

**MANAGED RISK MEDICAL INSURANCE BOARD**  
**Healthy Families Program Advisory Committee on Quality**  
**Meeting of November 20, 2008**

**Committee Members Present:** Alyce Adams, Em Arpawong, Jennifer Benjamin, Dr. Michael Cousineau, Dr. Mary Giammona, Lucy Johns, Dr. Paul Kurtin, Rita Marowitz, Ed Mendoza, Dr. Matthew Meyer, Lauri Ortega, Dr. John Pescetti, Elaine Robinson-Frank, Dr. Ulfat Shaikh, Terri Shaw, and Dr. Aaron Zaheer

**MRMIB Staff Present:** Shelley Rouillard, Cristal Schoenfelder, Muhammad Nawaz, Mary Watanabe, and Janette Lopez

1. Welcome and Introductions

Dr. Kurtin introduced himself as co-chair and welcomed everyone. He introduced new Committee members - Dr. Zaheer, Alyce Adams and Dr. Pescetti, and asked everyone to introduce themselves. During the introductions, E. Mendoza handed out the Office of the Patient Advocate 2009 Health Care Quality Report Card consisting of HMO ratings for nine health plans and referred members to a website for additional information on quality data ([www.healthcarequality.ca.gov](http://www.healthcarequality.ca.gov)).

2. Review of Minutes from September 10, 2008 Meeting

Dr. Kurtin asked if anyone had additional questions regarding the minutes. R. Marowitz commented that they were excellent. C. Schoenfelder stated that she will incorporate minor changes received earlier and send out the final copy to members.

*a) Action Item – HFP Demographics compared to the State*

Dr. Kurtin introduced the action item from the 9/10/2008 meeting regarding the HFP demographics compared to the State's demographics. M. Nawaz discussed his handout titled "Analysis of California State Population and Healthy Families Program Enrollment Data". He created 2008 State population projections using Department of Finance data. The HFP population data was taken from enrollment data available on the HFP website. The data shows that there are approximately 10,624,361 children in California between ages 1 through 18. Of that number, 8.35% are enrolled in the HFP.

L. Johns asked if MRMIB knew what percentage of the 10.6 million are eligible for HFP, but not enrolled. M. Nawaz stated this might be difficult information to obtain. A few Committee members then discussed various estimates. Dr. Kurtin suggested MRMIB research this issue further and S. Rouillard agreed. M. Giammona stated that counties should have this information.

***Action Item: Determine what percentage of the 10.6 million children in California are eligible (but not enrolled) in HFP.***

### 3. Healthy Families Program Updates

#### *a) 2008-09 Program Changes*

J. Lopez spoke about the following program changes:

Premium increases effective February 1, 2009 will impact 2/3 of the HFP population; those families with household income greater than 150% of FPL. Cost sharing as a whole, combining premiums and copayments, will be from 1.8% to 2.2% of the families' total income which is still relatively low. Premium changes have been shared with families in the October, November and December billing statements and is addressed in the Open Enrollment packets. Open Enrollment for the 2008-09 HFP benefit year started November 15<sup>th</sup> and ends December 31<sup>st</sup>. The new benefit year will begin February 1, 2009 and ends June 30, 2009.

A 5% rate reduction for all health, dental and vision plans was implemented in the budget effective February 1, 2009. There is also a new \$1,500 dental benefit cap per subscriber per benefit year, but that will not be implemented until July, 2009. There will be an additional rate reduction for dental plans in the 2009 – 2010 benefit year because the dental benefit cap is expected to reduce utilization. For vision benefits, tints and photochromatic lenses will no longer be covered unless they are medically necessary.

The November 19, 2008 Board meeting was challenging. The general fund deficit has hurt HFP because the Board is statutorily required to live within its means and the only way to be fiscally responsible is to establish a waiting list. If the waiting list alone does not remedy the situation, the Board will need to make a finding and begin disenrolling children. MRMIB is trying to avoid this action. Enrollment is at its highest with over 900,000 members and adding 27,000 new members each month. The Board will have to direct staff to establish a waiting list at the December 17, 2008 meeting. The waiting list would begin the next day. If funding is restored, children will be taken off in the order that they were placed on the list. Families will receive a letter explaining the waiting list and also will be given county information. M. Giammona asked what the drop dead date would be to avoid this and show that funding would be made available and J. Lopez stated that they would need proof of this before or at the Board meeting.

