MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of February 5, 2009

Committee Members Present: Mary Giammona, Paul Kurtin, Ed Mendoza, Mark Paredes, John Pescetti, Elaine Robinson-Frank, Teri Shaw and Ellen Wu.

Committee Members Present by Phone: Alyce Adams, Alex Chin, Moria Inkelas, Lucy Johns, Lori Ortega, and Matt Meyer.

MRMIB Staff Present: Dana Durham, Muhammad Nawaz, Shelley Rouillard, Cristal Schoenfelder, and Mary Watanabe.

1. Welcome and Introductions

Ms. Wu introduced herself as the facilitator and introductions were made. New board member, Mark Paredes of the Community Health Council, was introduced as well as new staff, Office Technician Dana Durham

2. November 20, 2008 Meeting Minutes

Ms. Wu called for the review and approval of the November meeting minutes. Ms. Johns moved for their approval and Ms. Shaw seconded the approval. The minutes were approved.

a. Action Item Review: Percentage of Uninsured in California

In response to a request from the Committee as to the number of uninsured children in California who are eligible for the Healthy Families Program, Mr. Nawaz referred to handout entitled Analysis of California State Population and Healthy Families Program Enrollment Data. There are 10.6 million children under the age of 18 in CA (US Census Bureau data). There are 1.8 million children under age 19 with family income between 150-250% FPL. As of December 2008, almost 50% of the 1.8 million are enrolled with the Healthy Families Program. Approximately 37.1% of children in families with incomes between 150-250% FPL are uninsured.

3. Healthy Families Program Update

a. SCHIP Reauthorization

Ms. Rouillard noted that the President signed SCHIP authorization yesterday. It is a 4-½ year reauthorization. The Committee noted that this was wonderful news and great for the State of California.

Ms. Rouillard reviewed a summary of the bill known as CHIPRA focusing on the Benefits and Quality provisions.

i. Dental Coverage: Dental coverage is now a mandated benefit under SCHIP. Dental care has always been covered in California. There is an optional dental-only supplement which would enable those families with employer sponsored coverage to purchase dental coverage through Healthy Families. Enacting this will depend, in part, on whether California can provide the matching funds.

Ms. Rouillard noted that it is unclear whether orthodontia is a required benefit under CHIPRA. If this is true, this would increase the overall cost for the Healthy Families Program. It was also noted that children who have severe malocclusions currently get orthodontia coverage through CCS.

ii. Mental Health and Substance Abuse Parity: CHIPRA includes a provision about Mental Health and Substance Abuse parity that states that financial requirements and treatment limitations cannot be any more restrictive than they are for medical and surgical benefits. There will likely be changes to HFP benefits because currently there are benefit limitations. A discussion ensued regarding the lack of child mental health professionals and attempting to meet the requirements of the SCHIP.

iii. Child Health Quality: Ms. Rouillard noted the bill provides some leadership at the Federal level around child health quality. The Secretary of Health & Human Services will develop core child health quality measures. The IOM will report to Congress by July of 2010 on pediatric health and health quality measures and the GAO will be issuing a report around access and making recommendations for improving access. MRMIB hopes that quality requirements will result in standards for SCHIP nationally.

iv. Encounter & Claims Data: There are a couple of provisions that lead MRMIB to believe that collection of encounter and claims data is necessary under the reauthorization. MRMIB has put the Encounter Data Project on hold because of California's Confidentiality of Medical Information Act (CMIA), which prohibits plans from sharing information about outpatient visits with a psychotherapist. The SCHIP law requires that MRMIB conform to certain Medicaid managed care requirements. Embedded in those standards is a requirement that the states obtain encounter data. MRMIB will analyze whether this will require MRMIB to get this encounter data.

v. CAHPS Requirement: SCHIP also includes a provision that requires reporting CAHPS data in the annual report to CMS. There

is enhanced funding for collecting and reporting child health data so MRMIB expects to conduct CAHPS in 2010 for calendar year 2009.

vi. Demonstration Project Grants: There are 10 grants for demonstration projects to use and test child health quality measures and promote use of health IT. Those are grants to states. There is also $25 million to community based health organizations for demonstration projects to combat obesity.

vii. Legal Immigrant Coverage: The new SCHIP law allows federal match for coverage of legal immigrants. The Committee would like updates on this issue.

It was noted that other parts of the bill streamline enrollment and retention and bonus payments for doing such. The stimulus bill includes additional funds for Health IT as well. The Committee pointed to the importance of California clarifying its position so that the State can advocate for what it wants/needs.

Ms. Johns questioned whether California has ever had the parent waiver. Ms. Rouillard responded that this bill prohibits parent expansion waivers and childless adult waivers using SCHIP funds. Additionally, Ms. Shaw noted that the Aug 17th CMS directive has officially been rescinded as of today.

