

MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of January 28, 2010

Committee Members Present: Alyce Adams, Mary Giammona, Lucy Johns, Ed Mendoza, John Pescetti, and Ellen Wu.

Committee Members Present by Phone: Alex Chen, Hattie Hanley, Moria Inkles, Mark Paredes and Terri Shaw.

MRMIB Staff Present: Dana Durham, Muhammad Nawaz, Shelley Rouillard, Mary Watanabe and Aiming Zhai.

1. Welcome and Introductions

Ms. Wu introduced herself as the facilitator and the participants introduced themselves.

2. Review of Minutes from November 19, 2009 Meeting

Ms. Wu called for the review and approval of the August meeting minutes. The minutes were approved.

3. HFP Update

a. Budget

Ms. Rouillard updated the committee about the Governor's proposed budget. The Governor has proposed a budget that assumes \$7.9 billion from the federal government (Option 1). If those funds do not come through, the budget proposes to eliminate HFP (Option 2). The Option 1 budget assumes that eligibility will be reduced from 250% FPL to 200% FPL. This would mean that about 203,000 children would lose coverage. The budget assumes that this would happen May 1st, but that would require that the trailer bill and budget are signed by March 1st.

The Option 1 budget proposes elimination of vision coverage at a savings of about \$10 million. MRMIB would no longer contract with vision plans but there are certain vision services that would be covered through the health plans such as preventive eye exams, treatment of eye injuries and infections. What would not be provided is glasses and lenses.

The Governor's budget also proposes to increase the monthly premiums in the category which covers children between 151% to 200% FPL. Premiums would increase from \$16 per child per month to \$30 per child per month. This

is higher than the current category "C" (over 201% to 250% FPL) premiums. The maximum family premium would increase from \$45 to \$90.

Mr. Mendoza asked if that accounted for the people who might drop out because they cannot afford the increase. Ms. Rouillard responded that she wasn't sure. She did note that last year the budget assumed some people would drop coverage, but that did not happen. Because of the economic situation, people may be doing whatever they can to keep their coverage.

The budget also assumes that First 5 is going to continue its commitment to the program. It assumes that the MCO tax will continue through the budget year. CMS has indicated they are not going to do anything regarding this tax until they promulgate regulations in the next federal fiscal year. The budget continues the changes that the Board made last November which raised co-pays for non-preventive services, brand name drugs, and emergency room visits, raised premiums, and the requirement that new children be enrolled in a dental HMO for the first two years.

Dr. Giammona wondered if MRMIB has thought about options for vision care such as whether grant funds would be available or if First 5 would cover vision care. She wondered that if the decision is made there is no money for vision care, there is no vision care at all.

Ms. Rouillard responded that there are discount glasses available through Walmart and other places. She did not know if private funds would be available for this.

Dr. Pescetti mentioned that he thought some health plans cover some vision benefits. For instance, Kaiser provides glasses. Ms. Johns asked if this benefit could vary by plan or by area or if it has to be a statewide benefit? Ms. Rouillard responded that a plan or area could provide the benefit but that the cost would not be covered by the State.

Ms. Wu asked if there have been any rollback of rates for the plans? Ms. Rouillard said the plans were told in preparing for the next contracting period, assume that there will be no rate increases for 2010-2011. The Board must live within its budget so if the Board decides to increase rates not as many kids will be enrolled.

If these proposals had not been made, MRMIB was projecting a 2010-2011 year end enrollment of over 1,000,000 kids. If all of these proposals go into effect then MRMIB is projecting about 824,000 kids enrolled at the end of the 2010-2011 benefit year. That figure assumes a growth rate of 8% over the benefit year.

The Option 2 budget proposal is very straightforward, so the committee did not see a need to discuss it.

Ms. Shaw pointed out that last year there was the wait list, the LAO has proposed increasing premiums instead of rolling back eligibility and considerations such as a wait list. Is there a reason that these budget proposals were put forth instead of the LAO suggestions?

Ms. Rouillard responded that this wasn't her area of expertise but that various options were carefully considered. MRMIB is making these evaluations with a heavy heart. Neither staff nor the Board want to make these considerations. They all would prefer that every child who needed coverage could have it.