E. Mendoza asked if there is money to collect quality data given the current budget situation. S. Rouillard stated that the plan contracts require them to submit HEDIS data annually. She added that MRMIB does not have funding for the outsourced CAHPS surveys, though because of the changes in the program, the upcoming year would be a good time to monitor how the changes have impacted members' experience with the program. R. Marowitz added that Medi-Cal will not be doing CAHPS this year.

Committee members discussed potential results of the program changes such as decrease in use of services and possible increased retention due to the waiting list. J. Lopez added that the program enrollment needs to be at 786,000 by June 2009 in order to live within our fiscal means. This would be accomplished through normal attrition

during the annual eligibility review process and not enrolling any new enrollees. Discussion commenced among members about how the cost for treatment will still exist within the State because uninsured children will be seeking care from publicly funded clinics and hospitals.

Dr. Zaheer asked what the cost is for one child to be enrolled in HFP. J. Lopez responded the cost is approximately \$110 per child per month for comprehensive coverage including dental and vision services and excluding the mental health and CCS carve outs.

M. Giammona asked what the pressure point is to stop the waiting list from happening. S. Rouillard stated that it could take a number of actions and added that at the recent Board meeting, one plan offered to take a retroactive reduction in its plan rates. If all plans agreed to do this, it might help. She added that making concerns known to the Governor and Legislature would be good places to start. J. Lopez said the Board would need assurance of an appropriation or urgency bill by the next meeting on December 17, 2008.

*b) Encounter Data Project*

S. Rouillard spoke about the status of the Encounter Data Project which is now on hold. This is due to the Confidentiality of Medical Information Act which limits MRMIB's ability to receive data regarding members who have received outpatient treatment provided by a psychotherapist. Right now, plans are prohibited from sending such data unless they have a signed release from every patient. This is not a practical option. Having plans clean the data also is not an option (too time consuming, might miss something, lack of resources). Though MRMIB would not get the actual names of the members in the data, CIN numbers are needed to confirm that the data is from HFP members.

L. Johns asked if obtaining signatures on the application upon enrollment would allow us to get data. J. Lopez stated a blanket authorization on the application would not suffice. Additionally, it is a joint application with Medi-Cal and it is not under our jurisdiction.

4. Presentation on HFP Health Plan Quality Reports

*a) 2007 CAHPS/YAHCS*

C.Schoenfelder presented the 2007 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Young Adult Health Care Survey (YAHCS) report authored by M. Watanabe.

CAHPS: These surveys assess member satisfaction in the 24 participating health plans. They were administered in five languages: English, Spanish, Chinese, Korean and Vietnamese. Results remain stable. Levels of satisfaction continue to be low for the

Asian languages. In general, the highest scoring plans were Kaiser and CenCal Health and lowest scoring were Anthem Blue Cross HMO and San Francisco Health Plan.

The survey included questions for children with chronic conditions. Only about 10% of respondents indicated their child had a chronic condition. Results showed that members with chronic conditions had a more difficult time getting needed care, but got care more quickly than the overall HFP population. MRMIB also used these questions to gain a better understanding of members' experiences with the California Children's Services (CCS) program. Only a small number (101 out of 1,090 or 9%) of children with chronic conditions received care in the CCS program and 83% of these children were satisfied with their treatment.

YAHCS: HFP is the only program that MRMIB knows of that has administered this survey in recent years. The survey was first conducted in summer of 2006 with a 46% response rate. The second survey was conducted in fall of 2007 with a 37% response rate. Teens are surveyed directly, whereas in CAHPS, parents complete the survey. The results show that overall, the majority of teens consider themselves to be in good health and few are engaging in two or more risky behaviors. They also see a doctor for routine care and are able to communicate with their doctor. Areas for improvement include increasing the level of counseling and screening for risky behaviors, being seen for comprehensive well-care visits, and receiving care in a confidential and private setting.

The future of these surveys is uncertain as they are not funded in the Governor's proposed budget. Conducting the surveys in the next year or two will be even more critical due to the program changes resulting from the budget changes.

Discussion: R. Marowitz asked about the survey translations being certified by NCQA. M. Watanabe said there was work done regarding this issue in the past and it was determined to be acceptable to do the surveys in these languages.

L. Johns asked if the surveys are administered by MRMIB or a third party and how we work with the plans having lower scores. M. Watanabe replied that DataStat is the outside vendor who administers the surveys. They handled the YAHCS sample differently the first time it was done (during the summer) which resulted in a better sample size.

