

MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of September 10, 2008

Committee Members Present: Jennifer Benjamin, Dr. Lily Boris, Dr. Alex Chen, Dr. Michael Cousineau, Dr. Mary Giammona, Hattie Hanley, Moira Inkelas, Lucy Johns, Dr. Paul Kurtin, Rita Marowitz, Ed Mendoza, Dr. Matthew Meyer, Lauri Ortega, Carline Rivas, Elaine Robinson-Frank, Dr. Joseph Scherger, Dr. Ulfat Shaikh, Terri Shaw, Tawyna Soden and Ellen Wu

MRMIB Staff Present: Shelley Rouillard, Cristal Schoenfelder, Muhammad Nawaz, Mary Watanabe, Willie Sanchez, Lilia Coleman, Lesley Cummings and Janette Lopez

1. Welcome and Introductions

S. Rouillard introduced herself and welcomed everyone. L. Cummings expressed excitement about the convening of the HFP 2008 Advisory Committee on Quality and then discussed current data collection methods such as HEDIS, CAHPS, DCAHPS, YAHCS. She spoke about quality evaluation challenges with the 'carve out' services (CCS and Mental Health). She stated she looks forward to input from the Committee on how to improve plan accountability and quality of services provided to HFP members.

Each person then introduced themselves and gave a contribution statement along with what they would like to get out of this process. (see attachment)

2. Selection of Co-Chairs

Shelley mentioned that L. Johns, E. Wu and Dr. Kurtin previously expressed interest in serving as Co-Chairs and asked if there was interest from any other Committee members. There was none. The three members then discussed what they each would bring to the position:

Dr. Kurtin stated improvement activities don't go very far without buy-in from the provider community. He would be helpful expressing the provider viewpoints and to help get meaningful measures that will result in quality improvement.

E. Wu stated she brings a consumer advocate perspective and would like to make sure that the consumer perspective is a priority of the Committee. She also served on the previous HFP Quality Improvement Work Group.

L. Johns stated that she volunteered because implementation of quality standards is where we are stuck right now statewide and nationally. She deferred her nomination to Dr. Kurtin. (tape cut out)

S. Rouillard recommended that both Ellen Wu and Dr. Kurtin serve as Co-Chairs. There was no opposition expressed by the Committee members.

S. Rouillard invited E. Wu to talk about her experience on the last HFP Quality Committee. E. Wu stated that initially the group talked about appropriate HEDIS measures. She recommended this Committee look at the outstanding questions from the prior Work Group and discuss them at some point. She added that the issue of accreditation came up along with performance measures and cultural and linguistic quality measures. S. Rouillard added that the Charter that was previously sent out includes brief recommendations from the prior Committee. Dr. Giammona asked if this group is something that can be continued or will only last for a brief period of time. Shelley responded that the intent is to focus on the next HFP contracting period and then went on to describe MRMIB's contracting process.

3. 2008 Charter Review

S. Rouillard acknowledged the broad representation of stakeholders on the Committee. She reiterated the request that members attend 90% of the meetings. She stated that the intent is to focus on using measures and standards already available, not to develop new measures. She added that members serve on a voluntary basis and that she has requested foundation funds for travel and hopes to hear from the foundation soon.

4. Overview of Quality Measurement and Reporting Activities

a) *Healthy Families Program* – S. Rouillard briefly discussed the history of HFP: Different states had different options of structuring their SCHIP programs and California opted for a program separate from Medi-Cal.

A Committee member mentioned the issue of kids not having access to vaccines via the VFC (Vaccines for Children) program and asked why the federal government set it up this way. Group discussion commenced about this issue. S. Rouillard mentioned that HFP requires plans to provide immunizations per the Advisory Committee on Immunization Practices guidelines. Another Committee member added that there is no funding stream available for VFC in the SCHIP even though Medi-Cal uses the VFC program to cover their children's immunizations. S. Rouillard suggested we discuss this issue at a later time.