Ms. Johns remarked on the work that has been done by MRMIB staff and wanted all present to acknowledge how many lives have been changed because of HFP. It is hard to ignore the remaining needs but staff needs to remember how many hundreds of thousands of people benefit. The committee agreed.

b. Plan Contract Language

Ms. Rouillard pointed the committee to documents related to proposed plan language. At the last meeting, staff proposed minimum performance levels for the 2010-2011 contract. Originally, MRMIB had proposed that plans report their HEDIS information by geographic region. In light of what MRMIB is trying to do with the Premium Discount Project and incorporating quality, staff thought it would be better to compare HEDIS results by geographic region rather than statewide data from the larger plans. MRMIB surveyed the plans regarding what it might cost to report by geographic region. When the plans indicated it would cost more than \$1 million, it became clear that there would be a significant financial burden in a time when there are no additional funds for increased plan rates. The HEDIS data will continue to be reported as it has in the past.

All of the standards for performance measures were taken out of the model contract. There is no minimum performance standard, goal, or benchmark. Fiscal restraints make this unfeasible at this point. There is work ahead to integrate quality performance measures in the future.

Next year's contract includes a requirement that health and dental plans submit encounter and claims data. This will give MRMIB a beginning point to understand utilization patterns within the HFP. CHIPRA requires, and CMS has clarified, encounter and claims data is required from the plans. That provision of federal law took effect July 1, 2009, so that is the date that MRMIB can get encounter/claims data going forward.

The Group Needs Assessment (GNA) remains in the contract. Staff is coordinating with the Medi-Cal Managed Care Division (MMCD) to complete one GNA for both product lines. Staff is working with a workgroup that MMCD has set up with various plan health educators to develop a GNA plan for Medi-Cal. Medi-Cal is in the process of developing its policy letter regarding the GNA. MRMIB's GNA policy and instructions will be similar. The GNA will be due September 30, 2011. The GNA will include not only cultural and linguistic needs and services there will be components that address health education. Health education has been part of the process for Medi-Cal in the past. Collaborating on the GNA process should make it easier on the plans and on MRMIB staff.

The HEDIS measures are the same except for the addition of Immunizations for Adolescents and Combinations 4 and 5 to the Childhood Immunization Status measure.

Finally, in the contract, there is a section on compliance with CHIPRA. As more information is available from CMS, MRMIB may have to amend the contracts to incorporate new directives. The contract states that this will be done with a 30-day notice.

Ms. Johns suggested that the work of the committee be published in a paper. This is a diverse citizen committee that has worked to improve health care quality for children by exploring how far to go and what should be done. It is clear that some of what we explored isn't financially feasible. However, the work of the committee should be preserved so that there is some record of the ground work that has been done to advance the state of the art in health care for children in this manner by this state program. The committee thought that was an intriguing idea.

Ms. Rouillard then stated that the work of the committee could be continuing in that MRMIB is in the process of creating a Quality Strategy that is a component of CHIPRA. She asked that the committee consider working to develop the quality strategy over the next year. The Quality Strategy would become the framework for the quality in HFP for the next three to five years.

4. CHIPRA Core Measures

Ms. Rouillard reviewed documents related to the initial core set of children's healthcare quality measures which were first released a few months ago. The final set released by CMS on December 29, 2009, is substantially the same. There are three measures that were in the initial core set that are not in the final. Ms. Rouillard led the Committee through each of the measures.

Action Item: Ms. Shaw requested that staff note which measures Medi-Cal reports. Ms. Rouillard said she would do that and send it out.

