

Setting a Medi-Cal Child Health Quality Agenda

February 2019



**Children
Now[®]**

Setting a Medi-Cal Child Health Quality Agenda

More than half of California children rely on Medi-Cal for health care, including access to critical preventive check-ups and other important health care services to ensure that children can stay healthy and on target developmentally. Especially for younger children, quality health care through Medi-Cal has the potential to improve their lifetime trajectories, overall population health, and long-run efficiencies. Measuring and tracking the quality of health care delivered to children in Medi-Cal is the first step to assuring access to services, improving the quality of services, enhancing the patient experience, and establishing efficiencies that can improve health outcomes. This brief reviews the current Medi-Cal landscape of child health quality measurement and provides immediate, ongoing, and longer-term recommendations on how the state can move forward in setting a Medi-Cal child health quality measurement agenda for 2019 and beyond to advance and improve child health outcomes.

I. Child health quality matters in Medi-Cal

The physical, cognitive, social, and emotional development of a child is impacted by many fundamentally important factors, including access to high-quality health care. The first three years of a child's life is an amazing period of growth and development for children where access to robust and quality preventive health care services is critical. In fact, prioritizing young children in Medi-Cal has the potential to improve their lifetime trajectories, overall population health and long-run savings.¹ Medicaid for children is unique in that it provides broader coverage as compared to private plans or Medicaid benefits for adults, because it has an explicit focus on prevention through the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit standard. EPSDT provides comprehensive and robust coverage for children under 21, focused on prevention, early detection, and treatment.² This benefit is intended to meet children's developmental needs. However, to ensure that children are receiving the health care services they are entitled to under EPSDT and that the services are timely and of high quality, the care must be measured, analyzed, and tracked over time to identify gaps in services and opportunities for improvement, and evaluate the effectiveness of those efforts.³

Ensuring and improving the value and effectiveness of health care are system-wide challenges, but are especially important for children in public coverage programs like Medicaid/Children's Health Insurance Program (CHIP), or Medi-Cal in California. As the source of coverage for more than half (54%) of all California children and nearly six out of ten (57%) young children under age 6,⁴ and the payer of nearly half (45%) of all births in the state,⁵ Medi-Cal has significant leverage to drive health care changes and quality improvements that can lead to positive change across the health care delivery system.⁶ Improving the quality of child health care in Medi-Cal will lead to better health outcomes for children, help eliminate health disparities, and further boost the long-term positive impacts of Medicaid coverage on children, such as higher educational achievement and greater economic success later in life.⁷

Robust child health care quality measurement is necessary to ensure children, especially young children, have access to quality care across the spectrum of Medi-Cal services and for all delivery systems. Importantly, with 89% of children in Medi-Cal enrolled in a contracted Medi-Cal managed care plan financed through public dollars,⁸ measuring the quality of child health care and benchmarking against performance targets are critical accountability checks on health plan performance.⁹ In addition, as more vulnerable children, like those with special health care needs in Medi-Cal's California Children's Services (CCS) program,¹⁰ are fully covered by managed care plans, plans must be held accountable for providing and coordinating all required services, not excluding specialty mental health, Substance Use Disorder (SUDs), behavioral health, and dental care. It should be noted that dental care in Medi-Cal is predominantly provided through the Denti-Cal fee-for-service delivery system (with dental managed care contracts in only two of the 58 counties), but quality measurement is equally important.

II. The basics of child health quality measurement in Medi-Cal today

There are a number of specific child health quality indicators that span a range of dimensions of health care including access, utilization of preventive and primary care, appropriateness of care in treating acute and chronic conditions, and patient experience or satisfaction. These indicators (including their technical specifications) are constantly evolving based on empirical experience or progress, and upon regular review by national accrediting or expert advisory bodies, among other factors.

Quality indicators are often grouped in “sets” based on programmatic oversight or accrediting bodies, agencies, or processes. Specifically relevant for Medi-Cal are two main sets of health quality indicators: the federal Child Core Set determined by the Centers for Medicare and Medicaid Services (CMS) and the state’s External Accountability Set (EAS) determined by the Department of Health Care Services (DHCS).¹¹ Both sets contain some overlapping child health quality indicators or metrics, but Table 1 highlights some of the other key features that differentiate the two.

Table 1: Features of the Child Core Set vs. the External Accountability Set

	Child Core Set (federal)	External Accountability Set (CA)
Agency responsible for reviewing and identifying indicators	Centers for Medicare and Medicaid Services (CMS) within US Dept. of Health and Human Services ¹²	Dept. of Health Care services (DHCS) within California Health and Human Services Agency ¹³
Reporting responsibility & requirements	Currently state Medicaid & CHIP programs may voluntarily report to CMS; mandatory reporting will begin in 2024	Medi-Cal health plans are contractually required to report to DHCS (via encounter data)
Frequency of review/evaluation	Annually	Every three years
Child-specific indicators only	Yes (there is a separate Adult Core Set)	No (9 of 17 indicators in 2018 are child relevant – see Appendix Table A) ¹⁴
Delivery system	Both fee-for-service (FFS) and managed care	Managed care only
Performance standards & requirements	None Currently	Medi-Cal health plans held accountable for performing at least as well as the national Medicaid 25th percentile; linked to at least one required quality improvement project

Key Terms Related to Medi-Cal Child Health Quality

- **Child Core Set** is a set of child-focused quality metrics developed for measuring the quality of health care for children in Medicaid and CHIP programs across all states, which states voluntarily report or CMS extracts from public data sources; mandatory state reporting of the Child Core Set will begin in 2024.
- **External Accountability Set (EAS)** is a set of quality metrics used by the DHCS to measure Medi-Cal managed care plan performance/quality.
- **Health Effectiveness Data and Information Set (HEDIS)** is a tool used by more than 90 percent of America's health plans to measure performance/quality on important standardized dimensions of care and service; HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA). The Child Core Set includes some HEDIS measures while the EAS consists primarily of HEDIS measures.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey** is a tool designed to assess patient experience in a specific health care setting, and in California is used to ask Medi-Cal managed care beneficiaries to evaluate their experiences with their health care and health care providers.
- **External Quality Review Organization (EQRO)** is an independent entity that has expertise in reviewing the quality of health care provided to Medicaid beneficiaries and that state Medicaid managed care programs are required to contract with to perform certain functions, like analyses of quality data.
- **Performance Improvement Project (PIP) or Quality Improvement Project (QIP)** is a structured process of identifying and measuring a targeted area (clinical or nonclinical), analyzing the results, implementing interventions for improvement, and re-measuring to determine if improvement in performance was achieved. In Medi-Cal, health plans are required to conduct and/or participate in two non-child-specific PIPs annually: one on a statistically significant health disparity (e.g., race, ethnicity, language spoken, gender, geographical location, provider, etc.) that may be related or unrelated to any of the current EAS metrics, and a second PIP topic linked to plan performance on EAS indicators, such as childhood immunizations.

