

**Managed Risk Medical Insurance Board
February 20, 2013, Public Session**

Board Members Present: Clifford Allenby, Chairperson
Richard Figueroa
Samuel Garrison
Ellen Wu

Ex Officio Members Present: Jack Campana
Robert Ducay, Designee for California Health
and Human Services Agency
Shelley Rouillard, Designee for the Secretary of
the Business, Housing & Transportation
Agency

Staff Present: Janette Casillas, Executive Director
Terresa Krum, Chief Deputy Director
Laura Rosenthal, Chief Counsel, Legal
Tony Lee, Deputy Director, Administration
Ernesto Sanchez, Deputy Director, Eligibility,
Enrollment & Marketing
Jeanie Esajian, Deputy Director, Legislative &
External Affairs
Ellen Badley, Deputy Director, Benefits & Quality
Monitoring
Jenny Phillips, Staff Counsel, Legal
Carmen Fisher, Staff Services Analyst, Legal
Jordan Espey, Manager, Legislative & External
Affairs
Anne Williams, Office Technician, Legislative &
External Affairs
Mary Watanabe, Manager, Benefits & Quality
Monitoring
Muhammad Nawaz, Manager, Benefits & Quality
Monitoring
Amanda Evans, Manager, Administration
Loressa Hon, Manager, Administration
Marie Jungkeit, Manager, Administration
Laurie Herrera, Manager, Administration
Elva Sutton, Associate Governmental Program
Analyst, Administration
Valerie York, Acting Executive Assistant to the
Board and the Executive Director
Jarrett Davis, Board Assistant

Also Present: René Mollow, Deputy Director, Health Care
Benefits & Eligibility, California Department of
Health Care Services

Public Comment: Elizabeth Abbott, Health Access
Kelly Hardy, Children Now

Chairman Allenby called the meeting to order at 10:03 a.m. The board went into Executive Session and resumed public session at 11:00 a.m.

Chairman Allenby introduced new ex-officio Board member Robert Ducay, who is representing the Secretary of the California Health and Human Services Agency.

REVIEW AND APPROVAL OF JANUARY 16, 2013 PUBLIC SESSION

The minutes of the January 16, 2013 public session were approved as submitted.

The January 16, 2013, Public Session Minutes are located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_3_Public_1-16-13_FINAL.pdf

STATE BUDGET UPDATE – HEALTHY FAMILIES PROGRAM CURRENT YEAR BUDGET SHORTFALL

Janette Casillas reported on Agenda Item 4, the State Budget Update – Healthy Families Program Current Year Budget Shortfall. In addition to the current year shortfall, Ms. Casillas shared information on the budget process. She clarified that there are two processes: first, in-house (MRMIB staff) assumptions and forecasting based on trends; second, the state budget process through which the actual budget is secured. She said that the assumptions for every HFP budget since 1998 were on target. Budget assumptions and forecasting are done at a point in time and then followed by regular updates. Ms. Casillas described the shortfall as a challenge not with MRMIB's budgeting, forecasting or assumptions, but with the process by which MRMIB secures its funding.

Ms. Casillas stated that there had been media reports about the HFP current-year shortfall, and there were budget shortfalls only twice in the past. As with the current shortfall, these also were not attributable to faulty forecasting or budget assumptions, but to the way the process works as the Governor's budget is put together and finalized through the legislative process.

She indicated that this year, for the third time that there was a budget shortfall, MRMIB's budget assumptions and fiscal forecasting were on target. Staff understands what the program needs, so it is not about not knowing or making wrong assumptions; staff is very clear about what level of funding MRMIB needs at a point in time. However, this year's budget presumed extension of the Managed Care Organization (MCO) tax. When that was not approved, there were no actions taken to backfill the dollars. HFP received a very recent additional appropriation of \$15 million from a special fund account. With those additional funds, staff will begin to make payments very shortly. However, HFP continues to have a shortfall of \$116 million in General Funds, which would be used to draw down approximately \$216 in federal funds, for a total current-year shortfall of \$332.6 million.

Ms. Casillas explained that MRMIB staff has worked closely with the Administration, which has put forward two solutions or options for the Legislature to consider. One option is the extension of an MCO tax and the other is a

supplemental appropriation, which would include budgetary needs of other departments. These two options have been aired and they are being considered by legislative committees.

Richard Figueroa said he appreciated the explanation of the estimating process versus the budgeting process and said that MRMIB has tried to be a good steward of the state's dollars and has worked very hard with contracted plans over the years to be a good business partner. This situation, which has been known since last October, is unfortunate. Mr. Figueroa said people are loath to talk about the MCO tax issue, which was linked to the Healthy Families transfer, because it was apparent there would be problems. As a result, it could be that the state's General Fund is out \$200 million as a result of the transition. He expressed hope that the Legislature and the Governor reach an accommodation so MRMIB can pay its bills.

Mr. Allenby expressed the hope that the resolution would occur quickly.

