

**Managed Risk Medical Insurance Board  
August 21, 2013, Public Session**

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

Ex Officio Members Present: Jack Campana, Chairman of the Healthy  
Families Advisory Panel  
Robert Ducay, Designee for California Health  
and Human Services 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  
Ellen Badley, Deputy Director, Benefits & Quality  
Monitoring  
Jeanie Esajian, Deputy Director, Legislative &  
External Affairs  
Morgan Staines, Senior Counsel, Legal  
Rebecca Dietzen, Senior Counsel, Legal  
Carmen Fisher, Analyst, Legal  
Amanda Evans, Manager, Administration  
Jordan Espey, Manager, Legislative & External  
Affairs  
Larry Lucero, Manager, Eligibility, Enrollment &  
Marketing  
Lilia Coleman, Manager, Benefits & Quality  
Monitoring  
David Bruglia, Analyst, Benefits & Quality  
Monitoring  
Maria Angel Garcia, Executive Assistant to the  
Board and the Executive Director  
Elva Sutton, Board Assistant

Also Present: Javier Portela, Chief, Plan Management Branch,  
California Department of Health Care Services

Public Comment: Kelly Hardy, Children Now

Chairman Allenby called the meeting to order at 10:00 a.m. The Managed Risk Medical Insurance Board went into Executive Session and resumed public session at 11:02 a.m.

### **REVIEW AND APPROVAL OF MINUTES OF JULY 17, 2013 PUBLIC SESSION**

The minutes of the July 17, 2013 public sessions were approved as submitted.

The July 17, 2013, Public Minutes are located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_3-Public\\_Minutes\\_7-17-13.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_3-Public_Minutes_7-17-13.pdf)

### **STATE BUDGET UPDATE**

Tony Lee presented Agenda Item 4, the State Budget Update. The MRMIB 2012-2013 Healthy Families Program budget originally assumed the MCO (Managed Care Organization) tax would be extended, as the budget included \$128.1 million in MCO tax funding as a match for the federal funds. However, the Legislature did not extend the MCO tax until June 27, 2013, leaving MRMIB temporarily without sufficient cash to pay 2012-2013 HFP invoices.

The recent enactment of SB 78 reauthorized the MCO tax and provided a General Fund loan of \$125 million, which was made available to cover HFP costs. The MRMIB staff was informed by the state Controller that all outstanding 2012-2013 payments owed to HFP health, dental and vision plans, and the administrative vendors were paid in full as of July 26, 2013.

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

### **TRANSITION OF ACCESS FOR INFANTS AND MOTHERS (AIM) LINKED INFANTS TO DEPARTMENT OF HEALTH CARE SERVICES**

Janette Casillas reported on Agenda Item 6, Transition of Access for Infants and Mothers (AIM) Linked Infants to Department of Health Care Services. Ms. Casillas presented a chart depicting the transition of AIM-linked infants by phases already transitioned and those planned. The chart categorized AIM-linked infants by federal poverty level (FPL) to help the Board become grounded on the total number of AIM-linked infants, counties of residence, HFP plans and new health plans.

The AIM-linked infant transition began in Phase 3, which occurred August 1. This prompted interest, on the part of advocates and stakeholder, in the overall AIM-linked infant transition. The data concerning these children are blended into DHCS statistics on HFP children transitioned in the different phases.

The AIM-linked infants who transitioned in Phase 3 met the criteria in Phases 1A, 1B, 1C, Phase 2 and Phase 3, and all were from families with incomes between 200 and 250 percent FPL. The document showed that 186 AIM-linked infants from families with incomes between 200 and 250 percent FPL will transition in Phase

4A on September 1<sup>st</sup>. The Phase 4B transition is scheduled for November 1. At that time two groups of AIM-linked infants will transition: those with family incomes between 200 and 250 FPL (611 infants) and those with family incomes between 251 and 300 percent FPL. The subtotal of the higher income infants in AIM is almost 3,700, bringing the total number of AIM-linked infants that will transition to DHCS on November 1 to 4,280.

Ms. Casillas said MRMIB staff is working with DHCS to modify the registration process for AIM-linked infants. Currently, when pregnant women in AIM deliver their babies, there is a registration process and the babies are enrolled in HFP. At some point before the end of the year, the babies will be enrolled directly into Medi-Cal in a health plan available in their county of residence.

