

MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of April 28, 2011

Committee Members Present: Rita Marowitz, Barbara Mendenhall, Ed Mendoza, John Pescetti, Terri Shaw, and Ellen Wu.

Committee Members Present by Phone: Alyce Adams, Elaine Robinson-Frank, Mary Giammona, Lucy Johns, Jennifer Lenz, and Aaron Zaheer.

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

1. Welcome and Introductions

Ms. Wu opened the meeting and requested that everyone introduce themselves.

2. Review of Minutes from January 27, 2011 Meeting

Ms. Wu called for the review and approval of the January meeting minutes. The minutes were not approved. The following amendments were offered at the meeting.

- Rita Marowitz and Mary Giammona were present at the last meeting.
- Barbara Marquez was not present at the last meeting.
- Page 8, paragraph 3, Lucy Johns said "Preventable Admissions".

Members with additional edits were invited to submit them to MRMIB. MRMIB will make final edits and send the final version to the committee.

3. HFP Updates

a. Budget

- Increase premiums for categories B & C for HFP.
- Increase copayments for ER visits from \$15 to \$50.
- Establish in-patient hospital copayments of \$100 per day with a \$200 (2 day) maximum copayment.
- Vision Service Plan worked on a proposal to keep vision services available and has submitted its proposal to the legislature, which the legislature has adopted.

The copayment changes will be implemented in HFP only if CMS approves them for Medi-Cal.

b. 2011-12 Model Contracts

Additional requirements for health plans:

- Educate parents how to access and navigate mental health services offered by HFP health plans.
- Establish a dental plan liaison to coordinate services when there are medical/dental issues.
- Inform providers about the availability of discounts on screening tools to assess developmental delays; report on activities to increase screening of young children.
- Educate parents on pediatric dental care and the need for dental visits at a young age.
- Provide historical encounter data from January 2008-forward.
- Cooperate with EQRO.

Additional requirements for dental plans:

- Establish a health plan liaison to coordinate services when there are medical/dental issues.
- Provide encounter data back to January 2008.
- Cooperate with quality improvement project consultants.
- Meet minimum performance levels for each of the 8 performance measures.
- Implement corrective action plans when plan does not meet minimum performance levels.

c. Outreach and Enrollment Grant

CHIPRA allotted \$100 million to outreach and enrollment activities, and \$80 million is going to states, local governments, and community based non-profits. MRMIB has applied for a \$2 million grant for using technology to facilitate enrollment and renewal. MRMIB is focusing on enhancements to the Health-e-app program, and specifically an interface with the IRS so subscribers won't have to bring in all kinds of documentation to prove their income. This will be available for new enrollments as well as annual renewals.

4. Quality Activities

a. Encounter Data

Mr. Nawaz reported that the trading partner agreements (TPAs) between Maximus and HFP health and dental plans are in place for all but two health plans and one dental plan. Some plans have already started submitting data. By June most health plans will be in the testing phase, and by the end of the year all plans should be submitting monthly data. Dental plans will begin submitting data in the 837 5010 format beginning in January 2012.

Ms. Marowitz noted that Medi-Cal Managed Care (MCMC) is conducting a data workgroup focused on improving quality of both encounter and financial data. The link is:

<http://www.dhcs.ca.gov/provgovpart/Pages/MMCDSB208DataWrkgrp.aspx>.

MCMC's biggest issue with data is one provider having multiple NPIs. Their other big issue is that some plans have poorly documented processes and procedures, so when a person leaves their position, the historical knowledge goes away too.

b. EQRO Solicitation

MRMIB will be submitting a solicitation for an independent External Quality Review Organization to conduct a quality review of the timeliness of and access to care, as well as quality of care received by HFP subscribers through the health plans. The scope of work for the EQRO includes:

- Validate performance measures.
- Validate and facilitate quality improvement projects.
- Compliance review.
- Validate encounter data.
- Conduct quality improvement projects.
- Provide technical assistance regarding the requirements of the EQRO.
- Develop a health plan report card.
- Coordinate an annual quality improvement conference.
- Conduct customer satisfaction surveys.
- Provide special consultative services to MRMIB as requested.
- Conduct focused quality studies as requested by MRMIB.