Mr. Figueroa added that, because of the Affordable Care Act, HFP has basically become an entitlement program with the expectation that all of the children will remain in the program and be served. He concluded by apologizing to the HFP plans for the situation and expressed hope that the Legislature and the Governor could reach agreement on MRMIB's \$400 million deficit.

Ms. Casillas said that the HFP plans were very understanding, but they have bills to pay as well, and they have provided services to HFP subscribers. She echoed support for efforts for a quick resolution, so that the plans could be paid.

Mr. Figueroa asked if the federal Centers for Medicare and Medicaid Services (CMS) was aware of the HFP shortfall. Ms. Casillas said she believed they were not, as their focus was on the transition.

TRANSITION OF THE HEALTHY FAMILIES SUBSCRIBER TO THE MEDI-CAL PROGRAM

Ms. Casillas reported on Agenda item 5, the Transition of the Healthy Families Subscribers to the Medi-Cal Program. The next group of children to be transitioned from HFP to Medi-Cal is Phase 1B, which is the second half of Phase one, minus the Health Net enrollment. This group is scheduled to transition on March 1, pending CMS approval. MRMIB staff continues to engage with CMS and provide input to questions CMS poses on the transition. A document shared with the Board based on September enrollment showed more than 95,000 lives slated for the Phase 1B transition. However, Ms. Casillas said January enrollment statistics indicated this figure is closer to 101,650 children. The transition scheduled for March 1 affects 16 counties and nine different plans.

The document on the Transition of the Healthy Families Subscriber to the Medi-Cal Program is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_5_HFP_Transition_to_Medi-Cal_Phase_1_Enrollment_Breakdown.pdf

Transition of Staff to Department of Health Care Services

Ms. Casillas reported on Agenda Item 5.a, the Transition of Staff to the Department of Health Care Services. MRMIB has begun conversations with DHCS on this process, which includes written notification to both the Legislature and MRMIB staff, consistent with union contracts. She indicated that the unions also would be notified of the process. MRMIB staff will be provided with written notification at a staff forum at the appropriate time. In attendance will be personnel officers from MRMIB and DHCS. The transition of staff will be approached as collaboration so staff can get questions answered consistently. She said that, while MRMIB staff is in high demand by both MRMIB and DHCS, it is important that they be duly noticed and are comfortable with and understand the changes that will take place in their work location and that they have context about the work they will be performing at DHCS.

So far, the conversations have indicated that both parties are on the same page. She said the discussions will proceed carefully because of sensitivities to affected staff. Staff will provide updates to the Board as this process moves forward.

Enrollment of AIM-Linked Infants in Healthy Families Program

Ms. Casillas reported on Agenda Item 5.b, Enrollment of AIM-Linked Infants in the Healthy Families Program. She stated that the Board packet included the business rules associated with this item and explained that AIM-Linked Infants will continue to be enrolled in HFP as they have in the past, even with the transition of HFP children to Medi-Cal. This is because the rules about who can notify the program to do an enrollment are different for AIM-Linked Infants and the HFP program already has most of the needed information except for birth outcome. Maximus posts the enrollment with a specific code to the Medi-Cal Enrollment Database System which is crucial because it establishes the infant's identity and the history and this provides for up to two years of coverage at 300 percent of federal poverty level.

If the family income of an AIM-Linked infant who has transitioned to Medi-Cal increases above the Medi-Cal maximum of 250 percent FPL, this coding triggers counties to transition the child back to HFP for the second year of coverage for which he or she is eligible. In addition to the importance of this information for counties, it is important for the state's Maintenance of Effort requirements established by the ACA, and to maintain eligibility processes and levels.

Ms. Casillas said her intention in this discussion was to provide a refresher and reminder of this process, which is consistent with the existing HFP business rules and processes.

Mr. Figueroa asked about options for pregnant women who are not eligible for Medi-Cal and whether they would be served by the Exchange or AIM. Ms. Casillas said legislation would be needed [if they were not to be served by AIM] because AIM is part of CHIP, which has a Maintenance of Effort provision through 2019. Mr. Figueroa said the Legislature would have to determine whether women and

children in the 250 to 300 percent FPL range are eligible for the Exchange, because Medi-Cal will probably not be extended to 300 percent FPL.

The document for Enrollment of AIM-Linked Infants in Healthy Families Program is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_5.b_Enrollment_of_AIM_Linked_Infants_in_HFP.pdf

Annual Eligibility Review Process for Non-Transitioned Children

Ms. Casillas reported on Agenda Item 5.c, the Annual Eligibility Review Process for Non-Transitioned Children. She said this process is business as usual for children whose annual eligibility reviews arise before they are transitioned to Medi-Cal. The only change to the process is for someone who attempts to add a child to the account. In such a case, the application for that child made on an “add-a-person” form would be transmitted to the counties for a Medi-Cal eligibility determination. The only exception is for AIM-Linked Infants.

