

MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of January 27, 2011

Committee Members Present: Lucy Johns, John Pescetti, Barbara Marquez, Barbara Mendenhall, Elaine Robinson-Frank, Terri Shaw, and Ellen Wu.

Committee Members Present by Phone: Alyce Adams, Alex Chen, Michael Cousineau, Mary Giammona, Hattie Hanley, Paul Kurtin, Ed Mendoza, Matthew Meyer, Ulfat Shaikh, Sonya Vasquez, and Aaron Zaheer.

Mercer Health & Benefits LLC Staff Present: Jennie Echols and Branch McNeal.

MRMIB Staff Present: Janette Casillas, Lilia Coleman, Dianne Ehrke, Heidi Holt, Donna Lagarias, Muhammad Nawaz, Shelley Rouillard, and Rachelle Weiss.

1. Welcome and Introductions

Dr. Kurtin opened the meeting and requested that everyone introduce themselves.

2. Review of Minutes from October 28, 2010 Meeting

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

3. HFP Updates

a. 2011 – 12 Governor’s Proposed Budget

MRMIB’s new Executive Director, Janette Casillas, discussed the Healthy Families Program impact in the Governor’s Proposed Budget. Three reduction proposals were proposed:

1. Subscriber premium increase for the highest income categories. Presuming this passes the Legislature by March 1, MRMIB would need approval from CMS before implementation because of Maintenance of Effort (MOE) provisions from the Affordable Care Act (ACA).
2. Increases in co-payments. A co-payment increase would raise the Emergency Room visit from \$15 to \$50 and inpatient hospitalization from \$0 to \$100 per day with a two day maximum. This proposal conforms to the Medicaid program, so if CMS does not approve the proposal for Medicaid, MRMIB would not implement it.
3. Elimination of vision coverage. CHIPRA mandates health and dental coverage but not vision. Coverage for eye infections and eye injuries would continue to be covered, but glasses would no longer be covered. VSP did a presentation of their proposal to the Board. VSP staff has proposed alternative ideas to reduce benefits without eliminating them.

Ms. Johns asked that if a subscriber cannot pay the co-payments, are they turned away, or is the debt taken on by HFP or the facility.

Ms. Casillas explained that the co-payment arrangement is between the provider and the subscriber's family. Healthy Families is not involved in collection of co-payments.

Dr. Kurtin inquired if there are plans to look at potential unintended consequences of raising the emergency room co-payments. Ms. Casillas said there are no such plans at this time.

Another budget proposal that would impact HFP was to continue what is referred to as the MCO Tax. The revenue generated from the tax on Medi-Cal Managed Care plans is used for various services provided under Medicaid and HFP. MRMIB received this funding in the current budget year and the federal government has permitted MRMIB to continue through the current year, but not beyond.

On January 26, First 5 gave Healthy Families \$81.4 million, which is needed to run the program until June 30, 2011. Because MRMIB will no longer receive the First 5 contribution, continuation of the MCO Tax money is critical to backfill the First 5 contribution. Eighty percent of First 5 funds come from the local county commissions and twenty percent comes from the State Commission.

b. 2011 – 12 Proposed Contract Amendments

Ms. Rouillard reviewed proposed changes to the 2011-12 model health plan contract, located on the HFP website at http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_011911/Agenda_Item_10.e.pdf. The main area of change concerned mental health. An evaluation of mental health and substance abuse services provided by HFP plans was done last year. The evaluation team conducted focus groups of parents in which they expressed difficulties with understanding how things worked, where they needed to go, and how they could get care for their kids.

Several recommendations were provided to MRMIB as a result of this evaluation. MRMIB has incorporated some of these recommendations into the proposed 2011-12 model contract. The resulting proposed mental health/substance abuse (MH/SA) related contract changes include:

- Provide more support to parents in navigating and understanding the mental health and substance abuse service systems within the plan and/or the county.
- Develop action plans for providing support to parents in the process of obtaining mental health care for their child.
- Track the time between referral to mental health services and first appointment.
- Report on mental health/substance abuse screening, screening tools being used, and the number of members screened.
- Coordinate care between plan MH/SA providers and/or county providers to help members navigate the systems.

Ms. Johns asked: What does MRMIB want the plans to do to get this information?

Ms. Rouillard answered that plans should educate parents on how to use the system effectively. Parents should be told what to expect during an assessment. Plans could compose literature for parents, add information to their websites, or provide information to help facilitate connection to care for a member who has been referred for MH/SA services.

Ms. Casillas added the majority of the plans stated they were already doing things to inform the parents around this issue. It was added to the contract, because it has been brought to our attention not all plans were relaying this information to their members.