SCHIP reauthorization is effective April 1st. MRMIB's current appropriation runs through March 31st. Ms. Shaw noted that the SCHIP did apply the Deficit Reduction Act (DRA) citizenship requirements that now make these requirements applicable to SCHIP as they have been to Medicaid. They allow for verification through the Social Security Administration.

b. First 5 Funding

Ms. Rouillard informed the Committee that First 5 of California and many of the county First 5 Commissions are contributing about $17 million to cover Healthy Families children ages 0-5 that would have been on a waitlist due to MRMIB reaching its maximum expenditure authority. The Board will be monitoring HFP expenditures on a monthly basis and hopes to be able to cover all of the 6-18 year olds through June 2009 as well. The First 5 funding is a one time gift. The estimates right now are that MRMIB will be able to cover all children through 250% of FPL.

4. Potential Quality Improvement Areas

a. Access to Primary Care Practitioners

Ms. Rouillard discussed the document entitled "MRMIB Healthy Families Program 2007 HEDIS & YAHCS Results." Plans are identified that had 4 or more HEDIS measures that were below the commercial 10th percentile. Staff highlighted measures related to Access to Primary Care

Practitioners. The Committee discussed data surrounding the Access to PCP measures at different ages. This was identified as a potential quality improvement area for a number of plans. It would be good to learn from the high scoring plans what they are doing and share that information that can with lower scoring plans.

Dr. Kurtin offered to do an exploration conference call with high scoring plans. There might be an opportunity for collaboration among the lower scoring plans in certain counties. The Committee thought this seemed like a good idea. Mr. Mendoza raised concern regarding regional differences. This led to a discussion of the map located included in the handout and the possibility of reporting based on regions by each plan.

Action Item: Dr. Kurtin will hold conference calls with high scoring plans to identify best practices.

b. Well Child Visits up to 15 Months of Life

At the last meeting, MRMIB staff noted that Well Child Visits up to 15 Months require six visits within the first 15 months of life. 57% of HFP kids received all 6 visits, but more than 90% of kids received 4 visits. The merits of the 9-month visit were discussed. Ms. Giammona and Ms. Watanabe noted the importance of development and testing at the 9-month visit. Dr. Kurtin noted at the last meeting that this measure should be viewed with caution because at the 9-month visit there is neither an immunization nor an additional reason to visit the PCP. Dr. Kurtin offered to contact the AAP and discover whether this is a standard of care for the industry. Dr. Chin inquired as to the development of W15 HEDIS. Ms. Ortega from the Health Plan of San Joaquin noted that for plans such as the one she is involved with, the sample size is very small and did not meet the required sample size of 411. Ms. Rouillard noted that there were 6 plans that did not achieve a sample size of 30. It was noted that the W15 is a hybrid measure.

Action Item: Dr. Kurtin will contact the AAP and regarding the standard of care for a 9 month visit.

c. Benchmark Comparisons

The Committee discussed the commercial population as a comparison population for Healthy Families. Dr. Chin questioned if there is an adjustment for socio-economic status. Ms. Rouillard noted that it is a straight comparison and historically the HFP has been viewed as being more like a commercial product than a Medi-Cal product. It was noted that both the commercial model and the Medi-Cal model fall short as benchmarks for comparison. Committee members commented that when there is consistent data from SCHIP programs this would be a better benchmark. Dr. Kurtin pointed to the available data and noted that if one

plan can achieve a high score, it can be done. If there were no high performing plans, then MRMIB would not necessarily be justified in pushing other plans to high performance levels. The committee agreed that setting a high standard was good.

d. Linguistic Access

Ms. Wu discussed language disparities and interpreter access. Staff have the beginning results of the cultural and linguistic surveys by the plans which suggest there is work to be done. In exploring the HEDIS and CAHPS data, there aren't significant differences except for the need for more preventive screening within the Asian population. A starting point might be working with the Access to PCP measures. MRMIB could request health plans to provide the demographic information regarding this data. It was noted that the HEDIS data set is too small to do this. Ms. Giammona offered that it might be easier to use administrative data than hybrid data. It was noted that when applying for HFP, the subscriber voluntarily reports their race, ethnicity and language preference. Ms. Robinson-Frank noted that that the point of the undertaking would be to help plans to identify the populations with needs and find out how to meet those needs, thus improving quality.

Dr. Kurtin observed that the practice being discussed is the basis of quality. You get the data, start looking at it and then start being held accountable for the data, which is a nice multi-step process. Discussion ensued on the ability to see if there are regional issues that are not necessarily plan issues.

