



How Does California Perform on the Quality of Health Care for Children Enrolled in Medicaid and CHIP?

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Since 2011, the U.S. Department of Health and Human Services (HHS) has released an “Annual Report on the Quality of Care for Children in Medicaid and CHIP.”¹ The report includes data submitted by the states on the Child Core Set of Health Care Quality Measures² (child core set) and summarizes the results of the External Quality Review (EQR) of Medicaid Managed Care Plans from state EQR technical reports. This analytic brief presents a snapshot of the 2015 report’s findings on the child core set of measures reported by California for calendar year 2014.³

Overall, California lags behind reporting on the child core set with only 12 states reporting fewer measures than the 12 measures reported by California in 2014. Without more robust reporting, assessing California’s performance in providing high quality health care is incomplete at best. Performance on the measures reported by California most often fall into the 2nd or 3rd quartile in comparison to other reporting states, illustrating that the state has room for improvement in order to become a top performing state in assuring access to care and advancing health outcomes for the 5.7 million low-income children served by the state’s Medicaid program known as Medi-Cal.

What is the Child Core Set?

The child core set is an evolving set of quality measures for children that states voluntarily report or HHS extracts from public data sources. The core set is reviewed annually, and over time certain measures have been retired and new ones added. For a primer on the basics, background, and status of quality measurement and improvement in Medicaid and CHIP, see “[Measuring and Improving Health Care Quality for Children in Medicaid and CHIP: A Primer for Child Health Stakeholders.](#)”

Background

Over the past two decades, efforts to improve the quality of health care while curbing costs has been a growing focus in both private insurance and public coverage programs. Comprehensive quality initiatives are multi-faceted and intended to create an effective and efficient health system by assuring access to services, improving the quality of care, enhancing the patient experience, and reducing unnecessary costs. In recent years, two major federal legislative initiatives – the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Affordable Care Act of 2010 (ACA) – have resulted in significant quality measurement and improvement activity at the federal level. Out of these efforts has emerged the National Quality Strategy, also called the triple aim: better care, smarter spending, and healthier people.



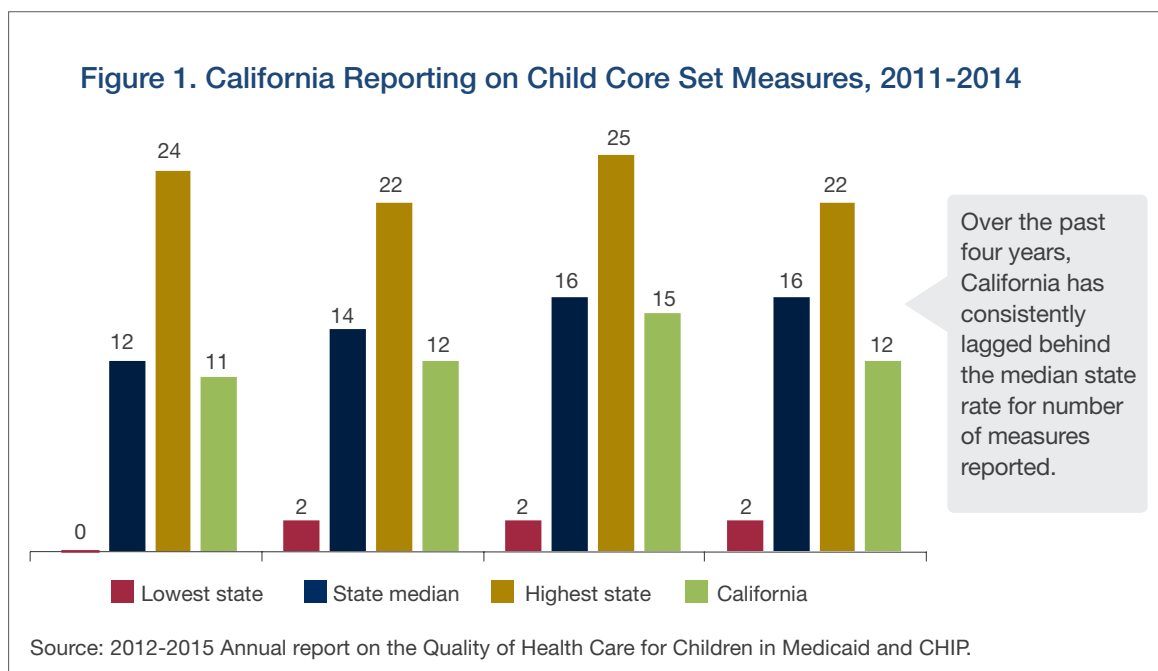
A concern for child advocates is that a primary focus in quality improvement is on bending the cost curve. Since children are generally healthy and the cost of covering them is low compared to other populations – children under 18 account for 50 percent of total Medi-Cal enrollment but only 29 percent of Medicaid spending⁴ – improving children’s access and quality may not be a top priority for the state or health plans. If quality of children’s health care is not a public policy priority, we will miss out on opportunities to improve children’s health in ways that would have longer term paybacks in better health, enhanced performance in school, higher productivity as future workers, and lower long-term health care costs.⁵

It is also important to note up front that while there is considerable opportunity to improve the quality of care children receive in Medicaid and CHIP, children enrolled in public programs fare as well in terms of access, cost, and outcomes if not better than children enrolled in private insurance, particularly when comparative studies are focused on the low to moderate-income families that qualify for Medicaid or CHIP. Research indicates that low-income children often receive higher levels of preventive medical and dental care than low-income privately insured children, and have

greater access to care and fewer unmet needs than low-income uninsured children.^{6,7,8,9,10} Despite these statistics, there remain challenges across all sources of coverage for low-income children and differences in access and quality in Medicaid across states. California-specific research commissioned by the California HealthCare Foundation, found that children enrolled in Medi-Cal were more likely than Medicaid-enrolled children in other states to not have had a specialist visit, a dental care visit, or a preventive care visit – suggesting that Medi-Cal lags behind other states in maximizing access to care for children.¹¹

How Does California Measure Up? Reporting the Measures

Nationally, the median number of child core set indicators reported by states has increased from 12 of the 25 measures in 2011 to 16 of the 22 measures in 2014.¹² Since 2011, California has lagged behind other states in reporting child health quality measures (Figure 1) and consistently falls in the lower half of states ranked by the number of child core set measures reported. While reporting on the core measures remains voluntary, it is the first step in assessing and improving the quality of care for children enrolled in public coverage programs.





On all measures in 2014, California reports combined data for Medicaid and CHIP-funded children, which is appropriate considering that Medicaid and CHIP were programmatically combined in California within Medi-Cal during the 2013 calendar year. However, given the large child enrollment in Medi-Cal – which now covers 54 percent of all California children¹³ – it would be useful for advocates and policymakers to have the disaggregated data available for identifying trends and population differences – especially given the important link between income and the environments that promote and support child health.¹⁴

Since 2011, California has lagged behind other states in reporting the child core set of health quality measures.

Performance Summary

HHS releases state comparative data and ranks state performance if at least 25 states report a specific measure. Several measures are reported as sub-measures, which report data by age or other factors.¹⁵ In total, data was published and state performance was ranked in quartiles for 26 measures and sub-measures for calendar year 2014.¹⁶ Notably, the quartiles vary for each measure and sub-measure based on the specific range of data reported by the states.¹⁷ (Table 3 in the Appendix lists the total number of states reporting each measure and the range of data reported.)

Within the 12 core measures California reported for calendar year 2014, there are 15 measures and sub-measures for which HHS released comparative data.¹⁸ Of the 15, California ranks in the bottom two quartiles on 7 and in the top two quartiles on 8 measures and sub-measures (Figure 2). Table 1 (below) lists California's performance grouped by quartile ranking.