Ms. Rouillard continued with proposed contract changes for health and dental plan contracts:

- Establish liaisons for health and dental contracts; i.e. health plans would designate a dental plan liaison to coordinate needed dental services and vice versa.
- Encouraging plans to make developmental screening tools available to providers. A flier that Maternal and Child Health developed announcing discounts on screening tools was sent out last year to the plans. It is not a mandate; MRMIB is encouraging the plans' providers to use the screening tools.
- Encourage pediatricians to educate parents about oral health. This is a first step toward better integration of health care and dental care, and the urgency for pediatricians to let parents know that children need to have their first dental visit by the time their first tooth erupts.
- Requirement for health plans to provide encounter data back to January 2008.
- Require plans to work with the External Quality Review Organization (EQRO) required by CHIPRA.
- Add reporting of two new HEDIS measures, Combination 10 for *Childhood Immunizations* and *Immunizations in Adolescents*.
- Dental plans will be required to show demonstrable improvement from year to year in their performance against a minimum performance level. This level was set to seventy-five percent of the HFP weighted average for each dental measure. If performance declines in any measure, the plan would be subject to six months reporting as well as conducting quality improvement strategies (what will be improved, how they will improve it, and in what timeframe). If performance doesn't improve, enrollment may be restricted or the agreement terminated.

These are all proposed contract changes and staff will be going back to the Board with the final model contracts in February.

4. 2009 HEDIS Report

Ms. Weiss provided highlights from the 2009 HEDIS Report. The report presents HFP weighted averages and individual plan rates for 2008 and 2009. The benchmarks used for comparison were the national commercial HMO averages and the national Medicaid HMO averages. Where the rates are available, HFP was compared against the state Medi-Cal Managed Care averages. Individual plan rates were compared against the commercial HMO 90th and 10th percentile rates.

In 2009, high performing plans, defined as at least five rates at the national commercial 90th percentile level for commercial HMOs, were Kaiser Foundation Health Plan - North and South, San Francisco Health Plan, and Alameda Alliance for Health. Lower performing plans, defined as at least seven rates or more below the national commercial 10th percentile were Blue Shield EPO and Community Health Plan. Overall, the weighted averages for HFP improved from 2007 to 2009. Nine of sixteen HEDIS rates were above the national benchmarks for Medicaid and commercial HMOs.

Ms. Mendenhall noted the Office of the Patient Advocate (OPA) does the Commercial HMO Healthcare Quality Report and contains a number of the same measures that Medi-Cal and HFP collect. OPA compares that report to Medi-Cal and HFP. The report will be released February 16, and the HFP and Medi-Cal data will be updated on the OPA website.

Ms. Weiss continued with a final note from the HEDIS report that HFP was lower than the benchmarks in *Chlamydia Screening in Women* and *Adolescent Well Care Visits*. Both measures have been below fifty percent since 2007.

In 2011, MRMIB will collect two new measures including the Combination 10 for *Childhood Immunization* and *Immunizations in Adolescents*.

5. Medi-Cal Managed Care Quality Improvement Program and Performance Measurement

Ms. Rouillard explained the focus of this meeting was quality performance and that Mercer was there to describe their role is assisting the State in preparing the CMS-required Quality Assessment and Improvement Strategy. In addition, HFP will take advantage of the Medi-Cal Managed Care Division's experience in doing a quality strategy. Rita Marowitz graciously agreed to orient the committee about what Medi-Cal has accomplished through their quality improvement strategy and to convey some suggestions and lessons learned.

Ms. Marowitz discussed the Quality Improvement Projects in Medi-Cal Managed Care. Medi-Cal Managed Care has a seventy-five percent federal fund match for these quality improvement activities. There are requirements in their plan contracts related to access, quality, and timeliness of care, Medi-Cal also looks at plan administration, structure, delivery of services, demographics, etc.

Medi-Cal primarily uses HEDIS measures to monitor quality performance. In 2012, new measures will be collected, and seniors and people with disabilities will be added as mandatory populations to report on. Some Medicare and Medi-Cal developed measures may be added as well. Plans are required to implement Quality Improvement Projects (QIPs). Consumer surveys cost about \$1.3 million and are conducted every other year. The plans are also required to have an information system that supports their quality improvement strategy. Medi-Cal has been required, for the last several years, to have an External Quality Review Organization (EQRO) do an objective review and validation, which has proven to be invaluable. The EQRO contract costs about \$2 million a year.

