

**Managed Risk Medical Insurance Board
December 16, 2009, Public Session**

Board Members Present: Cliff Allenby (Chairman), Areta Crowell, Ph.D.,
Sophia Chang, M.D., M.P.H., Richard Figueroa

Ex Officio Members Present: Ed Heidig, Jack Campana, and Bob Sands

Staff Present: Lesley Cummings, Executive Director; Janette Lopez, Chief Deputy Director; Laura Rosenthal, Chief Counsel; Shelley Rouillard, Deputy Director for Benefits and Quality Monitoring; Terresa Krum, Deputy Director of Administration, Ginny Puddefoot, Deputy Director of Office of Health Policy and Legislative and External Affairs; Ernesto Sanchez, Deputy Director, Eligibility, Enrollment, and Marketing Division; Thien Lam, Manager for Eligibility, Enrollment, and Marketing Division; Will Turner, Analyst with the Office of Health Policy and Legislative and External Affairs; Anjonette Dillard, Manager in the Eligibility, Enrollment, and Marketing Division; Muhammed Nawaz, Manager in the Benefits and Quality Monitoring Division; Maria Angel, Assistant to the Office of Chief Counsel; and Stacey Sappington, Executive Assistant to the Board and the Executive Director.

Chairman Allenby called the meeting to order at 10:00 a.m. The Board then went into Executive Session. It reconvened for Public Items at 11:30 a.m.

Chairman Allenby, noting that Bob Sands had accepted a position with the Department of Health Care Services (DHCS), presented Mr. Sands with a plaque acknowledging his enormous contributions to MRMIB both as an ex-officio Board member and as the Agency's Associate Secretary. The Chairman noted that the Secretary of CHHS has not yet appointed a replacement for Mr. Sands, but he thought it possible that the Secretary would do so prior to the next Board meeting. He commented that Mr. Sands had been on the Board during a very

difficult period, one in which anything that could go wrong, did go wrong. Mr. Sands did a gentleman's work to make sure that CHHS was informed and was an ally in trying to get MRMIB's programs what they needed. The Chairman thanked him for his work.

Ms. Cummings added that over the course of Mr. Sand's tenure, MRMIB's programs faced many really difficult times. When Mr. Sands was at Finance and at CHHS, he always viewed issues in their larger context. He saved MRMIB's bacon on many, many occasions. She said that MRMIB would miss Mr. Sand's presence immeasurably.

The other Board members all added their thanks. Mr. Figueroa noted that Mr. Sands had helped MRMIB navigate through sometimes treacherous waters in recent years. Mr. Campana commented that Mr. Sands was extremely competent and motivated by the values of public service. Dr. Crowell said that she had been heartened by CHHS' involvement in MRMIB issues, finding it supportive and helpful through Mr. Sands' participation. Dr. Chang and Mr. Heidig added their thanks.

Mr. Sands thanked the Board for its acknowledgement. He indicated that he had really enjoyed his work with the Board, noting that Board members are unpaid and present due to their commitment to public service. He commented that he and the Agency share this commitment and said that the best part of his job at CHHS had been working with Board members and staff. He thanked them for giving 100 percent effort.

REVIEW AND APPROVAL OF MINUTES OF NOVEMBER 18, 2009

Chairman Allenby asked if there were any questions or comments on the minutes for November 18. There were none. The Board unanimously approved the minutes.

The minutes can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Public_11_18_09_Draft.pdf

FEDERAL BUDGET, LEGISLATION AND EXECUTIVE BRANCH ACTIVITY

Ms. Puddefoot informed the Board that there were numerous documents in their packet related to federal healthcare reform. The most notable is the description of the Casey Amendment which would extend funding for the CHIP Program through 2019 and require a report in 2016 comparing CHIP benefits and coverage with the benefits and coverage under the exchange approach. The Casey Amendments would also increase the federal participation level beginning in 2014 and would require that states provide CHIP coverage to children at least

up to 250 percent of the federal poverty level. Presently, the amendment is being scored by the Congressional Budget Office.

The packet included a report issued by the First Focus Group that compares children in CHIP coverage with the exchange coverage. It comes out strongly in favor of CHIP as being more beneficial to children.

The packet also includes a report issued by the California Health Care Foundation on children's health coverage that looks at the status of children's health care from 2003 and 2007.

The report includes charts that highlight the benefits to children from being in the Healthy Families Program. Children do very well in terms of access to well-baby visits, and well-child visits, and dental care, compared to children who are uninsured, or are in Medi-Cal or other kinds of insurance programs.

