

MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of August 27, 2009

Committee Members Present: Alyce Adams, Lucy Johns, Paul Kurtin, Rita Marowitz, Ed Mendoza, John Pescetti, Elaine Robinson-Frank, and Ellen Wu.

Committee Members Present by Phone: Jennifer Benjamin, Mary Giammona, Lori Ortega, Mark Paredes, and Aaron Zaheer.

MRMIB Staff Present: Muhammad Nawaz, Shelley Rouillard, Cristal Schoenfelder, Raymond Titano, and Mary Watanabe.

Guest Visitors Present: Sandy Deckinger (Chinese Community Health Plan), Kelley Pfeifer and Nina Maruyama (San Francisco Health Plan).

1. Welcome and Introductions

Dr. Kurtin introduced himself as the facilitator and the participants introduced themselves.

2. May 28, 2009 Meeting Minutes

Dr. Kurtin called for the review and approval of the May meeting minutes. The minutes were approved.

As a follow up to the May meeting, Ms. Rouillard updated attendees on the status of the Community Provider Plan (CPP) redesign. MRMIB may have possible funding from the California HealthCare Foundation to help with the redesign of the CPP process to focus not only on traditional and safety net providers, but to also include quality performance. The proposal is going through the Foundation's review process.

3. Healthy Families Program Updates

a. Program Changes

Ms. Rouillard stated that there have been three board meetings in August because of the high volume of program activity. There are 71,000 children on the waiting list as of August 25, 2009. Approximately 35% of them are ages 0-5 years and the list grows by several thousand every day. At today's Board meeting, the Board focused on how to achieve program savings to avoid having to begin disenrolling children at the Annual Eligibility Review (AER) in September. First 5 has agreed to give \$81 million to fund coverage for children ages 0-5. However, MRMIB still needs \$100 million in the next two weeks to avoid disenrollment. There is a bill, AB 1422, that would make changes to premiums and provide

enough funding so that MRMIB could eliminate the waiting list and continue the Program without having to disenroll children for this current year.

Ms. Rouillard informed the committee that there would be premium increases for families in Categories B (150-200% FPL) and C (200-250% FPL). Category B premiums would increase from \$12 to \$16 per child with a new family maximum of \$48 per family per month and Category C premiums would increase from \$17 to \$24 per child with a new family maximum of \$72 per family per month. There will be no increase in premiums for the lowest income families. The estimated savings is \$5.5 million.

Ms. Rouillard further stated that the Board voted to increase copayment amounts on non-preventive services from \$5 to \$10. This would save approximately \$6.2 million. The Board also voted to increase copayments for brand name drugs from \$5 to \$15 dollars generating a \$1.1 million dollar savings. The savings occur because there would be a reduction in plan rates due to the increase in copays. Dr. Giammona commented on the issue of provider payments increasing with the copayments, while there is a decrease in rate payments to the plans.

Ms. Rouillard added that the Board also took action to place new subscribers in a dental HMO for two consecutive years before allowing them to transfer into a dental EPO. This mirrors the State employee benefit package requirements. This change saves approximately \$1.2 million. There will be some additional administrative vendor costs. Ms. Rouillard expressed some concerns about access and quality with the dental HMOs; however, the Board agreed to include this requirement as part of the program savings.

b. Contract Amendment Timelines

Ms. Rouillard discussed the staff efforts that are currently underway to update contract documents and referenced a handout showing the contract amendment timeline.

Ms. Rouillard said the Board is considering moving the benefit year from a 'Fiscal Year' to a 'Calendar Year' but it is not clear how this will affect the current contract amendment and/or extension process. Ms. Rouillard reviewed the current amendment process which goes from September through March. The reason for changing the Benefit Year is due to the difficulties that occur when rate negotiations take place before a State budget is passed. Ms. Rouillard added that moving to a Calendar Year would allow rate negotiations to take place in the fall, after a budget has been enacted, and the Board would set rates based on the appropriation determined by the budget.

