

MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of June 3, 2010

Committee Members Present: Lucy Johns, Ed Mendoza, Donna Trinchera, and Ellen Wu.

Committee Members Present by Phone: Alyce Adams, Jennifer Benjamin, Mary Giammona, Moria Inkelas, Paul Kurtin, Mark Paredes, John Pescetti, Elaine Robinson-Frank, and Terri Shaw.

MRMIB Staff Present: Dianne Ehrke, Muhammad Nawaz, and Shelley Rouillard. Later Lesley Cummings and Jeanie Esajian joined the meeting.

1. Welcome and Introductions

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

2. Review of Minutes from January 28, 2010 Meeting

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

There were some follow-up items from the last meeting minutes:

- The comments on the CHIPRA Quality Measures and the Screening Tools and Discounted Prices for Early Assessment Developmental Screening flyer were sent to the committee members.
- Dr. Giammona commented on the March 10th letter sent to the committee. She thought MRMIB captured the committee's comments very well and wanted to express her appreciation for MRMIB's work. Ms. Rouillard thanked her and the committee for their input on the quality measures.

3. HFP Update

a. Budget update

Mr. Nawaz updated the committee about Access for Infants and Mothers (AIM), HFP, and the Major Risk Medical Insurance Program (MRMIP). The year end projections for HFP show there is an estimated 6% increase in members despite the increases in premiums and co-payments. This means 55,000 children will be added in HFP this year resulting in 965,000 enrolled children by the end of the year. AIM and MRMIP enrollments are estimated to remain the same.

With the passage of Health Care Reform and the maintenance of effort (MOE) requirement, states are not allowed to decrease benefits, change benefit structure, or eligibility requirements. S-CHIP funds are connected with Medicaid funds, and it doesn't appear MRMIB will lose any HFP funding.

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The Senate budget committee rejected the Governor's proposed increases in premiums and co-payments. MRMIB is waiting for guidance from CMS as to whether these increases violate the MOE requirements. Both the Senate and Assembly budget committees have rejected the elimination of the HFP vision benefits; MRMIB will be negotiating with the vision plans.

Implementing the CHIPRA quality standards includes MRMIB being able to receive health plan claims and encounter data, as well as developing a quality strategy and contracting for external quality review. This will require MRMIB to hire more staff. At this point, there is funding in the budget for meeting these requirements and other Medicaid managed standards such as the CAHPS survey.

Dr. Giammona, of Health Plan of San Mateo (HPSM), stated their primary care physicians (PCP) are seeing fewer HFP children. This may be due to the increase in co-payments. Many of their HFP families have several children per family; the increase in co-payment cost will result in decreased visits. One of the PCP's has seen a significant drop in HFP children. HPSM calls the HFP families to remind them to bring their children in for a visit; they say the high cost is the prohibiting factor to visit the PCP. Ms. Rouillard believes it is important to do the CAHPS survey this year, so MRMIB can understand the reaction to the increases in costs to these families.

Lesley Cummings, Executive Director of MRMIB, joined the meeting. She expressed her thanks to the committee for their continued support of the HFP.

Dr. Kurtin mentioned several years ago, Kaiser studied the impact of raising co-pays on ED visits. He stated the low acuity visits were the visits most avoided not high acuity visits. A well child visit could be classified as a low acuity visit. Will the survey show us the amount of visits per child? Will it show an average? Will it show any well child visits that were missed? MRMIB will know more when we are able to get encounter data. Ms. Adams commented that Kaiser would be analyzing if children with increased co-payments have decreased their visits compared to those children who did not have an increase in co-payments, as well as the types of visits and services the children are being seen. She will share the results with the committee.

The Governor's May revise included an increase in the ER co-pay to \$50/visit and inpatient hospital days to \$100/day. These were not adopted by the budget committees. Until the budget is signed, MRMIB will not know the outcome.

