

**Managed Risk Medical Insurance Board  
June 17, 2009, Public Session**

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

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

Staff Present: Lesley Cummings, Executive Director; Janette Lopez, Chief Deputy Director; Laura Rosenthal, Chief Counsel; Ernesto Sanchez, Deputy Director for Eligibility, Enrollment, and Marketing; Shelley Rouillard, Deputy Director for Benefits and Quality Monitoring; Teresa Krum, Deputy Director of Administration, Ginny Puddefoot, Deputy Director of Office of Health Policy and Legislative and External Affairs; Ruth Jacobs, Assistant Deputy Director of Benefits and Quality Monitoring; Seth Brunner, Senior Staff Counsel; Tony Lee, Chief of Fiscal Services; Kathi Dobrinen, Eligibility, Enrollment and Marketing Division; Raymond Titano, Benefits and Quality Monitoring Division, Mary Watanabe, Benefits and Quality Monitoring Division; Will Turner, Legislation; Anjonette Dillard, Policy Manager, Eligibility, Enrollment and Marketing Division; Loressa Hon, Manager in the Fiscal Services Unit; Maria Angel, Legal Assistant to the 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.

**Review and Approval of Minutes of June 17, 2009**

The Board unanimously approved the minutes of the June 17, 2009 meeting.

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_052009/Public\\_5-20-09\\_draft.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_052009/Public_5-20-09_draft.pdf)

### **Federal Budget, Legislation and Executive Branch Activity (Including Healthcare Reform, Economic Stimulus & Budget)**

Ms. Puddefoot reviewed several reports and handouts on national efforts to reform healthcare that she had provided to the Board. One in particular that has received a lot of attention by national policy makers, including the President himself, is an article from the New Yorker. It looks at Medicare and discusses reforms that could be made to that system that are applicable to the larger healthcare discussion. She also informed the Board that since its last meeting, Senator Kennedy and the Senate Committee on Health, Education, Labor and Pensions has released a first draft of what is being called the "Affordable Health Choices Act". The draft is 615 pages long. Its release is significant, not necessarily in its particulars, but in the fact that there is actually now a working document for people to review and discuss. Staff will keep the Board apprised of developments.

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

The documents can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_4.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_4.pdf)

### **State Budget Update**

Ms. Krum noted that she had reported at the last Board meeting that the Governor had submitted two reduction proposals related to the General Fund shortfall, Plans A and B. Since then, the Administration has revised the shortfall estimate and abandoned some plans to borrow. As a result of this increased budget gap, the Administration has two additional reduction proposals, Plans C and D. Each of these impact MRMIB's programs to varying degrees, the most severe of which is a proposal to eliminate the Healthy Families Program (HFP).

Ms. Krum then reported on the actions the Budget Conference Committee has taken to date on MRMIB's programs.

HFP: The committee rejected the proposal to eliminate HFP. Ms. Krum observed that the committee had allowed for public testimony on conference issues. Many people, members of the public, enrollees and advocates, expressed strong support for the program. Staff has provided the Board with documents related to the Governor's proposal to eliminate HFP: A copy of a

letter PICO of California sent to the Governor urging him not to eliminate HFP, and a legislative update from California Health-Line that quotes Senate Pro Tem Darrell Steinberg saying that the Senate would not eliminate it. The committee also rejected the Governor's proposal to reduce HFP eligibility from 250 to 200 percent of the federal poverty level (FPL). The committee did act to reduce General Fund support for HFP by \$70 million and adopted budget bill language encouraging MRMIB to seek other funds to make up the funding gap. The committee did not reduce federal funding expenditure authority so that if MRMIB were able to obtain some alternative funding, the Federal Financial Participation (FFP) match would be immediately available. Staff has provided the Board with a copy of the Conference Committee document that describes the action. The Committee adopted the Administration's proposal to eliminate payment to certified application assistants (CAAs) as well as the proposal to reduce caseload because of the anticipated effect of CAA elimination on enrollment. Payments for CAAs will cease as of August 1, 2009. The Committee adopted the Administration's proposal to eliminate funding to conduct the Consumer Assessment of Health Plan (CAHP's) survey, a savings of \$170,000 in Proposition 99 funds. The Committee adopted the Administration's proposal to eliminate funding for a new round of Rural Health Demonstration Projects (RHDP), a savings of \$729,000 in Proposition 99 funds. Per the Administration's May Revise proposal, the Committee reduced CHIM funding to reflect reduced caseload as reported by the participating counties.