4. Follow up to Adolescent Calls

Dr. Kurtin updated attendees on the outcome of the calls to the plans with lower scores on adolescent care and satisfaction (Blue Shield, Community Health Plan, Kern Family Health Care and Ventura County Health Plan). Based on the conversation, teens did not appear to be a high level of priority for some of the plans.

Dr. Kurtin added that the plans seemed interested in improving their adolescent quality scores and talking with the high scoring plans. The group focused on how best to reach the teen population. Attendees agreed to a follow up call in January to check on the status of what they implemented and to discuss the outcome. Community Health Plan expressed an interest to reach out to some of the high scoring plans to get information about tool kits and other educational materials being used for providers. Dr. Kurtin recommended sending Community Health Group a note congratulating them on their collaborative efforts.

Ms. Marowitz added that four years ago, in Medi-Cal Managed Care, they had annual calls focused on quality improvement to review CAHPS results and QIPs. She stated this was very useful, but requires adequate staffing which is why these calls have not been done recently. Medi-Cal now has informal quarterly conference calls with the plans to share successful quality improvement results. Ms. Marowitz also stated that Medi-Cal recently released a QIP status report that focuses on the different areas of improvement the plans are working on.

Action Item: MRMIB to send a note to Community Health Plan congratulating them on their collaborative efforts following the conference call.

5. Case Mix Adjustment – CAHPS

Ms. Rouillard introduced Dr. Kelley Pfeifer, Medical Director of San Francisco Health Plan, who wrote a letter to MRMIB regarding the plan's interest in case mix adjusting the CAHPS survey results due to the high number of Asians within the plan. Dr. Pfeifer said although SFHP has high scores in HEDIS, the plan scores much lower in CAHPS. She stated that 2/3 of the plan's responses were from members who speak Cantonese and that no other plans have such a high number of Cantonese responses. She added that research shows that this explains SFHP's low scores because Cantonese tend to score lower on a grading scale (showing a bias in scoring because they never give an 'excellent' rating). Dr. Pfeifer added that she has had conversations with DataStat who said a case mix adjustment based on ethnicity would be cheap, easy, and not impact other plan scores greatly.

Dr. Pfeifer continued by saying that previous discussions about this issue had resulted in MRMIB agreeing to place notes in the handbook explaining that SFHP's scores could be low due to ethnic biases. She added that it is SFHP's recommendation to take the option of case mix adjusting to the Board because she believes the plan's scores do not truly reflect the quality of care that SFHP provides for members.

Dr. Kurtin asked if any plan in the United States does well with Cantonese speakers. Ms. Deckinger from Chinese Community Health Plan's (CCHP) responded that nobody does well. Dr. Kurtin referenced the articles that were included in the meeting packets and said that some issues relate to parents who do not allow providers to ask certain questions during patient exams, and this could impact scores. He asked how does one separate out a scoring bias vs. people's expectations not being met for legitimate reasons.

Dr. Pfeifer responded that there are differences in rating and experiences among the various ethnicities. Ms. Marowitz stated that Medi-Cal is not finding the CAHPS results helpful, that the surveys cost a lot of money, and the surveys do not get down to the provider level which makes it difficult to ask a plan where to focus their efforts for improvement. She added that reports should speak to this issue with both CAHPS and HEDIS and encourages that the HFP document and be transparent about this particular issue. Ms. Wu voiced concern that the case mix adjustment may mask the concerns of whether culturally competent care is being provided. She asked if the other plans in the same area have the same results as SFHP. Ms. Rouillard replied that other plans in San Francisco county are large state-wide plans so there is likely not enough Cantonese speakers in those plans to be able to compare.

Mr. Mendoza stated his concern that if the scores are adjusted for a certain population, one could adjust all the variations out of the scores, thereby not having valid comparisons. He said the data is providing good results in that it is raising some possible issues that the plan is addressing.

Ms. Deckinger raised the issue of bias in the CAHPS survey. The survey is based on the Western model of medicine where the doctor and patient are in a collaborative exchange of information. In the Chinese community, one does what the doctor says. It took CCHP three years to get a translated version of the CAHPS survey that everyone agreed on. The translations for responses such as "sometimes", "usually", and "always", come out about the same when saying them in Cantonese. She added that CCHP focuses improvement efforts in the areas with the lowest scores.

