

MANAGED RISK MEDICAL INSURANCE BOARD
Healthy Families Program Advisory Committee on Quality
Meeting of November 19, 2009

Committee Members Present: Alyce Adams, Mary Giammona, Lucy Johns, Ed Mendoza, Rita Marowitz, Lori Ortega, John Pescetti, Terri Shaw, Ellen Wu, and Aaron Zaheer.

Committee Members Present by Phone: Alex Chin, Elaine Robinson-Frank, and Mark Paredes.

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

Guest Present: Margie Powers (MRMIB consultant).

1. Welcome and Introductions

Ms. Wu introduced herself as the facilitator and the participants introduced themselves. Ms. Aiming Zhai was introduced as a new staff member at MRMIB. Ms. Margie Powers was introduced as a MRMIB consultant for the Premium Discount Project which will be discussed in the meeting. Dr. Kurtin's absence was mentioned due to health concerns.

2. Review of Minutes from August 27, 2009 Meeting

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

a. San Francisco Health Plan (SFHP) Follow Up

Ms. Rouillard cited a letter written by Dr. Pfeifer of the San Francisco Health Plan thanking the committee and MRMIB for listening to their concerns regarding their belief that SFHP's large Chinese population was skewing their Consumer Assessment of Healthcare Providers and Systems (CAHPS) results. As a result of the conversation at the last ACQ meeting, MRMIB has agreed to combine the 7, 8, 9 and 10 scores for the "overall rating" of health plan category. In the future, MRMIB or the CAHPS vendor may do a case mix adjustment analysis for the Chinese language. Many of SFHP's additional concerns are beyond MRMIB's control to address. SFHP suggested that MRMIB put a statement in the handbook that says "the results for some plans might be lower because the survey does not make adjustments for differences in the Chinese language." MRMIB is considering doing such.

3. Premium Discount Project formerly known as (Community Provider Plan (CPP) Designation)

Ms. Rouillard introduced the discussion of the Premium Discount Project. Currently, the CPP is a statutorily required designation. In each geographic region (defined as a county), MRMIB awards a premium discount to the plan with the most Traditional and Safety Net (TSN) providers in its network. It is a very competitive process. Currently the scoring is based on data from Dept of Health Care Services, Medi-Cal, CHDP providers and OSHPD. Hospitals, clinics and CHDP providers receive a weighted score based on claims from Medi-Cal Fee for Service system. On the hospital side, the score is assigned based on the number of discharges of persons on Medi-Cal or uninsured. The determination is time consuming and relies on data that has become unreliable and inadequate.

Ms. Rouillard explained the process was originally set up because providers that had historically served the Healthy Families population were concerned because they had not contracted with managed care plans. The CPP process provided an incentive for plans to contract with TSN providers and it was successful. Blue Cross, Health Net and other large plans have done a good job of contracting with TSN providers. The MRMIB Board is interested in incorporating quality performance into the process of awarding the premium discount. The California HealthCare Foundation has hired Margie Powers to help MRMIB determine which elements of quality should be included in the determination of which plan in a particular area will be awarded the premium discount.

Mr. Mendoza wondered what percentage of HFP clients currently receive the Premium Discount. Mr. Nawaz answered that it was 39%. The process creates an advantage for plans that are competing for the HF enrollees. Not only are subscribers more likely to choose the CPP because it is cheaper, but also if a Healthy Families subscriber does not select a plan, the subscriber is automatically assigned to the CPP.

Dr. Zaheer and others expressed concern if TSN providers were less likely to be contracted with plans if the discount goes away. What would protect TSN providers? Ms. Rouillard stated that it was an initial fear that the plans would be less likely to contract with TSN providers and that the TSN providers would lose patients to other, more commercial, providers. As far as hospitals are concerned, plans need specialty providers such as teaching and children's hospitals so it is likely that contracting with hospitals is not a concern. As far as Federally Qualified Health Centers (FQHC) are concerned, CHIPRA, with the new prospective payment requirement for FQHC and Rural Health Clinics, will make the clinics whole for their costs as they are in Medi-Cal right now. The plans will continue to contract with the clinics because the plans don't have to worry about the increased costs. There really is not anything that specifically protects CHDP providers except their relationship with the plans.