Because the EQRO audits every plan on-site to ensure that task and information systems are consistent with NCQA requirements, there is a high level of confidence in the results. The current EQRO provides technical assistance, conducts the CAHPS survey, writes an aggregate report, and validates all of the QIPs. The EQRO also conducts the plan's measurement report to make sure the QIPs are in compliance with federal requirements.

The EQRO developed a Quality Improvement Assessment Guide for the plans to use and posted it on the Medi-Cal website. The EQRO then verifies that plans' QIPs satisfy federal requirements. The EQRO reports quarterly, and offers improvement recommendations to the program and plans. In the three years Medi-Cal has used an EQRO, there has been tremendous improvement in the design and documentation of QIPs and HEDIS data.

The EQRO writes Medi-Cal's federally required technical report, which presents an overview on quality and access, and how Medi-Cal can improve. The EQRO also coordinates the Medi-Cal quality conference. Ms Marowitz cautioned that even a good EQRO doesn't know all the nuances of your particular program. Medi-Cal was in constant communication with the EQRO in the beginning, and they continue communication on a regular basis.

Medi-Cal rewards plans with default enrollment when they score higher on some HEDIS measures. The Medi-Cal HEDIS measures include *Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life*, *Adolescent Well Care Visits*, *Childhood Immunizations*, *Appropriate Treatment for Children with Upper Respiratory Infection*, *Prenatal and Postpartum Care*, *Breast Cancer Screening*, and *Cervical Cancer Screening*. Last year, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* was added.

New indicators are added every year. Diabetes care indicators were added last year, since diabetes is a chronic disease. Another measure was avoidance of antibiotics in adults with acute bronchitis. Medi-Cal can afford to audit about three more measures, and will probably move to some measures that won't be audited. There are no funds but there is pressure from the federal government and stakeholders to view more measurement and from various demographic groups.

A number of these measures use administrative data and are burdensome to the plans. Some measures require costly chart reviews. If the health plans are not given a rate increase, it is difficult for the plans to do more expensive requirements.

Ms. Wu commented UCLA did a study about whether default enrollment increased quality. Mr. McNeal added it was well documented that the default enrollment population tends to be healthier and less expensive.

Ms. Marowitz noted the general Medi-Cal default rate is about 20%. About 70% of the population choose plans and about 10% do not. Approximately ten percent are assigned to a plan because they were in that plan previously or have other family members already in the plan. Once seniors and people with disabilities are added, it will be interesting to see whether their rate of choice remains the same. Stakeholders have shared that these populations tend to be more involved and have a higher rate of choice than families.

Ms. Marowitz noted that Medi-Cal does not case-mix adjust their CAHPS results. Medi-Cal wants to be able to compare its results to national benchmarks and submit the results to the Nation CAHPS Benchmarking Database (NCBD).

Ms. Marowitz strongly encouraged the QIPs be consistent with federal protocol. CMS developed a tool kit that all of the plans should be using. Consistency will enable the plans to work with each other.

Some of the statewide collaborative Medi-Cal QIPs included reducing avoidable ER visits by 10%, improving rate of postpartum care visits, reducing asthmatic children's ER visits, increasing BMI documentation, improving cervical cancer screening among female seniors and persons with disabilities 21 – 64 years of age, and reducing risk and recurrence of stroke or TIA. All of the QIPs are posted on the Medi-Cal website.

Monthly, Medi-Cal monitors timeliness, percentage of errors, and the currentness of the encounter data submitted by the plans. Medi-Cal started with a 5% error threshold and now has a 1% error threshold. Most of the plans stay under the threshold.

Medi-Cal monitors utilization in different ways. The plans report on inpatient utilization, ambulatory care, and procedures. Medi-Cal used to monitor tonsillectomies, D&Cs, and ear tube placement. Medi-Cal discovered there was no problem with under or over utilization of these procedures, so other procedures were chosen from the limited Medicaid HEDIS measures. Medi-Cal used encounter data for utilization but is not doing a lot with results. There was not a strong sentiment that there was a problem; furthermore, there was not enough staff to do the work.

Ms. Marowitz noted some of the activities besides the quality strategy are the Annual Technical Report, which is an overview of how Medi-Cal monitors quality, access, and timeliness. Plans submit an annual QI program description, and report how they ran their utilization management program and other quality initiatives. Quality Awards are presented at the Annual Medi-Cal Quality Conference.

Speaking to patients about diabetes, asthma, and hypertension worked well but requires a large amount of money. Some plan requirements cause an undue burden such as reviewing medical records, which costs approximately \$35 per record. When asking a plan with multiple measures that require chart reviews, it should be kept in mind the total cost of the requirement.

