

MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of May 28, 2009

Committee Members Present: Aaron Zaheer, Mary Giammona, Lucy Johns, Ed Mendoza, John Pescetti, Elaine Robinson-Frank, Rita Marowitz, Hattie Hanley, Lori Ortega, Teri Shaw, and Ellen Wu.

Committee Members Present by Phone: Joseph Scherger, Mark Paredes, Ulfat Shaikh, Paul Kurtin, Alyce Adams, Alex Chin, and Mathew Meyer.

MRMIB Staff Present: Jeanette Lopez, Shelley Rouillard, Dana Durham, Muhammad Nawaz, Cristal Schoenfelder, and Raymond Titano.

1. Welcome and Introductions

Ms. Wu introduced herself as the facilitator and introductions were made. Ms. Rouillard announced new staff person, Raymond Titano. Ms. Rouillard also recognized and congratulated Paul Kurtin for receiving the National Initiative for Children's Healthcare Quality's Bergman award.

2. February 5, 2009 Meeting Minutes

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

a. Action Item Review: Best Practices in Adolescent Care - refer to handout

Paul Kurtin described the results of the conference calls with the highest scoring plans (Central Coast Alliance for Health, Health Plan of San Mateo, Kaiser, and San Francisco Health Plan) regarding best practices in adolescent care. Plans were enthusiastic about talking with us and proud of their work. High level points include the following:

- All four plans treat teens as a group regardless of payor.
- Three strategies seemed to be most successful:
 - notifying the teens of appointments
 - getting them to show up for appointment
 - making visits most effective by having providers ready to discuss issues.
- Three out of four plans provided incentives for teens such as movie tickets, raffle drawings for bikes, and gift certificates.
- Some plans give providers \$20 - \$90 monetary incentives for teen visits.
- Training providers to increase their comfort in talking to teens.
- Adolescent toolkits for providers.
- Bi-lingual and bi-cultural providers and office staff.

- All plans participated in a previous Medi-Cal Managed Care adolescent collaborative and were interested in sharing best practices with other plans.

Lucy Johns asked about the length of time for teens to get in for appointments and no show rates.

Medi-Cal has seen a continuous upward trend though progress is slow. Incentives have worked well. One member recommended texting which works better than e-mail with this population.

b. Action Item Review: AAP Standard of Care

Paul Kurtin reviewed AAP's standard of care regarding the 9-month well child visit. Some providers skip this visit because it is not tied to any immunizations. However, the AAP strongly recommends this visit because 6 months between the 6 to 12 month visit is too long given the rapid development at this age. The 9-month visit provides an important opportunity to evaluate and check for any developmental delays.

Low scores in the Well Child Visit measure that includes the 9 month visit might be due to data collection errors. Ms. Rouillard mentioned that this Well Child Visit measure does not delineate by specific age, it only represents visits for ages 0-15 months combined.

3. Healthy Families Program Update

a. CHIPRA

There is nothing new to report and MRMIB is still waiting for guidance from CMS.

b. Budget

Ms. Lopez noted that the Governor's May revision to the 2009-10 budget ("May Revise") eliminated the Certified Applicant Assistant (CAA) fees effective November 1, 2009. It also reduces program eligibility from 250% to 200% of poverty effective January 2010. One third (225,000 children) of the total HFP population would have to be reassessed and this would be done by the administrative vendor during the Annual Eligibility Review process.

Ms. Lopez noted that in addition to the General Fund decrease, there is a decline in Prop 99 funds. This affects AIM (reduced about 8% which would mean closing new enrollment as of midyear), MRMIP (reduced about 8% which would mean keeping current enrollment cap), and eliminates funding for CAHPS/YAHCS surveys and RHDP grants.

Ms. Lopez added that today, the Governor proposed eliminating the HFP. Ms. Rouillard stated this would mean a \$330 million General Fund savings if the program was shut down. The Legislative Analysts' Office recommended some other ways to reduce program costs such as implementing a copayment increase, a \$1,000 per subscriber dental cap, an \$8 - \$13 per month premium increase for subscribers at or above 150% FPL, and an AIM eligibility deductible provision. Ms. Lopez concluded by saying that there are many people advocating to keep HFP and MRMIB will remain optimistic.

c. Community Provider Plan (CPP) Redesign

Ms. Rouillard briefly described the CPP designation process and noted difficulties in MRMIB getting accurate data from DHCS. She mentioned the possibility of redesigning the process so that the focus is more on quality and not only on the Traditional and Safety Net (T&SN) providers. Lucy Johns asked who would be unhappy if this changed. Ms. Rouillard responded that clinics might be unhappy. She mentioned that the reason for the initial design was to encourage plans to contract with providers and clinics in order to provide continuity of care. The T&SN providers expressed concern about losing patients because the HFP model was based on contracting with private managed care plans and not directly with T&SN providers. Ms. Rouillard mentioned that the CPP has had its desired effect of encouraging plans to contract with T&SN providers because the process has gotten very competitive. She added that there is a CHIPRA requirement to implement the Prospective Payment System (PPS) whereby clinics get reimbursed actual costs for services provided to HFP members which should give even more incentive for plans to contract with clinics.

