



Confronting Healthcare Disparities in Medi-Cal Managed Care: The Role of Ethnicity, Race, and Primary Language

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The elimination of ethnic, racial, and linguistic healthcare disparities is a major challenge for U.S. healthcare systems. Healthcare disparities reflect a lower quality of care among our country's minority populations, and can lead to unnecessary complications for various health conditions, poorer health for minorities, as well as higher healthcare and social costs. While there is some progress in narrowing healthcare disparities, national efforts to eliminate these disparities are stalled by the lack of collection and analysis of performance data by ethnicity, race, and primary language.

Medicaid is the largest provider of healthcare services to low-income ethnic minority populations in our nation. Therefore, it is in Medicaid's best interest to reduce healthcare disparities in order to promote good health, reduce preventable medical complications, and reduce healthcare costs. Since California is ethnically diverse and has the largest Medicaid population in the United States, our state has a vested interest in reducing healthcare disparities too.

The California Department of Health Care Services operates a managed care program called Medi-Cal Managed Care Division (MMCD) that covers approximately half of the Medi-Cal population. California's diverse group of over three million MMCD enrollees consists of 55.2% Latinos, 16.6% non-Latino Whites, 13.1% Blacks/African Americans, and 11.7% Asians/Pacific Islanders. The primary languages spoken by MMCD enrollees can be divided into four broad categories: English, Spanish, Asian/Pacific Islander languages (e.g., Cambodian and Thai), and Other (e.g., Farsi, Polish, and American Sign Language). Despite the great diversity in the population, the evaluation of quality of care in MMCD by ethnicity, race, and primary language has been limited.

The University of California Los Angeles (UCLA) Department of Family Medicine undertook the first external statewide assessment of MMCD

healthcare disparities. This study analyzed data from several MMCD health plans and had three primary objectives:

- To assess racial, ethnic, and linguistic disparities in the quality of care for enrollees of MMCD plans;
- To assess current Medi-Cal collection systems for gathering information on race, ethnicity, and primary language; and
- To provide recommendations on how the collection system can be improved for future reviews.

Methods

All health plans contracting with MMCD received an invitation to participate in our study. Eight health plans volunteered to participate: Blue Cross of California, Central Coast Alliance for Health, Contra Costa Health Plan, Health Net, Inland Empire Health Plan, Kern Health Systems, LA Care, and San Francisco Health Plan. Collectively, these eight health plans provide services for 70% of MMCD beneficiaries. The health plans submitted 2006 data similar to the Health Plan Data and Information Set (HEDIS)¹ performance measures.

The "HEDIS-like" performance measures covered three areas of care: 1) child and adolescent healthcare, 2) women's healthcare, and 3) chronic and other diseases. The health plans linked their data with the State's Medi-Cal Eligibility Data System, which contains information on beneficiary ethnicity, race, and primary language. Our study analyzed performance outcomes by ethnicity, race, and language for all 16 measures, and analyzed the data collection process. These 16 "HEDIS-like" measures cover data on the treatment of health conditions, such as "Appropriate Treatment for Upper Respiratory Infection," and number of healthcare visits, such as "Well-Child Visits for Children between 3 and 6 Years of Age." The 16 "HEDIS-like" measurements are listed in the chart below.

Findings

The results of our study suggest that healthcare disparities by ethnicity, race, and primary language are widespread in the MMCD system. In particular, the quality of care is significantly lower for African

Americans than for other ethnic groups on 10 of 16 widely used measures; the non-Latino White group has the lowest quality of care for 3 of 16 measures. Similarly, quality of care is significantly lower for English speakers than non-English speakers in 13 of 16 measures. These ethnic, racial, and primary language disparities remained consistent across most health plans.

When examining differences in the use of healthcare services by ethnic and racial groups, our study found that wide disparities existed in each of the 16 areas of care. For example, disparities are found in:

- **Child Immunization Status:** The Asian/Pacific Islander (API) group shows an 82% rate for receiving all six vaccinations, followed closely by Latinos at 78%. Non-Latino Whites trail with a 67% rate, and African Americans trail even farther at 62%.
- **Breast Cancer Screening:** The API and Latino groups show similar performance rates at 56% and 55%, respectively. The non-Latino White group experiences a 49% rate, and the lowest rate of screening, 43%, is experienced by the African American group.
- **Hemoglobin A1c Testing:** Among diabetics, the highest rate of testing is experienced by the API group (76%), followed by the Latino group (75%), and the non-Latino White group (71%). The lowest rate of testing is experienced by the African American group (66%).

When examining differences in the use of healthcare services by primary language, our study also found wide disparities in most categories. For example, disparities are found in:

- **Child Immunization Status:** This measure indicates API-language speakers receive vaccinations at a higher rate (88%) than either Spanish-speakers (83%), or English speakers (68%).
- **Breast Cancer Screening:** Spanish and API-language speakers are screened at very similar rates (58% and 57%, respectively), while English-speakers show a significantly lower rate of screening (46%).
- **Hemoglobin A1c Testing:** The API-language group receives the highest screening rate at 80%, followed by the Spanish-speaking group at 78%, and by the English-speaking group at 69%.