Ms. Marowitz stated Medi-Cal has a Medi-Cal Managed Care Advisory Group that meets quarterly. The group consists of managers, plan medical directors, and stakeholders. Medi-Cal does not have an advisory group similar to the HFP Advisory Group on Quality.

Dr. Adams asked if the group of disabled patients required a different approach to measure quality, such as patient reported outcomes.

Ms. Marowitz stated that Medi-Cal had to do a lot of new things around care coordination and risk stratification for this population. For the first time, Medi-Cal shared fee-for-service utilization data, allowing plans to know the diagnosis and medications of their patients. The condition of getting the extra federal dollars was to cover that population and monitor performance measures. This allowed Medi-Cal to give plans data on their new members. There will be more customizing measurements for that population.

Ms. Rouillard noted Mercer will be working on aligning the HFP performance measures with the Medi-Cal performance measures for efficiency and resource purposes. Since the population for HFP differs from Medi-Cal, it may not be possible for all of the measures.

Dr. Giammona added when HPSM did the quality project, they did not differentiate between Medi-Cal and HFP. Sometimes the same child would be in both programs during that same year.

Dr. Kurtin noted that as providers are expected to do quality improvement, there is a debate on affordability. Only about thirty percent of the large scale change efforts were effective, lasting less than a year. In this model, what was the success rate, how many of the programs were hitting their targets, and how many were sustained over a year?

Ms. Marowitz noted in the quality improvement project, most of the projects that were well-designed achieved significant improvements. Generally as plans improve, they tend to keep improving and maintain that level; seldom do they improve and then fall back.

6. CHIPRA Quality Improvement Project

Ms. Rouillard introduced Branch McNeal and Jennie Echols from Mercer Health & Benefits LLC. MRMIB contracted with Mercer to assist in developing HFP's quality assessment and improvement strategy to meet CMS requirements. Mercer will also assist with the solicitation of the EQRO.

Ms. Echols asked the committee what the quality assessment and improvement strategy should contain.

CHIPRA is focusing its attention on quality and has provided funding for addressing healthcare disparities. As a result of the CHIPRA regulations, each state CHIP program that contracts with a Managed Care Organization will develop a quality strategy and procure an EQRO.

CMS developed a Tool Kit that outlined the mandated and optional activities of an EQRO. Mercer put together a Table of Contents. The topics in the Quality Strategy Overview Table of Contents are Introduction, Mission and Guiding Principles, Managed Care History and Impact, Quality Strategy Development, Quality Strategy Implementation, and Goals and Objectives.

For Mission and Guiding Principles, the mission is in place, but what would be the guiding principles?

Following the question, the committee had an active discussion around guiding principles and concluded that we should look at outcome measures over time, rather than just process measures.

Dr. Kurtin added the definition of health from the World Health Organization was not merely the absence of disease, but the state of improvement of the emotional and social well being and quality of life.

Some process measures are worthless if they don't tell anything about the outcome. Other process measures are helpful like an immunization rate. It is process measure; it was not an outcome.

With Chlamydia screening, it was thought that providers were talking to adolescents about risk taking behaviors. We don't know if that was true. We don't know if risk taking behaviors were falling or rising. Part of the challenges in pediatrics was fewer outcomes than in adults.

With asthma, days in the hospital was received throughout the system. It was hard to attribute responsibility, because some families would not take their children to get medication. Those children end up in the Emergency Department.

Dr. Pescetti added in pediatrics the outcomes were not always visible until age 18. Often the Pediatrician was not seeing the child at that age, but these issues around obesity and increasing rates of Type II Diabetes really starts when the child was in pediatrics. Pediatricians are separated from the outcomes by the nature of the field. There are surrogate measures to validate what the Pediatricians have done.

Ms. Shaw noted the area of focus would likely be the Prevention Process Measures and focusing on outcomes as much as possible including quality of life. Not just from a plan-by-plan perspective but from the whole population including geographic and various sub-populations.

Ms. Johns added that a preventable admission was a good outcome measure in the short term, since there were a lot of preventable admissions. With HFP decreasing rates by diagnosis for those conditions, it would save money. She further added that population based measures were needed while reducing disparities.

Dr. Giammona noted that MMCD medical directors came up with a list of the most sensitive ambulatory care Emergency Department conditions. Mercer may want to look at that.

Ms. Marquez commented the star ratings were used for the healthcare quality report card, and it got people's attention. It was an incentive and improves quality results. Many plans used the results to promote their services. Ms. Marquez noted OPA would be happy to share their experiences regarding public reporting and making the data useful.