S. Rouillard then outlined the mental health and CCS carve outs in detail. She reminded Committee members that families pay a monthly premium and copayments for certain services. The HFP model is different than Medi-Cal. MRMIB contracts with an administrative vendor who does all eligibility determinations, plan enrollments and premium collection. The HFP uses a managed care model to provide services. MRMIB contracts with 24 HMO and EPO plans, 6 dental and 3 vision plans. HFP is mandated to offer a choice of plans to subscribers.

S. Rouillard added that MRMIB is interested in examining demographic statistics when evaluating program quality and referred to the map showing the 6 regions MRMIB uses for its programs. She then discussed enrollment per county as shown on the map, age groups, ethnicity and language.

A Committee member asked how this compares to the population of the State. S. Rouillard was not sure but said she would check into this. Dr. Giammona said it's similar to the Healthy Kids population. L. Ortega would like the 0-5 range broken down even more to 0-2. S. Rouillard agreed and stated she would like to partner with First 5 on projects for the 0-5 age group. The Committee was informed that detailed demographic information is available on the HFP website. Action Item: Compare HFP demographics with the State.

S. Rouillard then talked about the quality assessments required in the plan contracts which include submission of annual HEDIS data. Each plan selects its own certified auditor. CAHPS surveys are conducted when funding permits and YAHCS was conducted last year. The links provided in the cover memo supply downloads to the most recent satisfaction survey results. The plan contracts include extensive cultural and linguistic access requirements mostly focused on interpretation and translation of materials. She added that plans are required to follow American Academy of Pediatrics recommended care to children and ACIP recommended immunizations. She referred the Committee to the Immunization report available on website summarizing the delivery of vaccinations in the HFP.

b) Medi-Cal Managed Care – R. Marowitz spoke about a major advantage Medi-Cal has in that they are required by the feds to do quality reviews using an EQRO (External Quality Review Organization) of their choice. The big advantage of this mandate is that Medi-Cal gets additional federal financing to cover this activity. Medi-Cal is charged to review activities that evaluate quality, access and timeliness.

She then outlined the core requirements that include the following: 12 selected measures (some with multiple indicators), plans are audited by an independent auditor with public rate reporting, CAHPS surveys administered every other year due to cost (\$1 million to administer each survey year), 2 quality improvement projects (QIPs) that meet the federal requirements underway at all times – some statewide and some just pertaining to that plan, and under and over utilization monitoring via CAHPS, HEDIS and encounter data. The QIPs must be reported to Medi-Cal on an ongoing basis.

She stated that Medi-Cal focuses on 3 domains: how effective the care is, access to the care, and use of services. Some populations are difficult to serve and this is reflected in the measure results. A prior focus was on women and children, but Medi-Cal has added measures on chronic disease and now the focus is on seniors and persons with disabilities. Medi-Cal serves people of all ages as opposed to HFP which serves only children. Plans are doing consistently well with many of the measures. In 2010, Medi-Cal is considering setting aside some of the measures and to start looking at blood lead screening and obesity prevention and treatment.

Medi-Cal has corrective action plans for the plans who fall below the minimum percentile. She then discussed the overall trends provided in the handouts. She stated Medi-Cal Managed Care uses an auto-assignment incentive for the plans who score the highest on 6 of the HEDIS measures. A Committee member asked about HFP and auto assignment. W. Sanchez from MRMIB said auto-assignment is rotated among plans when members do not choose their plan at the time of enrollment.

R. Marowitz then added that they also publish the HEDIS and CAHPS rates in the consumer guides that are sent in the enrollment packets to help Medi-Cal beneficiaries make an informed decision. She added that she doesn't think the information has a lot of impact in member choices. CAHPS is conducted in English and Spanish. She said the medical directors express frustration because the results are anonymous, they don't know where results are coming from, and members can have a positive perception but needs aren't necessarily being addressed. A Committee member commented that perception is important because that shows whether people will seek care.