**a. “Frequency of Ongoing Prenatal Visits, Timeliness of Prenatal Care,”
“Percent of Live Births Weighing Less than 2,500 Grams,” and
Cesarean Rate for Low-Risk First Birth Women”**

The first four measures are about prenatal care and infant weight. In terms of frequency of ongoing prenatal care, there may not be a large enough population of women. Dr. Giammona agreed that the pregnant population within the health plans is too small. Some of the women may be eligible for Medi-Cal and that would make the number even smaller. The statewide plans might have enough volume but the smaller plans will not. The committee agreed that this was true also for timeliness, percent of live births and cesarean births. Dr. Giammona said that in the combination of Medi-Cal and Healthy Families there were only 12 babies born by weighing less than 2,500 grams. Ms. Johns wondered if the numbers were too small to collect in the HFP. Dr. Giammona stated that timeliness of prenatal care is a HEDIS number, whereas Frequency of Ongoing Prenatal Care is recorded as the utilization rate. The cesarean rate is not collected presently but it is likely that Medi-Cal will move towards collecting it. Ms. Watanabe pointed out that the measure related to cesarean rate was developed by the California Maternal Quality Collaborative. Ms. Johns thought it would be helpful to note on the matrix which entities collect data on these measures.

b. “Childhood Immunization Status” and “Immunizations for Adolescents”

These measures are already collected by MRMIB. There were no comments on these two measures.

c. BMI Documentation 2-18 Year Olds

Ms. Wu reminded the committee that BMI is not the greatest measure. Dr. Pescetti pointed out it is a good place to start. The question is often asked if BMI is too low a standard. The assumption cannot be made that BMI is being gathered everywhere. Dr. Pescetti further wondered if MRMIB could gather BMI information and suggested that BMI be substituted for either the HEDIS measure “Appropriate Testing for Children with Pharyngitis” or the measure “Appropriate Treatment for Children with Upper Respiratory Infection.”

Dr. Giammona raised the concern that this is a hybrid measure. Dr. Pescetti believes that CHDP gathers the information electronically. This is true but Dr. Giammona pointed out that the CHDP information does not meet the HEDIS standard because HEDIS requires not only the BMI assessment but also the percentile and whether counseling was provided. For HPSM it would cost

\$25,000 at a minimum to collect. Medi-Cal is now requiring this data but does not plan to collect it. Medi-Cal took away a hybrid measure when it added BMI. As a pediatrician, Dr. Giammona is very concerned about obesity and HPSM is looking for ways to combat it. The health plan has a pay for performance program that involves BMI and is working to get the physicians to fill out the information electronically. The plan has worked to create a form that meets all of the HEDIS requirements but it is still a work in progress. The ultimate goal is to make the collection of data administrative.

Ms. Adams asked for clarification on whether the measure asks if the information was collected or if it inquired about more information. There was some disagreement about what was being asked in the measure and the committee thought it would be good to ask for clarification regarding whether this is the HEDIS measure. Dr. Kurtin said that a couple of years ago this was looked at for the CHDP reporting. It was estimated that only 10% of children had a BMI measurement. Mr. Mendoza speculated that even though only 10% children having their BMI recorded, the recording of height and weight is probably more prevalent and the BMI could be calculated using those measurements. If this data is collected electronically, the BMI could be derived from the database. Dr. Pescetti said that you could get a percentage of patients that had a BMI of over 95% but it would not give information on the alertness of physicians to BMI so that they would trigger some sort of intervention. Dr. Giammona stated that the physicians with whom she works wanted a pay for performance (P4P) initiative to collect BMI. The P4P has helped to increase reporting.

Dr. Kurtin pointed out there is no standardization of how BMI is measured. In some places, children were being measured with their shoes on and weighed with their clothes on. It would be good to gauge this issue because counseling is triggered based on BMI. Obesity is one of the biggest issues that we are facing as a state and on down the line there will be huge costs involved. If BMI is too hard to gather because it is a hybrid measure that should be included in the comments, but the committee felt it was an important measure to keep.

Ms. Shaw wondered about the denominator in this measure. It is children age 2-18 who are continuously enrolled in the measurement year. In particular, she expressed interest in knowing how well all children were doing in this area. Ms. Shaw asked about the impact of churning on the data. Ms. Rouillard responded that a plan cannot be held accountable if a child hasn't been enrolled in the plan for a continuous period. When the plan identifies a problem, it is then up to the plan to address it. The results of the work materialize in the HEDIS scores.