AIM: The Committee adopted the Administration's proposal to reduce Proposition 99 funding for AIM by \$85 million and transfer the funds to the Department of Health Care Services (DHCS) to cover Medi-Cal costs. That reduces the AIM appropriation from \$149 million to \$64.3 million.

Ms. Cummings interjected that staff estimate that the loss of these funds will result in program closure in January, 2010.

MRMIP: Ms. Krum indicated that the Committee approved the May Revise estimate of revenue (\$774,000) that will come to MRMIP as a result of fines and penalties collected by the Department of Managed Health Care (DMHC) pursuant to SB 1379. The Committee adopted the Governor's proposal to reduce Proposition 99 funding for MRMIP by \$6.6 million and transfer those funds to DHCS to cover Medi-Cal costs. That reduces the MRMIP appropriation from \$38.9 million to \$32.3 million.

Ms. Cummings reported that staff incorporated the funding level approved by the Committee in the analysis for establishing the MRMIP enrollment cap that will be discussed later in the agenda.

Ms. Krum went on to advise the Board on provisions of a recently issued Executive Order. The order precludes departments from making any purchases or entering into any contracts for the remainder of the 2008-09 fiscal year;

requires departments to disencumber any funds for any contracts issued on or after March 1st, 2009, and for which goods or services have not been provided; requires departments to prepare and submit a plan to reduce expenditures for services or purchase contracts by 15 percent in 2009-10; and, specifies that until each department's reduction plan is approved by their agency secretary, departments are precluded from entering into any new contracts for purchases or services, or amending any existing contracts, until that plan is approved.

The Executive Order provides for an exemption request process and it specifically exempts purchases and contracts made with certain funding sources, including local assistance. This means that the order does not impact our administrative vendor or health plan contracts.

Ms. Krum also reported on MRMIB staffing reductions related to the budget. MRMIB was directed to initiate the layoff process with two staff. Remaining staff continue to have two days of furloughs a month. The Governor has made a proposal to reduce state employee's base pay by an additional five percent. It is unclear whether or not the pay reduction would be associated with an additional furlough day.

Ms. Cummings added that MRMIB is also losing staff funded by a project that is ending, so the actual staff reduction will be 8 --close to a 10 percent reduction of staff.

HFP Shortfall: Ms. Cummings pointed out that while the Committee's action was to reduce the budget for HFP by \$70 million in state funds, it would take \$90 million General Fund to fully operate HFP in the budget year.

Chairman Allenby stated that the Board would hold a special meeting on June 29th to decide what it should do given the \$90 million deficiency. He encouraged staff to look everywhere for additional sources of funding. But if such funding does not appear, the Board will have to act to reduce program costs by curtailing enrollments. He pointed out that to save \$90 million in state funds would mean saving a total of \$270 million because for every dollar the state spends, the federal government provides two.

Ms. Cummings asked the Chairman to clarify whether the shortfall means that the Board would change its direction to staff to proceed with signing plan contracts as negotiated. Chairman Allenby replied that the Board would not change that direction to staff.

Ms. Cummings stated that staff will send out the notice of a special meeting to occur on June 29<sup>th</sup>, at which the Board will consider whether or not it needs to establish a waiting list or require disenrollment at Annual Eligibility Review (AER). The Chairman expressed his hope that by that date some alternate funding

would be identified. The Committee expects MRMIB to try to find alternate funds, and it is appropriate that staff make that effort.

Mr. Figueroa asked when the waiting list would have to go into effect to save \$90 million in state funds. Chairman Allenby replied that it would have to be July 1, and that even then the full \$90 million would not be saved. It would take 13 months of an enrollment freeze to save \$90 million.

Ms. Cummings advised the Board that the vote in Committee not to eliminate HFP was a three-two vote on each side. The vote not to reduce eligibility to 200 percent was a three-two vote on each side. The vote to reduce the HFP Budget by \$70 million in state funds and adopt the budget bill language that directs MRMIB to search for additional funding from other sources, was adopted on a five-zero vote on each side.

Dr. Crowell asked how quickly the wait list could go into effect given a Board meeting on June 29<sup>th</sup>. Ms. Cummings replied that it could take effect as early as July 1st.