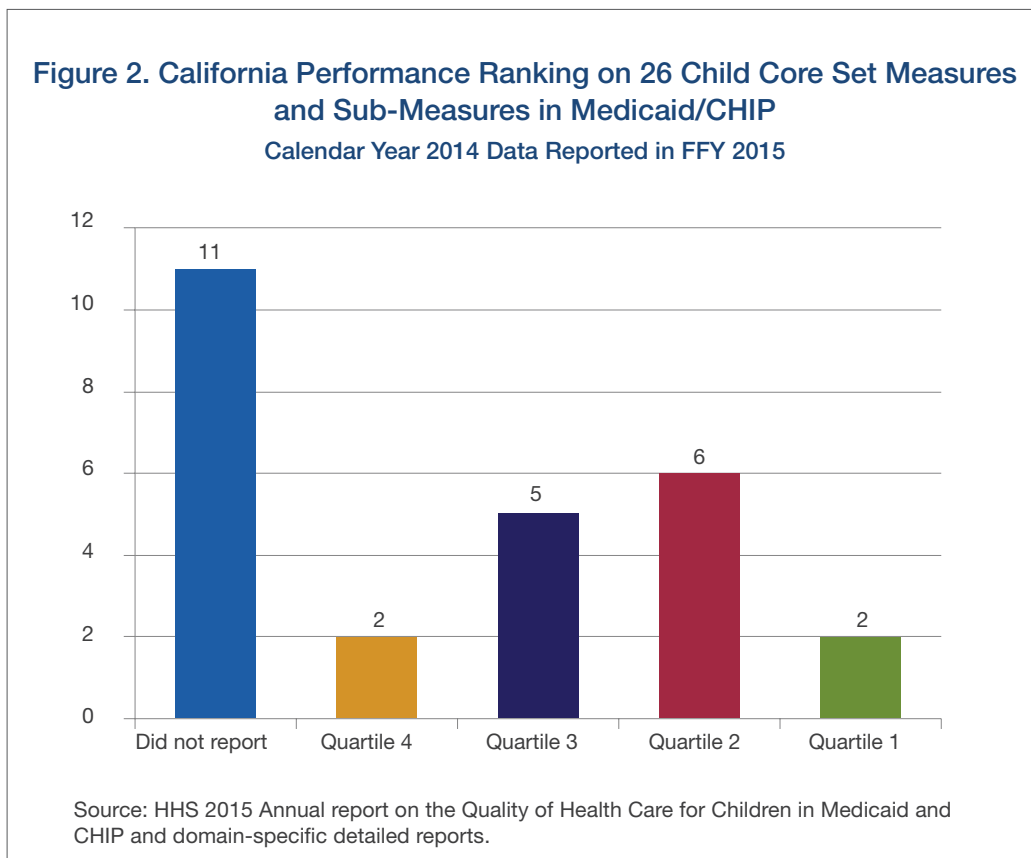




Table 1. California’s Measures by Quartile Ranking

Quartile Ranking	Measures
1 = Top/Highest	<ul style="list-style-type: none"> • Children Up to Date on Recommended Immunizations by 2nd Birthday • Body Mass Index Assessment for Children and Adolescents Ages 3-17 Years
2 = Next to Highest	<ul style="list-style-type: none"> • Children and Adolescents Receiving at Least One Well-Child Visit In Years 3-6 Years • Children and Adolescents Up to Date on Recommended Immunizations by 13th Birthday • Follow-up Visit After Mental Illness Hospitalization Within 7 Days • Follow-up Visit After Mental illness Hospitalization Within 30 Days • Emergency Department Visits per 1,000 Enrollees Ages 0-19 Years • Asthma Medication Management Combined Ages 5-20 Years
3 = Next to Lowest	<ul style="list-style-type: none"> • Children with a PCP Visit In the Past Year Ages 12-24 Months • Children with a PCP Visit In the Past Year Ages 25 Months - 6 Years • Children with a PCP Visit in the Past 2 Years Ages 7-11 Years • Pregnant Women with Prenatal Care Visit In 1st Trimester or Within 42 Days of Medicaid/CHIP Enrollment • Children Ages 1-20 Years Enrolled for at Least 90 Continuous Days and Received at Least One Dental Treatment Service
4 = Bottom/Lowest	<ul style="list-style-type: none"> • Children and Adolescents with PCP Visit in the Past 2 Years Ages 12-19 • Children Ages 1-20 Years Enrolled for at Least 90 Continuous Days and Received at Least One Preventative Dental Service

Assessing California’s Performance

HHS presents state-level data and groups reporting states in performance cluster maps on both the child and adult core set measures in a series of five domain-specific detailed reports: 1) preventive and primary care; 2) perinatal care; 3) behavioral health; 4) management of acute and chronic conditions; and 5) dental and oral health. It is important to note that the HHS reports round data to a full percentage point and, in some instances, the HHS performance cluster map groupings deviate from standard quartile rankings.

This analysis uses straightforward quartile rankings without rounding for all measures and sub-measures, and identifies any difference from the HHS groupings in

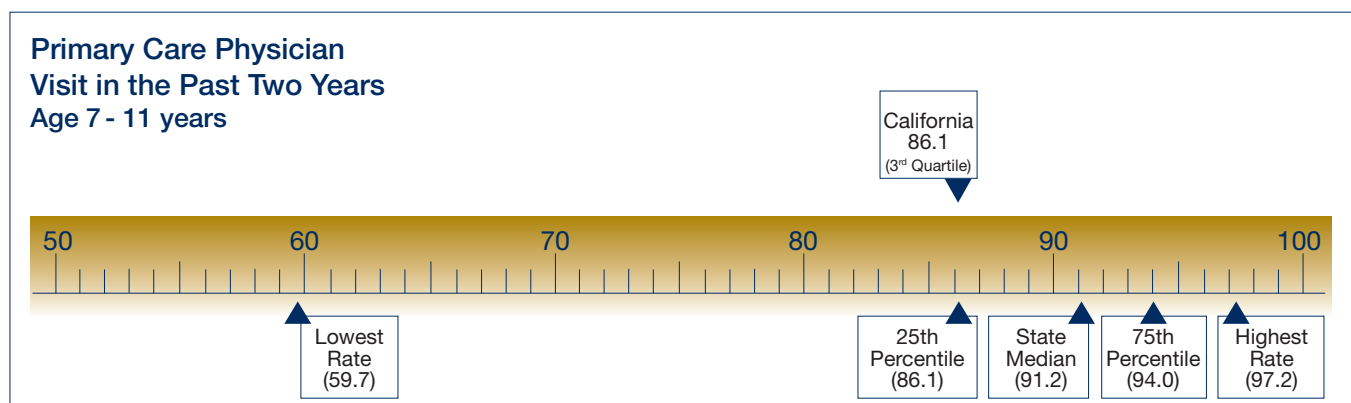
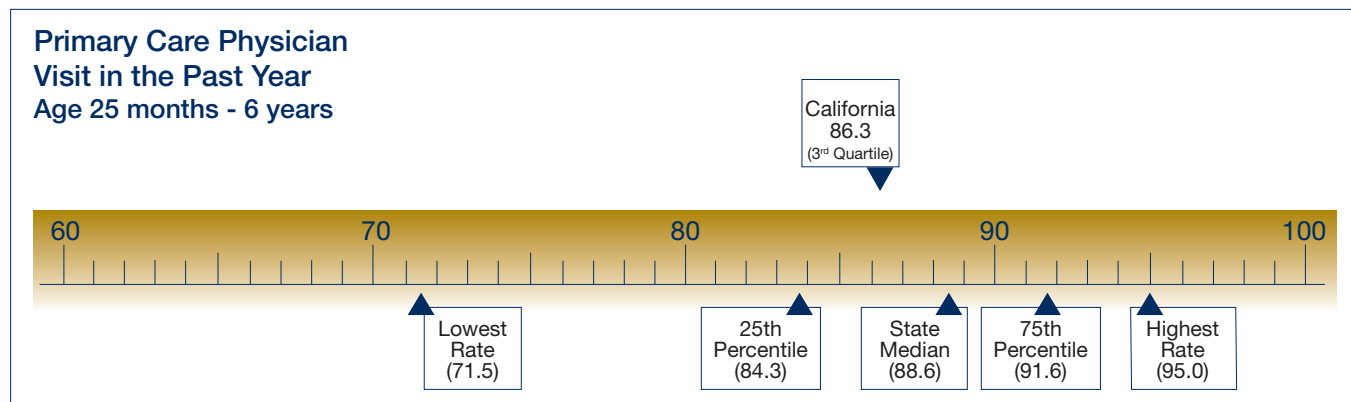
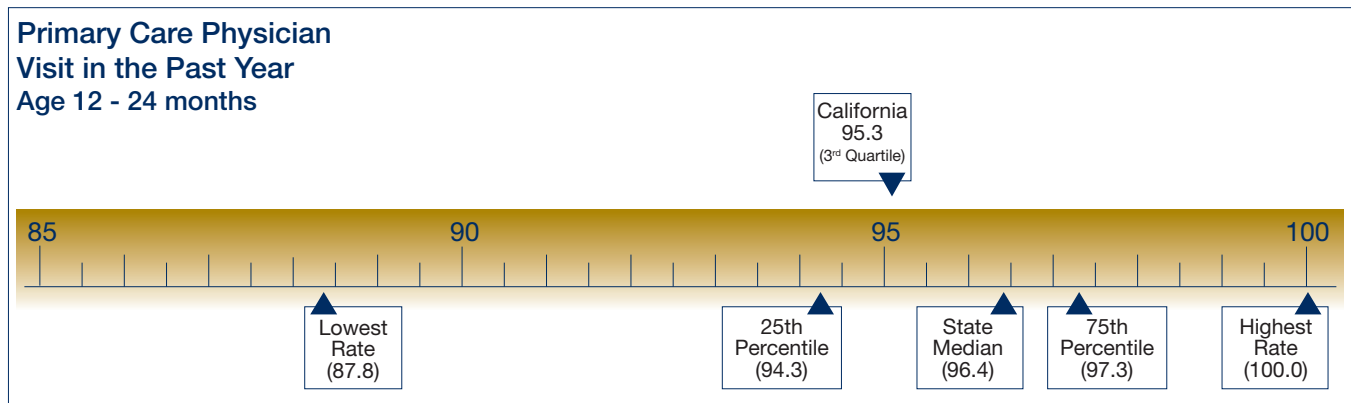
footnotes.¹⁹ Note that the 1st quartile refers to the top/higher performing states while the 4th quartile reflects the bottom/lower performing states. To visually reflect how a state compares to other reporting states on a measure, this brief shows the median, the 25th/75th percentiles, the highest and lowest reported data among states, and California data in a graphic format. The narrative describes each measure²⁰ and includes the quartile ranking and data for California along with the median rate among reporting states (referred to as the median), which is supplemented with information from the California Department of Health Care Services’ Quality Strategy, HEDIS reports, and communications with advocates.