Chairman Allenby asked for any questions or comments. There were none

These documents can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_4.pdf

STATE BUDGET UPDATE

Ms. Cummings reported on the status of CMS approval of the use of Managed Care Fees enacted by AB 1422. Staff previously told the Board that CMS had issued a preliminary conclusion that the 1422 Managed Care Fee did not pass muster and indicated that they would basically give the state until next September to cease drawing down federal financial participation (FFP) funds to match the fee.

There's been a significant campaign to convince CMS otherwise. Part of that is laid out in the letter from the local health plans of California which articulates the reasoning that supports drawing down FFP for the fee. There has been a lot of advocacy work by advocacy groups, the legislative leadership and the Administration.

Chairman Allenby opined that the local health plans argument seemed sound and thanked John Ramey for his work on the issue. Mr. Figueroa indicated that the Administration thinks the argument is completely appropriate. Dr. Crowell expressed thanks to those working to change the CMS view.

Chairman Allenby asked if there were any comments from the audience. There were none.

These documents can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_5_State_Budget_Update.pdf

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry Report

Mr. Sanchez indicated that he was bringing good tidings to the Board. The wait list no longer exists! MAXIMUS staff Michael Lemberg, Lane Adams, Lori Boulter, Kathi Prudhomme and Teresa Broff, all of whom were in attendance at the meeting, led the effort to clear the wait list. Mr. Sanchez asked MAXIMUS staff to stand and be acknowledged. On behalf of the Board, Chairman Allenby thanked MAXIMUS for its excellent work.

Mr. Sanchez indicated that enrollments for November are back up to historical levels. MRMIB enrolled over 35,000 new children. Since the wait list was lifted in September, HFP has enrolled over 80,000 children.

Mr. Sands asked how many children were actually enrolled from the waiting list. Mr. Sanchez replied that staff will evaluate this over the next couple of months. Staff need more time because there is still activity underway regarding incomplete applications. Staff expect to have a full evaluation in two to three months.

Chairman Allenby asked for any additional comments or questions. There were none.

This report can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_6.a_HFP_Enrollment_Report.pdf

Administrative Vendor Performance Report

Mr. Sanchez reported that MAXIMUS missed one performance area during the push to clear the wait list. It missed by half a percent the requirement to not abandon any more than five percent of the calls at the Single Point of Entry. But there was a significant call increase during the month, a 23,000-call increase in November compared to the same month last year. This is not too surprising considering so many things that were going on. Among other changes, the program changes took effect November 1 (increase in co-payments and premiums, dental plan enrollment changes) and this too contributed to the high call volume. Staff doesn't believe that this will be an ongoing issue. The vendor met all other standards.

Mr. Figueroa noted that the data showed that the vendor did reply to all voice mails within two days.

Chairman Allenby asked if there were additional questions or comments from the Board. There were none. He asked for any comments from the audience. There were none.

The performance report can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_6.b_HFP_Adv_Vendor_Perf_November_2009_Summary.pdf

Advisory Panel Summary from November 10, 2009 Meeting

Mr. Campana, HFP Advisory Committee Chair, reported to the Board on the November 10th meeting. He referenced the written summary before the Board.

During the meeting, members expressed a bit of concern about how long it would take to work through the wait list—an issue now resolved. Members were also concerned, after reviewing the October enrollment data, that it was not widely understood that the HFP had re-opened to new enrollment.

One concern the members discussed was in the context of the report on subscriber satisfaction. It had been alleged that one cultural group may be more critical than others. Several members cautioned staff about accepting this perspective, indicating that it could reflect real differences in services received or real differences in families believing that their needs are not met.

Chairman Allenby asked if there were any questions or comments. There were none.

The summary can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_6.c_HFP_Advisory_Panel_Summary_Draft_11_10_09.pdf

2010-11 Plan Contract Model Amendment Language

Ms. Lopez reminded the Board that staff had presented draft model health, dental, and vision contracts at the November meeting. In those drafts, staff attempted to strike some balance between pushing forward on plan accountability and quality while not increasing plans costs significantly. Staff heard plan comments on the drafts at the meeting and also solicited plan comments after the meeting. Staff held a conference call with plans on December 11th and requested that plans submit their comments in advance of the call via e-mail. Staff received comments from IEHP, Molina Health Care, Community Health Group in San Diego, the Local Health Plans of California, and Kaiser. The night prior to the Board meeting, the California Association of Health Plans provided comments which are contained in a letter in the Board packet.

Staff did not include the emails from plans who responded prior to the conference call in the packet, but these will be described in the presentation.