She reminded the Board that the wait list regulations provide that only the Board can impose a waiting list, but the Executive Director can lift the enrollment freeze if funding becomes available between Board meetings.

Mr. Figueroa asked whether the wait list savings presume that as children leave the program their slots can be filled with new enrollment. Ms. Cummings replied that to save the necessary funds would require a “hard” freeze, in which there is no new enrollment in the program at all. Staff will be working on estimates for the June 29 meeting, but present knowledge is that it means no new enrollment in HFP at all through the budget year. This is different from the “soft” freeze the Board uses with MRMIP, in which new enrollments are allowed to fill vacated slots up to an enrollment target (of 7,100).

Mr. Figueroa commented that HFP enrollment would thus decline to some unknown number. Chairman Allenby estimated it would be in the neighborhood of 700,000 children. Ms. Cummings replied that staff will try to have that number for the June 29<sup>th</sup> meeting.

Dr. Crowell noted that in past deliberations, the Board also considered delaying action until the cutoff date and then completely closing the program. Obviously, the Board would not want to have to do that.

Ms. Lopez reported that several HFP plans have been brainstorming ideas to save money in HFP. She noted that she had received a letter from Universal Care Medical Group with specific suggestions many of which staff has considered before and some new ideas as well. Anthem Blue Cross (ABC) is leading a work group with other plans to come up with additional ideas. Their

ideas include increasing premiums, and increasing copays generally and in particular for inappropriate use of an emergency room.

The Chairman asked whether the ideas would require a change in statute. Ms. Lopez replied that they would –and therefore they are ideas for a later budget. But staff appreciates the plans' initiative and efforts to think outside of the box.

Chairman Allenby asked for any comments or questions.

Crystal Myrna Lee with Children Now and the 100 Percent Campaign asked for clarification on whether the Board action on June 29th might go beyond wait listing children to also requiring disenrollments at AER.

Ms. Cummings replied that the Board has both levers available to it (wait list and disenrollment) and will determine at the meeting what the program's financial situation is and whether it needs the Board to pull either one or both levers at that time. She went on to say that if the Board were deliberating on the issue today, staff would recommend just freezing enrollment –even though doing so wouldn't generate all the savings that appear necessary. Then staff would monitor the budget to see if the Board needed to go further. If the program doesn't receive any additional money, the Board would have to revisit this issue in about three months. This is what the Board will be talking about at the next meeting.

Ms. Lee asked again if the Board would need to start disenrolling children to obtain the needed savings. Ms. Cummings replied that, according to staff estimates, even if a wait list goes into effect July 1st, the Board would still be short \$20 million. However, the Board is extremely reluctant to require disenrollments at AER and would want staff to do everything in its power to prevent having to do that.

Ms. Lee replied that in addition to being an advocate, she also is the mother of a special needs child. She obtained coverage for her child from public health insurance at one time and believes that she is successful today because those services were available to her. She commented that it would very helpful to know how many children would have to be disenrolled at AER to save \$20 million.

Chairman Allenby thanked Ms. Lee for her remarks. He asked for any other comments.

Ms. Cummings pointed out that she thought the action taken by the Legislature was the "best horrible option" they had before them. Some options under consideration would have changed the structure of HFP in ways that would be very difficult to recover from.

The documents can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_5\\_State\\_Budget\\_Update.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_5_State_Budget_Update.pdf)

## **STATE LEGISLATION**

Mr. Turner highlighted bills of interest to the Board from the regular and special sessions.

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

Ms. Puddefoot then presented an analysis of SB 227 (Alquist). The bill would provide additional revenue for the medically uninsurable program, MRMIP. The bill is scheduled for hearing in the Assembly Health Committee on June 30th. Overall, it is similar to last year's AB 2 (Dymally), which the Board supported. The bill would expand the state's capacity to serve medically uninsurable individuals by requiring individual market insurers, and to a limited extent, group market insurers, to either pay a fee that would fund MRMIP coverage or provide coverage directly to medically uninsurable individuals. It sets a maximum fee in statute. It also eliminates the annual \$75,000 benefit cap. In the past, this cap has prevented MRMIP from being eligible for federal high risk pool funding.