Ms. Shaw expressed her opinion that TSN remain a consideration because access is an important component. However, she noted that the process is complicated and it is difficult to ensure that TSN determination is correct. Ms. Rouillard went on to note that the process by which MRMIB currently determines the CPP is broken. One of the goals of the new process is to have data elements that can be used in an accurate and reliable way and are under MRMIB's control. As a whole, the committee agreed that the process should be restructured.

Dr. Giammona expressed apprehension that other plan models such as Kaiser would be taken into consideration in the designation process. Dr. Giammona wondered whether there will be risk adjustment taken into consideration for County Organized Health System (COHS) plans. Ms. Rouillard acknowledged the concerns and noted that today MRMIB begins the conversation about a potential new process. Risk adjustment is a potential element to consider. MRMIB's hope is that when Ms. Powers interviews each plan that concerns such as these will be discussed. Elements of quality will come into the process. However, a decision hasn't been made about which quality elements will be included in the final determination.

Ms. Wu shifted the discussion to talk about what elements of quality the committee thinks should become part of the designation process. Ms. Shaw noted that MRMIB should not only consider what data is currently available but also what could be available as the State is undergoing some huge data changes. MRMIB should not set the bar too low. Ms. Rouillard agreed that the bar should not be set low and added that improved data capability should be reflected in improved scores and better information.

Ms. Ortega asked whether geography is going to be taken into account as it seems to play an important role in quality. Ms. Rouillard noted that one of the proposals made in the plan contracts for the 2010-2011 benefit year is to have the plans report HEDIS according to geographic region. MRMIB has six regions by which statewide plans would be reporting HEDIS data. Medi-Cal requires plans to report HEDIS data by county. Ms. Marowitz confirmed that Medi-Cal does HEDIS reporting by county and added that Medi-Cal is moving to doing CAHPS that way as well.

Ms. Marowitz was asked to share the process Medi-Cal uses to award plans more members. She noted that the measures are well child 0-3, well child 3-6, adolescent well care, immunization screenings, cervical cancer, hemoglobin A16, and prenatal care. Plans get points for their HEDIS scores in relation to other plans in the county. Medi-Cal also gives points for the number of members who are assigned to a Safety Net Provider as a primary care provider. Medi-Cal does not look at whether members got services from TSN providers because it is more difficult to verify. The plans also get points for the percentage of discharges from safety net hospitals. Plans can earn improvement points. These points are not

just awarded to the highest scorer but also on the level of improvement a plan makes from one year to another. Ms. Marowitz went on to add that Medi-Cal has concerns about unintended consequences. She stated that because plans can earn more points for certain measures, they put more energy into those measures and other measures suffer. Medi-Cal is six years into this process and has been adding and swapping measures. Medi-Cal doesn't have money to pay bonuses but assigns members to the highest scoring plan in the county.

The group wanted clarification of the task. It was clarified that MRMIB is interesting in hearing which quality indicators the committee wants MRMIB to use and the process by which the committee determines which ones MRMIB should be focusing in on. Secondly, MRMIB will revise the current designation process. This does not mean that MRMIB will do away with TSN but the current process cannot continue as is. If MRMIB continues to use TSN, what is a good way to identify providers?

Dr. Giammona stated that quality should also be looked at from a clinical perspective to see if the change is clinically significant. Ms. Adams agreed pointing out that looking at clinical significance makes a lot of sense and even having a set of criteria such as equity. Ms. Adams went on to give an example. In terms of equity, what are the values with respect to equity? It sounds like continuity of care is a value. Is it possible to combine HEDIS measures with a couple of measures that would get at continuity? For example, the length of time that a child has been with their clinician and how comfortable they feel with their clinician might balance out concerns. The committee thought this was an intriguing idea, however it is difficult to find commonality in the other measures. Ms. Shaw said MRMIB should potentially be looking at the number of kids that are being affected. The larger the number of kids affected, the more attention a component should receive.