Mary Giammona said that including a quality component would be good, but the safety net provider component should also be kept. Ms. Giammona noted that the NCQA quality measures do not take into account who the members are and added that Healthy Families members are more similar to Medi-Cal members than to commercial members. She noted that 30 percent of providers in her plan (Health Plan of San Mateo) do not have computers.

Discussion commenced on how Kaiser might possibly excel in quality measurement due to their electronic ability to collect data, whereas other plans would not have the same capability. This could be an unfair advantage. Lucy Johns noted that the safety net is very important and it would be a strategic mistake to disregard it. Ellen Wu noted that the safety net provider preference was more important ten years ago and questioned whether this still needs to be addressed in the CPP process. Terri Shaw noted that safety and quality are not mutually exclusive. She added that electronic health records and other technology may improve data collection and noted that the state is actively engaged in developing Health Information Exchange (HIE), EHR (electronic health records) and other technological advances through the ARRA.

Other committee members noted that the choice isn't between quality and T&SN providers. Paul Kurtin noted that T&SN providers often do better on cultural and linguistic issues and should also be better at reducing disparities. He noted that it's important to broaden and enrich how quality is defined.

Ms. Rouillard concluded by saying MRMIB is taking a first step in looking at how to improve the process and is requesting outside assistance to explore this issue further.

d. Rural Health Demonstration Project (RHDP) Solicitation

Ms. Rouillard noted that the money for the RHDP has been taken out of the May revise so this was not presented to the Board.

e. Contract Amendment Timeline and Committee Role

Ms. Rouillard noted that one of the goals in creating the ACQ was to come up with contract language for the upcoming contracting period. She outlined the timeline for members and added that discussion about any potential changes should take place at the July ACQ meeting. Lucy Johns asked if this timeline could be shared with members. Ms. Rouillard agreed to provide it. Discussion commenced about focusing in on MRMIB's priorities and keep requests for additional information to a minimum in order to not over-burden the plans.

Action Item: MRMIB to send Contract Amendment Timeline to ACQ members.

4. Plan Performance Profiles & Plan Recognition

Muhammad Nawaz discussed the 2007 Plan Performance Profiles. The information included in the profiles includes each plan's HEDIS, CAHPS, YAHCS, enrollment, and medical loss ratio information. The dental plans' information included the D-CAHPS and Annual Dental Visit (HEDIS).

Plan Recognition was based on aggregate HEDIS, CAHPS and YAHCS results. MRMIB performed a cluster analysis to identify the health plans that were ranked superior, above average, average, below average, and poor. The Board gave awards to plans in the superior category at the May Board meeting last week. Shelley Rouillard noted that this was used to acknowledge the plans' efforts and also to drive improvement. She noted that in the future the Board would also recognize plans that made significant improvement. Lucy Johns recommended looking at more than just HEDIS to evaluate quality.

5. Potential Quality Improvement Areas

Ms. Rouillard asked the Committee for their thoughts on the kinds of quality improvement projects MRMIB should undertake. Rita Marowitz asked if the expectation is that all plans engage in the same project or if they could use their existing projects. Contractually requiring this would also mean setting up a structure

for monitoring the projects. Ms. Marowitz suggested asking the plans to identify what projects they are already doing as a starting point. This would give MRMIB more time to determine the objectives of the QIPs.

Discussion commenced on how best to proceed with potential quality improvement projects such as those described below. Mary Giammona suggested contractually requiring plans to be involved in a collaborative where plans share best practices via conference calls. Joe Scherger suggested moving from reactive care to strategically proactive care. Lucy Johns noted that HFP is already a good program that provides excellent care to children and perhaps MRMIB does not need to come up with something new at this point. Discussion continued on the Electronic Health Record and use of registries as a possible contract addition.

- a. Health Disparities
- b. Developmental Screening
- c. Adolescent Care
- d. Obesity
- e. Access to PCP
- f. Other ideas - Committee members noted asthma as a measurable health topic for the HFP population.

6. Next Meeting

The next Advisory Committee on Quality meeting will be on Thursday, July 30th from 1-4 at the Department of Rehabilitation. Topics to discuss include measures for the 2010 Contract Amendment, Fact Sheet revisions, C&L Survey and QIPs.