Staff is concerned about one of the bill's provisions that would allow the Board to increase the level of premiums paid by subscribers who have incomes above 400 percent of the FPL. Presently, subscribers pay between 125 and 137.5 percent of the standard market rate for these kinds of plans. The bill allows the Board to reduce the premium rate for lower income families, but it would also authorize a higher rate of 150 percent for those with incomes above 400 percent of the FPL. MRMIP premiums are high cost now, and staff believes raising premiums for this group would mean that the program was even less affordable for moderate income individuals. Chairman Allenby commented that the program is not really affordable now.

Ms. Cummings commented that Senator Alquist is very concerned about affordability for lower income people. This has also been a concern of the Board. The bill makes it possible to lower premiums for people with lower incomes – but then takes the point of view that for people above a certain income level, 150 percent of the average premium cost would be the right amount of money. That is the issue staff would like to discuss with the author's office.

Ms. Puddefoot stated that staff recommends that the Board support SB 227. The Board has taken a support position on similar bills: AB 1979 (Chan) in 2006 and 2007; and AB 2 (Dymally) last year. SB 227 has a number of positive components that are consistent with the Board principles for reform of MRMIP. While the amount of revenue generated would not allow the program to cover all

of the individuals eligible, it would expand enrollment somewhat and fund the elimination of the \$75,000 benefit cap. It would spread the cost of subsidizing coverage for those in MRMIP across a somewhat larger pool. Thus, staff recommends a position of support, or support as amended given the concerns about charging some subscribers premiums up to 150 percent.

Chairman Allenby asked if there were any questions or comments. He stated that the sense of the Board is that 150 percent would be too high. Dr. Chang agreed. The Chairman indicated that unless Board members wanted to express a different view, he thought a "Support if Amended" position was appropriate. No Board members opined otherwise.

The legislative reports and analysis of SB 227 can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_6.a\\_Legislative\\_Report\\_Regular\\_Session.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_6.a_Legislative_Report_Regular_Session.pdf)

and:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_6.b\\_Legislative\\_Report\\_Special\\_Session.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_6.b_Legislative_Report_Special_Session.pdf)

## **HEALTHY FAMILIES PROGRAM UPDATE**

### **Enrollment and Single Point of Entry Report**

Mr. Sanchez reported that as of the end of May, HFP had over 919,000 children enrolled. There were 36,000 new enrollees during the month. The majority of subscribers are Latino and 59 percent of the enrolled population reside in Southern California.

The Single Point of Entry screened over 34,400 applications, 69 percent of which were forwarded to the Healthy Families Program.

Mr. Campana asked if May was indicative of the second highest month of new enrollment in the history of the program. Mr. Sanchez replied that the numbers represented the highest for the month of May. April represented the highest new enrollment in the entire history of the program.

Ms. Cummings noted that the new enrollments figures include enrollment assisted by CAA's. Funding for CAA's has been eliminated in the budget adopted by the Budget Conference Committee. It is unclear how future enrollment numbers will be affected by this budget action.

Mr. Sanchez noted that the Board had asked at a prior meeting whether the administrative vendor was hearing from subscribers about budget reduction issues. MAXIMUS has been conducting a short survey and found very few questions about the budget related proposals.

The enrollment document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_7.a\\_HFP\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_7.a_HFP_Enrollment_Report.pdf)

### Administrative Vendor Performance Report

Mr. Sanchez reported that the administrative vendor continued to meet all performance standards in processing applications and all quality standards for screening applications, eligibility determinations, and sending records to the plans.

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

The report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_7.b\\_HFP\\_Adm\\_Vendor\\_Perf\\_May\\_2009\\_Summary.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_7.b_HFP_Adm_Vendor_Perf_May_2009_Summary.pdf)

### Advisory Panel Chair's Update

Mr. Campana reported to the Board on the Advisory Panel meetings of January 10<sup>th</sup> and May 14<sup>th</sup>. During the discussion of the implementation of CHIPRA at the January 10 meeting, panel members adopted a motion asking the Board and the Legislature to support the implementation of CHIPRA requirements and options. It also expressed the Panel's view that using birth certificate data to verify identity rather than social security information is highly preferable.

Mr. Campana indicated that the Panel will meet again on August 11th. A major focus of that meeting will be to look at the way HFP provides services to children with serious emotional disturbances.

Ms. Cummings reminded Mr. Campana that the Panel had passed another motion at its meeting on May 14<sup>th</sup>. Mr. Campana then told the Board that the Panel recommends that data on quality be considered when determining which plans are authorized to charge subscribers a discounted premium. In addition, the panel suggests that new resources be devoted to assisting plans that are not performing at desired quality levels.

