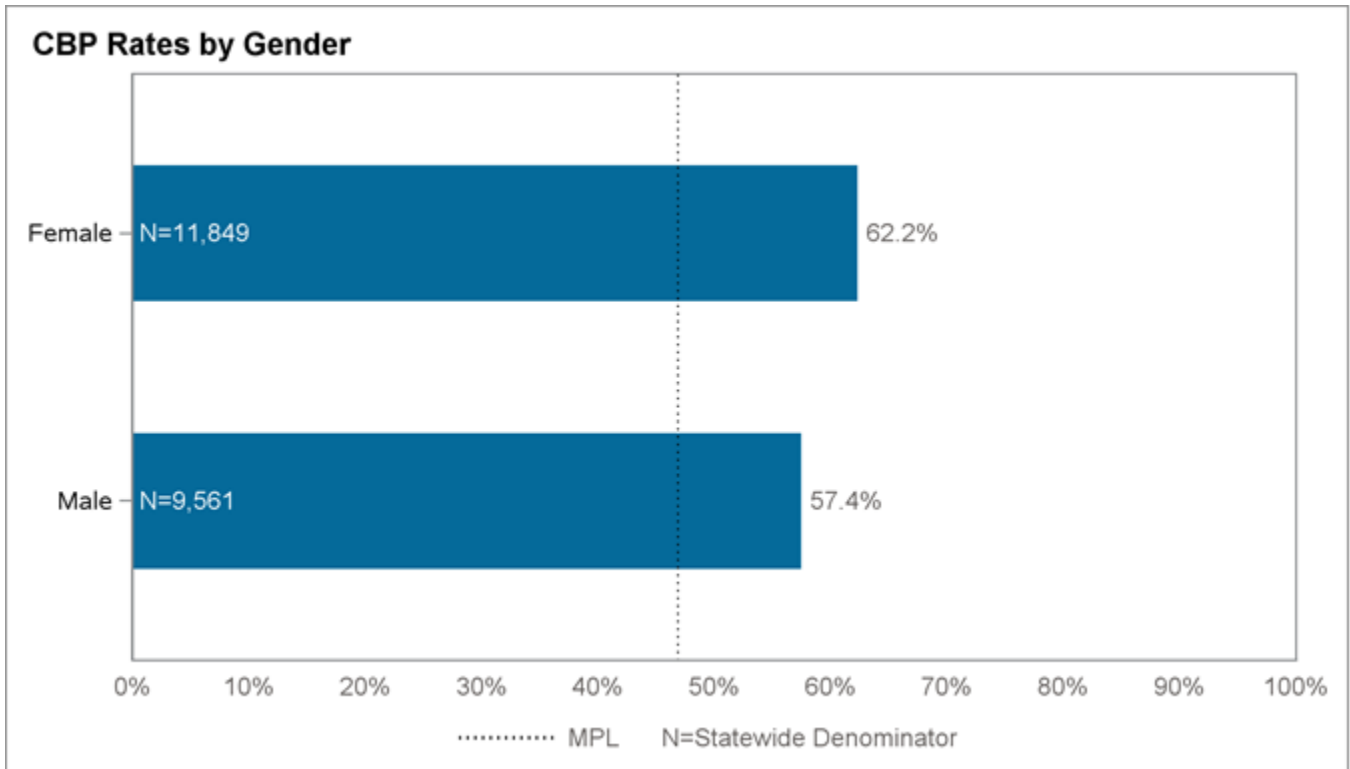
The minimum performance level represents the national Medicaid 25th percentile for this indicator.