Dr. Giammona stated that commercial plans get to use two years worth of data which is one of the reasons that commercial plans have better scores

than Medicaid plans. When the Medi-Cal data was looked at over a two year period, the data was actually better and approached the Commercial numbers. Ms. Johns suggested that there be a way to comment on the denominator, wondering if the change was a way to bring Medi-Cal and HFP more in line with the commercial plans.

A question was raised if this was true in other plans. Ms. Adams responded that data from Kaiser shows less churning in HFP than in CHIP plans in other states. When you get continuously enrolled data, you always get selection effect. Alternatives are requiring maybe 10 out of the 12 months or weighting could be done by the number of months. This does, however, complicate the calculation. The question, in the end, is what is the purpose of the measure? If the purpose of the measure is to compare across plans, then comparable data must be used.

Ms. Shaw noted that there is some discussion in the Federal Register about the purpose of the measure. Is it to measure plan performance? Is it to measure population health? The methodology that is being used does not capture the true health of the entire population. Ms. Shaw asked if MRMIB's comments were being coordinated with Medi-Cal. Ms. Rouillard responded that she will be talking with Medi-Cal about the measures.

Ms. Wu suggested that NCQA was a venue by which to comment and look at the issue. Ms. Adams is aware the NCQA is interested in partnering with plans. NCQA has released a white paper and is looking for partners to test issues related to measures. The committee encouraged participants to comment on the measures themselves if they are interested.

Ms. Johns reminded the committee that California is on an express train towards electronic records. The hybrid issue which takes up so much time currently will not be an issue in three to four years. Ms. Shaw reminded the committee that what will be driving the expansion of electronic medical information is the federal stimulus money which is based on the "meaningful use" standard. There are very few of these measures that are in any way reflected in the meaningful use measures. We may find ourselves with electronic health records and health information exchange that don't actually support the collection and tracking of this kind of data. It would be good for those who are having conversations about the HIT infrastructure to insert that concern into the conversation.

Ms. Rouillard asked for a definition of meaningful use. Ms. Shaw stated that the definition of meaningful use is in development and there is a proposed rule that is out for comment right now. CMS announced a notice of proposed rulemaking (NPRM) at the end of December, comments are due mid March. CMS will work towards finalization of the rule. Following finalization, it is up to each state to develop its own definition of meaningful use which has to at

least meet the federal floor but the state standard can go further and establish additional measures. There may be an opportunity to make sure that some of these types of measures are properly reflected in those requirements so that we are building the infra-structure and requiring technology to be used to meet these goals.

Dr. Giammona suggested that MRMIB contact Kim Ortiz, the acting director of the Medi-Cal programs integration with HIT, to talk about how HFP fits into the equation and comment on the definition of meaningful use. The committee members encouraged each other to talk about this issue in other settings so that it can be addressed in comments on meaningful use.

Ms. Shaw pointed out that another aspect of the federal rule is the standards for electronic health records. There is an open question as to how much detail these standards will entail and how much of a pediatric focus they will have. Even if there is an answer to this question overall concern exists as to whether providers will even use this tool.

d. “Screening Using Standardized Screening Tools for Potential Delays in Social and Emotional Development”

In its initial comments, MRMIB commented that the measure seemed promising. Ms. Inkelas believes that the standard is worded reasonably given the difficulty of accommodating different needs; not too detailed but not too vague. Dr. Giammona stated that she liked the measure but that HPSM does not have the resources to collect the information without more funding for the tool or to incentivize doctors to make an assessment. Ms. Rouillard stated that there is a discounted tool available. The Department of Public Health, the Material and Child Health section has been convening a screening collaborative which has negotiated a rate for these tools.

Action Item: Ms. Rouillard will send out a flyer that lists the screening tools and discounted prices for the State of California.

Dr. Pescetti remarked that the cost isn't related to the tool as much as the time to administer the tool and then to follow up regarding the outcome. Ms. Inkelas responded that this is a measure that if adopted, would prioritize giving doctors assistance in ways to mobilize resources and facilitate practice change. People will need to be persuaded that it can be done. There is evidence that it can be done.

Dr. Kurtin suggested that clarity be obtained around the word “screening” because something like the Denver developmental is very labor intensive while there are simpler tools, even parent administered tools, that can do screening.