A Committee member asked about the goals being at the 50<sup>th</sup> percentile and if MRMIB would like to set it higher. M. Watanabe said this is something we hope the Committee discusses to assist us in making this determination. Where should we set our benchmarks? Historically, MRMIB has compared scores to the HFP average or raw mean. We would like to set benchmarks to hold plans accountable.

R. Marowitz stated that HEDIS and CAHPS are different in that HEDIS measures what is actually happening and CAHPS measures member satisfaction based on the member's perception of care. Perceptions should be viewed as advisory rather than

used for corrective action. Medi-Cal Managed Care's goal is to reward plans who move up in scores and to avoid using a punitive approach. E. Mendoza said the results of the increase/decrease of scores compared to the benchmarks should be made clear to the plans. M. Giammona suggested setting the high end and low end and then a certain level of required improvement (say 5%) for the plans in the middle range. Dr. Kurtin suggested this be discussed during future meetings because this is a complex issue worth spending more time.

R. Marowitz asked if the plans receive their plan specific information. M. Watanabe responded that the plans get a very detailed binder with plan specific scores and a breakdown of age and ethnicity. R. Marowitz added that it would be good for the plans to work together to see what areas they could improve or possibly do collaborative quality improvement projects.

M. Giammona added that sometimes the teens may not always remember or recognize that they received certain types of care.

L. Johns mentioned that getting at provider behavior through the plans is extremely difficult and asked if MRMIB could get to the providers directly. S. Rouillard replied that MRMIB's relationship is with the plans so MRMIB cannot directly influence provider behavior. E. Robinson-Frank suggested looking into the California Quality Collaborative as a means of working with the providers. E. Mendoza said providers should be giving care in the same manner across all product lines.

#### *b) 2007 HEDIS*

M. Watanabe presented the 2007 HEDIS report which included eleven measures with three new measures (Appropriate Testing for Children with Pharyngitis, Appropriate Testing for Children with Upper Respiratory Infections and Chlamydia Screening).

Rates were generally higher than Medi-Cal Managed Care rates and closer to Commercial rates. Improvements were made in the Immunizations Combo 3 and Adolescent Well Care Visits measures. Although the Adolescent Well Care Visits improved, there is still room for improvement. The new measures seem to be areas for concern, especially measures related to Pharyngitis and Chlamydia screening.

Discussion: Discussion commenced among members on the Pharyngitis measure and how all data is collected. R. Marowitz said there are usually initial problems with new measures. Once a baseline is achieved, plans can take a closer look at what is actually going on. In Medi-Cal, low scores usually show a problem with coding. S. Rouillard added that high scoring plans typically have better system capabilities to capture and report this data. Dr. Zaheer added that he does not believe that the low HFP weighted average is entirely accurate because of what actually happens at the practice level and how data is reported. He commented that two plans in San Diego have very different scores even though the same providers participate in both plans. Dr. Kurtin stated that

improving data quality is part of quality improvement. R. Marowitz stated that this is a good reason for not setting performance criteria using new measurements.

M. Giammona raised an issue with the Chlamydia measure and stated that many of the younger women in Health Plan of San Mateo (HPSM) use the Family PACT program which provides this screening, but does not release this data to HPSM. She asked S. Rouillard if she would look into this further to see if they could get this data.

*c) 2007 Cultural and Linguistic Services Report*

S. Rouillard spoke about the Cultural and Linguistic (C&L) Services Report completed in October 2007. Health plan contracts require plans to report on the services provided. Ethnicity and preferred languages are indicated on the member applications.

80% of the plans inform their providers of member languages. Santa Clara indicated that all new providers are given a manual that includes Interpreter Quick Reference Cards and Language Identification Cards. Some plans use an "I speak" card which alerts providers to what language the member speaks.

Plans are required to provide language assistance to members. Most plans indicated they hire bilingual staff with a large portion speaking Spanish. Kaiser uploads all demographic information at the time of enrollment so any provider can see this information.

Plans are required to translate materials in certain threshold languages based on the criteria established in the contract. Almost all plans use contracted vendors to provide translation services.

Plans are required to develop internal systems to monitor and track language assistance services. Some plans use focus groups to get feedback on whether or not this assistance is useful. 80% of plans recruit staff that speak languages other than English. Some plans evaluate language assistance services via member complaints and satisfaction surveys.

The C&L survey has been updated and a copy is provided in the meeting packet. This year, plans will submit the data using Survey Monkey. MRMIB will also work with DMHC regarding the language assistance requirements.