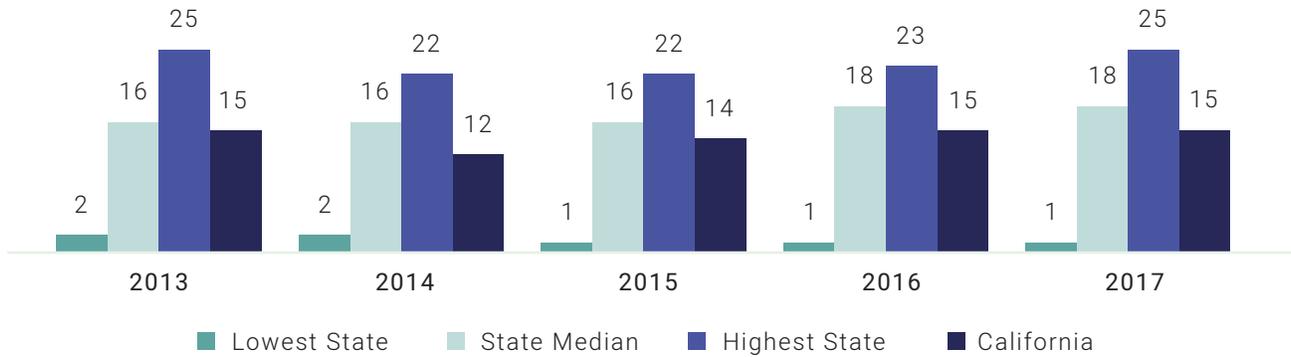
III. The importance of the Child Core Set for Medi-Cal child health quality

The original Child Core Set was developed several years ago as a means of measuring improvements and trends in child health quality over time and a standardized way of comparing child health quality across state Medicaid and CHIP programs. However, states have had latitude in how they use and implement child health quality measurement and improvement, and states can voluntarily report to CMS on the Child Core Set indicators of their choosing from year to year. As a result of a 10-year extension of the CHIP approved in early 2018, all states including California will be required to report data annually on all Child Core Set indicators to CMS beginning in Fiscal Year 2024.¹⁵

Historically, California has lagged behind other states in reporting on Child Core Set Indicators (see Figure 1). For example, in 2017 California reported on fewer Child Core Set indicators (15 indicators) than 35 other states.¹⁶

Figure 1: California Reporting on Child Core Set Measures, 2013-2017¹⁷

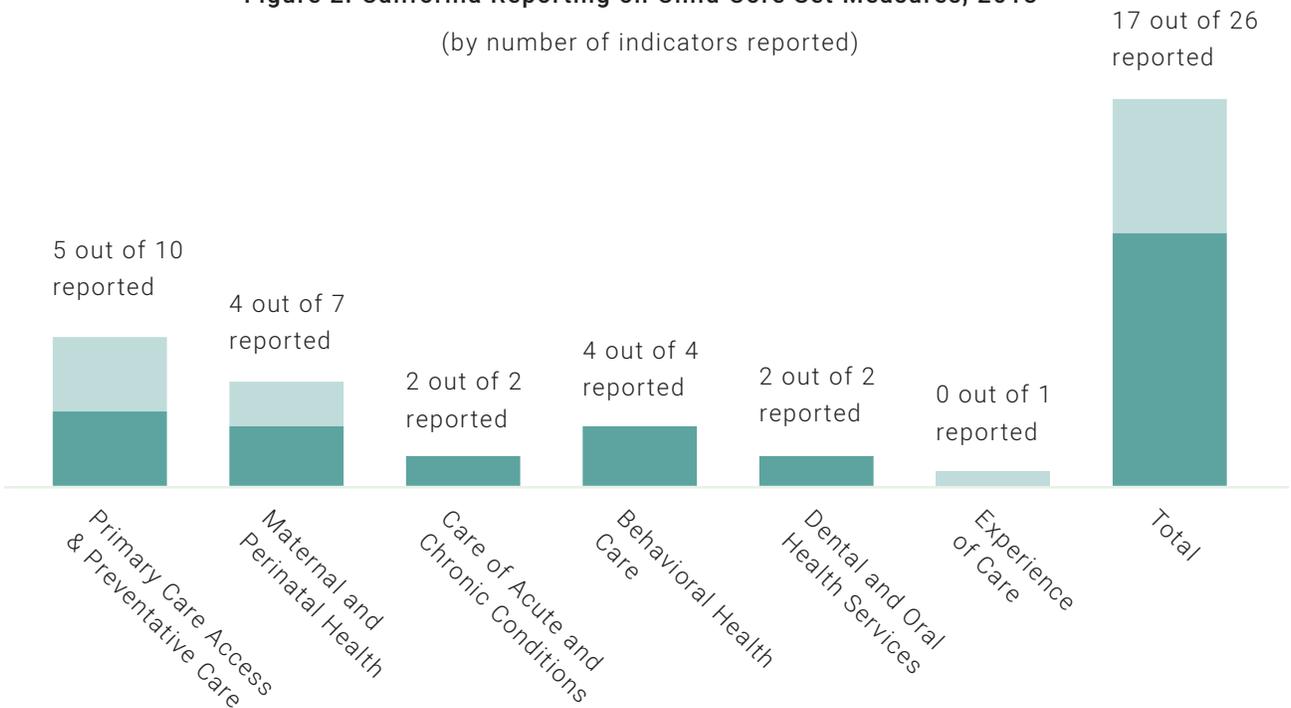
(by number of indicators reported)



For 2018, California is expected to report data to CMS on 17 of the 26 Child Core Set indicators as part of the EAS or some other mechanism (see Table 2).¹⁸ This means that there are nine Child Core Set indicators that California will not report data on in 2018; specifically in the areas of Primary Care Access, Maternal and Perinatal Health, and Experience of Care (see Figure 2). Because the 2019 Child Core Set indicators will be the same as the 2018 indicators,¹⁹ this reveals a significant and persistent gap between California’s current reporting on the Child Core Set and full compliance with the mandatory reporting requirement for Child Core Set reporting (in 2024).

Figure 2: California Reporting on Child Core Set Measures, 2018²⁰

(by number of indicators reported)



Note that most (7 out of 9) of the child-relevant EAS metrics are also included in the Child Core Set (see Appendix Table A); or said another way, with only two exceptions, the EAS does not include any additional child-relevant indicators that are not also in the Child Core Set.²¹ While the new federal reporting requirement of the Child Core Set is a significant step forward on measurement, California could go also beyond the Child Core Set or the EAS parameters to innovatively measure and improve child health quality in Medi-Cal through a comprehensive approach in partnership with other child-serving agencies.

Table 2: 2018 Child Core Set Indicators To Be Reported for Medi-Cal ²²

2018 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set) ²³	Data To Be Reported for Medi-Cal in 2018, and Total by Category
Primary Care Access and Preventive Care	5 out of 10
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	No
Chlamydia Screening in Women Ages 16–20 (CHL-CH)	Yes
Childhood Immunization Status (CIS-CH)	Yes (also an EAS metric)
Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)*	No
Well-Child Visits in the First 15 Months of Life (W15-CH)	No
Immunizations for Adolescents (IMA-CH)	Yes (also an EAS metric)
Developmental Screening in the First Three Years of Life (DEV-CH)	No
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)	Yes (also an EAS metric)
Adolescent Well-Care Visit (AWC-CH)	No
Children and Adolescents’ Access to Primary Care Practitioners: (CAP-CH)	Yes (also an EAS metric)
Maternal and Perinatal Health	4 out of 7
Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)	Yes (data reported by CMS) ²⁴
PC-02: Cesarean Birth (PC02-CH)	No
Audiological Evaluation No Later Than 3 Months of Age (AUD-CH)	No
Live Births Weighing Less Than 2,500 Grams (LBW-CH)	No
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Yes (also an EAS metric)
Contraceptive Care – Postpartum: Ages 15–20 (CCP-CH)	Yes
Contraceptive Care – Most and Moderately Effective Methods: Ages 15–20 (CCW-CH)*	Yes
Care of Acute and Chronic Conditions	2 out of 2
Asthma Medication Ratio: Ages 5–18 (AMR-CH)*	Yes (also an EAS metric)
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Yes (also an EAS metric)

2018 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)	Data To Be Reported for Medi-Cal in 2018, and Total by Category
Behavioral Health Care	4 out of 4
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Yes
Follow-Up After Hospitalization for Mental Illness: Ages 6–20 (FUH-CH)	Yes
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Yes
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Yes
Dental and Oral Health Services	2 out of 2
Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	Yes
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Yes
Experience of Care	0 out of 1
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	No (data not collected next until 2019)
Total	17 out of 26

* = The measure was newly added to the 2018 Child Core Set.