► Preventive and Primary Care

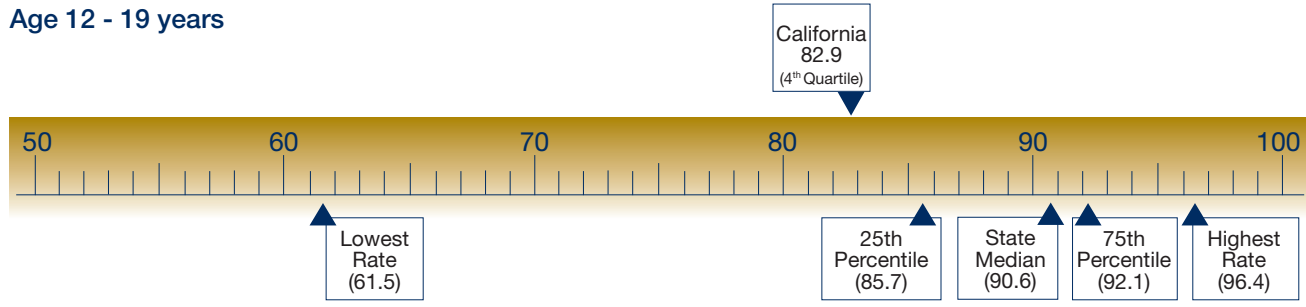
Access to Primary Care

Access to cost-effective primary care is critical for assuring healthy growth and development and access to care when children are sick. Across all states, children enrolled in Medicaid and CHIP have relatively high rates of access to primary care but California rates are below the median for all age groups with the state ranking in the lowest quartile for adolescents. These measures assess whether children under 6 years of age had at least one primary care provider (PCP) visit during the year and if children ages 6 years and older saw a PCP at least once in two years. California ranks in the lower half of all states in access to care for children and adolescents in Medicaid.





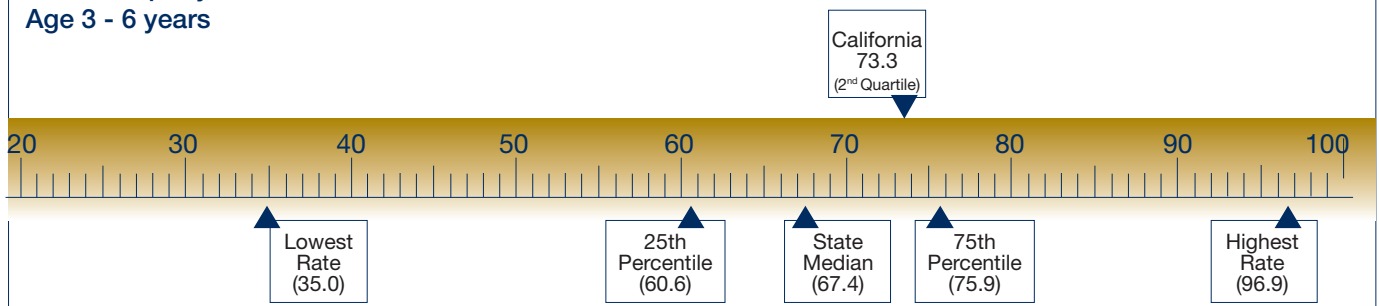
Primary Care Physician Visit in the Past Two Years Age 12 - 19 years



► Well-Child Visits

Despite the overall high rates of primary care access, the proportion of children across the country receiving well-child visits remains below levels recommended by the American Academy of Pediatrics in its ‘Bright Futures’ guidelines.²¹ Well-child visits are expressly designed to assess a child’s healthy development and screen for physical or developmental issues that can be treated early. Six well-child checkups are recommended by 15 months of age with annual checkups recommended for children 3 years of age and older. California only reported the measure for children ages 3 – 6 years, of which 73.3% received an annual well-child visit, which places California in the 2nd quartile. This means that more than one in every four 3-6 years olds in Medi-Cal did not receive a preventive visit in 2014. California did not report data on adolescent well-care visits, even though California ranks in the lowest quartile among states on the measure of adolescent access to primary care (see indicator above).

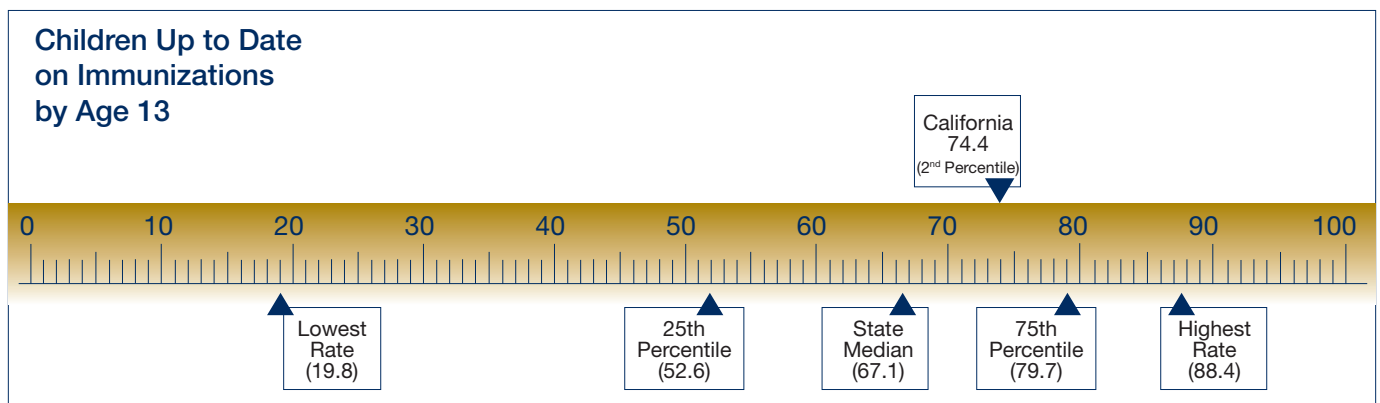
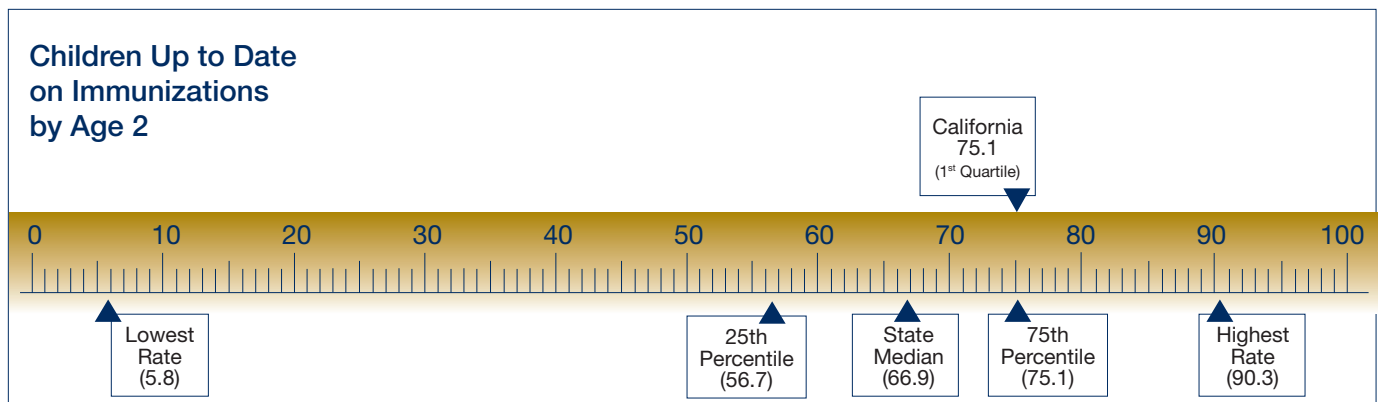
Well-Care Visits At least 1 per year Age 3 - 6 years





► Immunizations

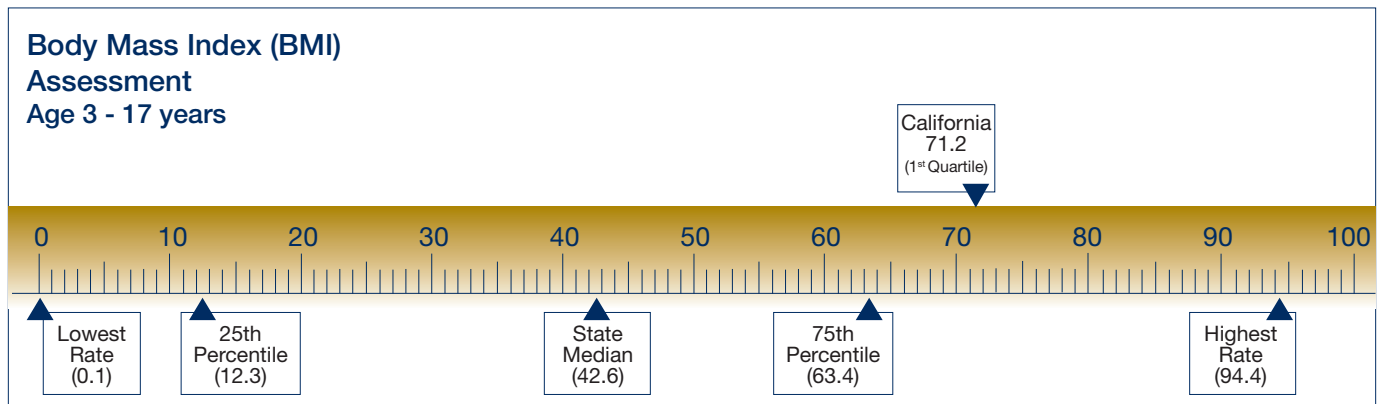
Childhood immunizations are critical to preventing infectious and potentially debilitating diseases. In California, three out of four children (75.1%) received the recommended immunizations by age 2 years, placing the state in the top quartile. Nevertheless, there is room for improvement, and the Department of Health Care Services has identified childhood immunizations as a focus area for quality improvement as the rate of immunization coverage declines, leaving children vulnerable to preventable diseases that have been increasing in California in recent years.²² However, the state drops to the 2nd quartile nationally with just under three quarters of adolescents being up-to-date on immunizations by age 13. California did not report the number of females receiving 3 doses of the HPV vaccine by their 13th birthday.