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

Minutes of the May 14<sup>th</sup> Advisory Panel meeting can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/HFP\\_AP\\_5-12-09\\_FINAL\\_DRAFT.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/HFP_AP_5-12-09_FINAL_DRAFT.pdf)

### HFP Current Year Expenditures

Ms. Hon reported that costs for HFP in the current year remain within the levels budgeted. Staff believes there is sufficient funding for the current year. Staff will continue to update the Board each month on current year expenditures.

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

### Report to the First 5 Commission on Enrollment of 0-5 Year Olds

Ms. Hon discussed the report recently provided to the First Five Commission on enrollments of children aged 0-5. The report covers expenditures for the period of March 1-April 30, 2009 for children enrolled in HFP after December 18<sup>th</sup>, 2008. Staff anticipates total expenditures for the fiscal year to be close to the \$16.7 million the Commission provided to forestall wait listing of 0-5 year olds.

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

The report can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/agenda\\_item\\_7.e.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/agenda_item_7.e.pdf)

### Adoption of Final Regulations, ER-1-09, Community Provider Plan Designation Process

Chairman Allenby asked for a motion to adopt the final regulations outlining the Community Provider Plan Designation Process. Specifically, he asked for a motion to adopt the resolution identified in agenda Item 7f-3.

A motion was made and seconded and the Board unanimously voted to approve the resolution.

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_7.f.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_7.f.pdf)

### Mental Health Evaluation Update

Ms. Jacobs updated the Board on recent activities associated with the evaluation of mental health and substance abuse services. MRMIB is conducting a three-phase study of HFP mental health and substance abuse services. The current phase of the study focuses on evaluation of mental health services and substance abuse services provided by plans. APS Healthcare (APS), the contractor doing the evaluation, is presently analyzing health plan documents (policies and procedures, provider lists, and documents addressing outreach and

education, assessment, coordination and authorization, quality improvement and member services). APS will submit a brief synopsis of its findings at the end of June.

APS will also be collecting data on utilization of mental health and substance abuse services, and conducting focus groups and key informant interviews with health plan representatives. The plans have been very cooperative in responding to APS.

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

#### Grievance Report for 2006-07 and 2007-08

Mr. Titano presented the report on HFP plan grievances. The report is based on grievance information that plans self-reported for two calendar years, 2007 and 2008. The report expresses grievances on a rate per 10,000 subscribers basis, an approach used by the Department of Managed Health Care (DMHC).

One-half of one percent of HFP subscribers filed grievances with their health plans in each of the two years. In 2007, the grievance rate was 43 per 10,000. In 2008, it was 51, an increase of 19 percent. For the health plans, claims-related grievances were the most frequent class of grievances, 28 percent in 2007 and 39 percent in 2008. The most common issue in the claims-related grievances class was plan failure to pay for treatment. The second most common issue was insufficient payment. After claims related grievances, the next most cited area were quality of care grievances. Mr. Titano mentioned specific plan results and also pointed to the demographic analysis of subscribers filing grievances.

MRMIB staff will be contacting plans with the highest grievances rates. Areas of greatest concern are: the high number of grievances for refusal to pay for treatment (Anthem Blue Cross), high numbers of grievances related to poor physician and staff attitude (Kaiser), and insufficient payment grievances (Care First, Community Health Group and L.A. Care.)

Chairman Allenby called for any questions or comments.

Dr. Crowell opined that the view of plan performance one has after looking at the Grievance Report seems different from the view after looking at consumer satisfaction results. For instance, subscribers report very high consumer satisfaction with Kaiser and yet more grievances. She asked if staff had thought about what this dissonance might mean. Ms. Rouillard confirmed that there are dissonances among the views provided by the different performance measures. The grievance data provides another piece of information that staff can use to

evaluate overall plan performance. Ideally, staff would like to follow up with the outliers of the plans.

Ms. Cummings emphasized that there is little staff capacity to work with plans one on one to correct performance. Given this, one has to assess what staff can do that won't take an enormous amount of time. Staff can be attentive to anomalies, such as really high grievance rates due to unpaid claims. Dr. Crowell observed that there were plan outliers in the consumer satisfaction data.

Mr. Campana asked if there were differences in the rate of grievances by geographic area. Ms. Rouillard replied that plan data was not reported by geographic area.