IV. Current Medi-Cal performance and focus on child health quality

A 2016 report found that compared to other state Medicaid/CHIP data, Medi-Cal (based on the data reported by California) failed to be a top performer on the Child Core Set.²⁵ A further review and comparison of California's 2016 and 2017 Child Core Set data (see Appendix Table B), as well as additional available analyses, reports, surveys, and presentations from DHCS,²⁶ with a particular focus on the Child Core Set indicators & topics, uncovered some of the ways that Medi-Cal is falling short in child health quality, providing many opportunities for improvement. Namely, there appear to be significant gaps and room for improvement in the performance/delivery of services, in addition to greater reliability in the collection and reporting of the data itself.

Performance Improvement Needed

- **Newly calculated developmental screenings rate is extremely low.** In investigating the feasibility of a Child Core Set indicator (that is not part of the EAS), a recent EQRO Focus Study found that only one-third (36%) of infants and toddlers in Medi-Cal were getting the required developmental screenings in 2015. Although the Medi-Cal administrative data on developmental screenings is incomplete, parent survey data confirms an under-utilization of developmental screenings (i.e., only 22 percent of California parents indicated that their young child received a developmental screening during a pediatric well-child visit).²⁷
- **Childhood immunizations identified as statewide area to improve.** Less than three-quarters of young children (72.3% of two-year olds) in Medi-Cal were fully immunized in 2017. Childhood immunizations have been identified by DHCS as an area for improvement, and also as an area with quantified health disparities within race, language, and geography (see box). In 2016-2017, five health plans participated in PIPs to improve immunizations of 2-year olds.²⁸ In 2018, health plans with low or declining performance on the childhood immunization EAS indicator are required by DHCS to participate in a childhood immunization-focused PIP.
- **Data shows lagging access to children’s primary care.** The rate of “Access to Primary Care Practitioners” decreased or had only very modest increases for every age subgroup of children from 2016 to 2017. In fact, California performed in the lower half of all states (i.e., below the median) when comparing rates on the “Access to Primary Care Practitioners” indicator across all age groups. The problem may be underscored by the fact that, as revealed through a new network adequacy monitoring process that commenced in July 2018, nearly one-third of Medi-Cal health plan reporting units were unable to meet the existing primary care timely access standard for pediatrics.²⁹
- **Deficiencies in dental quality and access to care are well-documented.** Over the past several years, many state legislative hearings, administrative initiatives, and independent evaluations and audits have documented the poor access to dental care for children in Denti-Cal, which is the Medi-Cal dental fee-for-service program, in addition to dental managed care. A new report by the Little Hoover Commission, an independent state oversight agency, found that policy changes to Denti-Cal in recent years have not translated to major improvements in access to dental care.³⁰ There are similar access challenges in the two counties (Sacramento and Los Angeles) with dental managed care contracts.
- **Infrequent consumer satisfaction data shows low performance.** Consumer survey information, like the Consumer Assessment of Health Plans and Systems (CAHPS) is important to provide performance feedback that is actionable and will aid in improving overall beneficiary satisfaction beyond the experience captured by formal grievances and appeals.³¹ Based on 2016 family satisfaction survey data for child populations, a majority of Medi-Cal managed care plans performed poorly with respect to “Getting Needed Care” (42 out of 53 plans) and “Getting Care Quickly” (48 out of 53 plans). Furthermore, California does not annually report CAHPS survey data that is representative of the Medi-Cal pediatric population, so that publicly-reported CAHPS data only happens every three years.³² The EQRO’s review of child CAHPS data for the general child population and for children with chronic conditions found that California performs below the 2016 national averages for nearly all dimensions.

Data Collection & Reporting Improvement Challenges

- **State adopted important changes to 2018 EAS indicators.** In 2018, DHCS added the first behavioral health indicator to the EAS (i.e., Screening for clinical depression and follow up in adolescents and adults) and made important changes to EAS metrics related to asthma and adolescent immunizations. DHCS will begin its “every three year evaluation” of the EAS metrics in early 2019.³³

• **More data and focus needed on child health disparities.** A recent analysis found racial and ethnic disparities in access to care for California Latino children,³⁴ and earlier this year lawmakers expressed concern that children’s health disparities in Medi-Cal could be “perpetuated and/or exacerbated by poor monitoring and oversight.”³⁵ Although DHCS requires health plans to focus one PIP on a health disparity and has acknowledged stakeholder interest in stratified performance metrics, very little disaggregated data on children with regard to access, utilization, and quality has been released by DHCS. The recently released inaugural health care disparities report by the EQRO analyzed gender, racial/ethnic, language access, and geographic disparities within 12 EAS metrics, including four metrics that are relevant for child populations. Significant racial, language, and geographic disparities were identified for children with respect to immunization rates for two-year-olds, well-child visits for young children (ages 3-6), immunization rates for 13-year-olds, and access to primary care practitioners for older kids. While this provides a starting point and framework for analyzing disparities, it is still unclear how DHCS will use the results to engage health plans, providers, and advocates about the promising interventions that could meaningfully close the gaps. Nevertheless, DHCS has indicated that it plans to make this an annual report,³⁶ thereby showing a commitment to understanding health disparities.

• **Data reliability in Medi-Cal remains a challenge.** DHCS quality reports have indicated challenges in the reliability and consistency of the underlying coding practices and data reporting systems from health plans and providers (e.g., encounter data) upon which much Medi-Cal child health quality analysis is based. In fact, provider coding and documentation practices were cited as one reason for low developmental screening rates in the EQRO’s Focus Study.