The document for the Annual Eligibility Review Process for Non-Transitioned Children is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_5.c_Annual_Eligibility_Review_Process_for_Non-Transitioned_Children.pdf

Schedule of Subscriber Notices

Ms. Casillas reported on Agenda Item 5.d, the Schedule of Subscriber Notices. This was provided instead of copies of all the various draft and final version subscriber notices in development by the Department of Health Care Services. The document also includes a distribution schedule and intended recipients. The schedule was developed consistent with what is required in statute. In some cases it is a 60-day notice and in other cases it is a 90-day notice. She said the reminder notice was included because MRMIB staff understands DHCS wants to continue a reminder notice process. Some of the dates listed on the schedule have not occurred; however, the schedule shows what has happened so far and anticipated dates. Some of the questions and data normally provided to the Board by staff come from Single Point of Entry (SPE) statistics, which MRMIB no longer oversees as of January 1, SPE is now under the purview of the Department of Health Care Services.

The document for the Schedule of Subscriber Notices is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_5.d_Schedule_of_Subscriber_Notices.pdf

Questions and Answers with Department of Health Care Services Representative

Ms. Casillas introduced René Mollow, Deputy Director of Health Care Benefits and Eligibility at DHCS; Ms. Mollow is leading the transition of HFP children to the Medi-Cal Program. She was present to fulfill a request of the Board that a DHCS representative attend MRMIB meetings to respond to questions from the Board or the public. Ms. Mollow said that DHCS released its first required monitoring report

to the Legislature and CMS on February 15. The reports are required on a monthly basis, and she said DHCS would make sure MRMIB also received the monthly report.

Mr. Figueroa asked Ms. Mollow if DHCS will post data on a monthly basis from applications that come through SPE. He said this data had always been part of the HFP Enrollment Report and included statistics on the number of new subscribers, how many went to HFP versus Medi-Cal, how many were assisted by Certified Application Assistants, the application's level of completeness and timelines of processing. He said the Board was very interested in continuing to see what happens with HFP subscribers who know they will be transitioning to Medi-Cal and whether there is a big drop off in enrollment. He noted that the Board has already seen a dramatic increase in subscribers requesting disenrollment.

He asked Ms. Mollow if DHCS would post SPE data very similar in format to what MRMIB reported in the past to the DHCS website so that the Board and public could continue to monitor applications, application processing, and negative or positive effects of the new program alignments and configurations.

Ms. Mollow said that this was the goal of DHCS, and that DHCS would be working with Maximus and the counties to obtain the information. She noted that there were differences in eligibility determination processes between MRMIB and Medi-Cal, and that this may cause an information lag because of the time frames established through the transition legislation for county processing of applications. She said that this information would help to further inform the monitoring reports that are due to both the Legislature and CMS on an ongoing basis.

Mr. Figueroa said he realized that SPE no longer screens applications for HFP, but wondered whether the time frames for application processing had changed. Ms. Mollow said SPE processing time frames were still followed for collecting information from individuals when applications come in and then conducting follow-up on incomplete applications. After the initial follow-up, the applicant information must be sent to the counties within 10 business days. If information is still missing, the counties then follow up. Accelerated enrollment also will be used at SPE and the business rules for that remain unchanged. Ms. Mollow said DHCS could make the new timeframes and related information available to the public. She said she would work with Ms. Casillas to determine what previously reported information was of value to the Board and the public so DHCS could determine how to develop similar reports.

Chairman Allenby asked if there were any additional questions from the Board or comments from the audience.

Beth Abbott thanked Ms. Mollow for attending the Board meeting. Ms. Abbott stated that, the previous month, she had indicated she was taken aback by the discontinuance of some of the reports that she and other members of the public were accustomed to viewing; these reports kept them informed of various trends.

Ms. Abbott noted the substantial number of HFP children transitioning to Medi-Cal, and complimented DHCS, MRMIB and DMHC for their joint work on the transition,

on consulting with consumer organizations, on their openness about some of the difficulties encountered and on responding to concerns raised by consumer advocates. She said the agencies involved would collectively receive high marks for having tried to be open and transparent on the transition.

Ms. Abbott said the public has not received reassurances that the reports they are accustomed to seeing, or their equivalent, will be available in a forum equivalent to MRMIB public meetings, where reports are shared and the public has an opportunity to ask questions about changes in reported data. She indicated that she had been told that DHCS also has a long tradition of disclosure and transparency but has not seen that since she began working in the advocacy community in 2006.

Ms. Abbott said that her supervisor is one of 35 persons who sit on the Stakeholder Advisory Committee that DHCS convened for the 1115 waiver. The group meets two or three times a year from 10 a.m. to 3 p.m., with 15 minutes at the meeting's conclusion for public comments. She said that this time allotment is insufficient. She commended MRMIB for providing monthly statistical reports and responding to questions. While MRMIB's process need not be duplicated, Ms. Abbott said some level of equivalency is needed beyond an open, transparent meeting where only a select group of people are allowed to comment in a circumscribed period of time. She said that, with DHCS taking on the HFP population of 850,000 children, the Department needs to develop something that fulfills the same purpose. She said Health Access and other advocacy groups have long had concerns about DHCS transparency.