► Screenings

Screenings detect underlying health issues that can be addressed with treatment or healthy habits. Excess weight and obesity contribute to numerous chronic conditions so establishing and maintaining a healthy weight should start in childhood. In California, 7 in 10 children received body mass index assessments, which places the state in the top quartile. California did not report the number of sexually active females ages 16 – 20 screened for chlamydia, a curable disease that if left untreated can seriously and permanently affect a woman’s reproductive system.



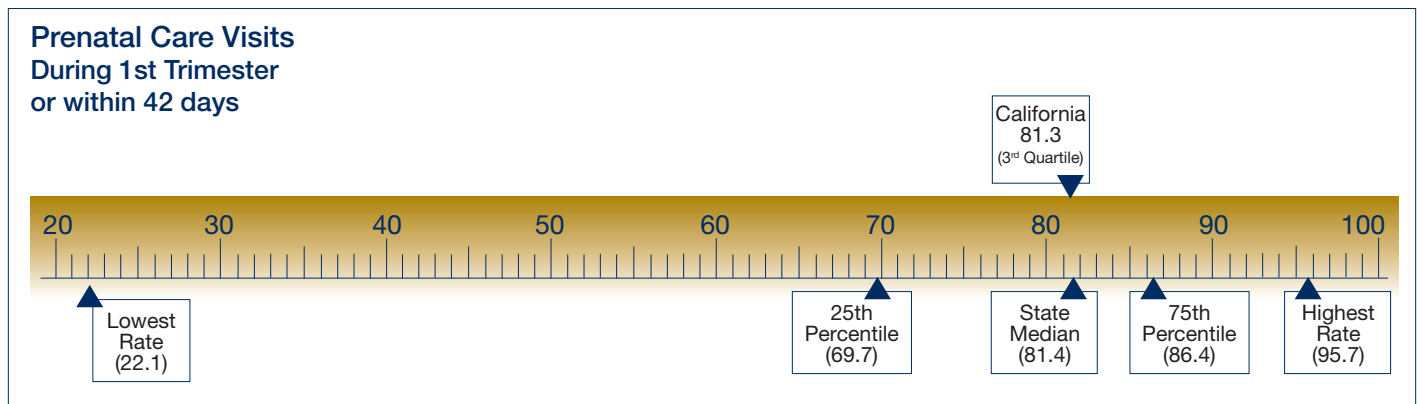
► Perinatal Care

Prenatal Care

Medi-Cal paid for nearly half (45%) of all births in 2014, representing a significant expenditure for the program and a service area where costs may increase without timely and routine prenatal care.²³ Given that a mother’s health during pregnancy impacts the health of the child at and after birth, measuring and improving perinatal care is important to a healthy start in life. Timeliness of prenatal care results in an early assessment of pregnancy risk and provides health education and counseling to facilitate a healthy pregnancy. Although more than four out of five (81.3%) pregnant women received a prenatal visit in the first trimester or within 42 days of enrolling in Medicaid,²⁴ California ranks in the 3rd quartile for timeliness of prenatal care.



Ongoing prenatal care is equally important as timely prenatal care to assuring a healthy pregnancy and delivery; however, California did not report the measure that assesses how many pregnant women received more than 80% of their expected number of prenatal care visits. Although post-partum care is not included in the child core set, it is included in the adult core set. For 2014, California reported that 48.7 percent of “Women [with Medi-Cal] Delivering a Live Birth had a Postpartum Care Visit on or Between 21 and 56 Days after Delivery”, below the national median of 58.2 percent.²⁵ To address this, the California Department of Health Care Services has identified post-partum visits as a focus area for quality improvement through 2020, which will have important impacts on children’s healthy development.²⁶



► Low Birth Weight

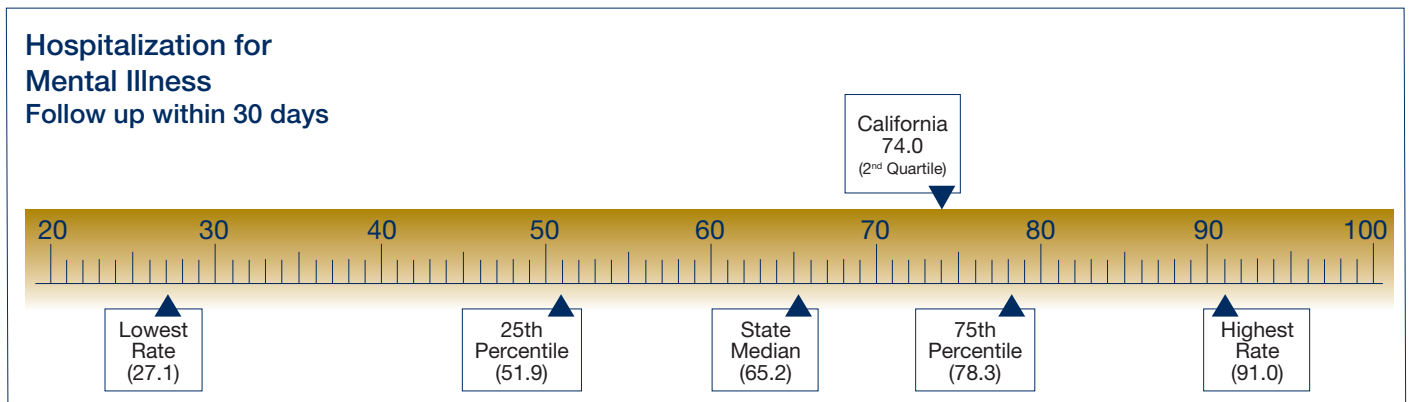
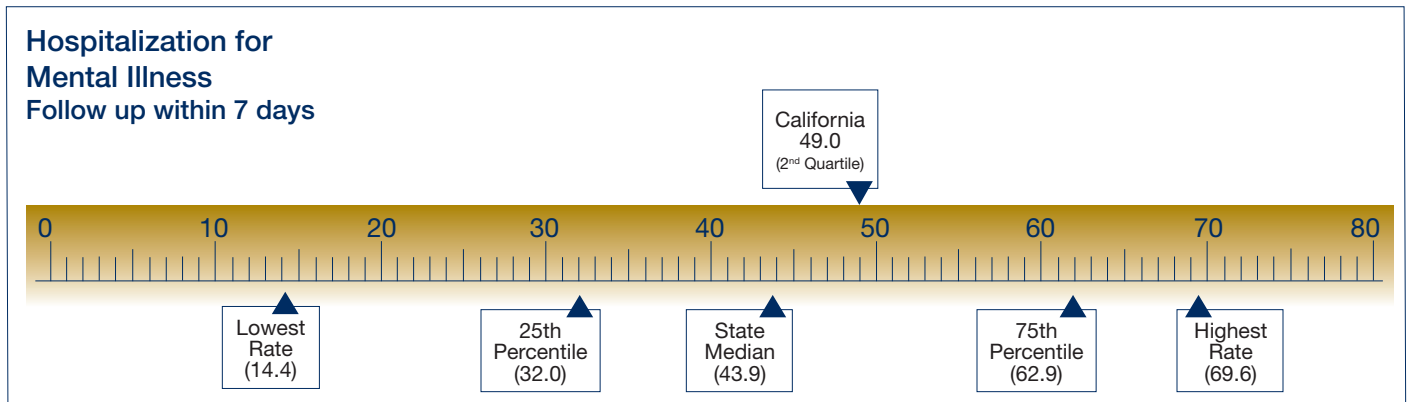
Prematurity and low-birth weight can affect a child’s health at birth and beyond. Infants weighing less than 2,500 grams (5.51 lbs.) are at greater risk of experiencing serious and costly health problems and development delays. Research data reflect significant racial disparities related to low birth weight – namely, both low birth weight and infant mortality affect black infants at roughly twice the rate of white infants.^{27,28} This disparity could be better understood through disaggregated data reporting practices that can help identify regional and racial/ethnic disparities in health and disease burden. However, California did not report this measure.



► Behavioral Health

Follow-up After Mental Health Hospitalization:

Following inpatient treatment of mental illness, timely outpatient care is needed to manage medications and provide counseling to ease the transition back to home and school and prevent readmission. In California, only 1 in 2 children (49%) received a follow-up visit within 7 days after discharge from a mental illness hospitalization while almost three of every four children (74.0%) received a follow-up visit within 30 days. California ranks in the 2nd quartile on both measures.