After the December 11th call, staff deliberated on plan comments and made several revisions to the model. These revisions are reflected in the proposed model contracts before the Board at this meeting. The revisions staff has proposed are a response to the dire fiscal straits HFP is in. They are difficult to propose given how much staff—and the Board --want to advance the agenda for plan accountability and quality.

Ms. Lopez then summarized the areas of plan concern and the extent to which staff addressed these in the revised model contracts. The major areas of plan concern were:

Mental Health. Every plan expressed concern with language that clarified that should there be a delay in obtaining county services for a child a plan believes is seriously emotionally disturbed (SED), the plan is responsible for providing the child any immediately needed service. Staff does not believe that this language alters the process as it exists today. Another provision specifies that a plan should also develop a treatment plan pending county assessment if there is a delay in the assessment.

In response to plan comments, staff re-instated language requiring the plans to develop memoranda of understanding (MOUs) with county mental health departments, “to the extent that doing so is feasible”. Plans wanted the language retained commenting that county response is not under plan control.

Staff added some additional plan reporting requirements in the first draft which are retained in the model proposed today. These refine the requirement that plans report on the number of children referred to a county and the number receiving services to specify that the plans need to provide an unduplicated count. Plans felt that MRMIB could get the data from the counties. Staff’s view is that the plans should know the unduplicated count and having them provide the data would allow for additional detailed analysis on the children needing SED services.

The plans agree that HFP children should get the services that they need. Their objection is that if they are going to be held accountable for providing the services they want funding for them. However, MRMIB staff does not believe that the language under discussion will change county practice. The May 2009 Mental Health Report showed that the rate at which counties have determined a child to have an SED has increased. There may be case-by-case situations where there are problems. Staff has asked that plans bring these to the attention of MRMIB staff when they occur so that MRMIB can document any problems.

Ms. Cummings added that MRMIB has two positions funded by Prop 63 funds, whose job it is to resolve any areas of conflict between a plan and a county.

Chairman Allenby commented that having these positions is important as resolving issues can be a challenge given that the 58 counties have 58 ways of doing things. It is essential that staff deal with plan/county problems so children get taken care of.

CCS. Many of the plans objected to language in the model which requires them to provide information on children referred for or receiving CCS services on an unduplicated count basis. Staff has retained this language because the information is essential for accurate analysis of CCS referrals and utilization.

Another area of plan concern was that the staff deleted a reference in the contract indicating that CCS would make retroactive payments back to the date of referral. Staff removed the language because MRMIB does not dictate CCS practice. However, in fact, CCS policy, as evidenced in an all-county letter sent to local CCS programs in July of 2003 is that CCS will make retro-payments back to the date of referral. Further, the template MRMIB staff created for the MOU between counties and plans references this payment requirement.

Plans also complained that there are discrepancies between the way that local CCS programs determine eligibility and the way HFP does. Counties make a determination based on whether an applicant is a resident of the county. HFP makes a determination based on whether the applicant is a resident of the state. Staff has asked that plans bring MRMIB into the loop when a county raises a county residency issue so that MRMIB is aware of the extent and particulars of the problem.

HEDIS Reporting. Today, plans report a statistically valid sample of around 400 records per HEDIS measure. This sample represents their entire book of business in HFP. The model contract contains a new provision requiring that plans report a statistically valid sample for each measure in each region in which they provide service. Medi-Cal requires plans to provide a statistically valid sample for each measure for each county in which they provide service. MRMIB staff believes that data are needed at least regionally. Plans complained that regional reporting would increase their costs because it would increase the size of the sampled population. After hearing from the plans, staff decided to revise the language to specify that regional reporting is required only where a plan has more than a thousand members in a region. This provision reduces the number of plans affected. The ones that are still affected are the larger plans and plans that have an HMO and an EPO product.

Plan Performance Standards. The model contract as first proposed established a process and construct for holding plans accountable for quality performance. After listening to the plans about the costs associated with the proposal, staff

reluctantly proposes to eliminate the provision from the model. Instead, the model brought to the Board today simply re-instates language from the existing contract, a paragraph that states that plans are supposed to monitor and report their HEDIS and quality data.

Ms. Lopez indicated that she had cautioned the plans that as a consequence of provisions in CHIPRA, CMS will, in the near future, be much more prescriptive on quality issues than it has in the past. Once CMS issues regulations on quality, MRMIB will be compelled to incorporate them into plan contracts. So, the removal of the language ultimately is just a delay in setting out quality requirements.

Ms. Lopez noted that the model contract also contains a provision requiring that plans acknowledge that as CMS rolls out CHIPRA requirements MRMIB will amend plan contracts as necessary. These amendments will be included after plan negotiation and approval.