Ms. Abbott said it was her understanding that DHCS has a long-standing consumer group, with which DHCS consults, but that the group represents parents of Medi-Cal children and does not include Medi-Cal adults or the disabled community. She suggested that DHCS reevaluate the composition of that group to determine whether it still fulfills the needs of the Department's and the public. She also said she was told that DHCS often makes documents available on its website. However, she said that, when she requests documents and does not request the correct one or is not aware of a specific document, the process is not very disclosive. She requested that DHCS revamp this process to serve all its populations. She said advocates are concerned not only about HFP children, but also about other Medi-Cal children.

She also asked that DHCS develop a public vetting process to inform the public of plans after the transition is completed. Whether or not the transition is successful, there may be residual issues of interest to parents, families, the public, advocates and other agencies that could be derived from evaluation of the process.

Other HFP Transition Issues

Ms. Casillas reported on Agenda Item 5.f, Other HFP Transition Issues. She said staff learned from an advocate that there were delays in sending refunds to HFP families. These refunds were due to families with children who were transitioned to the Medi-Cal Program. The delays were caused by the size of the refund files to be processed. MRMIB Chief Deputy Teresa Krum and staff from the

Administration Division worked quickly to resolve this issue and refund checks are expected to be mailed tomorrow. The resolution involved the Department of General Services and Bank of America. The refund checks were to families who more than likely had paid the three months in advance to get a free month. Additionally, the HFP vendor confirmed that administrative credits for the free month had moved over to Medi-Cal accounts for billing processes.

EXTERNAL AFFAIRS UPDATE

Jeanie Esajian reported on Agenda Item 6, the External Affairs Update. The last 30 days were a light period for media requests. However, there continued to be significant media coverage of the transition of Healthy Families Program subscribers to Medi-Cal. There was also some coverage of PCIP.

A news release of February 19, 2013, announced the California PCIP's closure to new enrollment.

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

The document on the External Affairs Update is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_6_022013.pdf

STATE LEGISLATION

Jordan Espey reported on Agenda Item 7, State Legislation. Since the last Board meeting, the State Legislative Report was expanded to include sections on special session and mandate bills. Additionally, 13 new bills were added to the report and are indicated by an asterisk.

Since the Legislative Report was submitted, SB 20 by Sen. Ed Hernandez was amended and now provides that, once the Major Risk Medical Insurance Program (MRMIP) is inoperative, all managed care administrative fines and penalty funds will be diverted to the Steven M. Thompson Physician Corps Loan Repayment Program. Currently, any amount in that fund over \$1 million goes to MRMIP. SB 20 was previously an intent bill to establish a basic health program.

A new bill, AB 357 by Assembly Member Richard Pan would require the California Health and Human Services Agency to establish the California Healthy Child Advisory Task Force, a statewide group charged with developing a vision for children's health throughout the state. Additionally, AB 411, by Assembly Member Pan, would require Medi-Cal managed care plans to analyze HEDIS measures or an external accountability set performance measure equivalent by race and ethnicity, and primary language, and to implement strategies to reduce identified disparities. These analyses would be reported to DHCS annually and posted to the DHCS website. Finally, AB1 X1 by Assembly Members John Perez and Pan, addressing the Medicaid expansion, passed out of the Assembly Health Committee on a 13 to 6 vote. These recent changes will be reflected in next month's Board report.

The report includes AB 209, also by Assembly Member Pan, which would require DHCS to develop and implement a quality improvement and monitoring plan to include performance standards, an advisory committee, at least quarterly public meetings and public comments, and to make up-to-date information on services publicly available.

Finally, Mr. Espey noted that the previous Friday was the last day for bills to be introduced.

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

The document for State Legislation is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_7_Legislative_Summary_2-20-13.pdf

PRE-EXISTING CONDITION INSURANCE PLAN (PCIP) UPDATE

Other Program Updates

Ms. Casillas reported on Agenda Item 8.f, Other Program Updates. States received word the previous Friday that the Centers for Medicare and Medicaid Services suspended new enrollment to PCIPs it operates on that day. CMS also gave states that operate PCIPs on behalf of CMS a 15-day written notice to stop taking new enrollment. The letter indicates that states are to suspend new enrollments for any applications received after March 2. The only exception would be for the purpose of portability, if a PCIP subscriber in another state moved to California, that person would have six months to apply for PCIP here.

She said this action was not unexpected and provided the Board with a federal report on nationwide PCIP enrollment and expenditures. Nationally, PCIP expenditures total only \$2.4 billion of the total \$5 billion appropriated by Congress. However, after careful analysis and projections, the federal government decided it was time to close the program to new enrollment. Analysis included close monitoring of enrollment trends, claims cost, average claims per subscriber per month and per year, medical conditions of subscribers and the cost of those claims.