Discussion commenced about the total number of Cantonese respondents across all plans and statistical significance. Dr. Kurtin asked how many adjustments are necessary to tease out what is happening. He asked how the instrument got approved if no one scores above a score of 6. Ms. Adams asked if MRMIB could have a cut off point (ie: scoring 5 or below) or perhaps other ways to distribute the responses.

Ms. Johns identified two main issues: MRMIB needs 1) a survey that informs the plan about whether there are problems and 2) information about the plan that looks

fair when patients are looking at it. She stated that these are two very different issues and should be addressed separately.

Mr. Mendoza recommended that SFHP request an exception when looking at the data. He thinks the data has produced a great result, even though it may be unfair, because it is causing SFHP to look closer at the data and determine what they can do about it.

Dr. Pescetti asked if the data could be presented in both formats (with the case mix adjustment and without). Ms. Rouillard said it would be a question of time and resources, but MRMIB could consider this option. She also recommended that MRMIB do the case mix comparison across all plans. Dr. Kurtin asked about oversampling. Ms. Watanabe stated that it is a possibility for future surveys. Discussion commenced about the various options suggested by DataStat.

Ms. Wu raised an option of requiring statewide plans to report data by county. Ms. Rouillard responded that Medi-Cal's statewide plans report HEDIS data by county. Ms. Robinson-Frank commented that requiring plans to report by county would be a lot of work for the larger plans.

Ms. Watanabe also raised the possibility of combining the 7,8,9,10 achievement scores together instead of the current 8,9,10 grouping. Dr. Pfeifer said this might be helpful.

Ms. Rouillard added that it is now up to MRMIB staff to determine what the next steps are for using and reporting the plan results. She added that staff will look into adding some statements to the information in the handbook that will help readers understand the scores.

Dr. Kurtin thanked Dr. Pfeifer for attending the meeting.

6. HFP Report Cards

Ms. Rouillard mentioned that the Office of the Patient Advocate (OPA) has offered some resources through Pacific Business Group on Health (PBGH), who helps OPA do the health plan and medical group report cards, to help with getting a web-based display of HFP quality information into a better format. MRMIB was working with OPA on displaying the HFP CAHPS scores, however, budget constraints have placed this project on hold. The goal is to use stars and bars to indicate plans' quality.

Mr. Mendoza added that it has been an OPA goal to bring some similarities to the way everyone displays data. He added that based on consumer testing, stars work well for consumer usability. He added that making information quick and easy for consumers to use is the goal. OPA has a target date of February 2010 to have the tasks accomplished.

7. Quality Language in the HFP Contract Amendment for 2010-2011

a. Proposed Quality Measures

Ms. Rouillard stated that MRMIB's intent is to establish performance standards for the plans to hold them accountable for quality. Current contract language is vague and not specific. She added that the language included in the handout was drafted from the Arizona combined Medicaid and SCHIP managed-care contracts which set minimum performance standards. MRMIB staff is proposing to set the minimum performance standard at the National Commercial 25th Percentile for HEDIS. In the 2007 HEDIS report, MRMIB highlighted plans that were at the 10th Percentile. Ms. Rouillard then added that the document also outlines the Contractor Performance Standards which include three performance standards: minimum, goal, and benchmark (found in the chart on page 2 of the handout). Before closing the meeting, Ms. Watanabe updated the group on the changes to the upcoming HEDIS measures.

b. Quality Improvement Projects

Ms. Rouillard explained that the proposed contract language requires plans to show demonstrative and sustained improvement and also requires corrective action plans if necessary. Ms. Marowitz suggested not requiring plans to meet standards for new measures in order to have a first year baseline. She also suggested using the term 'quality improvement plan' instead of 'corrective action plan' as the latter suggests something more punitive. Ms. Marowitz also recommended that MRMIB provide a standardized format for the Quality Improvement Plans (QIPs). She added that appropriate and qualified staff should be available to review the QIPs for credibility and to not over burden the plans. Ms. Ortega suggested using a simple action plan rather than a formal QIP. Ms. Rouillard stated a simple format was what she favored.