She concluded with encounter data which has only recently come into play. Plans are contractually required to submit information about every encounter that every member has. S. Rouillard added that MRMIB has plans to do something similar to improve quality and monitoring plans. H. Hanley asked about collecting Hemoglobin A1c data in addressing the huge diabetes epidemic.

Committee member question: What percentage of children in Medi-Cal are in managed care? R. Marowitz answered: about 75%.

c) Commercial HMOs – E. Mendoza said the Office of the Patient Advocate's goal is to educate HMO enrollees. OPA is statutorily mandated to produce an annual HMO quality report card. The first one was done in 2001. Every fall, OPA has the results available on the web. He added that not all plans are included. OPA's report card contains the largest plans that represent 90+ percent of the HMO enrollment statewide or 12 million enrollees.

Each plan is rated on 1) clinical quality and 2) member satisfaction/experience using HEDIS and CAHPS. The report card gives consumers comparative information about health plan quality in an easy-to-use format starting at an aggregate level and moving to specifics.

He added that the public use is important to the scope and design. There are no contracts mandating that OPA receive this data (plans work with them voluntarily). The report card includes information on language access. OPA has a portal page that gives users access to other data that might be useful. He then reviewed the HEDIS measure list provided in the handouts and added that there are only a few plans that use the same measures as HFP and Medi-Cal so it is difficult to compare plans across all product lines.

Dr. Scherger said what you don't measure, you can't improve. However, so much of this work is focused on measurement instead of actual improvement. If financial incentives are provided, people get creative about how to provide better care. In today's environment, the name of the game is to figure out work-arounds to achieve better results. He hopes the group will get creative with new models of care and asked how do we make care accessible and not dependent on visits. He stated that you can't improve care if the care is only episodic.

S. Rouillard asked if he could give examples of current creative projects. He mentioned the Redwood Coalition in Northern California where they have started using on-line communication and care. 87% of Americans are doing things on-line and the future is in re-designing models that go beyond the episodic brief visit with only 25-30% good outcomes. Maximizing office experience will improve these outcomes. Kaiser is a good example of using the computer to achieve better access results. Medical home concept is no longer the same as what it was before. Patients need to be able to get what they need when they need it. Productive interaction and multi-model communication links are essential.

S. Rouillard then spoke about the challenge HFP has in that we don't have direct contracts with providers, but rather with the plans. MRMIB could creatively construct its contracts to have the plans conduct quality improvement projects.

L. Johns urged we devote a future meeting to how payers can promote changes in the delivery system. Dr. Scherger said he would be delighted to give a presentation at a future meeting. Note: Check with PBGH.

E. Mendoza continued by outlining how OPA rates the commercial plans' care for children. He then reviewed their charting methods relating to the collected HEDIS measures for children. (refer to handouts) Discussion commenced on pay for performance. E. Mendoza said the plans that do this will pay their providers for certain services and is not sure if this has any impact on quality. For example, there is a clear difference in quality between Northern and Southern California but he is not sure what drives the difference.

Dr. Kurtin mentioned that most providers are not taught how to improve in measures and should be given the skills, knowledge and tools to be able to do this. E. Mendoza stated that the purchasers have more leverage to do this. Comment was made by Committee member that the quality improvement projects help do this and that finding and spreading best practices is key.

5. Discussion of Future HFP Quality Indicators

S. Rouillard reviewed the HFP contracting process and asked the Committee to consider what measures we should remove and/or keep.

C. Rivas asked if the assumption of reporting the measures is for pay for performance. S. Rouillard stated the purpose of reporting measures is for plan accountability on providing services to members. She added there is interest by the Board to move towards pay for performance or some type of incentive program around quality in the future. Measurements are important to be able to do this. She is interested in exploring potential pilot projects with the plans and possibly seeking grant funding to assist with this.