The timeline for contracting with the EQRO is as follows:

- Solicitation and contract will go to the board on May 12.
- Solicitation will be made available to potential vendors on May 16.
- Final response date for submission is June 15.
- The staff recommendation for the EQRO contract will go to the board on July 13.
- Contract effective date will be October 1.
- The contract is for one year with two additional one year options to renew.

The solicitation will be available on the MRMIB website after the board meeting on May 12.

c. Oral Health Quality Improvement Project

- Project funded by California HealthCare Foundation and Title XXI.
- MRMIB contracted with the Center for Health Care Strategies (CHCS) to facilitate the project.
- The project began in July 2010.
- Oral Health advisory board made up of practicing dentists, state dental officials and national academic experts in oral health.

To improve access to diagnostic, preventive, and treatment services for HFP children MRMIB, CHCS, and the HFP dental plans created a change package with following goals:

- Focus on young children ages 0-7.
- Increase the number of children with source of regular and continuous dental care.
- Increase the number of children aged 24 months who see a dentist.
- Improve coordination and integration of medical and dental services.
- Identify high risk children.
- Increase the number of young children who receive fluoride varnish.

The goals achieved by working on these components:

- Provider engagement through training and incentives.
- Patient self management and family education through outreach.
- Community engagement with entities such as WIC and First 5.
- Payment and alignment of incentives, by developing performance standards.
- Measurement and accountability by collection and reporting of data to MRMIB.

MRMIB, CHCS and dental plans are initiating a pilot project in four counties-Los Angeles, San Diego, Santa Barbara, and Ventura.

To evaluate dental plan performance, MRMIB and CHCS have developed a data collection tool. Plans will report data quarterly. The following measures will be studied for children ages 0-7:

- Rate of year-one dental visit.
- Rate of overall utilization of dental services.
- Rate of preventive dental services.
- Rate of exams and oral health examinations.
- Rate of treatment and prevention of caries.

d. Consumer Assessment of Healthcare Providers and Systems (CAHPS), Dental-Consumer Assessment of Healthcare Providers and Systems (D-CAHPS), Young Adult Health Care Survey (YAHCS)

CAHPS, D-CAHPS, and YAHCS are surveys being fielded this year to HFP parents and adolescents to get feedback on how they view the timeliness and quality of their health care experience. DataStat, the company hired to do the surveys, will complete the CAHPS reports for the health plans in July and the D-CAHPS reports for the dental plans in August. YAHCS, the adolescent survey, will have an option for completing the survey on the internet. The surveys are sent to parents in their preferred language - English, Spanish, Chinese, Korean, or Vietnamese.

A question was raised about why Medi-Cal Managed Care doesn't do these in five languages. Rita pointed out that the NCQA has only certified the English and Spanish versions, and that because their plans are NCQA certified, and want to be compared nationally, they use only NCQA-certified surveys. It was also pointed out that 20,000+ surveys for HFP are going out right now in California, and CHIPRA will be requiring it annually beginning in 2013, and NCQA should certify the other languages. Jennifer Lenz from NCQA offered to follow-up with their staff to get an update on the status of CAHPS survey development in other languages.

The group also briefly discussed the limits of stratifying these surveys by demographics such as preferred language because of the small sample size.

e. Quality Assessment & Improvement Strategy

CMS now requires State CHIPs to develop a Quality Assessment and Improvement Strategy (QAIS) to ensure that managed care organizations deliver quality healthcare. The QAIS requires health plans to conduct quality improvement projects in areas where the state as a whole, or a plan in particular, falls behind in some aspect of their quality of healthcare or delivery. CMS also requires an external quality review organization (EQRO) to, at a minimum; oversee three components of the QAIS: plan compliance to state and federal laws, validation of performance measures reported by the plans, and validation and oversight of quality improvement projects (QIPs) initiated by the plans and by the State.

The Healthy Families Program is developing its QAIS, and at this ACQ meeting, is beginning the conversation about specific issues and actions with promise to improve the quality of healthcare for our children.

The first discussion centered around basic definitions of quality and access to care, and members of the group suggested MRMIB use as guiding principles the Institute of Medicine's six aims for health care delivery re-design: that it be safe, effective, patient-centered, timely, efficient, and equitable.