Ms. Casillas also provided the Board with a PCIP Financial History document, which showed figures for program allotments for 2010, 2011 and 2012. California's allotment for these three years was \$472.8 million. California's original allotment was \$761 million. Based on current enrollment trends and current expenditures for each subscriber, California's PCIP will spend all of its original allotment and possibly more, even with the enrollment suspension.

Ms. Casillas indicated that the Board packet also included the CMS Annual Report for 2012, which provided a national overview of PCIP. In addition to what Ms. Casillas previously reported, the report showed that PCIP enrollment nationally was far less than anticipated and the actual cost per subscriber far exceeded what was assumed. The national average cost per enrollee in 2012 was

\$32,108. California's cost for that same year was \$37,200 per enrollee. Nationally, only 4.4 percent of PCIP enrollees accounted for more than 50 percent of claims paid over a one-year period, while two-thirds of enrollees generated \$5,000 or less in claims for the year.

Claims were broken down nationally to show that pharmacy costs account for 43 percent and inpatient hospitalization for 26 percent. California's claims pattern is very different, with 44 percent for inpatient hospitalization, 29 percent for outpatient facility services, 14 percent for outpatient professional fees, 9 percent for pharmacy and 4 percent for inpatient professional fees.

The federal government took steps in 2012 to reduce national program costs by making several changes in the federally-administered PCIPs: the provider network was changed, large-volume provider hospital claims were renegotiated, agent-broker fees were eliminated, out-of-pocket limits for subscribers were increased from \$4,000 to \$6,250 for in-network services and subscribers were required to use mail-order after the second filling of a maintenance prescription.

Also the previous Friday, CMS asked states to analyze the feasibility of aligning their benefit structure with that of the federal benefit structure to add program savings in state-based programs. If feasible, staff would need to determine how long the changes would take to implement with PCIP's third party administrator and vendor, as well as the cost of implementation. Additionally, an actuarial determination would be needed to determine the amount of program savings that might be achieved by adjusting the California PCIP program design.

These findings will be shared with CMS, which will provide direction to California and all other state-administered PCIPs.

Ms. Casillas also told the Board that CMS initially instructed states to remove the PCIP application from their websites. However, in California, PCIP shares a joint application with the state high-risk pool, the Major Risk Medical Insurance Program. Thus, California will be using an errata sheet in paper applications that are mailed and will post a website update for downloaded applications to clarify the new PCIP enrollment closure. Ms. Casillas also provided the Board with a copy of a news release that notified the news media of the new PCIP enrollment closure.

Staff is working to implement the suspension of new enrollments after March 2; this will have no effect on current subscribers.

Chairman Allenby asked if there were any questions or comments from the Board or the audience.

Mr. Figueroa asked whether the decision to change the benefit structure would be made by the federal government. Ms. Casillas said that this was correct.

The documents for the Other Program Updates are located here:
http://www.mrmib.ca.gov/MRMIB/Agenda_item8fFeb20_13.html

Enrollment Report

Ernesto Sanchez reported on Agenda Item 8.a, the Enrollment Report. A total of 877 persons enrolled in PCIP during January. The enrollment slowdown is similar to the national trend. For most of 2012, the program averaged 1,100 new subscribers per month. Enrollment in January 2012 was 801. As of February 19, California PCIP enrollment was 16,363. At the end of December 2012, enrollment was 15,101.

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

The PCIP Enrollment Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_8.a_PCI_P_Enrollment_Report_for_January_2013.pdf

Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 8.b, the Administrative Vendor Performance Report. The administrative vendor met all performance standards for processing applications, forwarding applications, data transmissions to the third party administrator, toll-free customer service, quality and accuracy reporting, applications, screenings, enrollment transactions and providing monthly premiums to the third party administrator.

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

The PCIP Administrative Vendor Performance Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_8.b_PCI_P_Adm_Vendor_Board_Report_January_data.pdf

Third Party Administrator Performance Report

Mary Watanabe reported on Agenda Item 8.c, the Third Party Administrator Performance Report. The TPA met all performance standards for January.

Chairman Allenby asked if there were any questions or comments from the Board or audience. Ms. Watanabe said staff noticed an increase in call volume of almost 1,000 more calls for the month.

The PCIP Third Party Administrator Performance Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_8.c_TPA_Performance_Report.pdf

Fact Sheet: Mental Health Services

Ellen Badley presented Agenda Item 8.d, the Mental Health Services Fact Sheet. The Fact Sheet presents an overview of services provided to PCIP subscribers to treat mental health disorders and covers the period from program inception in

October 2010 through the end of 2012. As of December 2012, a total of 2,539 PCIP subscribers were treated for a mental health disorder. This equated to about one in seven, or 13 percent of subscribers. Claims generated by these subscribers totaled \$16.2 million, with more than half for pharmacy claims. PCIP subscribers who received mental health services ranged in age from one to 89, with the average age being 43. Females accounted for 59 percent of these subscribers. The most common diagnoses were major depressive disorder, drug dependency, anxiety and anorexia/nervosa. The most common drugs were prescribed to treat depression, anxiety and pain.