Appropriate Treatment and Utilization

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

Figure A.71—All-Cause Readmissions (ACR) Rates by Gender
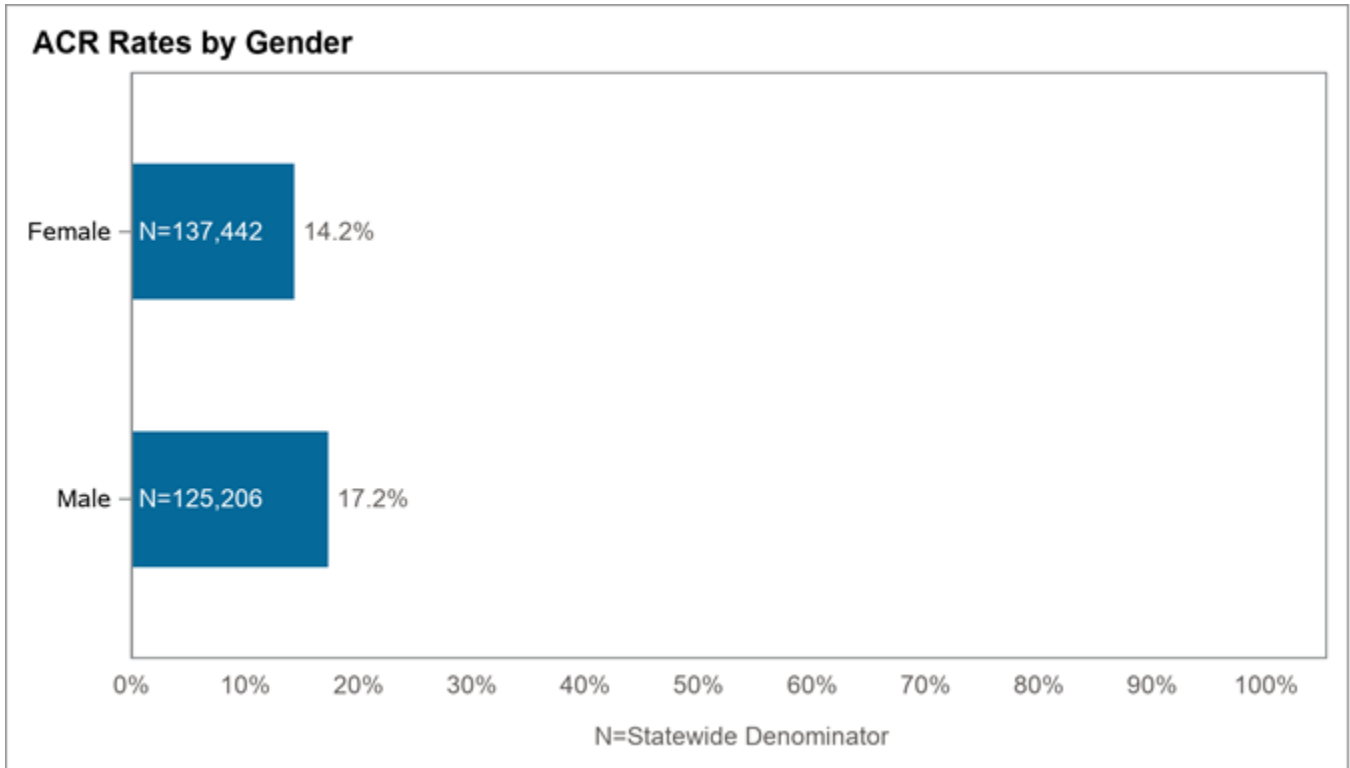
A lower rate indicates more favorable performance for this indicator.

The *All-Cause Readmissions* indicator was originally developed for the ACR Collaborative Quality Improvement Project; therefore, no minimum performance level was established for this indicator.

Figure A.72—Ambulatory Care—Emergency Department Visits (AMB–ED) Rates by Gender
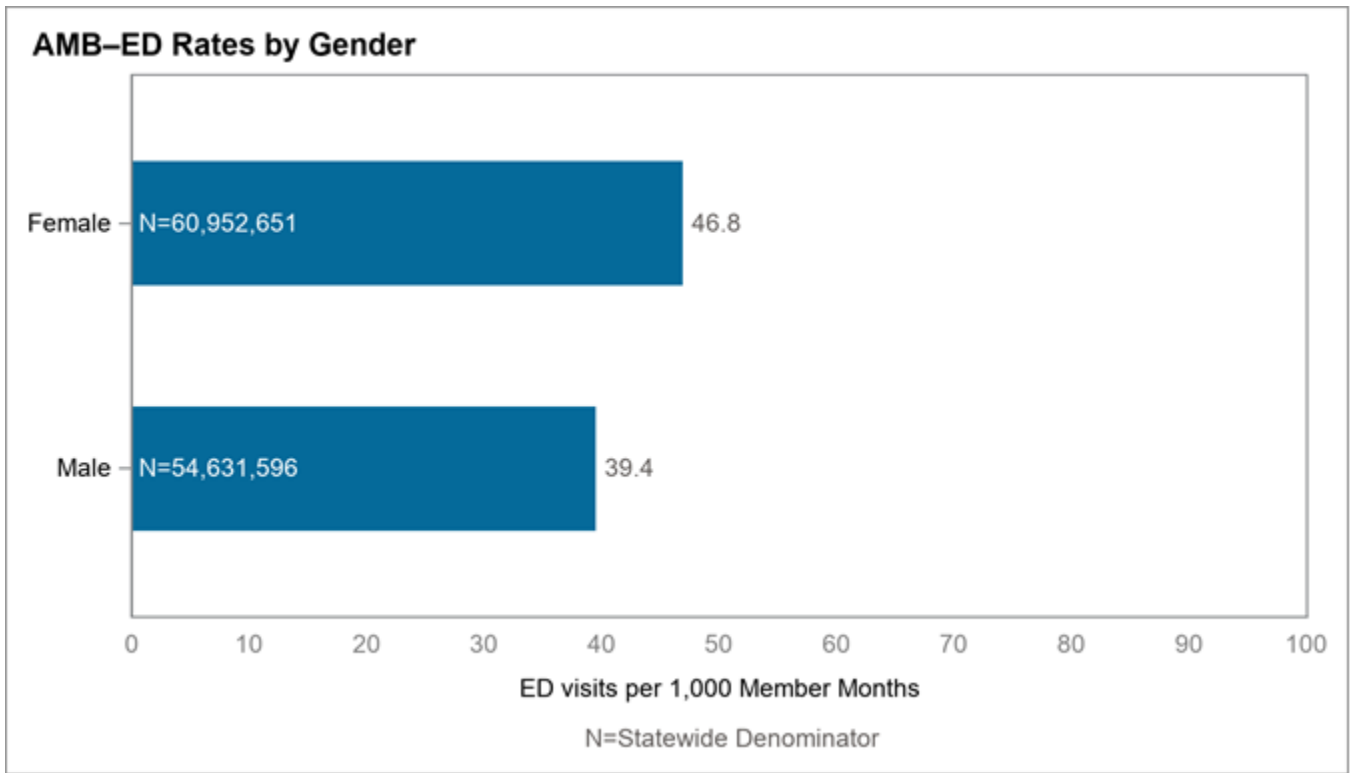
The *Ambulatory Care—Emergency Department Visits* indicator is a utilization indicator where a higher or lower rate does not indicate more favorable or less favorable performance; therefore, the minimum performance level is not displayed for this indicator.

