MEDICAL CARE ADVISORY COMMITTEE (MCAC) MEETING
MINUTES
February 18, 2015
3rd Floor 3-240 EOC Conference Room

Members Present	**Phone Conference**	**Members Absent**
Dr. John Lue	Dr. Michael Brooks	Mr. Steven Barber
Mr. Marvell Butts	Mr. A. Edward Cockman, RPh	Dr. Kim Hazelwood
Dr. Helen Gelly	Dr. Lori Paschal	Dr. Tyler-Hill
Ms. Georgina Howard		Dr. Lucky Jain
Dr. Hogai Nassery		Dr. Sandra Reed
Dr. Hugo Scornik		Ms. Sandra Washington
Ms. Sonja Allen-Smith		Dr. Bryan Williams
Ms. Carie Summers		
Ms. Arianne Weldon		
Mr. J. Reid Wilson		
Mr. Dave Zilles, Advocate		

The MCAC meeting began at 10:12 a.m. with a welcome by Ms. Patricia Jeter and an introduction of the new members; Sonja Allen-Smith, Dr. Helen Gelly, Georgina Howard, Carie Summers, Dr. Yasmin Tyler-Hill, Dr. Lucky Jain, Sandra Washington, and Bryan Williams. Mr. Marvell Butts, Vice-Chairperson, called the meeting to order. A motion was made to approve the November 19, 2014, minutes by Mr. Reid Wilson; Dr. Scornik seconded the motion and the minutes were approved as written.

The following agenda items were presented:

A. CAHPS® Performance Measures – Dr. Janice Carson, Deputy Director, PQO

Dr. Carson gave a presentation on defining Performance Measures: What They Are?; What Purpose Do they Serve?; How Are The Rates Generated?; What Populations Do We Monitor? and why Performance Measure Rates are generated. For this purpose, Performance Measures are defined as tools to assess the performance of individual clinicians, clinical delivery teams, delivery organizations or health insurance plans in the provision of care to their patients or enrollees. Our measure stewards include CMS, National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys, Agency for Healthcare Research and Quality (AHRQ), and The Joint Commission. In addition, we use measures identified in the CMS Adult and Child Core Sets of Performance Measures. Many of the CMS measures are HEDIS and AHRQ measures; we've added to that set of measures over time.

Our reason for conducting performance measurements is because it helps us to understand the healthcare delivery process, identify quality of care issues and increase the effectiveness of healthcare delivery. It also helps us benchmark our performance against other states. NCQA receives performance measure rates from Medicaid Manage Care Plans across the country and uses the data to generate percentiles. Today's presentation focuses on Families' Population as a collective and Fee for Services population. There is a significant difference between the progresses we're making in Managed Care vs. Fee for Service.

CMS doesn't mandate that we report Performance Measure Rates to them but they strongly suggest it and label it as "Voluntary Reporting." This data is used to generate a report called

the “Secretary’s Report” and is submitted to Congress, who in turn uses it to conduct a state-to-state comparison of performance measure rates. This report is available online and you can access it to see how Georgia’s Medicaid Program measures up nationally.

NCQA has determined that an adequate sample size is comprised of 411 members. Each measure has an eligible population which defines the denominator for the measure. This numerator criteria is specific for the rate we are trying to generate and data needed to populate the numerator most often comes from claims data; for Hybrid measure is a combination of claims data and Medical Record reviews. The population measured is comprised of all Medicaid and CHIP members, and is the population that is reported in the Secretary’s Report. We’ve identified a slight inaccuracy that could result in Georgia potentially having a lower PMR because the Performance Validation Process for the “All” population includes eligible “Dual” Population data and while Dual eligible members are included in the denominator, no claim data is available to use in calculating the numerator.

Our report lists the State targets; there are no State targets below the 50 percentile. Unfortunately there is a huge gulf between Performance in Georgia Families and FFS population. We’ve given our Managed Care Plans an improvement project called Bright Futures and they’ve been encouraged to identify the barriers preventing members from getting their preventive health visits. Effective January 2015, Georgia Families members, after a CMO is selected, can request services as early as the next day; Performance Measure Rate data will be available later this year.

B. <u>GEORGIA 2014 CAHPS® SURVEY RESULTS</u> – Tiffany Griffin, Program Specialist

Tiffany Griffin presented an overview of the Georgia 2014 CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey results. CAHPS is a quality improvement tool used to measure members reported experiences of care and represent an in-depth look into the quality of care and customer service rendered to members. National Committee for Quality Assurance (NCQA), a certified survey vendor is used in the collection process, as well as Computer Assisted Telephone Interviewing (CATI). A target number of completed surveys for each survey group has been established at 411. The survey is available in English and Spanish, contains 48-58 questions and collects specific demographic data (i.e., age, gender, education and ethnicity). Survey components is the same for all groups:

- Global ratings of health care
- Access to specialized services
- Communication
- Customer service
- Coordination of care

Georgia exceeded the national average response rate set at 29%.

Survey responses are measured on a 0-10 rating scale where zero represents the worst possible and 10 is the best possible. All responses of 8, 9, or 10 are considered an achievement. There are five composites on the survey as well, that represents an overall aspect of plan quality and allows member to say how well we are doing. These composites are related to whether they believe they’re getting needed care, getting care quickly, how well doctors communicate, customer service and shared decision making. Each composite represents an overall aspect of plan quality. Any response of: "Usually”, "Always“, “A lot” or “Yes” is considered an achievement.

DCH results were “Good.” In the overall rating questions regarding member’s personal doctor and specialist seen most often, we met or exceeded the 80% target rating. We also received a “Met” or “Exceed” rating on 4 out of 5 components responses. The area identified that we need

improvement on was Shared Decision Making. Several of the members surveyed felt they were not included in the decisions made about their own healthcare (or healthcare of their child). The areas fell below the national 46.2% average and were identified as needing improvement:

- Medical assistance with smoking cessation
- Flu shot for adults (ages 18-64)
- The risks and benefits of taking aspirin to prevent heart attack and strokes discussion

C. <u>MCAC Members' Round Table Discussion (general discussions on topics presented and to be presented)</u>

Dr. Lue opened the table to discussion of topics and presenters the Committee would like to have in future sessions. The following items were suggested:

1. Legislative update
2. Medical records electronic project update
3. Bioequivalent drugs
4. CMO pharmacy reps to present on formularies

Meeting was adjourned at 12:11 p.m.

The next MCAC meeting is August 20, 2015 at 10 a.m. 3rd Floor 3-240 EOC Conference Room.

MCAC future meeting dates:

August 20, 2015
November 19, 2015

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED, THIS 19th DAY OF August, 2015.

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John Lue, MD, FACP, Chairperson