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

The Grievance Report can be found at:  
[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_7.h\\_2\\_007-08\\_Grievance\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_7.h_2_007-08_Grievance_Report.pdf)

#### 2007 Dental Quality Report

Ms. Watanabe presented report highlights to the Board. She reminded the Board that in 2007 the HFP staff Dental Advisory Committee reviewed the existing dental quality measures as reported by the dental plans. The Committee thought the measures insufficient and developed a list of new measures. Staff brought these to the Board and the Board adopted them. The new measures are listed in the report. However, staff will first report on the data from the new measures for the 2008 year in the fall.

The data plans submitted for 2007 was for the older quality measures. Staff decided not to include this data in the report. This leaves the report with data on the one HEDIS measure that will continue to be used, as well as information from the 2007 dental consumer satisfaction survey, otherwise known as D-CAHPS.

CHIPRA requires detailed reporting on dental services, so once CMS weighs in there could be additional changes to the measures. One positive feature of federal data reporting standards is that it will result in comparative data from other states. The only comparison data we have right now is for national Medicaid plans for annual dental visit measures. We are the only program in the country that conducts the D-CAHPS survey.

HFP has two types of dental plans. There are the open network plans, Delta Dental and Premium Access. They serve approximately 52 percent of HFP members. In an open network, members choose a dentist within the network, but they are not required to have a primary care dentist. They also do not need a

referral to see a specialist, and providers are paid on a fee-for-service basis when a service is provided. Then, there are the plans with a primary care model, Access Dental, Health Net, SafeGuard and Western Dental. These serve about 48 percent of HFP members. In these plans members are required to select a primary care dentist, and they are also required to get prior authorization before seeing a specialist for non emergency services. The primary care dentist receives a capitation payment from the plan for each assigned member.

There are significant differences in how the plan types performed – something which has been true in all prior reports. The open network plans receive consistently higher ratings on D-CAPHS measures across the board and their members receive annual dental visits at a much higher rate.

Results for the one HEDIS measure, annual dental visits, shows that in 2007, 59 percent of HFP members received one dental visit. This is a slight decline from 2006, when participation peaked at 62 percent. Individual plan rates range from the high of 70 percent on open network plans down to a low of just 21 percent. The HFP weighted average exceeded the national Medicaid average of 47 percent. Ms. Watanabe then reported on demographic variables.

The satisfaction survey, D-CAHPS, was administered by Data Stat using an updated survey instrument. Generally, the results remained stable across all measures compared to past survey results. Survey results showed that seven out of ten members were satisfied with the care their child received from both their dentist and dental specialist. They reported fewer problems communicating with the dentist, and they felt they were treated with respect. However, one out of three members said they were not satisfied with their child's dental plan and reported a problem getting care quickly. As noted above, the open network consistently received higher rating. An interesting area of “dissonance” is that in the satisfaction survey, seven out of ten said that their children went to the dentist in last 12 months. According to the HEDIS data 59 percent did. The difference could result from parents not being clear on which of their children the survey was focused on, or on imprecise recollections of when visits occurred. The results also indicate that the majority of children saw a dentist for routine care. Less than half saw a dentist for a cavity. Less than a quarter went to a dental specialist, and there were only a few that reported going to an emergency room for dental care.

Ms. Watanabe went on to discuss results by different demographic variables. She then indicated that staff will be researching the areas where there are significant differences among the plan models. She acknowledged DataStat for their work on the survey project and Crystal Schoenfelder for her assistance with the report.

Ms. Cummings stated that even though parents prefer the open network plans, MRMIB will not be able to expand access to them because of cost issues. It is

important to figure out how to improve performance in the capitated model. Staff will approach a foundation with an interest in children's dental issues to support a project that focuses on how to do that.

Chairman Allenby commented that this would be a good idea and asked for questions or comments. There were none.

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_7.i\\_2007\\_Dental\\_Quality\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_7.i_2007_Dental_Quality_Report.pdf)

### CHIP Reauthorization Implementation: Prospective Payment Requirements for Federally Qualified Health Centers and Rural Health Centers

Ms. Puddefoot reported that the Secretary of the U.S. Health and Human Services Agency announced the appointment of Cindy Mann as the new Director of CMS. Ms. Mann had worked for CMS during the initial implementation of the S-CHIP program.