Ms. Johns brought the committee back to concern about a sentinel effect where that if you stop looking at something, people stop paying attention. She wanted the committee to look at two columns. The first column is something on which MRMIB cannot fall back. The second is concentrating on something that needs improvement and encouraging the plans to improve. If something in the first column falls, there are serious clinical consequences. If adolescent visits (which would be in the second column) don't rise, the clinical consequences are not discernable. She cautioned the committee to not just look at things that need improvement but also to find a way to keep quality at a high level when it is there. Ms. Robinson-Frank pointed to something like Medi-Cal's minimum performance. The committee thought this was a good idea.

Mr. Mendoza agreed that there is a delicate balance between not giving up what has been achieved and using the leverage you have to create behavior you would like to create in terms of quality improvement. He reminded the committee that the more measures one has, the more diluted the data because the behavior

is spread out over more measures. The leverage is incredibly important. It may not just be quality. It may be safety net and continuity and other things.

Dr. Zaheer reminded the committee that often the system is the problem. When people switch between plans, the provider is often not the problem but the plan and/or the State program is the problem. Often subscribers are assigned to one provider when they view someone else as their doctor. It would be good if the State system could link the provider and the patient. Ms. Marowitz stated that this is attempted but it doesn't always work. The committee discussed the desire to have this done but acknowledged the operational difficulties of doing it.

Ms. Wu encouraged the committee to write things down and make suggestions. There was some discussion about Asthma as an important measure and how that measure is captured. Ms. Ortega pointed out that asthma data was obtained by administrative data only and it is difficult to get good administrative data. Ms. Marowitz pointed out that on some of the measures, plans have to have good data in order to get good scores. Often Medi-Cal gets data with all sorts of data problems.

Dr. Giammona we look at some measures about which the committee was concerned but did not have a HEDIS measure.

Ms. Shaw suggested two columns on the access side to go along with the two columns on the quality side. One of those columns, column one would mark maintaining access at the current level and the second would be to increase access.

Ms. Johns suggested that one criterion might be that HFP and Medi-Cal activities converge so that the plans and the providers who contract with them are looking at the same indicators. Ultimately, decisions by Medi-Cal and HFP are affecting almost all the same people. A criterion for selecting measures could be that Medi-Cal already does it or Medi-Cal wants to do it and lets do it together because then we increase our leverage.

Mr. Mendoza said that in his twenty plus years of doing work like this, stakeholders question the reliability of data, the methodology that is used to apply said data and the process. It is important to have data that is reliable and easily accessible. It is important that the process be as simple as possible. Ms. Marowitz stated that another possible way of assigning points is to track how many years a plan maintains a certain score or does better and conversely how many years a plan remains below a minimum level. Medicaid takes points away for deteriorating. Medi-Cal compares one year to the next. Medi-Cal is now tracking HEDIS scores, where they are and does a plan maintain, go up or go below. Right now the minimum performance standard for HEDIS is the 25th national Medicaid percentile and the high performance is the 90th percentile.

Ms. Rouillard told the committee that in the contracts for 2010-2011 MRMIB is proposing a minimum performance standard of the 25th national commercial percentile and the 90th national commercial percentile at the top. The committee echoed the thought that plans at or below the 25th percentile was unacceptable. Mr. Mendoza suggested that MRMIB develop a plan to disincentivize care that is unacceptable and of poor quality.

Dr. Giammona inquired how different the 25th Medicaid percentile was from the 25th commercial percentile. Ms. Marowitz stated that it varies by indicator and that in some cases specifically in California Medi-Cal is higher than the commercial. A discussion ensued about the commercial percentiles versus the Medicaid percentiles. There was no consensus reached.

Dr. Giammona suggested that one criterion should be risk adjustment. In Medi-Cal risk adjustment has enabled COHS plans to do better than they might be otherwise. Ms. Rouillard affirmed that special considerations such as risk adjustment could be a factor in the scoring. Ms. Shaw pointed to risk adjustment as a way to potentially get at the issue of we don't have money to pay people for doing better. By using risk adjustment, you can justify that reallocation of funding.

Ms. Shaw suggested three criteria of quality improvement for a high number of kids, get quality improvement based on getting better preventive care and quality improvement by better managing care for kids with chronic conditions.