Chairman Allenby noted that, in Executive Session, the Board approved updates to the HFP health plan contracts so that all plans run through the end of June 2014.

The charts on AIM-Linked Infants Transitioned to Medi-Cal can be located here: [http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_6\\_Transition\\_of\\_AIM\\_Linked\\_Infants\\_to\\_DHCS.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_6_Transition_of_AIM_Linked_Infants_to_DHCS.pdf)

## **TRANSITION OF THE HEALTHY FAMILIES SUBSCRIBERS TO THE MEDI-CAL PROGRAM**

### Update on Staff Transition

Ms. Casillas reported on Agenda Item 5.a, Update on Staff Transition. She noted that 20 positions or full time equivalents were transitioned to DHCS in May. Ten of those positions were filled and 10 were vacant. Another 11 vacant positions will be transitioned to DHCS on September 1, and an additional five filled positions will be transitioned September 16. This will leave only 23 HFP positions at MRMIB. She said there is an identified need for at least 13 of those 23 positions to be maintained as infrastructure for operating AIM and the Major Risk Medical Insurance Program. Because these were the first programs established by the Board, staffing levels specific to those programs are very low.

### Update on Transitioned Children to the Medi-Cal Program

Ms. Casillas reported on Agenda Item 5.b, Update on Transitioned Children to the Medi-Cal Program. She provided a chart that showed all the phases and the number of children transitioned in each by county, Medi-Cal plan model, health plan, enrollment and dental plan.

She also provided a review of monitoring plan highlights for phases 1A, 1B, 1C and 2, and acknowledged DHCS's efforts at transparency in the manner in which the reports were presented. The reports acknowledge challenges encountered or improvements needed. She said that the reports noted delays in processing applications and eligibility determinations at the county level and that system changes were needed for disenrollments of Medi-Cal children who were transitioned from HFP and whose annual eligibility documents were not received.

This means that statistics for July and August will show an unusually higher number of disenrollments. Families already have been notified of their disenrollments, and system modifications are pending.

Continuity of care requests appear to continue as an outstanding issue, with very few requests made. It is difficult to determine whether families do not need the services, are happy with their current providers or do not understand that they can request this option. Advocates have raised the issue of more clarity around this and other subscriber rights.

The monitoring report for Phases 1 and 2 indicated that DHCS will incorporate HFP performance measures for HEDIS (Healthcare Effectiveness Data and Information Set), CAHPS (Consumer Assessment of Healthcare Providers and Systems) and dental quality. Ms. Casillas suggested that the HFP Advisory Panel be included in this discussion. The Panel, along with other stakeholders, has many years of experience with HFP quality measures and methodologies.

The Phase 3 monitoring report indicated that approximately 112,000 children were transitioned in 25 counties on August 1. All children in this phase were required to select a new health plan. A total of 57 percent transitioned into a single Medi-Cal plan in a county, where the plan was the only one available. The remaining 43 percent were able to choose among more than one plan available in their county. Ms. Casillas said she presumed that Medi-Cal sent information about plan choices to families of transitioning children in advance of the transition.

The Network Adequacy Assessment for Phase 3 showed little or no overlap with the HFP network. The report also noted a fairly good percent of primary care physicians in every county were accepting new patients. However, Ms. Casillas said the report also stated that 93 percent of primary care physicians were under enrollee assignment limits, and therefore not taking new patients. She asked that the DHCS representative in attendance at the meeting clarify this information.

An addendum to the Network Adequacy Report published on July 2 noted that the Kaiser subcontract had not been executed; however, HFP subscribers were transitioned to Kaiser on August 1. Ms. Casillas also asked the DHCS representative to clarify whether the Kaiser subcontract had been executed.

Ms. Casillas complimented DHCS on the Phase 4 assessment, which showed an extensive analysis of, and outreach to, dental offices that are frequented by HFP subscribers but are not already Denti-Cal providers. She said the provider outreach was conducted by a dental consultant hired by DHCS for that express purpose. This effort is reaching out to Denti-Cal providers who are not on the referral list, to ascertain whether they are willing to accept new patients and be added to the list. Additionally, workshops were being conducted to help providers with enrollment.

Further, the provider enrollment process was redesigned and streamlined for preferred provisional provider status, which allows providers that are not fully credentialed by September 1 to see patients in advance of their credentialing. A beneficiary customer service line was established and represents an improved

process for referral by implementing a warm transfer directly to the offices of providers who are accepting new patients. The old process was provision of three names and phone numbers of dental offices to beneficiary families who called.