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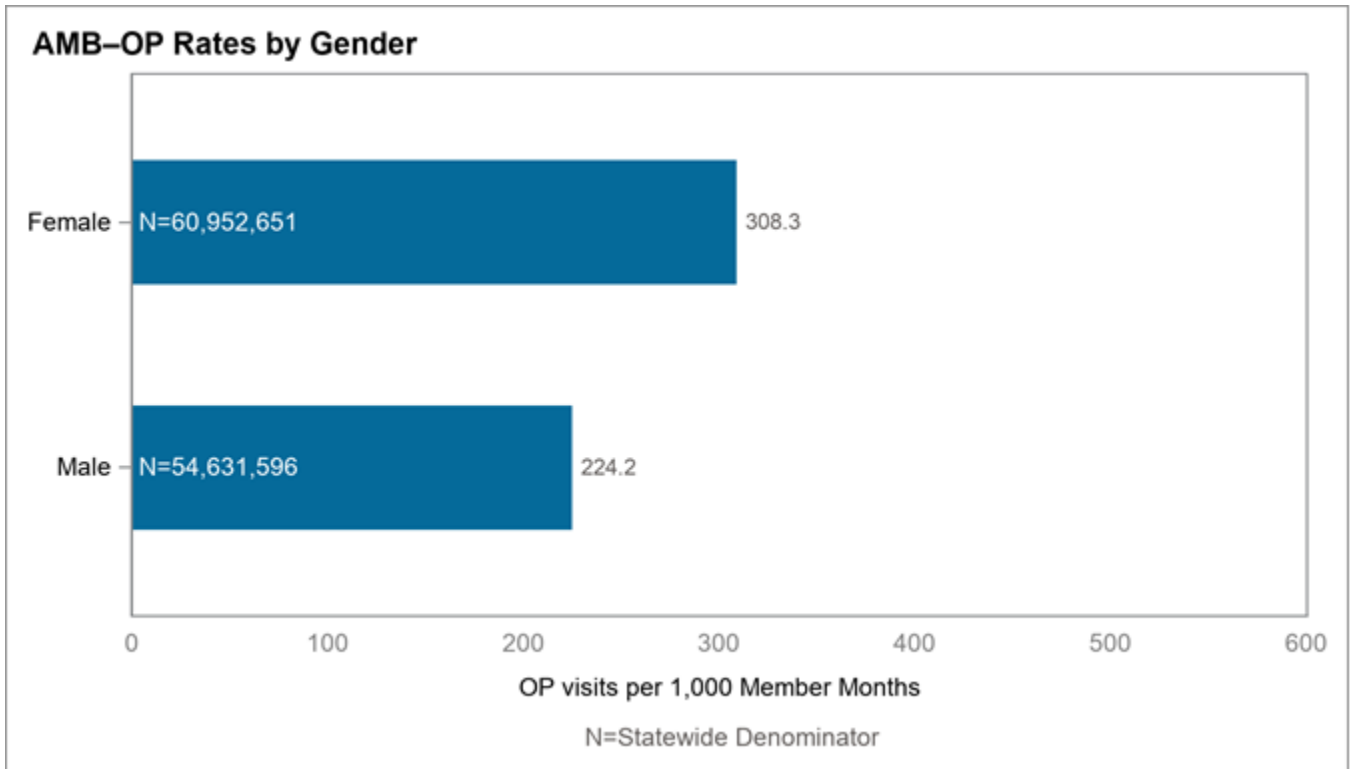
AMB–OP Rates by Gender