► ADHD Medication Management

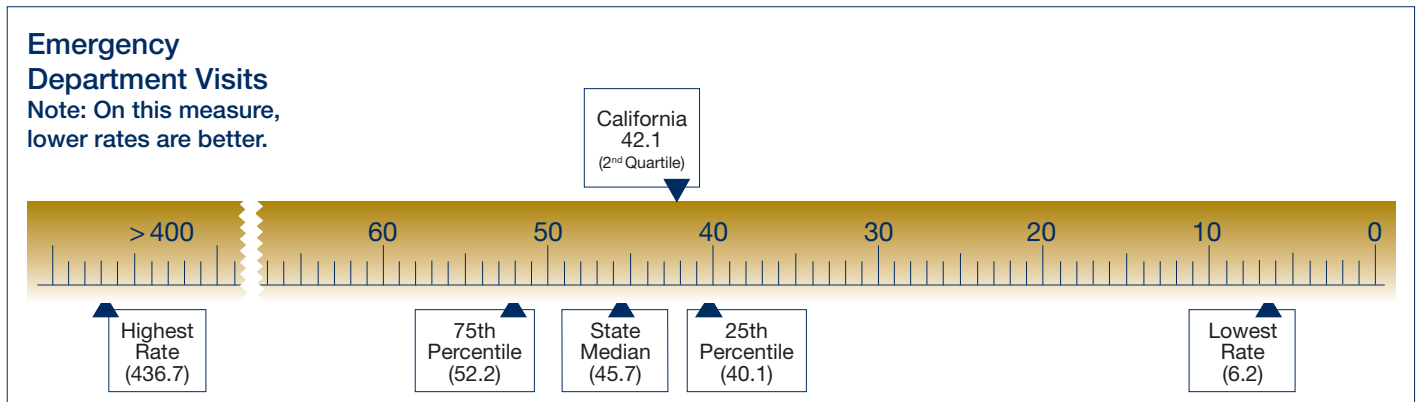
Attention deficit/hyperactivity disorder (ADHD) is a common condition among children, which causes academic, behavior or relationship issues. Clinical guidelines for effective ADHD medication management call for three follow-up visits in 10 months after prescribing ADHD medication with the first visit occurring within 30 days. Following the 30-day initiative phase, the 9-month continuation and maintenance phase is important to management and monitoring of the condition. California did not report these measures related to ADHD medication.



► Management of Acute and Chronic Conditions

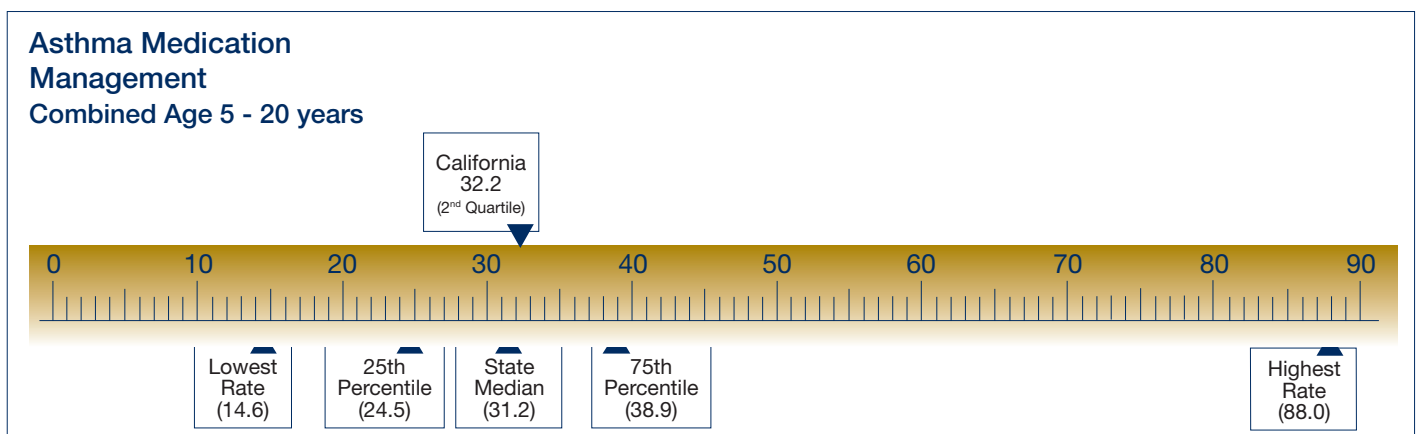
Emergency Department Visits

High rates of hospital emergency department (ED) usage for non-emergencies may signify a lack of access to continuity of primary care and can result in overcrowding and increase ED wait times. Measuring and assessing trends in ED visits can help pinpoint successful strategies to improve access to and use of appropriate sources of care. Measured in the number of visits per 1,000 enrollees (a lower rate is better), California's rate of 42.1 visits per 1,000 enrollees is lower than the state median, placing it in the 2nd quartile.



► Asthma Medication Management

Asthma is the most common chronic medical condition in children. Regular use of prescribed controller medications results in fewer asthma episodes, less frequent trips to the emergency department, and decreased costs associated with care. In measuring use of asthma controller medications among children with moderate to severe asthma, California did not disaggregate the data by age, however it did report the combined rate for children ages 5-20. Despite ranking in the next to top quartile, less than one in three children continue to use asthma medication through at least 75% of the treatment period. Beginning in 2016, California will change from reporting the core set's medication management (MMA) measure to the asthma medication ratio (AMR) measure, as some studies have indicated that the AMR is a better predictor of future asthma exacerbations than the MMA.²⁹

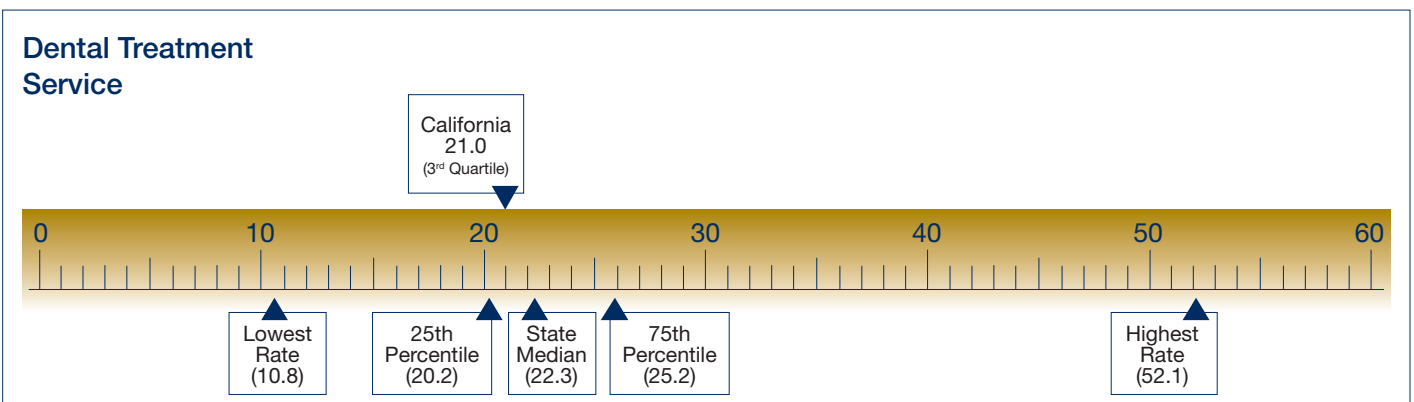
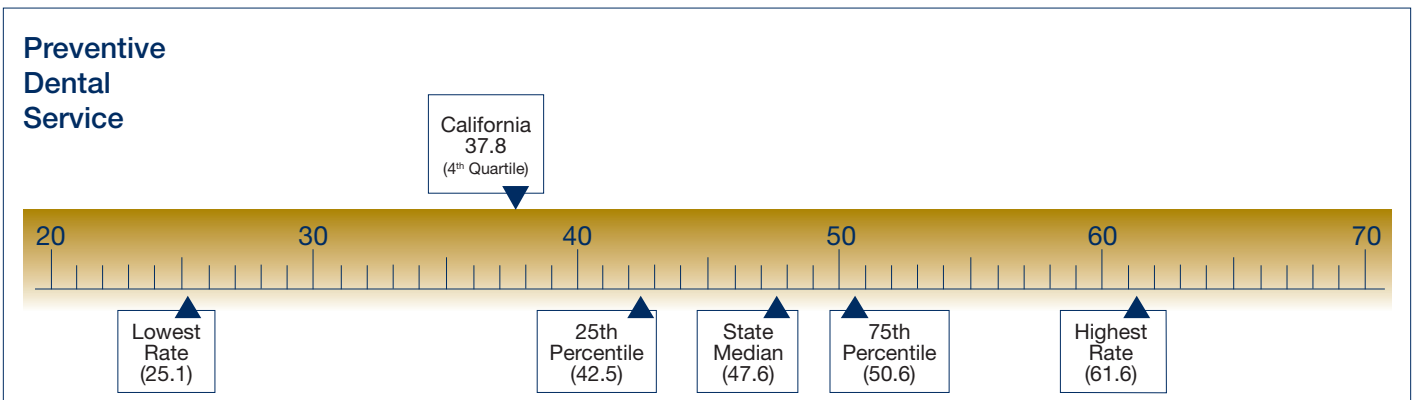




► Dental and Oral Health Services

Oral health care is a primary focus of improvement efforts in Medicaid and CHIP, yet less than two in five children in California enrolled for at least 90 continuous days received a preventive dental visit in 2014, placing the state in the bottom quartile. California improves in rank, rising to the 3rd quartile with 21.0% children enrolled for at least 90 continuous days receiving a dental treatment. It should be noted that the dental treatment measure is being dropped from the child core set starting in 2015 given that it is difficult to assess state performance without knowing the percentage of children who needed a dental treatment.