Conclusion: Ms. Lopez remarked that it had been extremely challenging to compromise on the improvements that were contained in the model contract, but it had seemed necessary to compromise on some given the financial strain under which the plans are operating. The final presented to the Board today strikes a good balance. She thanked the plans for their patience and effort. She then acknowledged the MRMIB staff who had worked with her on plan contract issues: Muhammed Nawaz, Mary Watanabe, Ruth Jacobs, Lilia Coleman, Sarah Swaney, Jill Young, and Dianne Ehrke, and, of course, Shelley Rouillard.

Chairman Allenby asked the Board for any questions or comments.

Dr. Chang commented that she is one of the board members who has really pushed for advancement of a quality agenda for some time. She expressed disappointment that it doesn't seem possible to make a significant move forward. But she acknowledged that the Board is trying to be extremely mindful of the difficult financial situation of its plan partners. And she acknowledged that many plans have stepped forward to help MRMIB build its quality agenda. Quality reporting is going to be coming relatively imminently, but there will be some time to figure out exactly what that will be. Plans should know that the Board hasn't given up on the quality agenda, but it will act to honor its relationship with them.

Dr. Crowell and Chairman Allenby concurred with Dr. Chang's remarks.

Mr. Figueroa asked Ms. Lopez to describe where the process is right now regarding plan contracts. She replied that the model contract presented to the Board is what staff plans to present to plans. The model is not an actual contract and staff are not seeking Board approval of a contract. Staff wants the Board to be aware and supportive of the model.

Chairman Allenby remarked that plans would be able to comment on the model again.

Ms. Cummings said the model represents what staff will send to plans and ask them to sign. There will be no further opportunities to comment on the model. Some MRMIB staff have suggested that it is not necessary to present a model contract for public discussion before the Board. Instead, staff could just negotiate plan by plan on final contracts. However, she believes that there is value in having a public discussion of what staff expect plans to do so that stakeholders, including plans, can convey their views to the Board. But what a model contract represents is what MRMIB will ask HFP plans to sign to participate in the program for the next benefit year.

Chairman Allenby noted that someone in the audience wanted to comment.

Brianna Hintze, representing the California Association of Health Plans asked whether, as the Chairman has indicated at the beginning of the discussion, the model was the beginning of a discussion, one step in a phase, or, as staff seem to be saying, a completed product. She noted that the version of the model contract staff presented is one that plans are seeing for the first time.

Ms. Lopez explained that the standard process is for staff to bring the model to two board meetings. Plans present their comments at the first meeting and subsequent to the first meeting. Staff then brings comments received and staff recommendations to the Board to the second meeting. What the Board actually approves later in the process are individual contracts with the plans. There could be minor, very minor, adjustments on a plan-by-plan basis based on negotiations. But for the most part, the model is the base.

Mr. Figueroa asked if a plan's final contract looks a little different than the model. Ms. Lopez replied that it could be slightly different on a plan-by-plan basis. Ms. Cummings added that it is generally true that staff work to implement the model with all plans.

Chairman Allenby remarked that the Board received comments as late as last night that staff may need to take into consideration. Ms. Lopez replied that while there's always room for adjustments, any such adjustments would be pretty insignificant. The model set forth at this meeting will be sent to the plans. Staff will then ask plans to turn in their service area grids and their financial reports on the rate development template based off of the model sent to them. Unless the Board decides otherwise, there would not be any changes of significance that would impact a plan's decision to stay in or out of a given county.

Ms. Cummings commented that the Board could ask staff to bring the model back to another meeting. But doing so would push up against the operational timeframes.

Chairman Allenby indicated that he did not want to call for a special meeting so staff should proceed as described. But, he asked that if a major issue develops, he wants to ensure that it can be addressed and that the Board is at least aware of it.

Mr. Figueroa again noted that some comments came in just last night. Ms. Hintze replied that the comments that came in last night were from CAHP.

Ms. Cummings noted that the issues raised in the CAHP letter were the same ones that plans had raised in their e-mail comments prior to the plan conference call. Staff has had time to hear from the plans and reflect on their comments. Staff made judgment calls on the issues, and for the most part, backed away from a number of things that would cost the plans money. The purpose of presenting the revised model at today's meeting is so that the Board can hear from diverse stakeholders (advocates, stakeholders, plans) on the model contract staff propose. If the Board directs changes to the model, staff will surely make them. If the Board directs staff to continue the dialogue and agendize the topic for a subsequent meeting, staff will do so. But, as previously stated, delaying the issue to another Board meeting will interfere with the operational schedule.