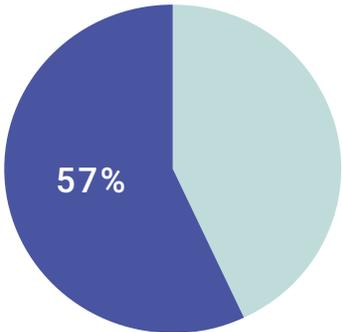
Disparities Among Immunization Rates for Young Children and Adolescents in Medi-Cal, 2015³⁷

- Statewide, two-year-old children who are Black have far worse immunization rates than two-year-old children who are not Black. Only 54% of two-year-olds who are Black were fully immunized and were significantly less likely to be immunized compared to their Asian/Pacific Islander and Hispanic/Latino counterparts who had about a 75% rate of immunization (in comparison, White children had a 62% immunization rate). Adolescents who are Black also have a significantly lower immunization rate (69%) than adolescents who are not Black.
- Racial and ethnic disparities also exist locally when county-level data is examined. For example, among two-year-olds, children who are Black and American Indian/Alaskan Native have among the lowest immunization rates in some counties. Among 13-year-olds, adolescents who are American Indian/Alaskan Native and White have significantly low immunization rates in many counties with available data. However, in some counties adolescents who are American Indians/Alaskan Natives have the highest immunization rates.
- Children in families who speak “Other European languages” (such as French, Italian, Polish, Portuguese, Russian, and Turkish) have lower immunization rates than children in families who speak other languages. For example, only 17% of two-year-olds and 49% of adolescents in families that speak “Other European languages” were fully immunized, compared to 91% of two-year-olds in Korean-speaking families and 95% of adolescents in Armenian-speaking families. As a comparison, the immunization rate was 81% for both two-year olds and adolescents in Spanish-speaking families.

The following snapshots of 2017 performance and data gaps for young children and adolescents in Medi-Cal demonstrates through the example of primary care that child health quality in Medi-Cal requires both performance improvement, in addition to more and better data reporting.

Snapshot of Preventive Care Performance and Quality Data Gaps for Young Children in Medi-Cal

Nearly six in ten (57%) young California kids 0-5 are covered by Medi-Cal



Through the important and comprehensive Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit, young children in Medi-Cal should get preventive care services, including:

- Multiple well-child visits in the first two years of life
- Routine developmental & autism screenings
- Immunizations for preventable childhood diseases

	Child Health Quality Indicator (required federal reporting by 2024)	CA Performance vs. National Median, 2017
Access	Children and Adolescents' Access to Primary Care Practitioners: Ages 12 - 24 months	CA = 91.1% US = 95.2% (48 states)
	Children and Adolescents' Access to Primary Care Practitioners: Ages 25 months - 6 years	CA = 81.7% US = 87.4% (48 states)
Well-Care	Well-Child Visits in the First 15 Months of Life	CA = NOT REPORTED US = 59.3% (49 states)
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*	CA = 75.6% US = 66.9% (49 states)
Immunization	Childhood Immunization Status^	CA = 72.3% US = 67.9% (41 states)
Screening	Developmental Screening in the First Three Years of Life	CA = NOT REPORTED US = 39.8% (27 states)

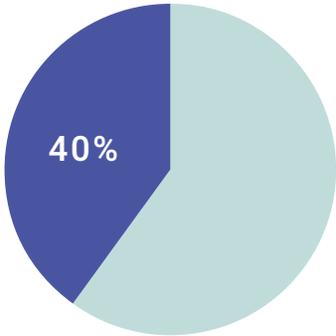
*California has known disparities for White kids for Well-Child visits in the third, fourth, fifth, and sixth years of life.

^California has known disparities for Black, American Indian, Alaska Native, and White kids & families speaking other European languages for childhood immunization status.

Snapshot of Preventive Care Performance and Quality

Data Gaps for Adolescents in Medi-Cal

Roughly four out of ten (40%) of California adolescents ages 12-18 are covered by Medi-Cal



Through the important and comprehensive Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit, adolescents in Medi-Cal should get preventive care services, including:

- Well care visits at least annually
- Screenings for sexually transmitted diseases
- Immunizations for common communicable diseases among adolescents

	Child Health Quality Indicator (required federal reporting by 2024)	CA Performance vs. National Median, 2017
Access	Children and Adolescents' Access to Primary Care Practitioners: Ages 12-19 years*	CA = 82.7% US = 90.1% (48 states)
Well-Care	Adolescent Well-Care Visit	CA = NOT REPORTED US = 44.7% (49 states)
Immunization	Adolescents Receiving Three Doses of Human Papillomavirus (HPV) Vaccine by Their 13th Birthday^	CA = 30.0% US = 20.8% (42 states)
	Adolescents Receiving Meningococcal Conjugate and Tdap Vaccines (combination 1) by their 13th Birthday	CA = NOT REPORTED US = 73.2% (43 states)
Screening	Chlamydia Screening in Women Ages 16-20	CA = 60.6% US = 49.4% (46 states)

*California has known disparities for Black kids & families speaking other European languages for children and adolescent access to primary care practitioners, ages 12-19 years.

^California has known disparities for Black, American Indian, Alaska Native, and White kids & families speaking other European languages for adolescents receiving three doses of HPV vaccine by their 13th birthday.

V. Recommendations to Establish a Medi-Cal Child Health Quality Agenda for 2019 and Beyond

Based on the above description and review of the current Medi-Cal landscape of child health quality measurement, there is ample room to improve the performance of the Medi-Cal delivery systems for children and youth. DHCS should continue to work closely with health plans, providers, advocates, and other stakeholders to improve Medi-Cal child health quality based on current data, metrics, and processes, but also take further action towards a more robust and comprehensive Medi-Cal child health quality agenda. Below are some immediate, ongoing, and longer-term recommendations for how the state can take leadership in setting a Medi-Cal child health quality agenda for 2019 and beyond to advance and improve child health outcomes.

Recommendation #1 (Immediate): Prepare to report on all Child Core Set indicators before the federal requirement in 2024, beginning immediately with the addition to the EAS of early childhood health indicators: developmental screenings in the first three years of life, well-child visits in the first 15 months of life, and annual reporting of the CAHPS survey for Medi-Cal child populations. Because California already lags behind other states in Child Core Set reporting, DHCS can further lay out an “on-ramping” timeline between now and 2024 for establishing data baselines on the remainder of the Child Core Set indicators and incorporating them into the EAS framework. To best meet the federal requirement, greater alignment of child health quality measurement should be a central component of DHCS’s activities in developing and implementing the next Managed Care Quality Strategy Report in 2019 and determining the 2019-2021 EAS measures. In addition, clear and consistent health plan and provider guidance (including Provider Bulletins and Provider Manuals) about appropriate coding and documentation practices is necessary so that reliable data baselines are appropriately established for all Child Core Set indicators.

Recommendation #2 (Immediate): Identify and take steps to reduce health disparities among children as a priority within Medi-Cal quality improvement. Improvements to the quality of health care will help eliminate child health disparities and further boost the broader impacts of coverage for children; however, without an explicit focus on disparities reduction, quality interventions run the risk of overlooking disparities or could have the unintended consequence of worsening health disparities. Disaggregated data is crucial to identifying racial and ethnic disparities and targeting potential interventions or improvement initiatives appropriately, so DHCS must ensure that disaggregated child health data is available and publicly reported to the greatest extent possible. Building on the initial EQRO health disparities report released in 2018, DHCS can further engage stakeholders on the findings on children’s health disparities and continue to refine and improve the methodology for more robust disparities analyses. DHCS can further define health disparities as part of managed care contracts in the upcoming managed care procurement process (beginning in late 2019)³⁸ and through other guidance, as well as acknowledge the intersectionality of health disparities with other social determinants. Formally collaborating with the Office of Health Equity in the California Department of Public Health would allow DHCS to build on and synergize with existing health equity efforts and activities in the state.