Serious and widespread issues and challenges related to access to dental care in California's Denti-Cal program have been well documented by numerous reports, audits, and studies,^{30,31} resulting in significant legislative oversight activity and leading to a Medicaid section 1115 waiver that includes up to \$750 million to improve access to dental care beginning in 2016.³² It should be noted that in addition to reporting the two dental core set measures, California currently requires reporting on a total of 12 oral health measures³³ for its troubled Medicaid managed dental care program (which is required in one county and voluntary in another county). However, the under-performance in children's utilization of dental care is pervasive throughout the Medi-Cal dental program.³⁴





► Measures Not Reported by HHS

As noted previously, HHS only reports state-level data and ranks state performance if at least 25 states report the measure. Only three of the 2014 child core measures did not make the cut for the 2015 report. California did not report any of the three measures as shown in the table below.

Table 2: 2014 Child Core Set Measures Not Reported and Ranked in 2015 HHS Quality Report

Measure	Reported by California?	Number of States Reporting
Developmental screening in first 3 years of life	No	20
Cesarean rate for Nulliparous Singleton Vortex	No	16
Behavioral health risk assessment for pregnant women	No	4

Trends in Medicaid Child Health Quality in California

At the state level, California reports many of the Child Core Set measures through the annual HEDIS report for Medi-Cal managed care. Analysis of the state’s 2015 HEDIS report offers some insight on California’s Medicaid performance over time. What is clear from the data (see Table 3) is that year-to-year variation is to be expected; yet, the latest year-to-year change (2014 to 2015 based on reporting year) indicates that five of twelve child health measures — nearly half—are decreasing. However, there is a more troubling longer-term trend (2012 to 2015 based on reporting year) where progress has been slow, with seven of twelve child health measures—over half—are decreasing. In addition, California’s statewide average for all four children’s access to primary care sub-measures in 2015

fell below the Minimum Performance Level (MPL), or the lowest national quartile of Medicaid programs. The MPL is also the standard used when evaluating against the Corrective Action Plan criteria that Medi-Cal managed care plans are subject to. In the Medi-Cal Managed Care Quality Strategy Comprehensive Review dated October 2016, DHCS identified the focus areas of postpartum care and immunizations of two-year olds based on review of the historical data.³⁵ The data confirm that these two areas are worthy of focus, but the data also suggest that access to primary care for children of all ages and well-child visits for young children are also areas in need of targeted improvement efforts.



Table 3: Trends in Select California Medicaid Child Health Quality Measures (Medi-Cal Managed Care)

HEDIS Measure/Sub-measure	2012	2013	2014	2015	2012-2015 Trend	2014-2015 Change	2015 Performance relative to MPL
Childhood Immunization Status - Combination 3	78.15	77.25	75.07	73.84	↓	↓	Above
Children and Adolescents' Access to Primary Care Practitioners (12 to 24 Months)	95.74	94.42	95.25	93.54	↓	↓	Below
Children and Adolescents' Access to Primary Care Practitioners (25 Months to 6 years)	87.13	84.89	86.27	85.39	↓	↓	Below
Children and Adolescents' Access to Primary Care Practitioners (7 to 11 years)	86.88	85.89	86.08	87.24	↑	↑	Below
Children and Adolescents' Access to Primary Care Practitioners (12 to 19 years)	85.82	85.62	82.90	84.10	↓	↑	Below
Immunizations for Adolescents (Combination 1)	62.99	72.66	74.44	73.51	↑	↓	Above
Prenatal and Postpartum Care: Postpartum Care	61.74	58.61	56.99	59.35	↓	↑	Above
Prenatal and Postpartum Care: Timeliness of Prenatal Care	83.77	83.17	81.33	81.80	↓	↑	Above
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Assessment)	68.33	71.55	71.17	77.47	↑	↑	Above
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Nutrition Counseling)	72.08	72.53	71.37	73.42	↑	↑	Above
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Physical Activity Counseling)	56.04	58.28	59.53	63.64	↑	↑	Above
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.77	74.50	73.29	72.78	↓	↓	Above



The Future of Child Health Quality Measurement & Reporting in California

This brief reflects data and measures California reported for calendar year 2014. Existing policy indicates that California will report on the same measures in 2015.³⁶ The California Department of Health Care Services (DHCS) also recently announced the final set of health quality indicators – known as the External Accountability Set (EAS) – for 2016 and 2017,³⁷ which precedes the release of the federal 2017 core set.

Table 3 provides a preview of core set measures California will report in 2015 and 2016 relative to measures reported in and changes since 2014. Although over time most states are reporting more core set measures, California remains relatively stagnant in its reporting. There is no difference between 2014 and 2015 measures, and there were only slight adjustments to the 2016 measures, so that California consistently collects only one dozen child core set measures. This trend means that California is reporting a smaller share of the federally recommended child core set measures over time as new measures are added to the child core set. For 2016, California will report on 12 of 25 (48%) of the federal child core set measures compared to 12 of 22 measures (54%) in 2014.³⁸ As a result, California is likely to fall further behind other states and the nation in measuring child health quality in Medicaid, thereby missing opportunities to address and improve health care for the 5.7 million California children who rely on Medi-Cal.³⁹

DHCS' recent announcement of the 2016-2017 EAS measures made slight modifications to the 2014-2015 EAS measures, including improvements towards quality measurement of asthma management and HPV vaccinations for adolescents. However, DHCS missed an opportunity in their 2016-2017 EAS selection to collect more data on preventive care for infants and adolescents, low birth weight newborns, behavioral health risks of pregnant women, and children's mental health.

Importantly, beginning in 2016, DHCS will engage the contracted External Quality Review Organization (EQRO) and stakeholders in a "focus study" of data to calculate the core set indicator on development screenings in the first three years of life. This measure is essential to understanding if children are being screened for development delays that can impact their health and future success in life. Studies show that compared to developmental surveillance alone, children with delayed development who get screened were more likely to be correctly identified with developmental delays and referred to early intervention services,⁴⁰ thereby resulting in greater individual outcomes, child well-being, and possible societal cost savings.⁴¹



Table 4. Comparison of California’s Reporting of Core Set of Children’s Health Quality Measures for Medicaid and CHIP

Core Set Domains and Measures ¹	Measures Collected by California (by Calendar/Measurement Year) ²		
	2014	2015	2016
Access to Care			
Child and Adolescents’ Access to Primary Care Practitioners (CAP)	Yes	Yes	Yes
Preventative Care			
Chlamydia Screening in Women (CHL)	No	No	No
Childhood Immunization Status (CIS)	Yes	Yes	Yes
Well-Child Visits in the First 15 Months of Life (W15)	No	No	No
Immunization for Adolescents (IMA)	Yes	Yes	Yes ⁶
Developmental Screening in the First Three Years of Life (DEV)	No	No	No ⁷
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	Yes	Yes	Yes
Human Papillomavirus Vaccine for Female Adolescents (HPV)	No	No	Yes ⁶
Adolescent Well-Care Visit (AWC)	No	No	No
Maternal and Perinatal Health			
Pediatric Central Line-Associated Bloodstream Infections - Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI) ³	Yes	Yes	Yes
PC-02: Cesarean Section (PC02)	No	No	No
Live Births Weighing Less Than 2,500 Grams (LBW)	No	No	No
Frequency of Ongoing Prenatal Care (FPC)	No	No	No
Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)	Yes	Yes	Yes
Audiological Evaluation No Later Than 3 Months of Age (AUD) ^{***}	N/A	N/A	No
Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)	No	No	No
Behavioral Health			
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	No	No	No
Follow-Up After Hospitalization for Mental Illness (FUH) ⁴	Yes	Yes	Yes
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)*	N/A	No	No ⁸
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)**	N/A	N/A	No
Care of Acute and Chronic Conditions			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Body Mass Index Assessment for Children/Adolescents (WCC)	Yes	Yes	Yes ⁹
Medication Management for People with Asthma (MMA)	Yes	Yes	No ¹⁰
Ambulatory Care - Emergency Department (ED) Visits (AMB)	Yes	Yes	Yes
Oral Health			
Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (SEAL)*	N/A	Yes	Yes
Percentage of Eligibles Who Received Preventative Dental Services (PDENT)	Yes	Yes	Yes
Percentage of Eligibles Who Received Dental Treatment Services *	Yes	N/A	N/A
Experience of Care			
Consumer of Assessment of Healthcare Providers and Systems (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC) ⁵	Yes	Yes	Yes
TOTALS			
Total Measures in the Child Core Set (excluding CLABSI)	22	23	25
Total Child Core Set Measures Collected by California (excluding CLABSI)	12	12	12
Percent of Child Core Set Measures Collected by California	55%	52%	48%



Table Notes

Source: Children Now analysis of CMS' Child Core Set indicators and DHCS' External Accountability Set indicators.

¹ The Child Core Set indicators and updates are available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html>; The 2015 additions or deletions from the Child Core Set are denoted by an asterisk (*) and the 2016 additions to the Child Core Set are denoted by a double asterisk (**).

² The External Accountability Set (EAS) indicators for 2014 and 2015 are listed in All Plan Letter (APL) 15-024 from December 20, 2015 at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-024R2.pdf>; Changes to the EAS for 2016 were announced by the Department of Health Care Services at the Medi-Cal Managed Care Advisory Group meeting on September 8, 2016.