Chairman Allenby replied that he understood these facts.

Ms. Hintze asked that the Board provide more time for conversation on the model. She opined that there still seems to be a number of areas of disagreement and plans haven't had a chance to digest the proposed changes.

Chairman Allenby asked the staff to comment.

Ms. Lopez replied that she didn't know how to respond given the operational timeframes which if unmet will not allow sufficient time for plans to prepare and submit coverage areas. She noted that plans had had 30 days to provide comments and CAHP only turned them in last night. Ms. Hintze replied that there had been no established deadline for comment. Chairman Allenby asked if the plans had had the opportunity to review the document presented at today's meeting. Ms. Hintze replied that they had not. Ms. Lopez commented that, in fact, the plans had the opportunity to review all of the proposed language, except for the new language: a placeholder for CHIPRA implementation, a placeholder for quality reporting when CMS provides clarity, and a provision that specifies that plans will have to co-operate with the external quality review organization (EQRO) MRMIB hires in accordance with CMS requirements. Other than that, staff simply deleted provisions of concern to the plans. And by establishing a 1,000 subscriber threshold for regional HEDIS reporting, staff mitigated the effect of that requirement on most plans.

Chairman Allenby asked again whether the plans have had an opportunity to review the modified model contract. Ms. Lopez replied that they have not. She suggested that if the Board wanted to provide plans with that opportunity, that the comments be limited to those provisions that are new. These would be CHIPRA, quality, EQRO, and HEDIS. Chairman Allenby indicated that he understood staff's concern but that he did think it important to provide plans the opportunity to comment on something they had not yet seen.

Ms. Lopez: replied that she would provide for that opportunity. Chairman Allenby asked if the Board was in agreement with this approach. Board members indicated that they were.

Ms. Hintze asked for clarification on whether the allowable comments would only be on new issues. She said that she had not understood that the model presented at this meeting would be final and thought that the conversation would continue on all outstanding issues. Ms. Lopez replied that this would not be consistent with the traditional process.

Chairman Allenby responded that the changes and adjustments made to the document were in relation to comments made by CAHP and other interested parties. He is aware that plans may not be happy with every decision made, but staff has captured and responded to the issues raised by the plans.

Ms. Hintze asked what the deadline for comments was. Ms. Lopez replied that the sooner the better and no later than a week.

Dr. Crowell commented that while it may not have been apparent in the presentation, in fact, staff has worked very hard and bent over backwards to address plan concerns. As Dr. Chang said, the Board backed off of a lot of provisions that it thinks are extremely important. Staff took virtually all of them out except where it was absolutely not possible.

Ms. Cummings asked the Chairman whether he wanted to schedule another meeting so that the Board could hear about any additional comments. He replied that he wanted comments to come to staff and for staff to use its general authority to negotiate language, as long as the intent remains the same. This is within staff's responsibility and authority.

John Ramey representing the Local Health Plans of California (LHPC) remarked that he was having a hard time keeping up with what had changed and what hadn't in the model contract. However, the area that is the most important—the way in which the program deals with carve-outs—remains unaddressed. Mr. Ramey suggested that having a discussion about the advisability of the carve-outs would be beneficial. LHPC's general perspective is that carve-outs are not in the best interest of beneficiaries because there's just too much opportunity for children to fall through the cracks.

He suggested that the way that the language has been changed in the model contract is an engraved invitation to prudent managers of county programs at mental health and CCS to delay authorization or eligibility for HFP children. The counties are experiencing the same funding crises that HFP is. Under the new language, counties know that if they delay services (which under the carve out they would be expected to provide), the plans would now have to provide them—and pay for them. While it is true that plans and counties have been able, generally, to work out these situations to the best interest of the children, the change in the language invites the counties to not provide services knowing full well that the child's health plan will have to.

Mr. Figueroa asked that staff explain again the CCS letter to counties requiring retroactive payment. Ms. Lopez replied that staff had deleted language from the model contract requiring CCS to make retro-active payments back to the date of referral. Staff deleted the language because MRMIB has no authority to dictate the obligations of county CCS programs. The plans expressed concern about this change in the conference call. However, after the call, MRMIB staff located a letter that the state CCS program sent to the local programs in July of 2003 that directed the local programs to pay retroactive to referral for eligible children.

Chairman Allenby asked why staff did not reference the letter in the contract. Ms. Rosenthal replied that MRMIB can't make a contractual promise on behalf of DHCS or the counties but staff could add language clarifying that it is the understanding of the parties that this DHCS policy exists. Chairman Allenby asked staff to do so and to cite the all county letter. Mr. Figueroa suggested that in his new position, Mr. Sands might encourage the CCS program to re-release the directive to the counties to remind them that it is their responsibility to do this.