Ms. Wu noted that plans are required to file information on language access and language documents with the DMHC. It is difficult to ascertain the number of LEP children. Do children get interpreter services or do they speak with bi-lingual staff or do they not get services? This issue is complicated because of the difficulty of getting information on the accurate use of interpreters from doctors, staff and patients. The Committee noted the importance of using an appropriate interpreter and reporting the information correctly especially when PCPs are identified as being bi-lingual or having staff interpreters. Each of the plan representatives noted that there is a gap, they are working to bridge it, and all added that brainstorming is being undertaken to encourage use of appropriate translators. The Committee concluded that it is difficult to track this issue but should be researched in the future.

5. Performance Goals

a. Inclusion in Future Contract Negotiations

Ms. Rouillard discussed three documents: (1) "Access to Primary Care Practitioners", (2) the draft "Levels of Performance Goals for 09-10", and

(3) an excerpt of the HEDIS report. Ms. Rouillard explained that it is the desire of MRMIB to eventually include Quality Improvement (QI) in plan contract negotiation. The QI proposal presented to the committee is to measure performance in two ways, absolute performance and performance over time. On the charts in handout 2, the plans are broken down into three tiers: top, middle and bottom. MRMIB would like to see improvement by all plans in all tiers. However, there will be a specific emphasis on getting the plans in the bottom tier to achieve improvement. Ms. Giammona noted that this is not a new concept as MRMIB has been signaling this change. Dr. Kurtin pointed out the benefits of breaking down the health plans into three levels; whether you are doing well, middle or bottom you are expected to improve. Good performance is not static it is dynamic. This process helps to capture the dynamic nature of quality.

b. Quality Improvement Tools

i. Access to Primary Care Practitioners: Ms. Giammona clarified that the Committee agreed to discuss performance goals in relation to access measures because they are more objective and it should be relatively easy to get kids into the doctor once a year. However, Mr. Mendoza pointed out even a movement of 1% can be difficult. One of the important things about this process is to give people obtainable goals. Dr. Kurtin reminded the Committee that we shouldn't let 'perfect' get in the way of 'good'. There is some argument to be made that the plans with the ability to buy the best data system have the best scores. MRMIB doesn't want to penalize plan X because they don't have the same ability to buy a data IT system that plan Y can purchase. The benefit of comparing a plan to itself is looking at how the plan achieves improvement. The Committee agreed that comparing a plan to itself is a good idea. If the goals are realistic, then the process will engender more buy-in. Ms. Rouillard requested clarification from the Committee about focusing on the access measures to try to improve the low scoring plans. The Committee thought this would be a good idea.

ii. Health Process Measures: Ms. Johns suggested picking one health process measure to work on along with access measures. This suggestion led to a discussion of the merits and difficulties of studying various health data measures. Ms. Frank suggested that the plans and MRMIB pick a health measure which scores low and set a goal for improvement. This would encourage each plan to have more ownership. The Committee thought this would be a good way to proceed.

iii. CPP Process: Ms. Rouillard also mentioned that MRMIB is exploring how to redesign the CPP process and connect it to quality issues. The Committee thought that tying quality to the CPP process would be a great idea. Some families care more about

which plan is the cheapest so it would be good to have the lower premium tied to the highest quality plan.

c. Data Collection Concerns

The different sample size from plans was discussed, noting that larger plans' scores might be more statistically significant than those of smaller plans. In the first year, the Committee suggested focusing on the lowest scoring plans and getting them to bring their scores up. The Committee took note that there is compression at the top of the Access to PCP in the first 15 Months of life measure, however within this measure the scores range from 85% to 100%. This means that there is room for significant improvement in the bottom range. In the adolescent measures, there is much more room for improvement.

The committee noted difficulty in obtaining encounter data from doctors. It is clear that there is no simple solution to this problem especially with the lack of a pay for performance system. Ms. Rouillard noted that MRMIB staff is in the process of compiling Plan Performance Profiles, which measure HEDIS, CAHPS and YAHCS scores by plan over time. These profiles will assist the Committee as its sets goals for the future.

6. Plan Recognition

Mr. Nawaz discussed MRMIB's desire to recognize high performing plans in HEDIS, CAHPS and YACHS. He has developed a cluster analysis that places the plans in 5 groups: superior, above average, average, below average and poor. Ms. Rouillard pointed out that the last time MRMIB publicly recognized plans was 2004. We want to begin to recognize the plans that have done well. MRMIB will recognize the superior plans at the 2nd Board meeting in March.

7. Next Meeting

The next Advisory Committee on Quality meeting will be on Thursday, March 26th from 1-4 at the Department of Rehabilitation. The following one will be May 28th.

*Note: This meeting was later canceled due to a conflict with the rescheduled second MRMIB Board meeting in March.