³ This indicator is not included in California's EAS because the measure is not directly reported by states but collected for all states from the CDC's National Health Safety Network.

⁴ This indicator is not included in California's EAS, but state-level data is reported to CMS by DHCS' Information Management Division.

⁵ California does not collect CAHPS data annually.

⁶ For 2016, DHCS has updated the EAS to adopt the NCQA's combination measure of Immunizations for Adolescents (IMA) with HPV for Female Adolescents. The combined IMA/HPV indicator will incorporate HPV for boys and girls, age 13. Technical specifications for the combined measure are forthcoming, and will presumably be in alignment with the Child Core Set measures.

⁷ DHCS has arranged for the contracted External Quality Review Organization (EQRO) to do a "focus study" on the developmental screenings data for feasibility of future reporting on this measure; results should be available in Fall 2017.

⁸ For 2016, DHCS has added a different behavioral health measure to the EAS focused on depression screenings and follow-up care for adolescents and adults; details have not yet been released.

⁹ For 2016, DHCS has removed the Body Mass Index (BMI) sub-measure for Weight Assessment and Counseling in Children and Adolescents from the EAS, but will still collect and report on the counseling for nutrition and physical activity components of the measure.

¹⁰ For 2016, DHCS has changed the EAS asthma measure to the Asthma Medication Ration (AMR) indicator, which is not a Core Set Measure, but is widely agreed upon to be a better predictor of asthma exacerbations.



Appendix Table 1. California Reporting on 2014 Child Core Set of Health Care Quality Measures for Children in Medicaid and CHIP

Measure ^a	Ranking by Quartile ^b	California Medicaid and CHIP Rate	All Reporting States Median
Preventive and Primary Care			
Children with a PCP visit in the past year			
Ages 12-24 months	3	95.3	96.4
Ages 25 months-6 years	3	86.3	88.6
Children with a PCP visit in past 2 years			
Ages 7-11 years	3	86.1	91.2
Ages 12-19 years	4	82.9	90.6
Children receiving 6 or more well-child visits in first 15 months	--	N/R	62.1
Children and adolescents receiving at least 1 annual well-child visit			
Ages 3-6 years	2	73.3	67.4
Ages 12-21 years	--	N/R	43.5
Children and adolescents up to date on recommended immunizations			
By 2 nd birthday	1	75.1	66.9
By 13 th birthday	2	74.4	67.1
Females receiving 3 doses of HPV vaccine by 13 th birthday	--	N/R	17.6
Body mass index assessment for children and adolescents ages 3-17 years ^c	1	71.2	42.6
Sexually active females ages 16-20 years receiving at least 1 test for Chlamydia	--	N/R	48.3
Perinatal Care			
Pregnant women with prenatal care visit in 1st trimester or within 42 days of Medicaid/CHIP enrollment	3	81.3	81.4
Pregnant women receiving more than 80% of expected number of prenatal care visits	--	N/R	65.8
Live births weighing <2,500 grams (5.51 lbs.) (lower percentage is better)	--	N/R	9.0
Behavioral Health			
Follow-up after mental illness hospitalization			
Within 7 days	2	49.0	43.9
Within 30 days	2	74.0	65.2
Follow-up after ADHD medication is prescribed			
1 visit within 30-day initiation period	--	N/R	44.1
During the 9-month continuation and maintenance phase	--	N/R	56.5
Management of Acute and Chronic Conditions			
Emergency department visits per 1,000 enrollees, ages 0-19 years (lower number is better) ^c	2	42.1	45.7
Asthma medication management			
Ages 5-11 years	--	N/R	30.3
Ages 12-18 years	--	N/R	28.2
Ages 19-20 years	--	N/R	33.2
Combined ages 5-20 years	2	32.2	31.2
Dental and Oral Health Services^d			
Children, ages 1-20 years, enrolled for at least 90 continuous days and received at least one:			
Preventive dental service	4	37.8	47.6
Dental treatment service	3	21.0	22.3

^a This table includes only measures reported by a minimum of 25 states for which HHS releases state level data and ranks state performance.

^b N/R = Not Reported; 1 = Top/Highest Quartile while 4 = Bottom/Lowest Quartile

^c CMS reported data for certain age groups but only ranked the measure for the combined age range shown in this table.

^d Dental services data were collected from State EPSDT Form 416 Reports.



Appendix Table 2. National Data Based on State Reporting on the 2014 Child Core Set of Health Care Quality Measures for Children in Medicaid and CHIP*

Measure	No. of States Reporting	Lowest (Medicaid/CHIP)	Mean	Median	Highest (Medicaid/CHIP)
Preventive and Primary Care					
Children with a PCP visit in the past year					
Ages 12-24 months	41	87.8	95.8	96.4	98.7/100
Ages 25 months-6 years	43	78.3/71.5	87.1	88.6	94.2/95.0
Children with a PCP visit in past 2 years					
Ages 7-11 years	42	66.9/59.1	88.9	91.2	97.2
Ages 12-19 years	42	66.6/61.5	88.0	90.6	95.6/96.4
Children receiving 6 or more well-child visits in first 15 months	41	30.9	61.5	62.1	88.8
Children and adolescents receiving at least 1 annual well-child visit					
Ages 3-6 years	46	45.7/35.0	67.1	67.4	96.9
Ages 12-21 years	44	28.1/18.0	45.5	43.5	71.5
Children and adolescents up to date on recommended immunizations					
By 2 nd birthday	35	5.8	62.1	66.9	86.3/90.3
By 13 th birthday	35	19.8	64.9	67.1	88.4
Females receiving 3 doses of HPV vaccine by 13 th birthday	32	2.9	17.2	17.6	35.9
Body mass index assessment for children and adolescents ages 3-17 years	33	0.1	41.3	42.6	94.4
Sexually active females ages 16-20 years receiving at least 1 test for Chlamydia	37	4.9	48.8	48.3	75.5
Perinatal Care					
Pregnant women with prenatal care visit in 1st trimester or within 42 days of Medicaid/CHIP enrollment	34	22.1	77.1	81.4	95.7
Pregnant women receiving more than 80% of expected number of prenatal care visits	27	1.4	56.6	65.8	84.9
Live births weighing <2,500 grams (5.51 lbs.) (lower rate is better)	29	12.6	9.0	9.0	5.4/0.7
Behavioral Health					
Follow-up after mental illness hospitalization					
Within 7 days	34	14.4	44.8	43.9	69.6
Within 30 days	34	27.1	64.2	65.2	91.0
Follow-up after ADHD medication is prescribed					
1 visit within 30-day initiation period	34	9.5	44.2	44.1	68.6/100
During the 9-month continuation and maintenance phase	31	23.0	53.9	56.5	84.4/100
Management of Acute and Chronic Conditions					
Emergency department visits per 1,000 enrollees, ages 0-19 years (lower rate is better)	37	436.7	55.1	45.7	6.2
Asthma medication management					
Ages 5-11 years	26	12.1	32.6	30.3	75.0/94.5
Ages 12-18 years	25	14.3/17.2	29.7	28.2	49.2/78.7
Ages 19-20 years (not all states cover this age group)	16	15.2	33.7	33.2	54.7
Combined ages 5-20 years	25	14.6	32.7	31.2	73.9/88.0
Dental and Oral Health Services					
Children, ages 1-20 years, enrolled for at least 90 continuous days and received at least one:					
Preventive dental service	51	25.1	45.6	47.6	61.6
Dental treatment service	51	10.8	23.5	22.3	52.1

Source: HHS 2015 Annual Report on the Quality of Care for Children In Medicaid and CHIP and related domain-specific reports.

* This table includes only measures reported by a minimum of 25 states for which HHS releases state level data and ranks state performance. The lowest or highest rate shown in the table represents the top and bottom of the range used by HHS to rank state performance.



Endnotes

¹ The HHS annual reports and related addenda are available on the Medicaid.gov website available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html>.

² For more information on the child core set, see <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/chipra-initial-core-set-of-childrens-health-care-quality-measures.html>.

³ Quality reporting is highly technical and the HHS reports include many footnotes highlighting nuances in the data. This brief is intended to provide a high level snapshot of the state's reporting and performance on the child core set of quality measure. For more detailed information on California reporting and performance, see the 2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP and its related domain-specific reports.

⁴ For 2011, see slide 19 of the Department of Health Care Services', "Understanding Medi-Cal's Child Population," (September 2015), http://www.dhcs.ca.gov/services/Documents/Child_Pop_Presentation_2015-09-04-1414.pdf.

⁵ A. Chester and J. Alker, "Medicaid Provides an Excellent Long-Term Return on Investment," Say Ahhh! A Child Health Policy Blog, Georgetown University Center for Children and Families, July 2015, accessed online January 9, 2015, at <http://ccf.georgetown.edu/all/medicaid-provides-excellent-long-term-return-investment/>.

⁶ A. Kreider, et al., "Quality of Health Insurance Coverage and Access to Care for Children in Low-Income Families," *Journal of the American Medical Association*, January 2016.

⁷ G.M. Kenney and C. Coyer, "National Findings on Access to Health Care and Service Use for Children Enrolled in Medicaid or CHIP," Urban Institute, August 2012.

⁸ S. McMorro, et al., "Trade-offs Between Public and Private Coverage for Low-Income Children Have Implications for Future Policy Debates," *Health Affairs*, 2014;33(8):1367-1374.