Dr. Chang remarked that there seemed to be two slightly different issues. One is the CCS issue and the second is the mental health carve-out. She wanted to ensure that these issues were discussed separately. The Chairman agreed and indicated that the present discussion was on CCS.

Dr. Chang moved on to a discussion of the mental health carve out. The goals, broadly shared by all parties, is to make sure that the children are getting appropriate services and that there isn't discontinuity in care. The Board has never felt that it had sufficient information on how many children face this problem. This has been the struggle the program has had all along. Given that there are staff who are designated and have a role and responsibility in this area, plans who are particularly concerned should work with these staff members to document issues such as delays so that the Board has a true picture of the problems.

The plans are concerned because the model contract changes language. But the Board is not changing policy. It is changing language to assure compliance

with federal requirements. The plans seem to suggest that there is a need for a policy change. They express a hypothetical concern, albeit one that has a real probability, that counties may act differently. Plans need to work with MRMIB to document a change of behavior if this, in fact, occurs. She asked plans and the staff to monitor the situation closely and provide the Board with information on whether the feared change actually occurs.

Mr. Figueroa agreed that the more information the Board has on issues with both carve-outs, the easier it will be for the Board to assess the need for policy change.

Dr. Crowell reminded the Board, and the public, that MRMIB is in the middle of a study of mental health and substance abuse services. The report on the study should be coming to the June Board meeting. She stated that she would hope that the plans would have been bringing problems to MRMIB's attention all along. They should certainly do so now and not wait for a contract that won't be implemented until October.

The model contract language can be found at:

http://www.mrmib.ca.gov/MRMIB/2010_11_Plan_Contract_Final.html

Approval of 3 Month Plan Contract Extensions

Chairman Allenby asked for a motion to approve the 22 resolutions included in Agenda Item 6.e for Healthy Families Health Plan Service contract renewals and the 22 resolutions included in Agenda Item 6.e for HFP State Supported Services contract renewals for the 22 health plans listed on page 1 of 2 in the document labeled "2009/2010 Fiscal Year Health Plan Contracts, Three-Month Extensions to 9/30/10". A motion was made and seconded. Chairman Allenby asked if there were any comments. There were none. The Board voted unanimously to approve the motion.

Chairman Allenby asked for a motion to approve the six resolutions included in Item 6.e for the Healthy Families dental plan contract renewals for the six dental plans listed on page 2 of 2 in the document labeled "2009/2010 Fiscal Year Health Plan Contracts, Three-Month Extensions to 9/30/10". A motion was made and seconded. Chairman Allenby asked if there were any comments. There were none. The Board voted unanimously to approve the motion.

Chairman Allenby asked for a motion to approve the three resolutions included in Item 6.e for HFP vision plan contract renewals for the three vision plans listed on page 2 of 2 in the document labeled "2009/2010 Fiscal Year Health Plan Contracts, Three-Month Extensions to 9/30/10." A motion was made and seconded. Chairman Allenby asked if there were any comments. There were none. The Board voted unanimously to approve the motion.

The resolutions can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_6.e_List_of_HFP_Renewals_12_16_09_Meeting.pdf

Update on Advisory Committee on Quality

Ms. Rouillard updated the Board on the November 19th meeting of the Advisory Committee on Quality. The focus of the meeting was to discuss the Premium Discount Project that the California HealthCare Foundation is funding. Through this project, a consultant will recommend to MRMIB quality related characteristics that might go into designating the plan that receives a premium discount. Presently, the only consideration in the designation is demonstrating the highest number of contracts with traditional and safety net (T&SN) providers. The consultant is interviewing various stakeholders, including the plans, and others about which elements of quality could be incorporated.

The committee's discussion was lively. There was disagreement about how much or whether a safety net provider should remain as part of the equation. Some felt strongly that because the premise of the CPP originally was to support the safety net, T&SN provider contracts should continue to be part of the equation. They expressed concern that plans might stop contracting with those types of providers if the premium discount was no longer tied to the number of T&SN contracts.

Others felt that using the designation to reward quality performance was the most important criterion to use. Members discussed the challenges of assessing and maintaining quality when children are moving in and out of Healthy Families, maybe to Medi-Cal. However, the HEDIS measures MRMIB collects control this by requiring continuous enrollment. The committee members also talked about which of the measures currently collected should be used in the designation process. Members also discussed whether there were other financial ways to incentivize plans for quality, such as withholding a certain amount of money and then giving it back based on quality performance. These kinds of comments and ideas are also surfacing through the interviews that the consultant is doing right now.