Ms. Adams requested clarification on who, other than primary care providers, might be administering screening and how that data is captured. The committee responded that it may be happening in a regional center. Ms. Inkelas remarked that demarcating the difference between screening and assessment is important. This is for screening and not assessment. There are a set of tools that the AAP recommended for screening in a primary care setting and several of the screening tools are easier to use.

Dr. Kurtin said that in San Diego the First Five Commission has funded a separate developmental evaluation clinic where pediatricians can refer kids especially if the pediatrician has concerns. Hopefully the screening information is getting back to the physician but it is unclear if this information is getting back to the plans. Dr. Giammona said that in San Mateo children can be sent to the Packard Children's Hospital if a pediatrician has concerns. She is not sure that there is formal screening being done with a formal screening tool by primary care physicians.

e. "Chlamydia Screening in Women", "Well-Child Visits in the First 15 Months of Life", "Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life," "Adolescent Well-Care Visits" and "Appropriate Testing for Children with Pharyngitis"

MRMIB currently gathers this information from the plans. Dr. Pescetti wondered how administrative data is gathered for the pharyngitis measure. Dr. Giammona responded that this information comes from claims data.

f. "Otitis Media with Effusion"

Dr. Giammona clarified that the definition of "otitis media with effusion" was an ear infection with fluid. The committee wondered why the AMA was the group developing this measure. Dr. Chen said he participated on both of the groups when the measure was developed or commissioned. The difficulty with the measure for otitis media was that the experts could not come to consensus on how to diagnosis otitis media in the primary care setting. Dr. Pescetti wondered whether the measure was that it is treated with antibiotics or not treated with antibiotics. The consensus is that if it is a true otitis media, it should be treated with antibiotics. Ms. Rouillard commented that the specifications on the measure are the number of children who are not prescribed antibiotics. Dr. Giammona commented that it meant that the otitis is no longer acute. As a group, the committee agreed that there was no need to comment on this issue.

g. "Emergency Department Utilization"

MRMIB commented in initial comments that the measure should look at appropriate versus inappropriate utilization of EDS. MRMIB will reiterate

concerns on this measure. A discussion ensued regarding appropriate use of the emergency room and the understanding of avoidable and unavoidable visits. Medi-Cal uses the New York algorithm which separates out by diagnosis admittance to emergency room. Dr. Chen talked about the New York algorithm missing several of the diagnoses because of coding.

h. “Pediatric Catheter-Associated Blood Stream Infection Rates”

MRMIB cannot report on this measure because more than likely children who are in the hospital with catheters are carved out to CCS and neither MRMIB nor the plans have this data. Department of Health Care Services could report this data.

i. “Annual Number of Asthma Patients with >1 Asthma Related ER Visits”

Several physicians stated the larger question related to asthma is whether the patient is on a controller medication. Ms. Adams remarked that the HEDIS measure is a low threshold for measurement that being was a prescription given. The ER measure might just serve as a further indication of whether the kids are in control of their asthma.

The physicians expressed concern that there are too many variables related to ER visits for this to be a good second indication. It is probably a better idea to further refine the measure relating to controller medication. Dr. Giammona suggested that if HFP did a collaborative that it be on asthma because that is most likely the number one diagnosis that HFP children have. It would be advantageous to have an asthma registry. Managing asthma could generate cost savings because it seems that care related to asthma is very costly within HFP. Ms. Hanley concurred that asthma is a really good area on which to focus. There is great scientific evidence about how asthma can be better treated and the disease is traumatizing to children.

j. “Follow-Up Care for Children Prescribed ADHD Medication”

Dr. Giammona commented that much of the data is unavailable because the children with ADHD are served under the carve out to county mental health departments. Pediatricians in HFP are not treating the ADHD. Dr. Pescetti commented that some physicians do care for those with ADHD in the primary care office. The committee reached consensus that the information would be incomplete because of the carve-out. Dr. Pescetti wondered what the measure was trying to understand. Because of laws in California, a person receiving treatment for ADHD must actually see a doctor to refill a prescription. If prescription is not refilled, it is often because the parents are opting not to continue treatment and this does not necessarily reflect poor

care. Ms. Adams wondered if the issue regarding prescriptions was only in California. There was no definitive answer to this question.