The next discussion centered around connecting encounter data, which is required from health plans serving CHIP programs, to better outcomes. The challenge will be to tap into electronic health records (EHR) and health information exchange (HIE) and aggregate data for use in informing and driving quality improvement that leads to better health outcomes. What data connects to better outcomes? There are many efforts using randomized trials with extended time studies, and comparative effectiveness studies to try to link operational health care with better outcomes. Some things are more obvious than others. Immunization was brought up as an example of something with a very strong connection to a healthy outcome.

The possibility of incentives was raised, as it has been used in prenatal programs. A pay-for-performance program for diabetes management was described by Mary Giammona, where physicians were made aware of their diabetes patients with no lab tests on record, or how many of their patients had A1cs that were too high. Dr. Giammona commented that the only way her plan gets quality data is through a pay for performance program.

It was again pointed out that data would be measuring access, process, and utilization, but not quality. Also brought up was the desirability of having a strategy with both immediate, short-term improvement elements and efforts that support forward-thinking, long-term goals. MRMIB does not need to start from scratch. There are many lessons that have already been learned.

MRMIB's immediate task is to come up with one topic for a Statewide QI effort. Each health plan will also come up with a topic for its own improvement efforts – something they (or MRMIB) have identified as an area needing improvement. It was pointed out that if the analysis starts from HEDIS results, it will be best to look at those with the greatest variation, and where California is below a national average. Since CAHPS is being fielded yearly now, that is another source of data MRMIB can use to determine areas needing improvement.

The next discussion centered around evaluation of services for various groups by race and ethnicity. Access to health care through HFP by looking at enrollment demographics is one way to examine equity. Another is what level of care kids are getting in various areas. HFP may, as a whole, be doing great on immunizations, but if we dig deeper, we may see Hispanic kids doing better and African American kids not. Then plans can develop strategies to reach out to the African American community and be sure they're protected for Pertussis, for example.

A final discussion involved costs, and how simple strategies or low-cost changes might be very effective. Since Medi-Cal Managed Care plans have considerable overlap with Healthy Families and both serve children, the question was raised as to whether a plan already with an improvement project in place could use that for its Healthy Families population. It was agreed that if the QIP was relatively new, and data included Healthy Families in an area needing improvement, we could not see any reason why not.

Referrals and connection to services such as mental health, was brought up as a question – will MRMIB see that information in the encounter data? Yes, if the mental health service is in the plan's data, MRMIB can link that service, and even count how many services, and when. Referrals, maybe not. A doctor making a referral that never materializes can't be collected or reported through the encounter system. MRMIB has received historical data from two plans and is in the process of getting that data. This will help MRMIB know how many linkages of this type there are.

The quality of encounter data was raised. MRMIB's experience with hybrid HEDIS measures (those that may be reported from administrative or chart review data) is that overall, about 1/3 of the data reported is being drawn from chart review.

Meaningful Use of EHR data was discussed as a driver for better data collection and use. The money connected to it might be a useful incentive to drive improvement. If the Statewide QIP was related to meaningful use, Healthy Families may be able to leverage this federal effort.

The immunization registry in California was discussed. There is a need to make the immunization registry and information network more robust. There is clearly much room for improvement, and it's not ready for use on a large scale - in some places it's more ready than

others. Dr. Giamonna expressed frustration that California's registry does not interface with EHR.

Several final comments on selecting a Statewide QIP were:

- Involve the health plans.
- Get ideas from HEDIS measures.
- V-codes from encounter data are a valuable resource.
- Evidence-driven is more important than a popularity contest.
- Find key issues, e.g. Pertussis;
- Or key populations, e.g. adolescents.
- Numerous reports have come out this year specifically on California's children that can serve as a valuable resource
- There are 20 or so Meaningful Use elements and there may be something there we can use – look not only at Stage 1, 2, 3 but also at the strategic plans.

Good-byes from the members were extended to Rita Marowitz, retiring from Medi-Cal Managed Care, with sincere appreciation. And thanks to the committee for its contributions today.

5. Next Quarterly Meeting

Thursday, July 28, 2011, 1:00-4:00pm