An unexpected finding is that non-English speakers received higher rates of care than English speakers in all but 3 of the 16 measures. There are several possible explanations for this and other findings in our project.

Our findings may reflect the success of various efforts by MMCD to improve services for populations with limited English proficiency. It is also possible that populations with low rates of testing may have more chronic or acute health conditions, and visit clinicians for the treatment of their chronic or acute physical conditions rather than for the preventive care treatments measured in our project. Another explanation could involve socioeconomic factors; however, since MMCD enrollees are low-income, socioeconomic characteristics cannot account for all the differences. Factors such as a patient's beliefs and attitudes toward healthcare may explain some differences. Finally, services may vary by type of provider (primary care or not), and geographic location, (urban or rural settings). Unfortunately, our database could not address these possible explanations.

When assessing the data collection process for ethnicity, race, and primary language, we noted high response rates for most of the measures and across most of the health plans. These high response rates demonstrate the feasibility and acceptability of collecting and using such data. Nevertheless, we noted that the current system of data collection has several inconsistencies contributing to potential problems in the quality of the data collected. For example, we noted different Medi-Cal application procedures for collecting ethnicity, race, and primary language information when contrasting the online application with an in-person application at a Los Angeles County Department of Public Social Service Office. As these differences can affect the accuracy of the data, improvements are needed in: 1) the collection of ethnic, race, and primary language data; 2) the development of ethnic, race, and primary language categories; 3) the reporting of this data to Medi-Cal managed care; and 4) the subsequent analysis of this data.

Policy Recommendations

California's collection of ethnicity, race, and primary language data, and subsequent analysis of this healthcare data, allowed us to examine how California's ethnic, racial, and primary language subpopulations experience large differences in quality of care as measured by HEDIS indicators. Across all ethnic and linguistic lines--from English speakers to non-English speakers, from African Americans and Whites to Asians/Pacific Islanders and Latinos--MMCD enrollees face major gaps between observed and desirable quality of healthcare. Achieving better healthcare of California's MMCD population starts with gathering uniform and accurate data. In order to

find solutions to healthcare disparities, we recommend that the State:

- Ensure standardization of the ethnicity, race, and primary language questions on the Medi-Cal application by using a single format for all Medi-Cal applications. Implement a method to allow patients to self-identify their ethnicity, race, and primary language in all settings.
- Provide standardized options for ethnicity, race, and language with specific subcategories for broad groups. The accepted national standard for data collection relies on categories in the Federal Office of Management and Budget's Directive 15.

Another step to improve data accuracy is to establish a process for validating ethnicity, race, and primary language data, and to establish a way to account for missing information. Several methods for validating data are currently in use by different state Medicaid programs. We recommend that MMCD:

- Implement a method of validating ethnic, racial, and primary language data after it is collected.

While collecting accurate and valid data on ethnic, racial, and primary language characteristics of enrollees is critical, it is only useful if such data is analyzed routinely when the State or health plans generate reports on the quality of care provided. We recommend that the State:

- Require the use of ethnicity, race, and primary language data to generate performance reports (i.e., HEDIS and CAHPS) by ethnicity, race, and primary language.
- Adopt consistent aggregations of ethnicity and language data that can be used in all state and health plan internal reports, and then analyzed to determine areas for improvement.

Once a process is in place to accurately identify ethnic, racial, and linguistic disparities, steps can be taken to help eliminate these healthcare inequities. By understanding sources of disparities we can investigate healthcare solutions. We recommend that the State:

- Require health plans to incorporate the goal of reducing ethnic, racial, and primary language disparities into future quality improvement projects.
- Support research to improve an understanding of the sources of these disparities, and determine why some disparities run contrary to typical expectations.

- Develop quality improvement projects specifically designed to reduce and/or eliminate disparities in healthcare.
- Offer technical, administrative, performance, and financial incentives to health plans and provider groups, encouraging them to address disparities in healthcare.
- Support research to assess the effectiveness of specific interventions to reduce healthcare disparities, and improve quality of care.

Our project underscores the importance of efforts to collect HEDIS data as a resource for tracking ethnic, racial, and primary language disparities. Reports to health plans, consumers, and policymakers about healthcare disparities could be a vital motivator for change. Such information could enable health plans and the State to tailor interventions for improving the clinical quality for ethnic, racial, or primary language populations.

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Funding for this study was provided by the California Program on Access to Care, an applied policy research program administered by UC Berkeley School of Public Health in cooperation with University of California, Office of the President. The authors' views and recommendations do not necessarily represent those of CPAC, UC Berkeley's School of Public Health, MMCD, or the Regents of the University of California.

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