Mr. Nawaz noted that there is funding for the CAHPS survey. The survey will be administered in five languages. The budget also anticipates First 5 to give HFP \$81.4 million for the 2010-11 benefit year, as they did last year. It is in the budget, but First 5 has not officially stated they would donate the money.

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b. Benefits Research project

The California HealthCare Foundation (CHCF) is funding a HFP benefits research project to look at the benefits in HFP and ways to save program costs. The Board wanted to research what other states are doing. CHCF hired Deborah Kelch and Mercer Health & Benefits LLC (Mercer) to conduct the research.

Mercer looked at data for commercial and Medi-Cal populations, because HFP does not have encounter data. Mercer expects the HFP experience would fall somewhere in between the commercial and Medicaid. Most of the spending in the HFP is for outpatient services.

The report noted the minimum benefits the federal law requires in CHIP. Some of the services not required by the federal law are required by state law making changes to reduce benefits to the federally required benefits would entail HFP plans getting an exception from the Knox-Keene Act. The cost savings would only be 1.1% of the total HFP capitation rate.

Mercer also looked at annual or lifetime benefit caps. A \$200,000 annual benefit limit would save only about 2% of the capitation rate or about \$7 billion in General Funds. Vision, dental, and mental health services were not included in this analysis.

An alternative benefit design was examined. This could include service-specific dollar or utilization limits such as limits on number of office visits or inpatient hospital days. In general, most states do not currently have these types of limits.

Mercer also looked at cost-sharing and the 5% threshold. Families in CHIP may not spend more than 5% of their income on the combination of premiums and co-pays. HFP has a \$250 annual co-payment maximum. Currently the HFP's cost sharing for Category B ranges from 3.10% of family income for one child to 3.21% for three children. Category C ranges 2.65% of family income for one child to 3.06% for three children. The governor's proposal for Category B premium increases would result in higher percentages of family income being paid for premiums and copays from 3.86% for one child to 4.73% for three children. For Category C families the range is from 3.39% for one child to 4.53% for three children. This raises some concerns since CMS has indicated each family should to be notified of their out-of-pocket maximum. MRMIB is trying to keep below the 5% threshold to avoid notification administrative costs. Mercer included there is room to raise premiums and co-payments and still remain below the 5% threshold. It is not what MRMIB wants to do, but it is the Governor's proposal. This would save the State approximately \$8.8 million.

Mercer also examined the potential for pharmacy savings. Mercer contacted some of the largest HFP participating plans and found all of the plans have generic drugs available, drug formularies, and discounts on wholesale prices. Mercer concluded that the plans were already doing a good job managing their prescription benefits, and therefore there is no potential savings in this area.

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The final report will be posted on MRMIB's website. Due to the minimal savings associated with the proposed changes, the Board stated they would not implement any of the proposed changes.

c. Regulations modifying mental health benefits and establishing a new benefit year

The Board adopted regulations to extend the 2009-10 HFP benefit year for three months, ending September 30, 2010. Subsequent benefit years will start October 1st instead of July 1st. The reason for the change is to give the Board more information regarding the budget status by delaying rate decisions until after the May revise. Currently, the Board makes rate decisions before the state has updated budget figures.

The regulations also prorated in-patient and out-patient mental health visits, chiropractic, and acupuncture visits. The 2009-10 dental cap was prorated to \$1875 instead of \$1500; the \$1500 cap will return in the next benefit year beginning October 1, 2010. The co-payment annual cap will remain at \$250.

The regulations also clarified HFP plan's responsibilities to treat children with mental health or CCS conditions if the County can not serve the child. If plans have problems with children being served by the County, they have been instructed to inform MRMIB.

d. CCS redesign

Paul Kurtin updated the committee on the CCS redesign project. The two important parallel processes with CCS are the Medicaid 1115 waiver and CCS program redesign. The CCS redesign is due to increasing rate costs making the program unsustainable. The rise of cost is greater than the rate of enrollment; it is unclear why this is happening. We don't know if it is due to the rise in prescriptions or NICU care. A Stakeholder group is looking at the future CCS model. Another group is looking at the principles of CCS as it moves forward, so they can advise CCS as the models are being talked about, and looking to make sure the guiding principles are adhered to. In a recent stakeholder meeting, principles were being prioritized; three principles came out on top.