Ms. Echols stated there was a section about the specifics of reporting. Should it be a driving principle that needs to be shared with stakeholders including consumers and providers?

Ms. Marowitz added an important thing to incorporate into the mission statement or objective was a commitment to ongoing quality improvement. One of the overarching goals should be a partnership for better ongoing quality improvement. It is not about who gets an A and who gets D or who gets four stars. It is essential to commit to a partnership between the people that makes ongoing quality improvements possible.

Ms. Echols noted the next item was deciding on objectives; there were very specific objectives that can and should be stated in the strategy. Percentile was discussed as an indicator for improvement. What are the appropriate benchmarks for HFP enrollees opposed to Medi-Cal enrollees? Is Medi-Cal a good benchmark? If so, is the objective of reaching the 50th percentile appropriate?

Ms. Marowitz added it is important that plans focus on improvement.

Ms. Robinson-Frank noted making a standard improvement goal was going to be tough, because if the plan was at the 95th percentile there may not be improvement.

Ms. Marowitz noted that being below the minimum on any measure means the goal was to improve.

Ms. Echols added maybe the plan has to show improvement over their lowest score until reaching the 90th percentile.

Ms. Johns suggested the HFP strategy should use a methodology that is sound for risk adjustment in order to do population based comparison.

Ms. Robinson-Frank asked if risk adjustment would get more equitable, so you could compare different populations.

Dr. Kurtin added it was about “my patients were sicker than yours”, which was why outcomes for my patients were not as good. He supports talking to an epidemiologist, but it is very hard to do. Most children don't have any chronic conditions. It is not like the average adult with many chronic conditions. That is really risk adjustment.

A couple of comments to think about would be to increase access to primary care or should it say every child deserves access to a medical home or a health home.

Ms. Marowitz added it can not only be about outcomes. Part of it has to be about how well your plans are doing year to year. Are the plans compliant? Are you getting what is expected? Maybe there are some measures that are not about outcome and quality, but about how well the plans are performing.

Dr. Giammona noted that CAHPS helps with that, because a lot of it has to do with are the children happy, are the members happy with the plan, are the members getting access to a doctor.

Ms. Echols added CMS sets measures that were recommended that included prevention, health promotion, management of acute and chronic conditions, and availability of care.

Ms. Echols discussed the measures currently aligned with CMS. The HEDIS measures currently reported may be a great starting point. If these can be tweaked, we could do a crosswalk with Medi-Cal and perhaps we would be on the right track to begin starting a list for your review of specific measures.

Ms. Marowitz noted to have some connection between the HFP measures and Medi-Cal Managed Care, there needs to be some coordination. Medi-Cal announces their measures every August and will be making some changes. These measures won't change; if MRMIB and Medi-Cal kept each other updated about our decision processes that might affect Medi-Cal's decision about the measures. Those decisions will be made by October with the medical directors.

Dr. Giammona noted HPSM was deciding what the next collaborative steps would be. Knowing what HFP was going to do collaboratively would be of assistance.

Mr. McNeal added in the longer term, overt coordination might look symmetrical with the timing and processes. Not that the measures have to mirror Medi-Cal, but it would make it easier to mirror if it was decided to.

Ms. Echols stated the important part of the strategy would be the quality improvement project. The quality improvement projects are usually written in the strategy and changed through the next cycle, since it is updated based on whether those QIP would be maintained or changed. There is a federal requirement for QIPs, but MRMIB has not received guidance yet from CMS.

Ms. Marowitz noted Medi-Cal sought guidance from CMS on the number of QIPs required. CMS said, “In the regulations, the QIP has an “s” on the end, so that means two.”

Ms. Echols noted for the quality strategy; the plans are giving feedback now. A draft will come out towards the end of February. The results of that draft will be circulated for review. A lot of the work will come when the measures are introduced. Mercer would like feedback about the measures

because that has to drive the EQRO procurement. There are some things the strategy has to have in place, so the EQRO that knows what to do and can write that correctly.

Ms. Marowitz asked when the plan requirements were to be released in their contracts.

Ms. Rouillard answered the 2011-12 contract speaks generally about the need to participate and work with the EQRO. The specific activities will probably be in the 2012-13 contract.

Ms. Echols added that the final draft will go to the Board and this committee, and then be posted for public comment. Most states post the drafts on their websites; MRMIB would post their first draft when it goes to the Board.

Ms. Rouillard noted the next ACQ meeting is in April, and if final draft is close to finished, staff will it send to the committee to follow-up this discussion.

Dr. Kurtin thanked the committee for their participation and noted the next meeting is April 28, 2011.