A very small number of children were enrolled in the program; for children, the most common diagnoses were delays in development for those under age 12 and bipolar disorder and anorexia/nervosa for teens.

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

The PCIP Fact Sheet: Mental Health Services is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_8.d_Mental_Health_Services_Fact_Sheet.pdf

Utilization Reports

Mary Watanabe reported on Agenda Item 8.e, the PCIP Utilization Reports, which included the fourth quarter of 2012 (October through December) and Inception to Date.

For the fourth quarter of 2012, claims continued to show that inpatient services accounted for more than half of PCIP costs, while outpatient services accounted for 40 percent and prescriptions for 10 percent. The top diagnoses and procedures as a percentage of payments continued to be related to cancer, heart disease and joint disorders. End-stage renal disease (ESRD) was a top diagnosis for the first time in both the Inception to Date and fourth quarter of 2012 reports. She noted that persons with ESRD are Medicare eligible. However, CMS directed states that these individuals could choose to remain in PCIP. Ms. Watanabe said PCIP has quite a few ESRD patients that chose to stay in PCIP versus Medicare. Laura Rosenthal said that this was permissible only if the subscriber was not actually enrolled in Medicare. Ms. Rouillard asked how many persons with ESRD were enrolled in PCIP. Ms. Watanabe said the latest Inception to Date report reported 71 such subscribers.

Ms. Watanabe said the top prescriptions by claims payment were for the treatment of HIV/AIDs, rheumatoid arthritis, cancer, pain, mental health disorders and diabetes. Generic drugs accounted for 76 percent of pharmacy utilization, but only 24 percent of cost. Statistics continued to show a decrease in the cost for brand-name drugs, which now account for only 61 percent of total pharmacy costs. By comparison, the 2011 fourth quarter statistics showed that brand-name drugs accounted for about 66 percent.

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

The PCIP Utilization Reports are located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_8.e_PCIP_Utilization_Report.pdf

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Mr. Sanchez reported on Agenda Item 9.a, the Enrollment Report. A total of 151 new subscribers enrolled during January, bringing enrollment to slightly more than 5,700, which is approximately 1,300 under the enrollment cap. He noted that MRMIP will likely become the available option for high-risk applications with the announced closure of new enrollment in PCIP. No applicants were on the wait list. However, 15 applicants were serving the deferred enrollment period. Kaiser has the largest enrollment at 67 percent. The top 18 counties accounted for approximately 91 percent of enrollment. The 50-64 age group accounted for approximately 48 percent of subscribers, who were predominantly female.

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

The MRMIP Enrollment Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_9.a_MRMIP_Board_Report_Summary_for_Feb_2013.pdf

2012-13 Second Quarter Financial Report

The 2012-13 Second Quarter Report was not presented to the Board.

Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 9.b, the Administrative Vendor Performance Report. The administrative vendor met all performance standards for processing eligibility determinations and for toll-free telephone line customer service.

The MRMIP Administrative Vendor Performance Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_9.b_MRMIP_Adm_Vendor_Perf_for_Feb_2013.pdf

Other Program Updates

No Other Program Updates were presented to the Board.

HEALTHCARE REFORM UNDER THE AFFORDABLE CARE ACT

Agenda Item 10, Healthcare Reform Under the Affordable Care Act, was not presented to the Board.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment Report

Mr. Sanchez reported on Agenda Item 11.a, the HFP Enrollment Report. There were approximately 6,300 new subscribers enrolled through December 31, when CMS approved the initial transition of Phase 1A to Medi-Cal. This includes enrollment of AIM-Linked Infants, who were exempted from the HFP enrollment freeze. Total enrollment at the end of January was 657,113 children. There were no major shifts in subscriber demographics. Nearly 30 percent of enrollment was in two Anthem Blue Cross products. The largest dental enrollment was in Delta Dental. VSP had the largest vision plan enrollment.

Mr. Sanchez indicated that the report tracks disenrollments in more detail, based on interest expressed by Mr. Figueroa. The largest reason for disenrollment continued to be nonpayment of premium. The report now tracks the number of individuals who are transitioned out of the program. As a result of Phase 1A, 178,113 children were disenrolled from HFP. For January overall, a total of 209,000 children were disenrolled from HFP.

Mr. Figueroa said the number of requested terminations went up dramatically between November and January. He questioned whether this was a cyclical trend or whether it might be due to subscribers' not wishing to transition to Medi-Cal. He said there also was a trend in nonpayment of premium, which went up by almost 50 percent between December and January. He said it was unclear whether this was seasonal or transition related. However, he noted that these two very noticeable differences in the last three months coincided with the transition. He asked whether it was possible to obtain additional longitudinal data to determine whether this was something the Board should be concerned about.