Discussion commenced among the group and questions were raised such as:

- o What is the intent of the QIP?
- o How will MRMIB utilize this information?

Comments included:

- o Reviewing the information annually would be better than reviewing it every six months.
- o Plans should be given ample time (3 years is better than 1 or 2) to improve.
- o If improvements are evident, then plans should work on operationalizing QIPs.
- o NCQA changes should also be considered.
- o MRMIB should consider other areas besides HEDIS.

- o Connecting quality improvement to plan membership allocation (carrot vs. stick).

Ms. Rouillard responded that she hopes to be able to revise the CPP process to tie quality into the CPP determination.

c. Health Disparities

Ms. Rouillard identified and discussed the proposed contract language regarding health disparities (page 3 of the handout). MRMIB would require plans to identify and share how they are addressing health disparities. Ms. Marowitz suggested MRMIB determine the format for plans to use to report this information. She added that one can't assume disparities exist until they show up in the data. Ms. Wu commented that the key is to have plans identify whether race/ethnicity disparities exist or not. Ms. Johns recommended having the plans identify and address whatever disparities they find.

d. Changes to C&L Survey

Muhammad Nawaz shared that MRMIB staff are reviewing the most recent C&L Survey responses from plans. There are some difficulties with the way the questions are asked and the amount and quality of data that plans submit. Staff is working to simplify this survey to gather the necessary information from the plan using a new format that also improves the review process.

e. Fact Sheet

Ms. Rouillard referenced the Fact Sheet document that was distributed to the ACQ members prior to the meeting. The Fact Sheet is sent to the plans each year with the contract amendment package. She stated that the Fact Sheet consists of various questions regarding asthma, diabetes, teen services, developmental screening of young children, and existing quality improvement projects. Ms. Johns suggested asking the plans how the outcomes of the quality improvement projects are measured and where the information is reported.

Ms. Adams raised the issue of Kaiser's difficulties when answering the questions on the Fact Sheet specific to HFP members because Kaiser members are "Kaiser members first" who happen to be enrolled in the HFP.

In regards to developmental screening, Dr. Giammona suggested that plans use developmental screening programs that give screening tools to plan providers. She asked if HFP and First 5 could partner to do this to give screening tools to providers at no cost. Ms. Rouillard mentioned that First 5 is funding a program to give discounts on screening tools for providers. Dr. Giammona added that discounts are not good enough. The tool would have to be free or included in the

rates. Dr. Pescetti added that the barrier at the provider level isn't necessarily the cost, but rather the time and resources to do the developmental screening.

Ms. Johns mentioned that many people looking into asthma, obesity, and diabetes are starting to take a community oriented approach. There is no question on the Fact Sheet that asks the plans if they are considering the community aspect of these conditions. Ms. Johns recommended HFP ask a community oriented question. Dr. Giammona agreed this is a good idea. She suggested HFP ask plans what community initiatives they are currently involved in as this would be a good way to address the stated health conditions. Ms. Johns recommended adding two questions:

- 1) What community initiatives are plans participating in?
- 2) What are plans doing to prevent and/or address asthma, obesity, and diabetes.

Ms. Watanabe updated ACQ members on the HEDIS measures for the 2010 measurement year to be reported in 2011. The Childhood Immunization Combination 2 has been retired so MRMIB will collect Combinations 3, 4, and 5. The adolescent immunization measure is the only new measure. NCQA is proposing that the commercial plans move to administrative method for well child measures. Ms. Ortega added that this would be an unfair comparison because FFS plans are very different from capitated plans.

Dr. Zaheer ended the discussion offering two suggestions:

- 1) HFP and Medi-Cal should create medication formularies to help at the provider level.
- 2) Plans should do secondary prevention by offering gym memberships in the local area.

8. Next Meetings

The next Advisory Committee on Quality meetings will be on Thursday, November 19, 2009 from 1:00 pm – 4:00 pm at the Department of Rehabilitation in Sacramento.