Ms. Cummings noted that Ms. Mann is a very important advocate for children's health services and was responsible for providing testimony before Congress during CHIPRA reauthorization.

Ms. Puddefoot went on to say that although staff is continuing to participate in weekly all-state CHIPRA calls, little guidance is coming forth from CMS yet. It is hoped that with Ms. Mann's appointment, states will have clear direction in the near future.

Ms. Puddefoot proceeded to a discussion of an issue paper setting forth options for complying with one of the requirements of CHIPRA-- reimbursement of federally qualified health centers and rural health clinics at prospective payment system (PPS) rates. Presently, clinics are reimbursed by plans at rates negotiated by the two parties. CHIPRA requires a change in the mechanism to a PPS approach, which is similar to fee-for-service. This is something that has been required in the Medicaid program for some time. But it is new for CHIP. Using the PPS method has major cost implications for HFP.

Ms. Puddefoot then reviewed the various options for compliance identified in the report.

Mr. Figueroa suggested that the Board adopt the mechanism used by Medi-Cal. Ms. Puddefoot replied that using the Medi-Cal mechanism is staff's recommendation as well. Chairman Allenby opined that building on the Medi-Cal approach seemed sensible, but that he would like staff to take a harder look at alternatives that might be more straightforward.

Ms. Cummings noted that the Medi-Cal like approach has been worked out in statute and is understood by the clinics as well as program administrators. The downside of the approach is that it creates fiscal incentives for plans to negotiate rates with clinics knowing that they will be getting supplemental payments that make them “whole” at the end of the day. Because this is an enormous incentive for plans to contract with traditional and safety net (T&SN) clinic providers and will result in significant new revenue to those clinics, it raises the issue of whether the Board needs to continue using a subscriber premium discount to reward contracting with T&SN providers. The discount could be used for as a lever to reward plan performance on quality issues. The choices as staff sees them are 1) model on Medi-Cal either by contracting with DHCS or the HFP administrative vendor or 2) place the obligation to pay the PPS rates on HFP plans as they are planning to do in Florida.

Dr. Chang commented that it seems efficient to build existing infrastructures particularly because the HFP plans also serve Medi-Cal and are familiar with that process. The benefits of stakeholders understanding the process and knowing how to do it is huge. She expressed interest in using incentives to reward quality but indicated that the safety net providers are a little bit further behind many of the commercial providers in their ability to report quality data. Ms. Cummings commented that HFP quality reports tend to show, fairly high performance for local health plans. Dr. Chang replied that local health plan performance is not necessarily at the clinic level nor the center level, either. There are different distributions of those providers within the plans and how it shakes out is not clear.

Dr. Crowell indicated that she did not feel she had sufficient information on the topic. Ms. Cummings asked if the Board would like to put the issue over to the next Board meeting to provide time to respond to Dr. Crowell’s questions.

Ms. Cummings emphasized that staff are looking to the Board for general direction on the issue and would be returning to the Board with more detailed analysis on the selected approach as staff proceeded to analyze the issue. It seems that the sense of the Board is to proceed with a Medi-Cal like option. But members did not get the report in advance of the meeting and the direction need not occur today. There is a bit of time.

Chairman Allenby asked for any further comments.

Elia Gallardo with the California Primary Care Association (CPCA) thanked the staff for a very diligent look at a complex issue. She indicated that she had only been able to quickly skim the report but wanted to point out that the GAO a did a study of all the federal programs across every department and found that federally qualified health centers (FQHC) were among the top ten most cost-effective programs. CPCA strongly supports the staff recommendation to implement option one, the Medi-Cal like approach. Working that approach out

with DHCS was a difficult, long term process. Implementing something different in this program seems very unappealing. CPCA continues to differ with MRMIB staff on the effective date for the PPS requirement and is hoping that CMS will be able to start providing guidance with the appointment of Cindy Mann.

Dr. Crowell asked how many clinics California has. Ms. Gallardo replied that there are 119, the vast majority in the nation-- and that's just the corporations which have multiple sites. Dr. Crowell asked for a list. Ms. Gallardo agreed to provide it. She noted that CPCA has been providing staff with a lot of information on the clinics and will continue to do so. Ms. Cummings affirmed that CPCA has provided staff with a lot of information. She pointed out that CPCA does not represent the rural health centers which are also eligible for PPS payment. Ms. Gallardo corrected Ms. Cummings, saying that CPCA does represent private, not-for-profit rural health centers. It does not, however, represent the for profit centers.