- Patients have had a problem with accessing health care.
- The new program should treat the whole child, not just the CCS condition.
- Patients establishing a Medical Home. Although most of the CCS families feel they have a Medical Home, about one-third do not have one. Children with chronic conditions or special needs will benefit from having Medical Homes.

Another topic discussed was the conditions CCS covers. CCS is considering revising the covered condition's to those that have duration of at least 12 months. This would exclude some conditions that require only one surgery such as a broken bone. Although diabetes

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currently is a CCS-eligible condition, stakeholders recognize that primary care physicians can treat this condition.

The Stakeholder group is researching CCS delivery models. The CCS delivery models are: Enhanced Primary Care Case Management (EPCCM), Provider-Based Accountable Care Organization (ACO), and Specialty Health Care Plan (SHP). The Working Group, children's hospitals, specialists, and advocates are working with the CCS program on the delivery models. Almost all of the models are being proposed to be tested. A robust evaluation project must be done to know which of the pilot models to propose to the counties for testing.

The Medicaid 1115 Waiver will be submitted in July which will allow the State to organize and pay for services in a different way than they are now.

4. Health Care Reform

a. Impact on HFP

Ms. Rouillard updated the committee on federal health care reform. The legislation reauthorizes CHIP through 2019 and continues the funding through 2015. There will have to be another appropriation from Congress for the last four years of the program. Beginning January 1, 2014, there will be the state-based health insurance exchanges where people will buy insurance if they do not already have it. It is uncertain how California will structure the exchange.

Medicaid will be expanded to cover people up to 133% of the FPL. HFP children who are between 100 – 133% of FPL would go into Medi-Cal. There are quality of care, wellness, and access initiatives in the legislation that would impact children and adults. A maintenance of effort and the five year waiting period for lawfully residing immigrants remains in effect. There will be increased financial assistance for CHIP starting in 2016; the federal match will go from 65% to 88%. There is an option to provide CHIP to children of state employees and provisions to streamline an enrollment process. There are community outreach and consumer advocacy programs called Navigators. They will help with public education and enrollment. With the exchanges, there will be different benefit packages, child-only programs, and increased reimbursement for Medicaid. Quality measures for CHIP will be extended to adults in Medicaid, federal health care reform, supports establishment of Medical Home model, expands family planning coverage, and provider grants for early childhood home visits.

California Pan-Ethnic Health Network (CPEHN) has developed four fact sheets targeting: African Americans, Native Americans, Latinos, Asian Pacific Islanders, and how health care reform impacts these groups. The fact sheets are located on the home page at www.cpehn.org.

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b. High Risk Pool

Ms. Cummings noted that the Governor said MRMIB is going to run the Federal Temporary High Risk Pool. Temporary High Risk Pools will end in 2014. California's allocation is \$761 million to run the program. MRMIB is in the process of negotiating with plans to participate in the High Risk Pool; it will be separate from MRMIP. The federal rules state a person must be without insurance for six months. If a person is enrolled in MRMIP, they are not eligible for the High Risk Pool. MRMIP has a \$75,000 annual benefit cap, and the federal pool will not. Enrollees in the federal pool will be charged 100% of the standard rate, while MRMIP premiums are set at 125% of the standard rate for individual coverage. Consumers will have a choice between MRMIP and the federal pool. When the federal pool begins, there will have an outreach campaign which may bring more attention to MRMIP. Currently there is not a waiting list for MRMIP.