Female – N=60,952,651 — 308.3

Male – N=54,631,596 — 224.2

OP visits per 1,000 Member Months

N=Statewide Denominator

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

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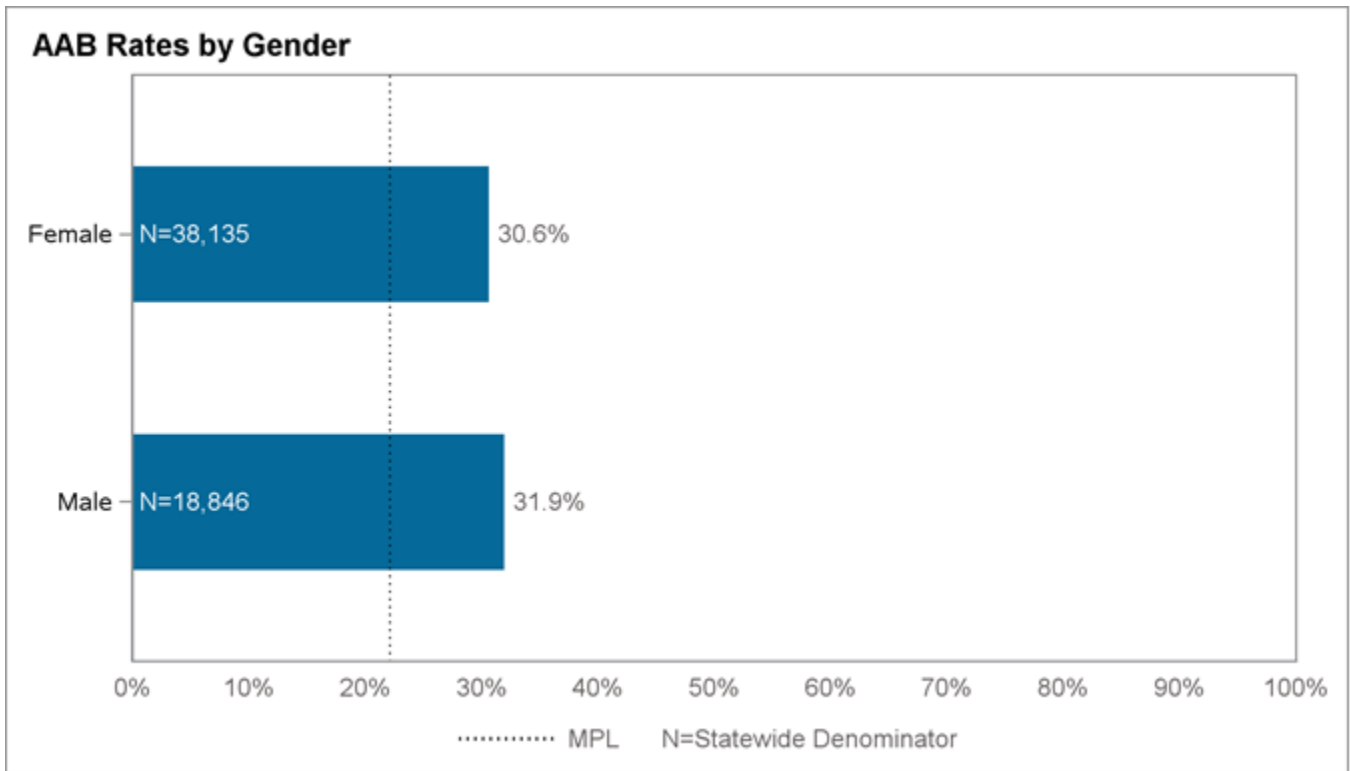
AAB Rates by Gender