The discussion did not result in a consensus, but a number of good ideas were put on the table.

Staff had originally intended to wrap up the advisory committee at the end of 2009. However, with the enactment of CHIPRA and CMS's requirement for states to develop a quality framework with the input of stakeholders, this committee will continue. The next meeting is scheduled for January 28, 2010.

Chairman Allenby asked for any questions or comments from the Board. There were none. He asked for any comments from the audience. There were none.

The Chairman advised Ms. Rouillard to keep up the good work.

Update on Dental Quality Report

Mr. Nawaz reminded the Board that Mary Watanabe had presented a draft report on dental plan performance at last month's board meeting. The report's most significant finding was that the performance of the capitated plans was not on par with the performance of the open network plans. The difference in the plans' performance varied from one to four times between the plans. Some of the plans commented at the last meeting that they thought there were problems in the data they had submitted. They asked for the opportunity to analyze the data and potentially to resubmit it. Since then, staff heard from three plans that intended to re-submit data. Data from two of them came in last night. Staff has established a deadline for resubmission which is the end of January. Once the data are received, staff will re-analyze the data and update the report.

Mr. Nawaz also indicated that he needed to correct a statement staff had made at the last Board meeting. Staff had informed the Board that the plan data was unaudited. In fact, the plans' contracts require that the data be audited. Staff asked the plans to submit verification of audits and, to date, five plans have done so.

Chairman Allenby asked for any questions or comments from the Board. There were none. He asked for any comments from the audience.

Ty Hamilton representing Premier Access Insurance Company and Access Dental Plans informed the Board that after the last meeting the company did some pretty extensive re-evaluation of their data submission. They found that after they corrected some math errors and worked to complete the form correctly, the outcome measurements improved substantially in two areas. The report was successful in getting the plans' attention and they are committed to providing the quality and value in both products. Ms. Hamilton indicated that the company felt that the Board does need to recognize the differences between the capitated and open network models when establishing performance measures. They each have their own value and challenges that are unique. Further, the Board should also take into consideration that there are unique challenges in providing coverage in rural areas. These differences cannot be accounted for by simply looking at performance in a region because there are urban and rural areas in each region. The Board should look at those areas separately so that it can identify more meaningful performance measures.

CHIP Reauthorization Implementation – Work Plan Update

Ms. Puddefoot reviewed recent changes to the CHIPRA work plan, noting that these changes are highlighted in the document provided to the Board.

CMS has issued two State Health Official (SHO) letters on CHIPRA's application of certain Medicaid managed care standards to CHIP. One of these discuss a standard that requires states operating a separate CHIP program to give subscribers enrolled in managed care an alternative plan or delivery system in the subscriber disenrolls. The alternative must be available in each geographic area. Staff has brought this issue to the Board's attention previously, but the SHO letter is a recent development. As Ms. Lopez had mentioned earlier, MRMIB is in the process of talking with DHCS about using Medi-Cal fee-for-service providers as the second choice in areas with just one plan.

CMS has issued a SHO letter describing states' responsibility to development and implement a quality assessment and improvement strategy for CHIP. Ms. Rouillard briefly discussed this in her update on the Advisory Committee on Quality. The good news is that the David and Lucile Packard Foundation will provide funding for a consultant to assist MRMIB in developing the strategy. The consultant will also assist MRMIB in developing a contract with an EQRO, another requirement described in the SHO letter.

CMS has issued a SHO letter on dental coverage requirements. The letter specifies that orthodontia is a covered benefit. Staff are still attempting to discern what exactly this would mean. The letter also says that the dental benefit package must be equivalent to one of three specified benchmark plans or be a plan developed by the CHIP Program and approved by the Secretary. Staff is still assessing these approaches.

Regarding CHIPRA's mental health and substance abuse parity requirements, as Ms. Lopez had discussed earlier in the meeting, MRMIB has added language in the health plan model contract to ensure that plans are responsible for the smooth transition of children needing services for SED to county services.

Under the performance bonus section, staff has added language explaining that DHCS and MRMIB submitted California's request for performance bonus to CMS on November 5th

Under the section on outreach funding, staff has reported that on September 30th, 2009, CMS issued the grant awards for outreach activities. Two California-based organizations received a total of just over \$700,000 for a two-year period.

Under the section on quality demonstration project grants, staff reports that MRMIB is collaborating with DHCS on a proposal to improve CCS services. The proposal is due to CMS in early January 2010. MRMIB staff also wanted to submit a proposal for development of a quality framework for HFP, but concluded it was not feasible due to a CMS requirement that plans involved in a project must report all 22 quality measures that CMS has advanced. This would result in increased plan costs at a time of financial scarcity.