Recommendation #3 (Ongoing): Double-down on a commitment to prioritize child health quality and performance improvement through concrete steps with stakeholders and within Departmental initiatives. The statutorily authorized Medi-Cal Children’s Health Advisory Panel (MCHAP)³⁹ and other stakeholders must be deeply engaged in a focused child health quality priority-setting development process, including a review/update of the Medi-Cal Children’s Health Dashboard⁴⁰ and other public reporting of children’s health data to highlight best practices in performance and improvement. Further, a strong focus should be placed on children’s quality of care in any discussion on broader Medi-Cal quality improvement, care coordination, alternative payment models (APMs)⁴¹, pay-for-performance,⁴² or value-based initiatives, especially ones that aim to change the existing financial disincentive Medi-Cal health plans face in making investments that could improve health outcomes and reduce spending.⁴³ Pediatric health providers, however, may need additional support in using quality data and reporting to guide quality improvement efforts.⁴⁴ In addition, incorporating children’s quality of care into value-based initiatives would need to take into account that for children value will primarily be in improved quality rather than in the efficiency or cost-savings portion of the value equation. It is important that children’s issues and pediatric care does not get lost or masked in a larger quality strategy.

Recommendation #4 (Ongoing): Drive improvements in child health quality performance, data, reporting, and alignment across children’s health services in the Medi-Cal delivery system. There are a number of ways that the foundations of the Medi-Cal data collection processes could become more robust and timely, and further the goals of quality improvement. DHCS should seek these data improvements across the disparate child-serving Medi-Cal delivery systems in medical, dental, and mental/behavioral health. Some examples of Medi-Cal data improvements include:

- Improving the reliability and robustness of timely encounter data for children’s health care services, especially in capturing the preventive services (such as screenings) that take place during routine well-child visits;
- Evaluating how to align the Denti-Cal performance measures across the fee-for-service and dental managed care delivery systems, while maintaining robust measurement of dental care access and utilization;
- Exploring more streamlined ways to track and report on the data beyond paid claims or encounter data, creating better data collection protocols and systems/data warehouses to extract the information from, and ensuring there is a clear plan and timeline in place for robust and timely reporting on physical and mental health services measures, including those envisioned and/or required by the Performance Outcomes System and the special terms and conditions to the state’s 1915(b) waiver; and
- Substantially increasing the Minimum Performance Level (MPL) above the nationwide 25th percentile for children’s health measures in order to drive quality improvement by holding plans accountable for achieving higher EAS scores;

Recommendation #5 (Longer-term): Explore the role of Medi-Cal child health quality measurement beyond the traditional indicator sets in addressing comprehensive whole-child health and early childhood development in alignment with other state goals for child outcomes. Positive child health outcomes data should be the ultimate standard of quality care for children given that these factors play such a significant role in children’s health. Whether under existing or new quality improvement or value-based initiatives, DHCS with its sister agencies can comprehensively explore how Medi-Cal child health quality measurement (beyond the current Child Core Set or the External Accountability Set indicators) can best align with and support the state’s multi-disciplinary goals, particularly for young children who are served by multiple state and local systems. As the box below describes, some potential areas to explore the role of Medi-Cal performance in contributing to and aligning with state goals include: blood lead screening; child development & early intervention; voluntary maternal and child home visiting; and readiness for school entry.

Potential issues where Medi-Cal quality measurement and performance improvement could support broader child outcomes:

- **Blood Lead Screening.** DHCS has already indicated potential consideration of a quality metric around child blood lead screening levels⁴⁵ given the state's low blood lead screening rate and the seriously detrimental impact that lead has on children's development. Tracking and improving blood lead screening among the children in Medi-Cal aligns with certain environmental health activities at the California Department of Public Health (CDPH), and there could be a synergistic impact of reducing childhood blood lead poisoning if those efforts were more closely paired.

- **Referral to Early Intervention Services.** Developmental screenings, a Child Core Set indicator that the state does not currently report on, is just the first step in the process of appropriate early identification and intervention for infants and toddlers. When a developmental screening identifies a young child with a developmental delay or the risk of developmental delay, that child should be referred to available early intervention services in a timely way. This is the key intent behind the Child Find requirement of Part C of the federal Individuals with Disabilities Act (IDEA), the infant and toddler early intervention program called Early Start in California and administered by the Department of Developmental Services (DDS).⁴⁶ Therefore, in addition to reporting on the Child Core Set developmental screening indicator for Medi-Cal health plans, there should also be an exploration and pioneering of Medi-Cal quality metrics of referral to early intervention services and, if necessary, subsequent treatment in service of the state's goal to support families of infants and toddlers with developmental disabilities.

- **Voluntary Maternal and Child Home Visiting.** Many other states already leverage Medicaid to deliver voluntary maternal and child home visiting services and improve outcomes within their child-serving health care systems.⁴⁷ DHCS should explore how voluntary maternal and early childhood home visiting can optimize data collection, performance, and quality within Medi-Cal. In California, there is a diverse localized network of home visiting programs, including state-administered programs overseen by the California Department of Public Health and the California Department of Social Services, as well as locally- and federally-funded efforts through First 5 Commissions and Early Head Start programs, that could be engaged and mobilized in such an effort.⁴⁸

- **School Readiness.** Following on the ground-breaking work in Oregon and New York to leverage and align health and educational data, DHCS should explore how indicators of children's health at school entry might be considered as a child health quality metric. Precisely because Medi-Cal is one of the earliest and most consistent system contact points for children and their families,⁴⁹ Medi-Cal child health quality measurement could be a core mechanism by which the state can foster children's readiness for school and to meet the educational goals, expectations, and outcomes set forth by the California Department of Education for Kindergarten entry.

Appendix Table A: Child-Relevancy in the 2018 External Accountability Set Measures⁵⁰

#	Measure Acronym	Measure	Indicator includes child populations	Indicator included in 2018 Child Core set?
1	ACR*	All-Cause Readmissions	No	No
2	AMB-OP* AMB-ED*	Ambulatory Care: Outpatient visits, Emergency Department visits (Children), Emergency Department visits (Adults), Emergency Department visits (Total)	Yes	Yes
3	MPM-ACE MPM-DIU	Annual Monitoring for Patients on Persistent Medications (2 Indicators): ACE inhibitors or ARBs, Diuretics	No	No
4	AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	No	No
5	BCS	Breast Cancer Screening	No	No
6	CCS	Cervical Cancer Screening	No	No
7	CIS-3	Childhood Immunization Status—Combo 3	Yes	Yes
8	CAP-1224* CAP-256* CAP-711* CAP-1219*	Children & Adolescents' Access to Primary Care Practitioners (4 indicators): 12-24 Months, 25 Months – 6 Years, 7-11 Years, 12-19 Years	Yes	Yes
9	CDC-E CDC-HT CDC-H9 CDC-H8 CDC-N CDC-BP	Comprehensive Diabetes Care (6 indicators): Eye Exam (Retinal) Performed, HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Medical Attention for Nephropathy, Blood pressure control (<140/90 mm Hg)	No	No
10	CBP	Controlling High Blood Pressure < 140/90 mm Hg (except < 150/90 mm Hg for ages 60-85 without diabetes)	No	No
11	IMA-2^	Immunizations for Adolescents (meningococcal, Tdap, HPV)	Yes	Yes
12	AMR	Asthma Medication Ratio	Yes	Yes
13	PPC-Pre PPC-Pst	Prenatal & Postpartum Care (2 indicators): Timeliness of Prenatal Care Postpartum Care	Yes	Yes
14	DSF*	Depression Screening and Follow-Up for Adolescents and Adults	Yes	No
15	LBP	Use of Imaging Studies for Low Back Pain	No	No
16	WCC-N WCC-PA	Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents Counseling for nutrition Counseling for physical activity	Yes	No
17	W-34	Well-Child Visits in the 3rd 4th 5th & 6th Years of Life	Yes	Yes

* = MCPs will not be held to a Minimum Performance Level (MPL)

^ = MCPs will be held to a benchmark for HEDIS 2018 pending the availability of the benchmark from the NCQA.