Mr. Paredes expressed concern that the committee is suggesting going from three months of intensive work to four or five months of intensive work. However, if the original legislative goal was to not have TSN abandoned along the way somewhere, it should still be a consideration. He suggested that if Medi-Cal has already done a lot of that work at least in terms of identifying who the TSN providers and MRMIB should consider using those designations.

Mr. Nawaz pointed to the complexity of identifying the TSN providers and acknowledged it will continue to be difficult as MRMIB looks to comparing regional HEDIS data to county HEDIS data. Ms. Shaw wondered if we could use some of the Medi-Cal data for each county to compare HEDIS. While it is true that many plans participate in both Medi-Cal and HFP, Ms. Robinson-Frank pointed out that there are different patient populations and therefore, different data. Ms. Shaw suggested that we join the populations of Medi-Cal and HFP for HEDIS. Ms. Marowitz stated that this does not meet the Federal requirements for Medi-Cal auditing and is not possible.

It was suggested that since the plans are making money in those counties, they should be responsible for reporting the data by county. Ms. Rouillard offered a financial reality check. Blue Cross pulled out of 12 counties last year because they could not afford to stay in. If they have to report data for 58 counties, that

will be more costly. That is why MRMIB went to the region reporting. Getting the plans to report regional data is going to be difficult enough in itself. Each time a plan does a different sample (each sample size is 411); it is expensive and difficult to do. In Medi-Cal Managed Care, there is an external organization that does all of the HEDIS work. Medi-Cal Managed Care pays for the auditing, MRMIB does not. Ms. Marowitz stated that this is a huge difference in costs. She went on to state that one of the things that happens when you develop an incentive program, there are a lot of up front costs. The costs get less expensive following the upfront costs because year after year, all the numbers are dumped into the existing formula.

Ms. Wu asked if Ms. Rouillard or Ms. Powers had any questions following the discussion. Ms. Rouillard stated that the brainstorming was helpful and that the ideas will be informative as Ms. Powers goes to the plans and ask what they think about this or that. Ms. Johns suggested that the committee rank their suggestions. This was done during the break. (The ranking is attached as Attachment 1.)

Ms. Johns inquired regarding the timeline for the process. Ms. Rouillard stated that there needs to be legislation in 2010 the change in premium discount to take effect in the 2011-2012 benefit year. MRMIB expects there to be legislation in this in either March or April. The question is how to change this process with no money. Ms. Rouillard asked the plan representatives to help facilitate the conversations with Ms. Powers. Ms. Powers will start calling either next week or right after Thanksgiving.

4. CHIPRA Core Measures

Ms. Rouillard pointed to the document entitled "Recommended Core Measures for CHIPRA." The Centers for Medicare and Medicaid Services (CMS) worked with the Agency for Healthcare Research and Quality (AHRQ) to develop a list of core measures that all States would be reporting. This is the first set of 25 measures that has been sent to CMS for review. These are voluntary measures right now. Eventually, reporting quality measures, whether these or others, will be mandatory. By January 1, 2010, the Secretary will publish for public comment the core measure set. MRMIB submitted comments to CMS about the proposed measure set. Ms. Shaw requested a copy of the comments that MRMIB submitted. Ms. Rouillard said that she would be happy to get Ms. Shaw a copy. Ms. Johns inquired as to who came up with these core measures? Ms. Rouillard responded that Agency for Healthcare Research and Quality set up an advisory committee to provide the information to CMS. There is a website that shows who they are. As requested, Ms. Rouillard said that she would send a link to the committee.

Action Item: Send MRMIB's comments on the proposed core measures and a link to the AHRQ advisory committee.

Ms. Wu asked if there are issues with the measures? Ms. Rouillard responded that MRMIB can already report some and some would be problematic.

Ms. Johns wondered what would be done with the results. Ms. Rouillard said there will be national comparison data and information on all the States that are reporting the data. The data will enable MRMIB to know how California compares with other CHIP programs. Ms. Johns inquired when is the first reporting year? Ms. Rouillard responded that CMS publishes them in 2010; the first reporting year will probably be 2011. Ms. Wu stated that the California Pan-Ethnic Health Network commented on the measures having some sort of equity/disparity measures. Mr. Mendoza proposed that given that data could be reliable and accessible, these measures might be helpful for use in the Premium Discount Project.