Discussion: A Committee member asked if HFP has a minimal literacy level requirement for reading materials. S. Rouillard stated that the contracts set the reading level at 6<sup>th</sup> grade. Members responded that this is high.

A Committee member asked how HFP deals with different linguistic needs within a family. S. Rouillard responded that all members should receive interpreter assistance by plans.

Dr. Zaheer asked why HFP surveys the plans and not the providers and patients directly. S. Rouillard stated that MRMIB has the contractual relationship with the plans, not the providers. Discussion commenced on using CAHPS surveys to gather this information and to perhaps send supplemental questions that address this issue.

R. Marowitz asked if HFP has a facility site review requirement where plans have to go out and review provider sites to determine if they meet the C&L requirements. S. Rouillard stated this is not a contractual requirement but this information should be reflected in the DMHC audits which staff receive. Dr. Giammona said that HPSM follows up on all member complaints pertaining to cultural and linguistic issues.

## 5. Ideas for Future Quality Indicators/Quality Improvement Programs (QIP)

### *a) Overview on Patient Centered Medical Homes from NASHP Conference*

S. Rouillard began by reminding Committee members that HFP does not tell plans how to conduct their business. Plans are expected to work with their providers to comply with program requirements. MRMIB hold plans to the standards in the Knox Keene Act. A challenge for MRMIB is that the contractual relationship is with the plans so MRMIB does not have any direct relationships with the providers.

S. Rouillard then spoke about attending a conference on Patient Centered Medical Homes (PCMH) which is a popular concept being discussed among plans, providers and the American Academy of Pediatrics. A handout outlining the principles of PCMH is included in the meeting packet. PCMH envisions complete and comprehensive care coordinated by one primary physician but where a member can receive multiple types of services at one location. The practice takes care of the whole person and offers acute as well as preventive care, along with supplemental services such as nutrition education and counseling (patient centered care). She would like the Committee's perspective on whether this model is something that should be incorporated into the Healthy Families Program.

Discussion: R. Marowitz mentioned that Department of Health Care Services (DMHC) has a major initiative to reach a point where every member has a medical home. This may be an opportunity for partnership.

L. Johns recommended Tom Bodenheimer's report on PCMH located on the California HealthCare Foundation website.

Dr. Kurtin spoke about the issue of necessary funding to be able to create these medical homes. Group discussion then commenced on payment mechanisms, funding, etc. Dr. Kurtin asked the group to focus on some short term goals.

J. Lopez also mentioned recent discussions with plans about the PCMH model and ways to ensure cost efficient care. HFP is not in the position to pay more for this.

Dr. Zaheer spoke about a provider perspective regarding disenrollment and re-enrollment with a different provider. J. Lopez reviewed the HFP enrollment process.

L. Johns asked why adolescent smoking doesn't appear on any of the data sets. She then handed out a document consisting of criteria to consider when adopting new measures.

J. Benjamin mentioned four short questions on the PCMH available on the Commonwealth Fund's website which might be helpful in our discussions. She also mentioned the group should consider measures that look more closely at children's functioning.

Dr. Kurtin mentioned the HFP survey that he previously worked on that looked at the functional status and quality of life of the members.

E. Mendoza stated the Committee should look at what MRMIB is going to do with the reporting and/or measurement data. Data collection should be practical and reliable. Data collection and producing reports costs money and this should be kept in mind. Dr. Kurtin then spoke about measures for improvement vs. measures for accountability.

D. Giammona said there might be recommendations regarding quality that may not be measurable. The vision can be that every child has a medical home which would mean X (something to be defined). The focus of quality improvement should not only be on NCQA HEDIS measures.

R. Marowitz offered an idea to survey the plans to find out where they are at regarding PCMH and also if they know where their providers are at with this idea. It might be best to start with a quality improvement project. Regarding the measures, perhaps pick areas that are important to the program. Build on improvement in existing measures as opposed to choosing new ones.

Dr. Zaheer mentioned a plan survey he received as a provider and suggested HFP require plans to send something similar to their providers to facilitate communication and improvement.

In closing, Dr. Kurtin thanked everyone for their comments. S. Rouillard asked for suggested areas of focus for the next meeting. R. Marowitz recommended MRMIB create a list consisting of the ten most compelling things to focus on.

S. Rouillard added that the plan performance profiles should be available at the next Committee meeting.

The next Advisory Committee on Quality meeting is scheduled for January 29, 2008 from 1pm to 4pm at the Department of Rehabilitation in Sacramento.

Please see Cristal Schoenfelder for information pertaining to travel reimbursement.