⁹ L. Dubay and G.M. Kenney, "Health Care Access and Use Among Low-Income Children: Who Fares Best?," *Health Affairs* 2001;20(1):112-121.

¹⁰ T.M. Seldin and J.L. Hudson, "Access to Care and Utilization Among Children: Estimating the Effects of Public and Private Coverage," *Med Care*. 2006;44(5):119-126.

¹¹ California HealthCare Foundation, "Medi-Cal Versus Medicaid in Other States: Comparing Access to Care," (July 2015), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MediCalAccessComparedUrban.pdf>.

¹² There are 23 measures in the 2014 child core set. This report excludes the Pediatric Central-Line Associated Blood Stream Infections in the Neonatal and Pediatric Intensive Care Units because the measure covers all newborn and pediatric hospitalizations, not just those covered by Medicaid and CHIP. Further, the measure is not directly report by states but collected for all states from the CDC's National Health Safety Network.

¹³ See Figure 2, Department of Health Care Services, "Proportion of California Population Certified Eligible for Medi-Cal by County and Age Group—Sept. 2015 (Jan. 2016), available at http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_Penetration_Brief_ADA.PDF.

¹⁴ L. Dubay, L. Clemens-Cope, & N. Anderson, "The link between income and the environments that promote child health," Urban Institute (April 22, 2015), <http://www.urban.org/urban-wire/link-between-income-and-environments-promote-child-health>.

¹⁵ For example, Child and Adolescent Access to Primary Care Providers is a primary measure but it is reported for multiple age groups, which are counted as four sub-measures in this brief.

¹⁶ One of the 23 measures in the 2014 child core set – the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a qualitative survey of consumer and patient experience with the health care system – is excluded from the HHS analysis. This analysis also excludes the Pediatric Central-Line Associated Blood Stream Infections described in Endnote #12. Of the remaining 21 measures, the minimum threshold of 25 reporting states was reached on 18 primary measures. Several of the 18 measures are broken down by age or other detail, resulting in 26 measures and sub-measures that are included in this brief.

¹⁷ Quartiles are based on the actual data range reported by states on a specific measure. For example, if 40 states reported a range of data between 20 percent and 80 percent, the 75-100 percentile range or top quartile will include states reporting data between 66% – 80%; the second quartile will include states reporting data between 50% – 65%, and so on.

¹⁸ This report references the quartiles as the 1st or top quartile for states with data that falls in the 75 – 100 percentile; 2nd quartile for the 50 – 75 percentile; 3rd quartile for the 25 – 50 percentile; and the bottom or 4th quartile for the 0 – 25 percentile range.

¹⁹ According to email correspondence with HHS, the quality reports create four buckets to categorize states for the maps that in some cases differ from the quartiles (median and 25th/75th percentiles). In those cases, the rationale was that the statistical threshold would not meaningfully distinguish states as being higher or lower performing. For example, when states were clustered around the median or 25th/75th percentiles, HHS opted not to categorize states with a very small difference (e.g., one- or two-tenths of a percentage point) in higher or lower categories. In addition, states did not consistently report their data to one decimal. HHS has indicated that future reports will use the median and 25th/75th percentiles to categorize the states for the maps given new reporting requirements and improvements in the accuracy of reported data over time. Considering HHS' future direction, we chose to conduct our analysis based on quartile rankings. Footnotes reflect where a state ranking deviates from the cluster map groupings reported by HHS.

²⁰ The narrative description of the measures draws heavily from the five domain-specific reports released by HHS, which report state-level performance data and rank states in one of four performance groupings.



²¹ “Well Child Visits in the First 15 Months of Life,” National Committee on Quality Assurance (NCQA), accessed online at <http://www.ncqa.org/Portals/0/Well-Child%20Visits%20in%20the%20First%2015%20Months%20of%20Life.pdf?ver=2009-12-01-172218-000>.

²² The rate of childhood immunization coverage fell from 74% in 2014 to 71% in 2015 according to the DHCS Medi-Cal Managed Care Quality Strategy Comprehensive Review (October 2016), draft shared with stakeholders on September 20, 2016.

²³ The California HealthCare Foundation, “Maternity Care in California: Delivering the Data,” (June 2016), available at <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20MaternityCareCalifornia2016.pdf>.

²⁴ The HHS report groups California in the 2nd highest grouping for this measure. However, California’s rate of 81.3 is below the national median of 81.4, placing it in the 3rd quartile.

²⁵ Department of Health and Human Services, “Perinatal Care in Medicaid and CHIP,” (February 2016), available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/secretarys-report-perinatal-excerpt.pdf>.

²⁶ Ibid (21).

²⁷ “Infants Born at Low Birthweight, by Race/Ethnicity,” Lucile Packard Foundation for Children’s Health, available at <http://www.kidsdata.org/topic/302/lowbirthweight-race/table> and “Births of Low Birthweights as a Percent of All Births by Race/Ethnicity,” Kaiser Family Foundation (2014), available at <http://kff.org/other/state-indicator/low-birthweight-by-raceethnicity/>.

²⁸ “Infant Mortality Rate, by Race/Ethnicity,” Lucile Packard Foundation for Children’s Health, available at <http://www.kidsdata.org/topic/295/infantmortality-race/table>.

²⁹ Anne Kelsey Lamb, et al., “Re: Recommendations on asthma quality indicators for the 2017 EAS,” Regional Asthma Management, St. John’s Well Child Family Center, San Francisco Asthma Task Force, The Children’s partnership, Propeller Health, Esperanza Community Housing Corporation, Pulmonary Case Manager, Breathe California, Asthma Coalition of Los Angeles County, Clinicas de Salud del Pueblo, Inc., Alameda County Healthy Homes Department (letter, May 2016).

³⁰ California State Auditor, “California Department of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children’s Access to Dental Care; Report 2013-125” (December 2014), available at <https://www.auditor.ca.gov/reports/summary/2013-125>.

³¹ Little Hoover Commission, “Fixing Denti-Cal, Report #230,” (April 2016), available at <http://www.lhc.ca.gov/studies/230/Report230.pdf>.

³² California Department of Health Care Services, “Dental Transformation Initiative (DTI),” (August 2016), available at <http://www.dhcs.ca.gov/provgovpart/Pages/DTI.aspx>.

³³ California Department of Health Care Services, “Dental Managed Care Plan Utilization,” available at http://www.denti-cal.ca.gov/WSI/ManagedCare.jsp?fname=dental_managed_care_plan_util. The Denti-Cal Managed Care Performance Measures are: 1) Annual Dental Visits; 2) Use of Preventive Services; 3) Use of Sealants; 4) Sealants to Restoration Ratio; 5) Treatment/Prevention of Caries;

6) Exams/Oral Health Evaluations; 7) Use of Dental Treatment Services; 8) Preventive Services to Fillings; 9) Overall Utilization of Dental Services Year 1; 10) Overall Utilization of Dental Services Years 1 & 2; 11) Continuity of Care; 12) Usual Source of Care.

³⁴ The California State Auditor issued a report in December 2014, which found that the program’s statewide utilization rates for child beneficiaries in the Denti-Cal fee-for service system for 2011, 2012, and 2013 were 39.2 percent, 40.4 percent, and 41.4 percent, respectively (See pg. 19, <https://www.auditor.ca.gov/pdfs/reports/2013-125.pdf>). In addition, the California Department of Health Care Services reported that the weighted average of dental utilization in managed care for children ages 0-20 in years 2011 and 2012 were: 32.3% and 43.7%, respectively in Sacramento and 24.6% and 36.8%, respectively in Los Angeles County (see pg. 13, of the March 2013 “Activities Relating to Medi-Cal Dental Managed Care Report to the Legislature,” http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Dental%20Managed%20Care/Medi-Cal_DMC-Mar2013.pdf).

³⁵ California Department of Health Care Services, “2015 HEDIS Aggregate Report for Medi-Cal Managed Care,” (Revised March 2016), available at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/HEDIS_Reports/CA2015_HEDIS.pdf

³⁶ California Department of Health Care Services, “Quality and Performance Improvement Requirements,” APL 15-024 (December 10, 2015), available at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-024R2.pdf>.

³⁷ Changes to the External Accountability Set indicators for measurement years 2016 & 2017 were announced by the Department of Health Care Services at the Medi-Cal Managed Care Advisory Group meeting on September 8, 2016; and included in the DHCS Medi-Cal Managed Care Quality Strategy Comprehensive Review (October 2016) draft shared with stakeholders on September 20, 2016.

³⁸ There are 26 measures in the 2016 Child Core Set. In this count, the Pediatric Central-Line Associated Blood Stream Infections is excluded for reasons described in Endnote #12.

³⁹ “Medi-Cal Children’s Health Dashboard,” Department of Health Care Services, pg. 1, (May 2016), available at <http://www.dhcs.ca.gov/provgovpart/Documents/May2016PediatricDashboardv2.pdf>

⁴⁰ For example, see J. Guevara, et al., “Effectiveness of Developmental Screening in an Urban Setting,” *Pediatrics*, 2013; 131(1):30-37, see <http://pediatrics.aappublications.org/content/131/1/30>.

⁴¹ F. P. Glascoe and H.L. Shapiro, “Introduction to Developmental and Behavioral Screening” as cited in NCQA Child and Adolescent Well-Care Visits, (2007) available at <http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/child-well-care-visits>.



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