Mr. Figueroa asked whether it is the nature of the HFP contracting system that every county is a managed care county and whether this is because of a federal rule or because subscribers must choose a primary care physician or are in an EPO.

Ms. Rosenthal replied that it's a feature of the HFP statute because under the HFP statute the vehicle for delivering care in the entire program is managed care. This is the approach the Legislature chose in establishing the HFP program. If MRMIB needs to provide for any type of system other than managed care in order to provide the second choice, HFP statute would need to be amended to change the structure of the program in that way.

Ms. Cummings reported that she had asked CMS why moving a disgruntled subscriber to a different provider was not sufficient for compliance. CMS replied that it would not satisfy the requirement.

Mr. Figueroa asked whether this meant that there had to be a completely different system—something he thought was quite strange.

Ms. Cummings replied that she had complained about it. CHIPRA, in a number of ways, has applied the rules of an entitlement program to a non-entitlement program. This is making MRMIB tie itself up in knots trying to figure out how to comply.

Chairman Allenby asked for any questions or comments from the Board. There were none. He asked for any comments from the audience.

Ms. Puddefoot went on to inform the Board that she had decided to leave MRMIB and that this would be her last meeting. She expressed her gratitude for the opportunity to be part of MRMIB.

Board members told Ms. Puddefoot that they would miss her and wished her well.

The Workplan can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_6.h_CHIPRA_Impacts_Implementation_Chart.pdf

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report/Administrative Vendor Performance Report

Ms. Lam presented the enrollment report. In November there were over 860 new subscribers enrolled in the program. The program has over 6,900 subscribers enrolled. Mr. Figueroa noted that overall enrollment trend has been steady or

down. Ms. Cummings replied that Ms. Krum would be reporting to the Board on the fiscal impact of the enrollment trend in a subsequent agenda item.

Ms. Lam then presented the Administrative Vendor Performance Report. She indicated that the administrative vendor continues to meet all of the seven areas of performance, quality, and accuracy standards.

Chairman Allenby asked the Board for any questions or comments. There were none. He asked for any comments from the audience. There were none.

The Enrollment Report can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_7.a_AIM_Enrollment_Report.pdf

The Performance Report can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_7.b_AIM_Adm_Vendor_Perf_November_2009_Summary.pdf

AIM Financial Status

Ms. Krum reported to the Board that based on analysis of current expenditure trends, staff has cautiously concluded that there will be sufficient funds for the AIM Program through the remainder of the current fiscal year. Staff will continue to monitor expenditures closely.

Mr. Figueroa informed the audience that the staff had informed the Board earlier in the year that it might have to close AIM in the spring. Ms. Krum's report means that this is no longer the case. Chairman Allenby expressed relief noting that he served on the Board when it had closed AIM and it was a very unpleasant experience.

Mr. Figueroa commented that national data on birth rates show that people are having fewer children –something that has an effect on a number of different programs. This would appear to be an example of the recession's impact on families

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Ms. Dillard reported that as of December 1st, the enrollment level in MRMIP was 6,757. This is lower than the enrollment cap of 7,100. Staff has noticed that the take-up rate for coverage, when offered, is not as high as it has been in the past. Staff intend to conduct a survey to those who decline coverage to ascertain the reason for the decline. Staff will also further refine the process to get more people enrolled in the program. As of December 1st, the wait list total was 238.

Chairman Allenby asked the Board for any questions or comments. There were none. He asked for any comments from the audience. There were none.

The Enrollment Report can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_8.a_MRMIP_Enrollment_Report.pdf

Update on Enrollment Cap and Waiting List

Ms. Dillard reported that as of this week the Enrollment Cap and wait list total is 323. MRMIB will instruct the vendor to make offers to all remaining individuals on the wait list. She asked if there were any questions.

Mr. Figueroa asked if this meant the wait list was completely cleared. Ms. Dillard replied that it was.

This document can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_8.b_MRMIP_Enrollment_Cap_and_Waiting_list.pdf

Administrative Vendor Performance Report

Ms. Dillard reported that the vendor had met all of its performance requirements. She asked if there were any questions. Chairman Allenby indicated there were none.

The Performance Report can be found at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_8.c_MRMIP_Adm_Vendor_Perf_for_November_2009.pdf

Chairman Allenby asked if there was anything else to bring before the Board. When no one brought any issue forward, he adjourned the meeting. Public session concluded at 1:07 p.m.