5. Dental Quality Project

Muhammad Nawaz presented the Dental Quality Report based on 2008 dental plan data. The Dental Quality Report is located on the MRMIB website at http://www.mrmib.ca.gov/MRMIB/Dental_plan_rpts.html. The report compared the dental plans on eight dental measures. There are four capitated plans and two open-network plans. The performance for the open-network plans is significantly higher than the capitated plans. For the annual dental visit measure, the open-networks were at 75% compared to 40% for the capitated plans. The percentage of HFP children receiving an oral health evaluation was 60% for the open-network plans and 30% for the capitated plans. Throughout the eight measures, there are significant differences in the open-network vs. the capitated plans. There are differences in regions as well. Southern California's scores are consistently lower than Northern California, but the open-networks are not available in Southern California which may account for some of the lower scores.

After reviewing the data results, MRMIB solicited a dental consultant to help MRMIB improve dental quality in the HFP. The California HealthCare Foundation gave MRMIB a grant for the project. The Center for Health Care Strategies (CHCS) will be the contractor and will:

1. Establish a Dental Advisory Leadership Group to develop a work plan based on national best practices and the goals of MRMIB.
2. Engage with contracted dental plans to implement clinical-level best practices.
3. Establish a Healthy Families Oral Health Quality Improvement Workgroup to develop a three year quality strategy, an associated change package and measurement strategy with current measures and baseline performance, consider clinical best practices and identify links to primary care, and publicly recognize the improvements made by each plan.
4. Develop and propose dental plan contract amendments that revise requirements for plan performance, care improvements, and a dental visit periodicity.

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The project should start in the near future and last for 18 months. MRMIB is looking for participants in each group; the persons should have knowledge of dental care for children.

6. CHIPRA

a. Quality Assurance Project

Ms. Rouillard updated the committee on CHIPRA requirements. MRMIB received a grant from the David and Lucile Packard Foundation that will be matched with federal funds to contract with a vendor to assist the State in implementing the required CHIPRA Quality Assurance Standards.

The standards require state CHIPs that contract with managed care organizations (MCOs) to develop and implement a Quality Assessment and Improvement Strategy. The strategy must address access to care standards, and other measures of care and services related to quality such as grievance procedures, marketing information standards, monitoring procedures, and a process for periodic revision of the strategy.

Another portion of the Quality Assessment and Improvement Strategy requirement is an annual external review of the quality of care provided by the MCOs. The review must be conducted by a qualified and independent external quality review organization (EQRO). The results of these reviews must be conducted in accordance with protocols developed by CMS. The EQRO produces a detailed technical report that describes the manner in which the data from all activities were aggregated and analyzed, quality conclusions, timeliness, and access to the care furnished by the MCO.

There are five voluntary activities the States can choose to include such as the EQRO doing a patient satisfaction survey and HEDIS and encounter data validation.

MRMIB prepared a solicitation for the Quality Assurance project. Out of five proposals, MRMIB is in the final selection process. MRMIB hopes to have the contract in place by August 1st and have the selected vendor attend the next ACQ meeting. MRMIB would like the vendor and the committee to discuss the quality strategy. Medi-Cal has recently updated their quality strategy, and MRMIB is looking to see what they have done. CMS would like the CHIPs to look at the Medicaid strategies and model them. In California, CHIP and Medicaid are different, but there may be areas for collaboration. Medi-Cal's EQRO is Health Services Advisory Group (HSAG).

b. Core Set of Quality Measures

MRMIB submitted comments to CMS; we have not heard a response at this time. Dr. Chen is putting a proposal together to expand the CHIPRA core quality measures.

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7. ACQ Vacancies

a. Subscriber parent

MRMIB would like to add a subscriber parent or family representative to the ACQ. If anyone on the committee can recommend a HFP family representative, please let MRMIB know. It would be helpful to get consumer feedback on the HFP. There is money to pay for travel, but we are unclear if there is money for their participation.

8. Future Meeting Dates

August 26, 2010 – 1:00pm to 4:00pm

October 28, 2010 – 1:00pm to 4:00pm

January 27, 2011 – 1:00pm to 4:00pm