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

Figure A.75—Use of Imaging Studies for Low Back Pain (LBP) Rates by Gender
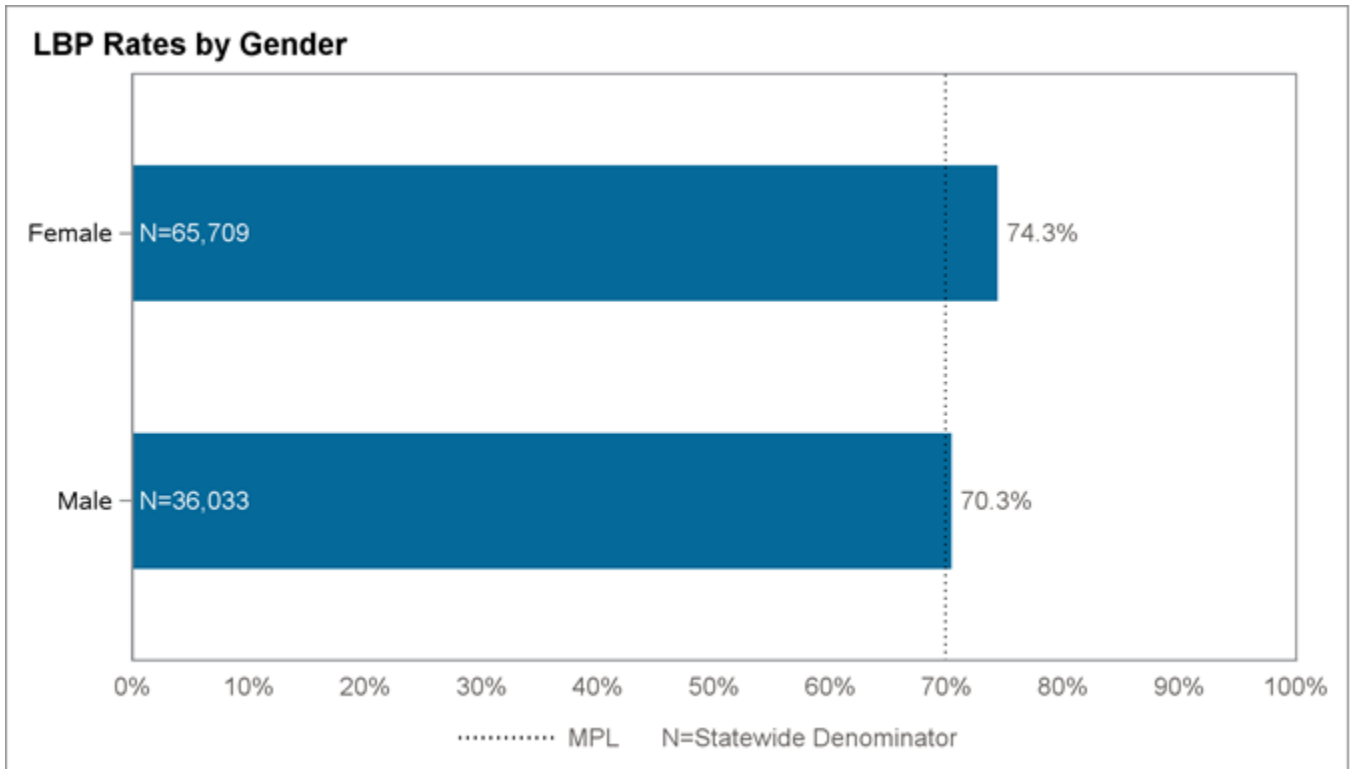
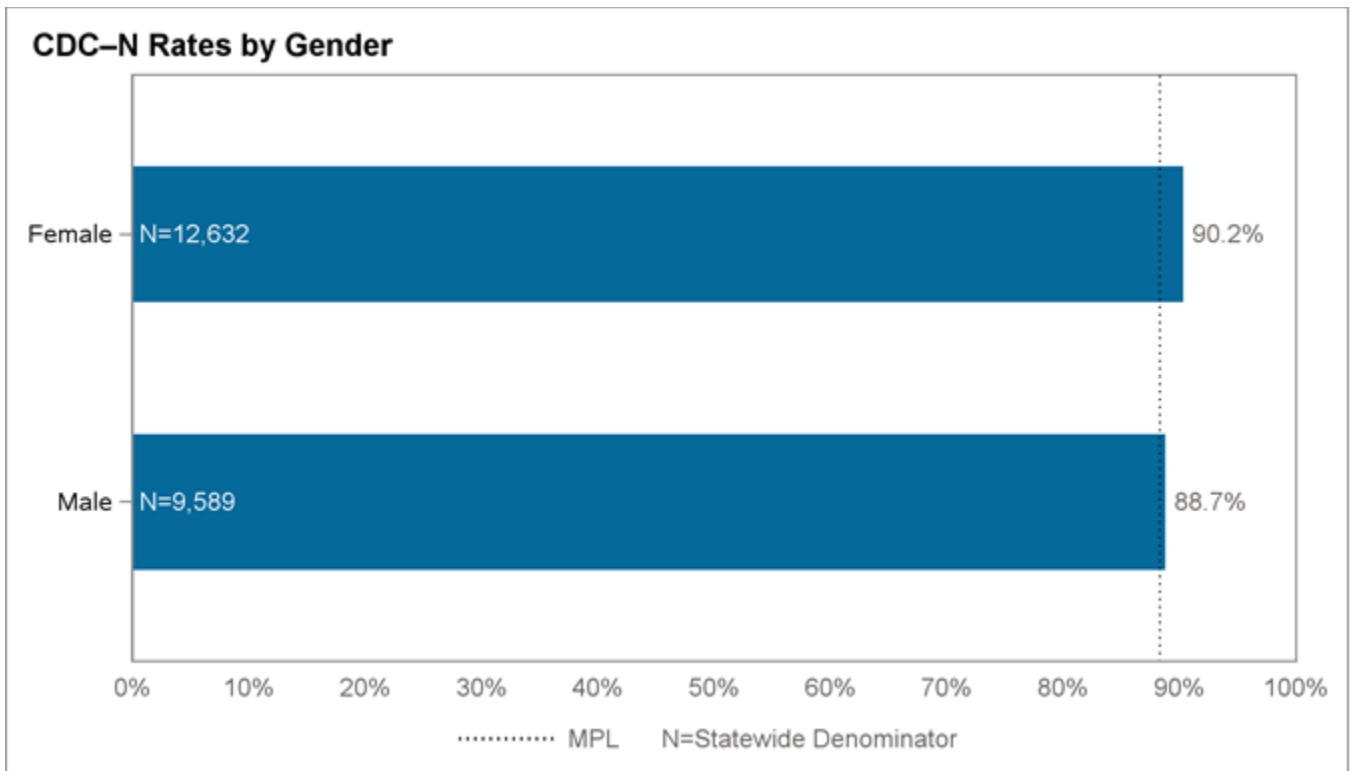The minimum performance level represents the national Medicaid 25th percentile for this indicator.