Denti-Cal will honor all prior authorizations for treatment if the treatment is a Denti-Cal benefit. Denti-Cal also is adopting all HFP performance measures and will report separately on former HFP children.

There was very low overlap of mental health providers. However, DHCS is assessing the possibilities of streamlining the enrollment process for HFP providers, particularly in the area of mental health. Ms. Casillas suggested that DHCS consider strategies for health and mental health services similar to those used in Denti-Cal to identify providers, conduct outreach, and offer warm transfers. She also asked the DHCS representative to elaborate on a new term in the document, "regional county plan."

In closing, she complimented DHCS staff for their work, noting that a great deal had been done on dental and health services, with more work ahead. She noted that the latest monitoring report was more transparent about the challenges that need more work.

She said the next transition phase would be extremely difficult and that DHCS is making efforts to encourage providers to join Medi-Cal on the specialty mental health and dental side. However, at the same time, DHCS will be initiating a 10 percent provider payment reduction. She asked that the DHCS representative address the Board in several areas, including an explanation of the advance notification of Phase 3 subscribers, how DHCS solicited the subscriber to make a plan selection or conducted auto-assignment, the percentage of provider overlap in Phases 3 and 4, and how many children had to select a new PCP (primary care provider).

Ms. Casillas also asked the DHCS representative to clarify data that shows new primary care providers taking new patients but an even higher percent that are on enrollee assignment limits. She also asked the DHCS representative to confirm that the Kaiser subcontract was executed by August 1, provide a description of a regional county plan and confirm whether the 10 percent provider reduction will apply to dentists in both the Medi-Cal fee-for-service and capitated systems, to health plans and to pediatricians.

#### Questions and Answers with Department of Health Care Services Representative

Javier Portela said he has been part of the HFP transition to Medi-Cal since its inception and has assisted with much of the development and overall structural process with MRMIB staff to ensure that improvements were made and lessons learned from each transition phase. He said the two departments have worked very well together to ensure a smooth transition both for employees transitioning to DHCS, and for beneficiaries to receive the most appropriate care available to them.

In responding to questions posed by Ms. Casillas, he said the Phase 3 notices were developed in a way that allowed choice. The notices were previously shared with the Board and posted online. In addition to the notices, DHCS was able to use data to target beneficiaries who had to choose a new plan and provide them with a Medi-Cal choice packet that offers both a manual mail-in process and the option of calling a “Health Care Options and Enrollment” broker to choose a new plan. These beneficiary choices were recorded and saved, and took effect on the first day the beneficiary was enrolled. Mr. Portela said DHCS and MRMIB staff worked to assign those beneficiaries who did not make a choice to a health plan that offered their HFP primary care provider, when possible, or used an algorithm that accounts for quality and for the presence of traditional and safety net providers in the community. He said that the actual numbers were not currently available but that he hoped they could be provided in the next monitoring report and provided to Ms. Casillas to share with the Board.

Mr. Portela said HFP subscribers were given at least 60 days to make a choice before auto-assignment took place. The goal was to provide continuity of care. In addition to looking at the primary care provider or the default algorithm, the process looked to see whether other family members had been assigned to a Medi-Cal plan in the past six months and attempted to link the beneficiary so as not to cause access to care issue, or result in beneficiaries’ having to change later if they didn’t make a choice in the beginning. He indicated that these are some of the safeguards used in Medi-Cal’s assignment process.

Answering Ms. Casillas’ question about enrollee limits, he said they are generally part of a contract with a primary care provider in which the provider has the ability to determine the number of new Medi-Cal beneficiaries the provider can take. However, he said that transitioned HFP subscribers were not considered new enrollees so transition to their existing primary care doctors would not cause a capacity concern. He noted that a provider can determine that he or she has the capacity to support a specific number of patients and, therefore, the plan will not assign more patients unless the provider is willing to take them, or if there is a continuity of care issue and the provider wants to continue serving the patient.

Mr. Portela said that the Kaiser subcontract was successfully executed for Phase 3 and that all children with Kaiser at the time of transition were able to maintain Kaiser through their primary health plan contracted with Medi-Cal. Additionally, he said Kaiser entered into five additional subcontracts throughout the state, which allowed for five additional counties to have Kaiser coverage. He said that DHCS staff is in the process of ensuring that Kaiser is represented in DHCS’s documentation for new enrollees.