Mr. Sanchez said MRMIB and call center staff would work to develop more reasons behind disenrollment requests and disenrollments due to nonpayment. He noted that, in the past, there was a sweep period that caught payments which came in one day late; the inability to re-enroll into HFP may have had a role in increasing disenrollments.

Mr. Sanchez said the Enrollment Report now tracks the decline of enrollment as HFP children are transitioned to Medi-Cal.

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

The HFP Enrollment Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_11.a_HFP_January_2013_Summary.pdf

Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 11.b, the Administrative Vendor Performance Report. The new report format does not include statistics for SPE, which is no longer administered by MRMIB.

The administrative vendor met standards for processing appeals, program reviews, data transmissions and toll-free customer service. Standards for quality and accuracy, eligibility determinations, adjudication of appeals and generating electronic transactions were also met.

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

The HFP Administrative Vendor Performance Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_11.b_HFP_AV_Perf_Report_2-20-13.pdf

Appointment of HFP Advisory Panel Members

Chairman Allenby introduced Agenda Item 11.c, Appointment of HFP Advisory Panel Members. The motion he requested was to reappoint Ronald Diluigi as the business representative, Karen Lauterbach as the nonprofit clinic representative and Elizabeth Stanley-Salazar as the substance abuse provider representative.

Mr. Campana said all three of these individuals had served admirably and contributed to the panel. He recommended their membership continue. Shelley Rouillard asked whether there were other vacancies on the panel for which members are being recruited. Mr. Sanchez said there were four additional vacancies: disproportionate share hospital representative, pediatrician representative, subscriber with a special needs child representative and county public health provider representative. Mr. Sanchez said that recruitment would continue and that recommendations of new Panel members would be brought to the Board for future action. Ellen Wu asked for the definition of county public health provider. Mr. Sanchez said that included county clinics, county public hospitals or a doctor working for county public health.

The requested motion was made, seconded and unanimously passed by the Board.

The document for the Appointment of HFP Advisory Panel Members is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_11.c-HFP_Adv_Panel_Recommendations_2-2013.pdf

Health-e-App Update

2000-2012 Summary of Enhancements

Mr. Sanchez reported on Agenda Item 11.d.i, the Health-e-App Update. He provided the Board with a summary of enhancements that were made to Health-e-App, which also transitioned to DHCS in January.

Mr. Sanchez provided a summary of the project, which was a collaborative effort with the California HealthCare Foundation, the California Endowment and DHCS. He indicated that the launch of the Spanish version of Health-e-App allowing applicants to complete their annual eligibility reviews, the add-a-person form, the continued enrollment form and HFP program requests, would be completed during the month.

Mr. Sanchez reiterated that the Health-e-App can be used, along with the paper application, to apply for coverage for children. The application will be shifted to the Medi-Cal Program. As of December of 2012, more than 100,000 applications were submitted by public users using Health-e-App since its inception. In July of 2012, the English version of add-a-person, AERs, continued enrollment and program review were launched.

Mr. Sanchez indicated that the Health-e-App research brief was released in March of 2012. Health-e-App dates back to January of 2001, where MRMIB worked with the California HealthCare Foundation to pilot the online application at six sites in San Diego County.

Mr. Figueroa asked whether the Health-e-App summary of enhancements and the briefing could be sent to the Legislature as part of the normal monthly transmission of information. Ms. Casillas said it would be sent to the Legislature.

The 2000-2012 Summary of Enhancements is located here: wrong link below
http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_item_11.d%28i%29_02-20-13_Meeting_Health-E-App_2000-2012_Summary_of_Enhancements.pdf

Health-e-App Public Access: A New Online Path to Children's Health Care Coverage in California

Mr. Sanchez reported on Agenda Item 11.d.ii, the Health-e-App Public Access: A New Online Path to Children's Health Care Coverage in California. This report was issued by Mathematica Policy Research in partnership with MRMIB and with support from the California Health Care Foundation and the David and Lucille Packard Foundation. The study's author was Leslie Foster of Mathematica.

The brief looked at online enrollments and demographics during 2010. The briefing document also included an optional survey of nearly 15,000 applicants that used Health-e-App Public Access and its findings. Most Health-e-App public users reported they were regular Internet users at least three times a week. At least 70

percent of them reported some college education. Approximately two-thirds reported owning their own computer and 97 percent indicated that they had high-speed Internet access.

In relating their experiences using Health-e-App, 93 percent of respondents said it was easy or very easy to use; 97 percent said the instructions were very clear; and 53 percent said they used the “learn more” function or a help page. Only 10 percent said they had to call the toll-free number to ask a question on usage. Ninety-three percent indicated they would recommend the use of Health-e-App to a family member or friend and 90 percent reported that they would use Health-e-App for their annual eligibility review.