Overview

A health disparity is the difference in health outcomes between groups within a population.[11] To assess and improve health disparities, DHCS contracted with Health Services Advisory Group, Inc. (HSAG) to conduct a health disparities study using the EAS performance measures reported by the 23 full-scope Medi-Cal MCPs for reporting year 2017 with data that is derived from calendar year 2016. EAS measures reflect clinical quality, timeliness, and access to care provided by MCPs to their beneficiaries, and each MCP is required to report audited EAS results to DHCS annually. The goal of the Health Disparities Report is to improve health care for Medi-Cal beneficiaries by evaluating the health care disparities affecting beneficiaries enrolled in Medi-Cal MCPs. This report does not include data for fee-for-service (FFS) beneficiaries in Medi-Cal.

For the 2016–17 contract year, HSAG evaluated EAS measure data collected for reporting year 2017 at the statewide level, which consists of data collected during calendar year 2016 also known as HEDIS measurement year 2016. Several EAS measures include more than one indicator; therefore, this report will refer to EAS indicators rather than measures. The EAS indicator set for this analysis included 27 HEDIS indicators and one indicator originally developed by DHCS and MCPs (with guidance from HSAG), for a total of 28 EAS indicators. Please note, HSAG did not include the *Screening for Clinical Depression and Follow-Up Plan* (*CDF*) indicators in the health disparities analysis due to unreliable data and inconsistent reporting by MCPs. For each indicator, MCPs used numerator and denominator criteria and minimum enrollment requirements defined by the applicable technical specification, such as the HEDIS specification for the Medicaid population. HSAG aggregated EAS results from 23 full-scope MCPs and then stratified these statewide rates for all EAS indicators by the following demographic stratifications:

♦ Race/ethnicity
♦ Primary language
♦ Age
♦ Gender

Although HSAG stratified all EAS indicators by race/ethnicity, primary language, age, and gender, 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.

---

[11] 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.