k. “Follow-Up After Hospitalization for Mental Illness”

The number of children was too small to be meaningful when this measure was gathered in the past. Therefore, MRMIB discontinued using it and will reiterate that in its comments.

l. “Annual Hemoglobin A1C Testing”

MRMIB is unable to gather information related to “Annual Hemoglobin A1C Testing (children with diabetes) because diabetes is a CCS-eligible condition and MRMIB does not have the data.

m. “CAHPS 4.0 Survey with Chronic Condition Supplemental Items” and “Children and Adolescents’ Access to Primary Care Practitioners”

MRMIB hopes to conduct the CAHPS survey in 2010, but would need funding for it.

n. Non-CHIPRA Measures Collected by MRMIB

MRMIB provided the committee with the additional measures collected by MRMIB that are not part of the proposed core set. Ms. Watanabe commented that when CMS put their initial list together, they inquired about dental measures and MRMIB sent CMS the dental measures currently being collected.

o. Additional Comments

Dr. Giammona asked if the committee wanted to suggest adding anything about fluoride varnish. Children often have delayed access to dental care and it would be good to encourage fluoride varnish. HPSM pays \$18 above the cap rate to apply fluoride varnish. They worked with CHDP to market the program. The benefit was given three times in a year up to age six and the service was given to a group of children at a time. They are able to give the benefit to 80% of the kids that are in their plan. Dr. Pescetti commented that the ADA and the AAP recommended establishing a dental home by the age of one year. In his practice, all of the kids are referred to their dentists at one year and they get a fluoride varnish and a dental home is established.

Ms. Wu asked for any additional comments and added that CPHEN will comment on the need to look at disparities. Ms. Shaw asked if there was a concrete idea that could be used to strengthen the need to look at disparities. Ms. Wu said that some health plans commented that this could be looked at with administrative

data that is already being collected. MRMIB's initial comments were that information be collected by race, language and ethnicity in order to identify disparities in the population. The committee agreed that this was a good place to begin. Ms. Adams wanted the committee to note that the direction data is heading is that there are fewer disparities in the process measures but they are still occurring in the intermediate measures. For example if one has diabetes, one is less likely to have the condition under control if that person is Latino or Black.

Comments are due March 1. Ms. Rouillard is on a workgroup with the National Academy of State Health Policy (NASHP). NASHP will be submitting comments as well.

5. Premium Discount Project

Mr. Nawaz reviewed the Premium Discount Project. MRMIB has a statutory requirement to select one health plan in each county based on their use of TSN providers. He reviewed the process for selection pointing out that the current process has data integrity problems, is complicated and labor intensive. The California HealthCare Foundation has hired a consultant to help MRMIB revise this process. Margie Powers was in attendance at the last ACQ and has been conducting interviews with the HFP plans and stakeholders. She is in the process of writing a report on her findings.

While most plans desire to keep an emphasis on TSN, the current process is broken but has to be done until a new process is in place as a statutory change is required to make the designation in a different way. When looking at moving to incorporate quality indicators, it is clear that the data available is not comparable in that some plans report statewide data and others are county based. MRMIB is looking forward to reviewing the report findings and recommendations and sharing that information with the committee. Ms. Rouillard stated that MRMIB will be convening a work group of six plans to help make a TSN designation process feasible. The committee discussed the process and the difficulty of making changes even when they are necessary.

6. Encounter Data Update

Mr. Nawaz stated that the original encounter data project began in 2007 but stalled in 2008 due to the California Confidentiality of Medical Information Act (CMIA). CHIPRA 2009 gave MRMIB the authority to collect encounter data, so the project was restarted in September 2009. Maximus is building a data warehouse to store and receive the data. MRMIB and Maximus are working to put in place the pertinent privacy and data transfer agreements between MRMIB, the administrative vendor, and the health plans. Five health plans have agreed to function as pilot plans. Those plans will be submitting encounter data beginning in either March or April 2010. The pilot testing will continue through

the end of the year. By the end of 2010 all of the plans will begin to participate. Initially, MRMIB did not include dental plans in the encounter data process. However, MRMIB believes CHIPRA mandates that this be done and MRMIB will be working with the dental plans to bring them into the encounter data process.