Appendix Table B: Comparison of California Medicaid Child Core Set Data, 2016-2017⁵¹

2016 & 2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP ⁵²	2016 CA Aggregate Rate	2017 CA Aggregate Rate	Change from 2016 to 2017 CA	# of states reporting measure in 2017	Change from 2016 to 2017 CA
Primary Care Access and Preventive Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	78.4%	Not Reported	N/A	37	61.1%
Chlamydia Screening in Women Ages 16–20 (CHL-CH)	57.9%	60.6%	Increase	46	49.4%
Childhood Immunization Status (CIS-CH)	70.6%	72.3%	Increase	41	67.9%
Well-Child Visits in the First 15 Months of Life (W15-CH)	Not Reported	Not Reported	N/A	49	59.3%
Immunizations for Adolescents Age 13 (IMA-CH) ⁵³	74.2%	N/A	N/A	N/A	N/A
Adolescents Receiving Three Doses of Human Papillomavirus (HPV) Vaccine by Their 13th Birthday (IMA-CH)	N/A	30.0%	N/A	42	20.8%
Adolescents Receiving Meningococcal Conjugate and Tdap Vaccines (combination 1) by their 13th Birthday (IMA-CH)	N/A	Not Reported	N/A	43	73.2%
Developmental Screening in the First Three Years of Life (DEV-CH)	Not Reported	Not Reported	N/A	27	39.8%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)	71.3%	75.6%	Increase	49	66.9%
Adolescent Well-Care Visit (AWC-CH)	Not Reported	Not Reported	N/A	49	44.7%
Children and Adolescents' Access to Primary Care Practitioners: Ages 12 - 24 months (CAP-CH)	90.3%	91.1%	Increase	48	95.2%
Children and Adolescents' Access to Primary Care Practitioners: Ages 25 months - 6 years (CAP-CH)	81.4%	81.7%	Increase	48	87.4%
Children and Adolescents' Access to Primary Care Practitioners: Ages 7-11 years (CAP-CH)	86.1%	85.4%	Decrease	48	90.8%
Children and Adolescents' Access to Primary Care Practitioners: Ages 12-19 years (CAP-CH)	83.4%	82.7%	Decrease	48	90.1%
Human Papillomavirus Vaccine for Female Adolescents (HPV-CH) ⁵⁴	14.5%	N/A	N/A	N/A	N/A
Maternal and Perinatal Health					
PC-02: Cesarean Birth (PC02-CH)	Not Reported	Not Reported	N/A	16	Not Reported
Audiological Evaluation No Later Than 3 Months of Age (AUD-CH)	Not Reported	Not Reported	N/A	2	Not Reported
Live Births Weighing Less Than 2,500 Grams (LBW-CH)	Not Reported	Not Reported	N/A	25	Not Reported
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	79.2%	84.0%	Increase	39	Not Reported
Contraceptive Care – Postpartum: Ages 15–20 (CCP-CH)	Not Reported	Not Reported	N/A	22	Not Reported

* = Indicator since retired from Child Core Set.

Appendix Table B: Comparison of California Medicaid Child Core Set Data, 2016-2017

2016 & 2017 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP	2016 CA Aggregate Rate	2017 CA Aggregate Rate	Change from 2016 to 2017 CA	# of states reporting measure in 2017	Change from 2016 to 2017 CA
Care of Acute and Chronic Conditions					
Medication Management for People with Persistent Asthma who were Dispensed Appropriate Medication and Remained on Medication for at Least 75% of Treatment Period: Ages 5-11* (MMA-CH)	24.9%	29.2%	Increase	49	27.9%
Medication Management for People with Persistent Asthma who were Dispensed Appropriate Medication and Remained on Medication for at Least 75% of Treatment Period: Ages 12-18* (MMA-CH)	24.0%	28.5%	Increase	40	26.9%
Medication Management for People with Persistent Asthma who were Dispensed Appropriate Medication and Remained on Medication for at Least 75% of Treatment Period: Ages 5-20* (MMCA-CH)	24.6%	28.9%	Increase	39	27.3%
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	37.3%	34.0%	Decrease	47	42.3%
Behavioral Health Care					
1 Follow-Up Visit During 30-Day Initiation Phase for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication, Ages 6-12 (ADD-CH)	44.0%	43.5%	Decrease	37	50.0%
At Least 2 Follow-Up Visit During the 10-Month Continuation and Maintenance Phase for Children Prescribed Attention-Defecit/Hyperactivity Disorder (ADHD) Medication, Ages 6-12 (ADD-CH)	50.0%	55.2%	Increase	37	61.5%
Follow-Up Within 7 Days of Discharge After Hospitalization for Mental Illness: Ages 6-20 (FUH-CH)	66.8%	67.5%	Increase	44	47.8%
Follow-Up Within 30 Days of Discharge After Hospitalization for Mental Illness: Ages 6-20 (FUH-CH)	79.6%	79.8%	Increase	45	69.2%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Not Reported	Not Reported	N/A	24	Not Reported
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	4.2%	3.6%	Decrease	35	2.7%
Dental and Oral Health Services					
Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	23.0%	24.4%	Increase	30	22.9%
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	35.9%	45.0%	Increase	50	48.2%
Experience of Care					
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Not Reported	Not Reported	N/A	40	Not Reported

* = Indicator since retired from Child Core Set.

Credits & Acknowledgments

This brief was researched and written by Mike Odeh & Gail Yen, with support from Ashley de Alba, Adrienne Bell, Eileen Espejo, Lishaun Francis, Kelly Hardy, Jessica Haspel, Ted Lempert, Nima Rahni, and Angela Rothermel.

Funded in part by The David & Lucile Packard Foundation and The California Endowment.

We would like to thank the following for their advice and input on the this brief: Kristen Golden Testa, The Children’s Partnership; Tricia Brooks, Andy Schneider, & Elisabeth Wright Burak, Georgetown University Center for Children and Families; Carrie Fitzgerald, First Focus; Alicia Kauk, National Health Law Program; Liane Wong, LWSolutions Consulting; Dr. Naomi Bardach, University of California at San Francisco; and David Panush, California Health Policy Strategies, LLC.



Children Now is on a mission to build power for kids. The organization conducts non-partisan research, policy development, and advocacy reflecting a whole-child approach to improving the lives of kids, especially kids of color and kids living in poverty, from prenatal through age 26.