Dr. Giammona asked if there are any projects currently underway. S. Rouillard stated not like what Medi-Cal has. The QPIP report done in 2006 is based on 2004 HEDIS scores identifying plans with low scores and what they should be doing as well as best practices. She added that MRMIB develops plan performance profiles which are presented to the Board and this year cultural and linguistic information will be added to the profiles. The profiles are used when considering contract negotiations. Dr. Giammona suggested MRMIB focus on project creativity unrelated to HEDIS measures within various communities which may lead to improvement.

R. Marowitz asked if plans are scoring universally low in any of the measures we are using now. M. Watanabe commented on the adolescent measures which typically score low and seem to be an area for improvement. R. Marowitz asked if plans are expressing concerns about the number of measures and whether collection is hybrid vs. administrative. S. Rouillard said she has not heard from anyone about this. R. Marowitz added that Medi-Cal collects and reports on their data but feels like they should be looking at what they really want to address within their program while being mindful of the plans' resources.

H. Hanley expressed interest in having a future discussion about adding the Hemoglobin A1c measure and spoke about the obesity epidemic.

E. Robinson-Frank commented on the existing HEDIS BMI measure being purely a chart review measure which is time consuming and costly. Discussion commenced about height/weight questions on CAHPS survey. Dr. Giammona spoke about a formal pediatric pay for performance program within the Santa Clara Family Health Plan to measure BMI. SCFHP pays providers additional money to submit the data after obtaining the BMIs. SCFHP consulted with Kaiser about a screening questionnaire on physical activity, nutrition, etc. and added that CHDP has something similar. She then stated that the percentage of diabetes among their population is less than 1%. S. Rouillard added that most kids in the HFP with diabetes would be referred to CCS.

Dr. Giammona added that she does not think it would be practical for HFP to measure Hemoglobin A1c and thinks it's best to focus on projects that would address obesity. A Committee member then suggested HFP use the RHDP projects to address obesity. Another Committee member mentioned that BMIs are typically 38% inaccurate.

The group then discussed the various HEDIS measures on the chart and wanted to know a little more about what the data has shown before making any recommendations. R. Marowitz suggested the possibility of using QIPs to tackle issues.

E. Wu suggested looking at race and ethnicity data while looking at the HEDIS measures for both HFP and Medi-Cal. R. Marowitz stated that Medi-Cal has experienced difficulties matching enrollment data to the HEDIS data. M. Watanabe mentioned that MRMIB matches enrollment data from our administrative vendor to what the plans report for HEDIS. A Committee member stated that the hybrid sample is random and there is no way of knowing the member's name to be able to match the enrollment (race/ethnicity) data to this data.

S. Rouillard asked R. Marowitz why they dropped the chlamydia screening measure and R. Marowitz responded it was because the plans were doing generally well and there were other measures they wanted to add. A Committee member then asked about measure rotation. R. Marowitz said they might rotate a few measures in the future.

A Committee member asked if there was any way to combine HEDIS data collection for both Medi-Cal and HFP at the same time. Dr. Boris suggested collecting pharmacy data that includes something related to the new obesity measure to educate providers. She added that sometimes there is a mis-match between what is collected and what is actually going on. A Committee member spoke up and said only about 30% of kids have a BMI measured in the CHDP program and kids are being measured with shoes and clothes on. Another member spoke up about not knowing what constitutes good and bad care. An additional member stated that pharmacy data is the most accurate and should be utilized along with collecting measures.

Several members stated that as we are looking at what measures to include in HFP plan contracts, we need to look at the problems facing the population and that projects (QIPs) may be the best way to go. J. Benjamin stated the direction of the NCQA measures can be summarized as prevention, acute and chronic care. NCQA is looking for SCHIPs to participate in pilot testing during the first year.

7. Future Meeting Schedule

S. Rouillard discussed the future meeting schedule and asked for feedback. No concerns were expressed. She added that we will provide a data analysis of HEDIS measures over time for the next meeting. She then thanked her staff for assisting with the meeting preparation and closed the meeting.

8. Next Meeting

The next Advisory Committee on Quality meeting is scheduled for November 20, 2008 from 1pm to 4pm at the Department of Rehabilitation in Sacramento.