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_7.j.ii\\_CHIPRA\\_PPS\\_Requirements\\_Issue\\_Brief.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_7.j.ii_CHIPRA_PPS_Requirements_Issue_Brief.pdf)

### **Access for Infants and Mothers (AIM) Update**

#### **Enrollment Report**

Ms. Dobrinen reported on AIM enrollment. In May there were 1,053 new subscribers enrolled in the program. The program has 7,096 subscribers currently enrolled. The majority of subscribers are Latina and the top three counties, Los Angeles, San Diego and Orange represent 49 percent of the AIM population.

Chairman Allenby asked if there were any questions or comments. Mr. Figueroa pondered why enrollment had declined, speculating that it resulted from the recession. He noted that the decline started in earnest around September 2008. Chairman Allenby added that the period of the great depression also lead to a decline in population numbers. Mr. Sands noted that he had checked the Department of Finance birth rate information and the numbers are going down.

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_8.a\\_AI\\_M\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_8.a_AI_M_Enrollment_Report.pdf)

#### **Administrative Vendor Performance Report**

Ms. Dobrinen reported that the administrative vendor continues to meet all performance and quality standards.

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_8.b\\_AIM\\_Adv\\_Vendor\\_Perf\\_May\\_2009\\_Summary.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_8.b_AIM_Adv_Vendor_Perf_May_2009_Summary.pdf)

### Emergency Regulations to Eliminate Durational Residency Requirement

Chairman Allenby requested approval of two motions, the first to adopt the findings of emergency and the second to adopt an emergency regulation to eliminate the AIM program durational residency requirement. This change is as a result of a court decision. Both motions were made, seconded, and unanimously approved.

The documents can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_8.c.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_8.c.pdf)

### Major Risk Medical Insurance Program (MRMIP) Update

#### Enrollment Report

Ms. Dillard reported that MRMIP had an enrollment of 6,719 as of June 1<sup>st</sup>. Current enrollment has fallen below the enrollment cap of 7,100.

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_9.a\\_MRMIP\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_9.a_MRMIP_Enrollment_Report.pdf)

#### Update on Enrollment Cap and Waiting List

Ms. Dillard reported that there were 232 people on the wait list as of this time. There were 331 enrollment slots offered as of June 11<sup>th</sup> with an effective date of August 1<sup>st</sup>.

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_9.b\\_MRMIP\\_Enrollment\\_Cap\\_Wait\\_List.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_9.b_MRMIP_Enrollment_Cap_Wait_List.pdf)

#### Administrative Vendor Performance Report

Ms. Dillard reported that the administrative vendor continues to meet performance standards.

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_9.c\\_MRMIP\\_Adm\\_Vendor\\_Perf\\_for\\_May\\_2009.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_9.c_MRMIP_Adm_Vendor_Perf_for_May_2009.pdf)

#### Semi-Annual Enrollment Estimate

Mr. Lee reviewed a document prepared by PricewaterhouseCoopers (PWC) outlining the Semi-Annual Enrollment Estimate. Based upon MRMIP current expenditures, revenues, and projections for fiscal year 2009-10, PWC recommends that MRMIP enrollment remain at the current 7,100 cap. PwC's recommendation was based upon enrollment, premium and claim data files provided by the health plans, the amount of funding the budget as passed by the Conference Committee provides in Proposition 99 funding (a \$6.6 million reduction from and anticipated fee revenue from resulting from SB 1379 (\$774,000).

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Enrollment\\_Limit\\_May\\_2009-Public.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Enrollment_Limit_May_2009-Public.pdf)

#### Financial Report

This item was moved to the next meeting.

#### Emergency Regulations Concerning Guaranteed Issue Pilot Program (GIP) Reconciliation

Ms. Rosenthal reported that the emergency regulations staff proposes are technical and intended to eliminate a disparity between a provision of the GIP statute concerning reconciliation with health plans and language in the regulations specifying the formula for reconciling costs. Statute governs over regulations, but the regulations should state the formula as it is stated in statute. Staff will ask the Board to adopt the regulations at the July meeting.

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

This document can be found at:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_061709/Agenda\\_Item\\_9.f.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_061709/Agenda_Item_9.f.pdf)

There being no other items, the Chairman adjourned the meeting.

DRAFT