Learn more at www.childrennow.org

Endnotes

1. E. Burak, "Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP)," Georgetown Center for Children and Families (October 2018), <https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf>
2. J. Perkins, "EPSDT is Essential," National Health Law Program (March 2017), <https://healthlaw.org/resource/epsdt-is-essential/>
3. T. Brooks, "Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders," Georgetown Center for Children and Families (March 2016), http://ccf.georgetown.edu/wp-content/uploads/2016/03/Measuring_Health_Quality_Medicaid_CHIP_Primer.pdf
4. Department of Health Care Services, Research and Analytic Studies Division, "Proportion of California Population Certified Eligible for Medi-Cal By County and Age Group – September 2015" (January 2016), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_Penetration_Brief_ADA.PDF
5. California Department of Public Health, "California 2013: Medi-Cal Paid Deliveries".
6. The 2018 DHCS Strategy for Quality Improvement in Health Care highlights the goals, priorities, guiding principles, and specific programs that advance population health and high-quality health care for all DHCS managed care and fee-for-service delivery systems.
7. See Children Now, "Medi-Cal: The Cornerstone of CA Kids' Health Care," (October 2016), <https://www.dropbox.com/s/o57twelytkhyu/Medi-Cal-CA-kids-2016.pdf?dl=1>
8. In Quarter 1 of 2018, according to the "Medi-Cal Children's Health Dashboard" (October 2018): https://www.dhcs.ca.gov/services/Documents/October_2018_Dashboard.pdf
9. See A. Schneider, "How Can We Tell Whether Medicaid MCOs are Doing a Good Job for Kids?," Georgetown Center for Children and Families (February 2018), <https://ccf.georgetown.edu/wp-content/uploads/2018/02/How-Can-We-Tell-Whether-Medicaid-MCOs-are-Doing-a-Good-Job-for-Kids.pdf>
10. More information about the California Children's Services Whole Child Model can be found at <https://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx>
11. More information about the federal Child Core Set can be found at www.medicare.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html and the state External Accountability Set can be found at <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfEAS.aspx>
12. "Advising CMS' quality activities is the Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF), a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in health care. MAP is comprised of both voting and non-voting members that span consumers, businesses and purchasers, labor, health plans, providers, communities, states, and the federal government." See also, T. Brooks, "Recommendations for Changes to the Child Core Set of Health Care Quality Measures," Georgetown Center for Children and Families (August 5, 2015), <https://ccf.georgetown.edu/2015/08/05/recommendations-changes-child-core-set-health-care-quality-measures/>
13. According to APL 17-014, "DHCS selects the final EAS measures after consulting with MCPs, the EQRO, and stakeholders.", see: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-014.pdf>
14. Measurement Year 2017 / Reporting Year 2018 External Accountability Set (http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/EAS_Measure_List_RY_2018%20F1.pdf)
15. Section 50102 of the ACCESS Act (P.L. 115-123, passed on February 8, 2018) mandates reporting on the Child Core Set of measures beginning with the annual State report on FY 2024. CMS will provide additional guidance and technical assistance to states as they prepare for mandatory reporting. See CMS, State Health Official Letter #18-010 "RE: Key Provisions of Legislation Extending Federal Funding for the Children's Health Insurance Program." (October 5, 2018), <https://www.medicare.gov/federal-policy-guidance/downloads/sho18010.pdf>

Endnotes Continued

16. CMS, "Quality of Care for Children in Medicaid and CHIP: Findings from the 2017 Child Core Set, Chart Pack" (September 2018), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-chart-pack.pdf>
17. Centers for Medicare & Medicaid Services (CMS), Child Core Set Chart Packs, FFY 2013-2017, available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>
18. In addition to the data collected from health plans, DHCS also has data from the Denti-Cal Division, the Performance Outcomes System, the Information Services Division, the California Health and Human Services Open Data Portal, and others.
19. Centers for Medicare & Medicaid Services (CMS), Informational Bulletin: "2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets" (November 20, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf>
20. Comparative review of Child Core Set and External Accountability Set indicators and information provided by the Information Management Division within DHCS.
21. The exceptions are around the depression screenings EAS measure which follows the NCQA specifications and covers a broader age range than the Child Core Set depression screenings measure; and the Weight Assessment and Counseling for Children and Adolescents metric for which the EAS includes the Nutrition and Physical Activity components, but not the BMI component that is part of the Child Core Set.
22. Comparative review of Child Core Set and External Accountability Set indicators and information provided by the Information Management Division within DHCS.
23. 2018 Child Core Set for Medicaid/CHIP (www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf)
24. "CMS will report this measure for states based on data submitted to the National Healthcare Safety Network. States will not be asked for, and will not be able to provide data for this measure to CMS." According to the Child Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting (February 2018), <https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf>
25. T. Brooks, S. Koslov, & M. Odeh, "How Does California Perform on the Quality of Health Care for Children Enrolled in Medicaid and CHIP?" (October 2016), Georgetown Center for Children and Families; <https://ccf.georgetown.edu/wp-content/uploads/2016/11/CA-quality-of-care-Final-10.28.pdf>
26. Included in the review: External Accountability Set 2017 Results (September 2017), <http://www.dhcs.ca.gov/services/Documents/MCAG/EAS2017.pdf>; All Plan Letter 17-014, "Quality and Performance Improvement Requirements" (September 11, 2017), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-014.pdf>; <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-014.pdf>; "Developmental Screenings Focus Study Results" (September 2017), <http://www.dhcs.ca.gov/services/Documents/MCAG/DevelopmentalScreening.pdf>; "2016 CAHPS Summary Report" (January 2018), http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CAHPS_Reports/CAHPS_2015-2016.pdf; Medi-Cal Children's Health Dashboard (March 2018), <http://www.dhcs.ca.gov/services/Documents/March-2018-Pediatric-Dashboard-4.17.2018.pdf>; March 2018 Statewide Aggregate Report on the Performance Outcomes System, http://www.dhcs.ca.gov/services/MH/Documents/20180313_EPSDT_STATE_FINAL_WITH_COVER.pdf; "Medi-Cal Managed Care External Quality Review Technical Report July 1, 2016–June 30, 2017" (April 2018), http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/TechRpt/CA2016-17_EQR_Technical_Report_F1.pdf; "Medi-Cal Managed Care Quality Strategy Report" (June 2018), <http://www.dhcs.ca.gov/formsandpubs/Documents/ManagedCareQSR062918.pdf>; June 2018 Medi-Cal Managed Care Performance Monitoring Dashboard, <http://www.dhcs.ca.gov/services/Documents/MMCD/June2018Release.pdf>; and "2015–16 Disparities Focused Study 12-Measure Report" (July 2018), https://www.dhcs.ca.gov/dataandstats/reports/Documents/MCQMD_Disp_Rpts/CA2015-16_FS_Disparities_12-Measure_Report_F3.pdf.
27. According to the 2016 National Survey of Children's Health data (Indicator 4.10) from "Data Resource Center for Child & Adolescent Health," <http://www.childhealthdata.org/browse/survey>