Data Sources

HSAG received an NCQA-required patient-level detail (PLD) file from each MCP for each HEDIS reporting unit. The reporting year 2017 PLD files followed NCQA's PLD file instructions and included the member ID, date of birth, member months, and gender for beneficiaries included in the audited HEDIS rates. Additionally, the PLD files indicated whether a beneficiary was included in the numerator and/or denominator for each applicable HEDIS indicator. HSAG validated the PLD files to ensure the numerator and denominator counts matched what was reported by MCPs in the audited HEDIS IDSS files. Please note, it is possible that non-certified eligible beneficiaries were included by some or all MCPs in the reporting year 2017 HEDIS rates. HSAG used these PLD files, along with supplemental files (e.g., demographic data provided by DHCS), to perform the evaluation. The following indicator files were obtained from each MCP:

♦ NCQA-required PLD file
♦ CA-required *ACR* PLD file (for the *All-Cause Readmissions* [*ACR*] indicator)
♦ CA-required *AMB* PLD file (for the *Ambulatory Care* [*AMB*] indicator)

The following demographic file was obtained from DHCS' Management Information System/Decision Support System (MIS/DSS) data system:

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

Combining Data

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

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

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

♦ HSAG prioritized records from the same reporting unit. If there were no records within the same reporting unit, then HSAG used records from other reporting units to retrieve missing information.

♦ HSAG prioritized the most recent non-missing observation within the measurement year using the following logic:

■ HSAG first tried to recover the missing demographic values from the most recent non-missing observation within calendar year 2016.

■ If HSAG could not recover the missing demographic values from a record within calendar year 2016, then the most recent non-missing observation from calendar year 2015 was used.

■ If HSAG could not recover the missing demographic values from a calendar year 2016 or calendar year 2015 record, then the earliest non-missing observation from calendar year 2017 was used.

♦ If HSAG could not obtain data for the missing demographic values, then they were assigned a value of "Unknown/Missing."

Step 3: HSAG combined the demographic file to the indicator file by Medi-Cal Client Identification Number (CIN) 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. If a CIN had multiple records in the demographic file with a date of birth (DOB) within 10 years of each other, the most recent non-missing demographic information was used. Additionally, to avoid combining a parent record with a child record that contains the same CIN, HSAG only considered a CIN to match if the DOB in the demographic file was within 10 years of the DOB recorded in the indicator file. If HSAG could not obtain data for gender or county from the demographic file, then HSAG did the following:

♦ If gender had a value of "Unknown/Missing" when the demographic file was matched to the NCQA-required PLD file, then the gender from the NCQA-required PLD file was used. Please note that this was not done for the CA-required *ACR* and *AMB* PLD files as a gender field was not provided in those indicator files.

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

In order to address the duplicate CINs within the *AMB* PLD file, HSAG used the following logic:

♦ If there were duplicates in the demographic file but not the *AMB* PLD file, the record was assigned to the older beneficiary.

♦ If there were duplicates in the *AMB* PLD file with non-matching denominators, the larger denominator was assigned to the older beneficiary.

♦ If there were duplicates in the *AMB* PLD file with matching denominators but non-matching emergency department numerators, the higher emergency department visits were assigned to the younger beneficiary.

♦ If there were duplicates in the *AMB* indicator file with matching denominators and matching emergency department numerators but non-matching outpatient numerators, the higher outpatient visits were assigned to the younger beneficiary.

♦ Otherwise, all duplicate CINs were matched to the demographic file randomly.

♦ If HSAG could not find a matching CIN, then all demographic fields were assigned a value of "Unknown/Missing."

Indicators and Stratifications

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

Table B.1—Demographic Stratification Groups

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, 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, Unknown/Missing
Age	Vary depending on indicator specifications (see Table B.3)
Gender*	Male, Female

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

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 off data collection guidance from the federal Office of Management and Budget as well as the US Department of Health and Human Services. Primary language stratifications were derived from the current threshold languages for Medi-Cal Managed Care counties as of July 2016.

Table B.2—Racial/Ethnic Stratification Groups

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, Other Asian or Pacific Islander*
American Indian or Alaska Native	American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander	Hawaiian, Guamanian, Samoan
Other	Other
Unknown/Missing	Unknown/Missing

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

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

Table B.3—EAS Indicators with Associated Indicators, Methodology, and Age Groups

EAS Indicators with Associated Indicators	Methodology	Age Groups
Preventive Screening and Children's Health		
Childhood Immunization Status—Combination 3	H	2 Years
Children and Adolescents' Access to Primary Care Practitioners—12 to 24 Months	A	12 to 24 Months
Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years	A	25 Months to 6 Years
Children and Adolescents' Access to Primary Care Practitioners—7 to 11 Years	A	7 to 11 Years
Children and Adolescents' Access to Primary Care Practitioners—12 to 19 Years	A	12 to 19 Years
Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	H	13 Years