Those surveyed said it was realistic to think that Health-e-App could be used more and that was an attractive option because it would create easier access for populations who have access to high-speed Internet. The survey showed an interesting jump, from 27 to 60 percent in individuals with annual incomes under \$40,000, who indicated that they have access to high-speed internet. This is an important point in the discussion of whether lower income communities have computer and broadband Internet access.

The report also provides comparisons of Health-e-App with other online applications across the nation and the implications this might have for an online enrollment portal under the ACA. The conclusion was that online enrollment portals are a convenient high-speed way for people to apply without the assistance of an assistor or navigator and that an outreach campaign would be important to its future use. Mr. Sanchez indicated that there will be a final brief addressing the impact of the public access outreach campaign and how Health-e-App could be used to assist families from the CAA perspective.

Chairman Allenby asked if there were any questions or comments from the Board or the audience.

Ms. Wu asked whether the researchers looked at Health-e-App users by race and ethnicity. She noted the study found that users preferred to be communicated with in English.

Mr. Sanchez said most Health-e-App users were comfortable communicating in English even though there was a wide range of demographics. However, he said the study did not have the ability to say how many Latinos felt just as comfortable using Health-e-App in the English versus the Spanish option. He noted that Health-e-App was available only in English and Spanish, but is used predominantly English.

Ms. Wu asked whether the application was mobile phone compatible. Mr. Sanchez said it does not have a mobile app.

Mr. Figueroa said the California Endowment was working with Social Interest Solutions on mobile versions of Health-e-App. He said that, given the timing of development, the app will probably be used more in association with the Exchange. He said the Endowment was funding both phone and tabloid versions

of an app to observe functionality through pilots in the North Coast and San Diego. Mr. Sanchez said One-e-App, which was derived from Health-e-App, has a mobile app in development.

Kelly Hardy said she recently was contacted by a man who was trying to enroll his child and was turned away from a county office, where he was told that HFP was not open anymore. She said she was able to direct him to Health-e-App, where he enrolled his child. He said Health-e-App was very easy to use. However, she noted that, in directing this parent to Health-e-App, there was nothing on its home page saying children were still eligible. She asked if some language could be added to make this explanation.

Ms. Casillas said the paper application and Health-e-App are part of SPE, and, as such, were now under the purview of DHCS. She said she was informed that DHCS had already made changes to Health-e-App and, while not stating that HFP is not taking new enrollment, offers the positive option of the Medicaid Expansion. She said the changes include the Medi-Cal logo and the eligibility screening. Applications submitted through Health-e-App run through SPE and are sent to the counties. Ms. Hardy said she would follow-up with DHCS to obtain more information.

The document on the Health-E-App Public Access: A New Online Path to Children's Health Care Coverage in California, Research Brief 2, January 2013 is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_11.d.ii_02-20-13_Health-E-App_Public_Access_Research_Brief_2.pdf

Extension of Contract with DataStat, Inc. to Conduct Consumer Assessment of the Healthcare Providers and Systems (CAHPS), Dental CAHPS (D-CAHPS) and Teen Surveys

Chairman Allenby requested a motion to adopt the resolution included in Agenda Item 11.e, authorizing extension and amendment of the DataStat contract. The motion was made, seconded and unanimously adopted by the Board.

The signed Resolution is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_11.e_DataStat_Resolution.pdf

Other Program Updates

No Other Program Updates were presented to the Board.

ACCESS FOR INFANTS AND MOTHERS(AIM) UPDATE

Enrollment Report

Mr. Sanchez reported on Agenda Item 12.a, the Enrollment Report. A total of 667 new subscribers enrolled in January, bringing program enrollment to slightly less

than 6,400. The majority continued to be Latinas. The top 18 counties accounted for 88 percent of enrollment.

Mr. Figueroa noted that a decline in births traditionally signals a recession. Mr. Campana said the birth rate for teenagers has dropped significantly, which is positive.

The AIM Enrollment Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_12.a_AIM_Jan_2013_summary.pdf

Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 12.b, the Administrative Vendor Performance Report. The administrative vendor met all standards for processing applications, assisting applicants and subscribers through the toll-free lines, and quality and accuracy standards for processing applications.

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

The AIM Administrative Vendor Performance Report is located here:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_12.b_AIM_Adm_Vendor_Perf_Jan_2013_Summary.pdf

2012-13 Second Quarter Financial Report

Amanda Evans reported on Agenda Item 12.c, the Second Quarter Financial Report for the Perinatal Insurance Fund. The beginning fund balance on July 1, 2012, was \$18.14 million. Anticipated revenue is \$47.8 million. Expenditures through December 31, 2012 were \$30.1 million. Estimated expenditures for the rest of the year are \$30 million. Anticipated fund balance on June 30, 2013 is \$6 million.

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

The AIM 2012-13 Second Quarter Financial Report is located at:

http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_022013/Agenda_Item_12.c_2d_Quarter_Financial_Report.pdf

Other Program Updates

Other Program Updates were not presented to the Board.

The meeting was adjourned at 12:20 p.m.