Endnotes Continued

28. From July 1, 2016, through June 30, 2017, the following health plans had PIP topics on childhood immunizations: California Health & Wellness Plan, Central California Alliance for Health, Gold Coast Health Plan, Kern Family Health, and LA Care.
29. The primary care standard is that an appointment should be available within 10 business days of the request and within 10 miles or 30 minutes from the beneficiary's residence. DHCS' network certification reports are available at: <https://www.dhcs.ca.gov/formsandpubs/Pages/NetworkAdequacy.aspx>
30. See "Letter to Governor Brown and Legislature on Denti-Cal Update," Report #243 (September 2018), <https://lhc.ca.gov/report/letter-governor-brown-and-legislature-denti-cal-update>; and S. Caiola, "Denti-Cal 'Remains a Seriously Troubled Program', Commission Report Finds," Capitol Public Radio (October 2, 2018), <http://www.capradio.org/articles/2018/10/02/denti-cal-remains-a-seriously-troubled-program-commission-report-finds/>.
31. See, C. Yoshiko Kandil, "Thousands of Medi-Cal Patients Report Poor Treatment by Doctors, Staff," California Health Report, (August 16, 2018), <http://www.calhealthreport.org/2018/08/16/thousands-medi-cal-patients-report-poor-treatment-doctors-staff/>
32. According to APL 17-014, "The EQRO administers the CAHPS® survey for the adult and child Medicaid population every three years and for the Children's Health Insurance Program Medicaid population, which includes children with chronic conditions, annually." See <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-014.pdf>
33. As presented by DHCS at the September 13, 2018 Medi-Cal Managed Care Advisory Group meeting.
34. State Health Access Data Assistance Center (SHADAC), "Latino Children in California Face Inequitable Access to Care (Infographic)," (October 31, 2018), <http://www.shadac.org/news/latino-children-california-face-inequitable-access-care-infographic>
35. See R. Shinkman, "Alarmed by Disparities, Lawmakers Order Audit on Children's Access to Medi-Cal Doctors," (May 17, 2018), California Health Report, <http://www.calhealthreport.org/2018/05/17/alarmed-disparities-lawmakers-order-audit-childrens-access-medi-cal-doctors/>
36. According to DHCS' response as written in the "Medi-Cal Managed Care Advisory Group Written Responses to Stakeholder Proposed Agenda Items from March 8, 2018 Meeting", available at <http://www.dhcs.ca.gov/services/Documents/MCAG/030818Responses.pdf>
37. Department of Health Care Services, "2015–16 Disparities Focused Study 12-Measure Report" (July 2018), https://www.dhcs.ca.gov/dataandstats/reports/Documents/MCQMD_Disp_Rpts/CA2015-16_FS_Disparities_12-Measure_Report_F3.pdf.
38. Medi-Cal managed care procurement will take place beginning in Late 2019 through Early/Mid 2021, depending on the managed care model type in each county; "Medi-Cal Managed Care Request for Proposal (RFP) Request for Application (RFA) Schedule by Model Type Updated 5/16/17," https://www.dhcs.ca.gov/services/Documents/MMCD_RFP_RFASchedule.pdf
39. "MCHAP advises DHCS on policy and operational issues that affect children in Medi-Cal. The Panel consists of a 15-member advisory body whose members are recognized stakeholders/experts in their fields, practicing and/or certified medical professionals, advocates who represent the interest of children's health, as well as parent members who provide feedback on topics that impact children in Medi-Cal." For more about MCHAP, see http://www.dhcs.ca.gov/services/Pages/Medi-Cal_Childrens_Health_Advisory_Panel.aspx
40. Letter from 19 organizations to MCHAP with recommendations on the Children's Health Dashboard, (October 1, 2018).
41. See Carolyn S. Langer, Richard C. Antonelli, Lisa Chamberlain, Richard J. Pan, David Keller, "Evolving Federal and State Health Care Policy: Toward a More Integrated and Comprehensive Care-Delivery System for Children with Medical Complexity," Pediatrics (March 1, 2018), <https://www.lpfch.org/publication/evolving-federal-and-state-health-care-policy-toward-more-integrated-and-comprehensive>

Endnotes Continued

42. See Sarah Lally and Jennifer Wong “Aligning Performance Measures Across Medi-Cal Managed Care Pay-for-Performance Programs,” Integrated Healthcare Association (March 2018), <https://www.iha.org/resources/aligning-performance-measures-across-medi-cal-managed-care-pay-performance-programs>
43. See Franz Krtiz, “In San Joaquin, Two Medi-Cal Health Plans Struggle to Improve Quality,” California Health Report (July 31, 2018), <http://www.calhealthreport.org/2018/07/31/san-joaquin-two-medi-cal-health-plans-struggle-improve-quality/>; and the “premium sliding” discussed in California HealthCare Foundation, “Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs,” (March 2018), <https://www.chcf.org/wp-content/uploads/2018/03/IntendedConsequencesMediCalRateSetting.pdf>.
44. For example, see J. Zickafoose, et al., “Primary Care Physician’s Experiences With Attitudes Toward Pediatric Quality Reporting,” *Academic Pediatrics*, 16(8), (November-December 2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5847285/pdf/nihms939025.pdf>; and AHRQ, “How are CHIPRA quality demonstration States using quality reports to drive health care improvements for children?,” Evaluation Highlight No. 11, (April 2015), <https://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/highlight11.html>
45. “DHCS will also consider the addition of the blood lead metric during the next review of required quality metrics,” according to DHCS’ letter of opposition to Assembly Bill 2122 (June 22, 2018)
46. The Early Start program is described as “California’s response to federal legislation ensuring that early intervention services for infants and toddler with disabilities and their families are provided in a coordinated, family-centered system of services that are available statewide.” at <https://www.dds.ca.gov/EarlyStart/WhatsES.cfm>
47. Becky Normile, Karen VanLandeghem, and Alex King, “Medicaid Financing of Home Visiting Services for Women, Children, and Their Families, (August 2017), National Academy for State Health Policy, <https://nashp.org/wp-content/uploads/2017/09/Home-Visiting-Brief.pdf>
48. See Children Now, “Voluntary Evidence-based Home Visiting in California,” (2018), <https://www.dropbox.com/s/ad0bgrnmiotc1eh/Home%20Visiting.pdf?dl=1>
49. See C. Howard, et al., “School Readiness: The Next Essential Quality Metric For Children” Health Affairs Blog (July 18, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180711.857544/full/>; and Elisabeth Burak, “School Readiness as an “Essential Quality Metric” for Children: A Hook for Medicaid in Cross-System Work” (July 19, 2018), <https://ccf.georgetown.edu/2018/07/19/school-readiness-as-an-essential-quality-metric-for-children-a-hook-for-medicaid-in-cross-system-work/>
50. Review of DHCS, “External Accountability Set for MCPs – MY 2017 / RY 2018 (Updated as of August 30, 2017).” (http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/EAS_Measure_List_RY_2018%20_F1.pdf)
51. CMS, “Child Health Quality Measures Dataset, FFY 2016,” available at <https://data.medicaid.gov/Quality/2016-Child-Health-Care-Quality-Measures/wnw8-atzy>; and “Child Health Quality Measures Dataset, FFY 2017,” available at <https://data.medicaid.gov/Quality/2017-Child-Health-Care-Quality-Measures/t8ub-nmh7>
52. Note that this chart excludes the CLABSI measure, which is obtained from CDC’s National Healthcare Safety Network.
53. In 2017, the technical specifications for the Immunization for Adolescents (IMA) measure were changed, and CMS reported on the measure as two sub-measures – one on the HPV vaccine and the other on Meningococcal “combination 1” vaccines.
54. In 2017, CMS “removed the standalone specification for the HPV vaccination rate; the measure was added as a new rate in the Immunizations for Adolescents (IMA) measure,” according to the “Summary of Updates to the Child Core Set Measures Technical Specifications and Resource Manual, (May 2017), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>.