EAS Indicators with Associated Indicators	Methodology	Age Groups
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total; Counseling for Physical Activity—Total	H	3 to 11 Years 12 to 17 Years
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	H	3 to 6 Years
Preventive Screening and Women's Health		
Breast Cancer Screening	A	52 to 64 Years 65+ Years
Cervical Cancer Screening	H	24 to 29 Years 30 to 44 Years 45 to 64 Years
Prenatal and Postpartum Care—Postpartum Care; Timeliness of Prenatal Care	H	<18 Years 18 to 20 Years 21 to 34 Years 35 to 44 Years 45+ Years
Care for Chronic Conditions		
Asthma Medication Ratio	A	5 to 11 Years 12 to 17 Years 18 to 20 Years 21 to 44 Years 45 to 64 Years
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg); Eye Exam (Retinal) Performed; HbA1c Control (<8.0 Percent); HbA1c Poor Control (>9.0 Percent); HbA1c Testing; Medical Attention for Nephropathy	H	18 to 20 Years 21 to 44 Years 45 to 64 Years 65+ Years
Controlling High Blood Pressure	H	18 to 20 Years 21 to 44 Years 45 to 64 Years 65+ Years

EAS Indicators with Associated Indicators	Methodology	Age Groups
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs; Diuretics	A	18 to 20 Years 21 to 44 Years 45 to 64 Years 65+ Years
Appropriate Treatment and Utilization		
All-Cause Readmissions	A	21 to 44 Years 45 to 64 Years 65+ Years
Ambulatory Care—Emergency Department Visits; Outpatient Visits	A	<1 Year 1 to 5 Years 6 to 11 Years 12 to 17 Years 18 to 20 Years 21 to 44 Years 45 to 64 Years 65+ Years
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	A	18 to 20 Years 21 to 44 Years 45 to 64 Years
Use of Imaging Studies for Low Back Pain	A	18 to 20 Years 21 to 44 Years 45 to 50 Years

Rate Spreadsheets

After performing the analyses, HSAG compiled and produced EAS indicator rate spreadsheets in an Excel format that provided all indicator data for all stratifications (race/ethnicity, primary language, age, gender). HSAG produced a statewide and 23 MCP-specific rate spreadsheets that contain applicable numerator, denominator, eligible population, demographic, and rate data for each reporting unit. HSAG did not suppress any data in the rate spreadsheets and did not weight rates.

Statistical Analysis

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

Pre-Analysis

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

Some of the indicators were event-based rather than beneficiary-based, which allowed for denominators greater than one. 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 four and a numerator value of three, HSAG created four separate observations that each had a denominator value of one; three of which had a numerator value of one and one of which had a numerator value of zero). HSAG applied this logic to the following indicators:

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

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

Statewide-Level Health Disparity Analysis

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

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

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

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

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

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

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

Reporting

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

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

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

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

Geographic Variability by County for Select Indicators

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

♦ *Childhood Immunization Status—Combination 3*
♦ *Prenatal and Postpartum Care—Postpartum Care*
♦ *Comprehensive Diabetes Care—HbA1c Testing*
♦ *Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis*

To highlight regional performance differences, HSAG first assigned a county to each beneficiary based on the county code provided in the DHCS demographic file. If the county code was missing for a beneficiary in the demographic data file, HSAG 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 beneficiaries within a county. For each indicator, HSAG and DHCS determined cut points (e.g., 60.00%, 65.00%,

70.00%, 80.00%) based on the distribution of county-level rates to display the variation of county performance. HSAG then created performance levels (Lowest Performance [dark blue], Low Performance [light blue], Middle/Average Performance [gray], High Performance [light magenta], and Highest Performance [magenta]) based on the cut points for each indicator. Once the performance levels were set for each indicator, each county was shaded the corresponding color of the performance level. Table B.4 displays the performance levels and corresponding colors for each indicator.

Table B.4—Performance Level and Corresponding Colors

Indicator	Performance Level and Corresponding Colors
Childhood Immunization Status—Combination 3	Below 60.00%
	60.00% to 64.99%
	65.00% to 69.99%
	70.00% to 79.99%
	80.00%+
Prenatal and Postpartum Care—Postpartum Care	Below 55.00%
	55.00% to 63.99%
	64.00% to 67.99%
	68.00% to 71.99%
	72.00%+
Comprehensive Diabetes Care—HbA1c Testing	Below 83.00%
	83.00% to 85.49%
	85.50% to 87.49%
	87.50% to 89.99%
	90.00%+

Indicator	Performance Level and Corresponding Colors
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	Below 25.00%
	25.00% to 29.99%
	30.00% to 34.99%
	35.00% to 39.99%
	40.00%+

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

Caveats

Hybrid Indicators

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

Limiting Beneficiaries

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

Geographic Variability

The results of the geographic variability analysis should be interpreted with caution because HSAG did not weight the county rates for hybrid indicators by the total eligible population. Due to this, all MCPs, regardless of size, count equally toward the county rates.