Ms. Rouillard has been invited by National Academy for State Health Policy (NASHP) to participate on a quality workgroup with representatives from different states. The group will respond to CMS on behalf of the states on the core measures and other quality activities.

Ms. Adams stated that she thought CMS is doing a Request for Proposal to pilot some of these measures. The results from the projects would then be used to inform the process. Several committee members mentioned seeing something related to this and Ms. Rouillard is reviewing a request for proposals which might be pertinent. Ms. Wu recommended that people be on the lookout for measures which will be in the federal register. She further requested that Ms. Rouillard flag the measures when they appear. Ms. Rouillard said that she would.

Action Item: Notify committee members when the proposed list of core measures is published for public comment.

5. Healthy Families Program Updates

a. Contract Amendments

Ms. Rouillard started the discussion of program updates by talking about proposed contract changes for the 2010-2011 benefit year. The Board has decided to change the timeframe for the benefit year from July to June to October to September. Ms. Rouillard reviewed the proposed contract language changes which include regional reporting of HEDIS measures, performance standards, encounter data, and Group Needs Assessment. Ms. Wu commented that disparities language did not make it in. This was affirmed and Ms. Shaw commented that there is more work to be done.

Medi-Cal and HF are coordinating the policy and procedures regarding the GNA. The GNA will be due September 30, 2011. From that point, it will be

due every four years. MRMIB is proposing to broaden not just to C&L but also health status.

Ms. Rouillard stated that the first viewing of the proposed contract was at yesterday's Board meeting. MRMIB will be holding a conference call with all the plans to review the contract. Plan representatives have remarked that each of the requested contract changes have value but wondered where the money to pay for them would be found. Ms. Rouillard stated that she will send the link to the website where the contract is located.

Action Item: Send link to the proposed contract language.

The final enclosed piece of the contract pertaining to quality is the Attachment III, the HEDIS measures. Ms. Watanabe explained the additions for 2010-2011 are immunizations for Combinations 4 and 5 (adolescent immunizations) and regional reporting. Ms. Marowitz asked why 2008 is being used as the benchmark and suggested that the benchmark be updated to a more current one.

Dr. Giammona inquired about the percent increase MRMIB is asking for between 2010 and 2011. Ms. Rouillard responded that the "Goal" is the midpoint between the minimum and the benchmark.

Ms. Ortega wondered if the Medi-Cal or commercial benchmark was being used. Ms. Watanabe explained that originally MRMIB had intended to use the commercial standard for all but for lead screening the Medicaid is being used because there is no commercial benchmark.

Mr. Mendoza wondered about using a measure regarding alcohol and drugs.

Ms. Rouillard responded that those measures are really low and do not hold much information.

Dr. Giammona commented that Chlamydia screening is not accurately reported because often the children receive the care outside of the plan's network so the providers do not report the service.

Ms. Johns inquired about adding OBGYNs as a category of providers on the measure, "Children and Adolescents' Access to Primary Care Practitioners," number 4. Ms. Marowitz responded that it is a HEDIS measure and this is how the specifications are written for it. She was unsure if OBGYN could be added. Ms. Rouillard responded that she would look into it.

b. Budget Update

Ms. Wu then focused discussion on the budget update. Ms. Rouillard reminded the Committee that there are dire circumstances in the State of California. It is estimated that there will be a \$21 billion deficit in the next 18 months, seven billion of that being in the current year and the remaining \$14 billion in the coming year. An additional impact for the budget could involve the Medi-Cal Managed Care Health Plans agreement to tax themselves in order to provide funding for HFP. CMS has some concerns but is letting California get the money through the federal fiscal year. Ms. Johns wondered what concerns CMS had. Ms. Rouillard responded that she did not know the specifics. Ms. Shaw responded that the important point is that California is able to use federal funds through September 30, 2010.

c. Waiting List

Ms. Rouillard reminded the Committee that there were approximately 90,000 children on the wait list. About 80% of those applications have been processed. Fifty five thousand (55,000) children have been enrolled in HFP since the wait list was lifted. Maximus expects to have all of the waitlist applications processed by the end of the month.