Mr. Mendoza inquired as to what date data analysis can begin. Ms. Rouillard explained that the health plans will begin submitting monthly data by the end of this year. Plans will be phased into the process. The dental plans will start submitting test data in December. A year from now we should have enough data to analyze utilization in Healthy Families. Ms. Wu asked if this makes it easier to do race, ethnicity analysis. Ms. Rouillard responded that it does.

Ms. Johns inquired about the encounter data reporting.

Ms. Rouillard responded that Maximus developed the data dictionary and encounter data companion guide which describes the data elements that need to be submitted, how to submit it and other descriptive information. Ms. Johns wondered if that was proprietary. Ms. Rouillard responded that it wasn't and would be available if desired. However, the information is comprehensive, very technical and over 100 pages long. There will be standard reports generated and over time various ad hoc reports will be produced. MRMIB will look at diagnosis and procedure codes, all the demographics of the children, what drugs children are taking, how many days of hospitalization, and eventually MRMIB hopes to be able to use this information to generate HEDIS or other quality reports. The health plan data will be matched to the enrollment data and that will be stored in the data warehouse from which reports will be generated.

Mr. Mendoza wondered where the data is generated. Ms. Rouillard responded that the physicians report the information to the plans who in turn report the information to Maximus. She acknowledged there will be challenges and Ms. Watanabe responded that is why MRMIB is years away from using the information for HEDIS. Mr. Mendoza observed that the reports will be based on what the information shows. Ms. Wu expressed concern about some of the information being incomplete. Mr. Nawaz responded that there are standards for submission that will reject records if they are incomplete. Ms. Hanley expressed optimism about the process being able to show that care is being delivered for the money that is spent.

Ms. Giammona commented that the encounter data will be more developed for HPSM because they pay fee for service for HFP, as opposed to encounter data in Medi-Cal. HPSM gets only 20% of encounter data from its primary care providers because they don't have an incentive. For example, the utilization for adolescents is much higher in HFP than it is in Medi-Cal. Ms. Giammona suggested several ways of looking at the data for variation such as low income verses high income. Ms. Watanabe expressed concern over the ability to do this

analysis because privacy laws only enable us to analyze aggregate data and not individual data.

7. Quality Strategy

The David and Lucile Packard Foundation has given MRMIB a grant to hire a consultant to help MRMIB develop a quality strategy for the HFP which is a CHIPRA requirement. This is also a requirement for Medi-Cal. The solicitation will go to the Board in February. So far, the direction from CMS is to look at the Medicaid rules and procedures for developing a quality strategy. MRMIB has put out a request for interest to potential vendors and so far ten vendors who have submitted interest. MRMIB hopes to have a consultant in place June 1st. Ms. Johns wondered if these were nationwide or state based firms. Ms. Rouillard responded that those interested represented a mix of the two. There are two parts to the project. 1) to develop a quality strategy and 2) to manage solicitation for the EQRO which is an additional requirement for CHIPRA. Similar to Medi-Cal, there are three required activities that an EQRO has to do and there are five optional ones.

Medi-Cal released its updated quality strategy in December. That will serve as an aid in creating the strategy for MRMIB.

8. Future Meeting Schedule

Ms. Rouillard thanked the committee for the work that has been done over the past year. She requested that committee members consider continuing with the group for at least another year to form the basis for a multi-stakeholder group that gives input on the quality strategy and the members present agreed to do so. Ms. Rouillard requested that the committee suggest additional members. The committee specifically mentioned having a local health plan representative, a subscriber representative and a representative from NCQA to replace Lori Ortega who has taken a different position.

9. Next Meeting

The next Advisory Committee on Quality meeting will be held on Thursday, March 25, 2010 from 1:00 pm – 4:00 pm at the Department of Rehabilitation in Sacramento.

The meeting adjourned at 4:00 pm.