d. Encounter Data

Ms. Rouillard began the discussion about encounter data by referencing the discussion that occurred during the explanation of the contract changes. MRMIB will be getting encounter data. The requirement for it will be in the contract. Dr. Giammona wondered if the plans were expected to have the data. Ms. Rouillard responded that when MRMIB began a discussion about encounter data a year ago, the plans did not seem to think it would be a problem. Mr. Nawaz pointed out that MRMIB might be able to use encounter data for the Premium Discount Project.

e. Dental Quality Proposal

Ms. Rouillard introduced the dental quality proposal. Although this Committee is not dealing with dental quality, Ms. Rouillard wanted to let the Committee know that MRMIB released the results of the dental quality measures to the Board yesterday. The findings are concerning particularly in the capitated plans. Due to budget cuts, children will have to enroll in the capitated dental plans for the first two years that they are in the Healthy Families Program. Several dental plans responded that there were data problems and that they would rerun the data. However, even the "good" capitated plans are serving less than 50% of their enrollees in areas of prevention and treatment.

The plans complain that they cannot get the providers to submit the data. Ms. Shaw wondered how this compared to Medi-Cal. Ms. Rouillard responded that Medi-Cal does not have managed dental care except in a couple of counties so Medi-Cal wouldn't have this data. In fact, no state does managed dental care like California.

MRMIB has applied to the California HealthCare Foundation (CHCF) for a project on how to hold plans accountable for quality, particularly in a capitated environment. Hopefully the grant will help MRMIB identify what to do to ensure that kids get the dental care they need and how to incentivize the plans to ensure that the appropriate care is given.

Dr. Giammona wondered if the dental problems were an access issue, an issue of network adequacy. Ms. Rouillard responded that access could be part of the issue. Ms. Wu asked if MRMIB had considered convening the dental plans to discuss this. Ms. Rouillard replied that MRMIB is already planning on doing that after the revised data has been submitted.

MRMIB had a dental advisory board that established these measures. The advisory board ended in 2007. Mr. Mendoza suggested that when MRMIB talks to the foundation, focus groups should be considered. Dental care seems like a popular benefit. However, it seems that not a lot of members are getting services. It appears that it is difficult to discover whether it is an access issue or a data issue.

Ms. Johns expressed concern that dentists never work on nights or weekends and that it is often difficult to get into the dentist. She hopes that MRMIB will raise the issue of access in terms of hours and days because if a parent works two jobs, often they are never going to get to a dental office.

Dr. Giammona stated that something her health plan is doing is applying fluoride varnish. The plan has trained a majority of their physicians and clinics to do this. The children are brought together and taught about dental care. This has been proven as effective in dealing with at least a subset of dental care. In the end, it is a money maker for the providers.

Mr. Mendoza wondered if there any DPA or CalPERS benchmark data. Is this part of the HMO dental model that they just get lousy dental utilization? Delta has told MRMIB in the past that when people first sign up for dental care, the utilization is high due to unmet needs. The Committee thought this might be true and would be a good thing for the CHCF consultant to delve into.

f. Benefits Design Research

Ms. Rouillard mentioned that a couple of Board members have asked staff to look at the HFP benefit package to identify ways to save program costs. CHCF is considering a research project for MRMIB on other state benefit packages, particularly those that have "Secretary-approved" benefits. A state can model its CHIP benefits after the benefits of federal or state employees, a large commercial HMO, or a state can develop its own benefits package which must be approved by the Secretary of Health and Human Services. Part of the process will involve an actuarial analysis of any contemplated benefit changes.

g. External Quality Review Organization (EQRO)

Under CHIPRA, MRMIB will have to contract with an EQRO and develop a quality strategy. The Packard Foundation is considering funding a consultant to facilitate the EQRO solicitation, set up evaluation criteria, and facilitate the quality strategy process. It was pointed out that the EQRO would most likely be doing audits which would save the plans between \$15K and \$20K per plan for each HEDIS audit. Currently, MRMIB has four grant proposals in process. The grants will free up staff to do other things.

6. Follow Up Meeting in January

The next Advisory Committee on Quality meeting will be held on Thursday, January 28, 2010 from 1:00 pm – 4:00 pm at the Department of Rehabilitation in Sacramento.

The meeting adjourned at 4:00 pm.