Regarding the 10 percent reductions in provider payments, he said that DHCS staff will follow-up with the Board on exactly how that will be implemented. He said DHCS has released some guidance, on its website, identifying the areas of reduction in Assembly Bill 97. He said the cuts will affect anyone who participates in Medi-Cal and is not exempted.

Chairman Allenby asked how DHCS would establish what percentage is subjected to the cut in a managed care plan. Mr. Portela said a methodology was developed

to calculate the cut based on a policy assumption that assumes utilization patterns and determines the appropriate cut from primary capitation paid. He noted that there is an allowance for a bump this year for primary care and some specialist providers, depending on the services they are providing, so there will be a balancing effect. He noted that the AB 97 cuts will affect Medi-Cal's Managed Care and Fee-for-Service systems in different ways. He said more details could be provided on how this affects this transition. However, he said the impact would be on a go-forth basis, since the providers previously were providing HFP benefits, not Medi-Cal benefits.

Regarding the regional model raised by Ms. Casillas, Mr. Portela said this model is similar to the County Organized Health System (COHS), two-plan and geographic managed care models in the manner that services are delivered. However, the model itself is delivering services to a specific region; this is unique to the state, where generally services are provided on a county-specific basis. There are four regions in this expansion, in which one COHS serves eight counties. Phase 4 of the transition will have that region serviced by a partnership called a county-organized health system model.

For Phase 4B, there are 18 designated regional areas that will be serviced by two plans. This is a regional effort because access in these rural areas needs to be done on a regional basis, not in a county-specific basis. Residents travel between counties to obtain services they need, so this is a regionally defined model. This is a new model, both in infrastructure and processes, to ensure that the model can operate in a way that is sufficient for that regional expansion. This phase is set for November 1. Two health plans in the regional model are Anthem Blue Cross and California Health and Wellness Plan. Responding to a question from Mr. Allenby, he indicated that the California Health and Wellness Plan is a new health plan to California and Medi-Cal. He said this plan has more than 20 different Medicaid contracts throughout the nation under the corporate name of Centine.

Mr. Portela said it was DHCS' goal that Anthem Blue Cross take on their existing membership in the 18 counties in Phase 4B and that there is a seamless transition so these beneficiaries do not have to choose a new plan. They have the freedom of choice once they join Medi-Cal, but the goal is to keep them with the health plan they have chosen through HFP.

Mr. Portela indicated that the last two models are the San Benito and Imperial models, both unique because they are county-specific. DHCS wanted to keep some nuances about the rural nature of those counties intact by creating a few new models. San Benito will have only Anthem Blue Cross, which will keep its HFP enrollment for purposes of the transition. Others will have the right to choose Anthem as well. Imperial County will not have Anthem Blue Cross, so beneficiaries will need to choose a health plan. HFP subscribers will have the same process as in Phase 3, which allowed them choice.

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

Kelly Hardy said she agreed that there has been a coordinated effort, especially to recruit new dentists for Denti-Cal. She noted that so far, the results have been disappointing, despite all the outreach. She said she suspected that this was due largely to the fact that payment does not cover the cost of serving these lives. She said this problem is worsening and, despite these great efforts, advocates remain very concerned about not only the dental network, but also the mental health and medical care networks. She said Children Now and other organizations stand ready to assist however they can, but think that the payments are a limiting factor.

She also noted that advocates continue to hear about families' confusion, not only that families have no idea what continuity of care requests are or how to file them, but also that they have more general confusion about the process. For example, the mother of an HFP subscriber in Alameda County said she received a notice two days earlier stating that her daughter was disenrolled as of August 1; however, the daughter had already been transitioned. The mother tried to obtain information through to the Medi-Cal help line, but was unable to get through on the first day. She got through on the second day and was told that her daughter was being disenrolled from Kaiser because Kaiser was not participating with children transitioned from HFP.

Ms. Hardy said she assured the Alameda County woman that this information was not true and that Kaiser was keeping its HFP children. She said the story illustrates that there is a lot of confusion about notices families are receiving. She expressed concern that this mother received a notice mid-month stating that her child had been disenrolled at the beginning of the month. Ms. Hardy said her organization would follow-up internally with DHCS to bring that specific case forward. However, she noted that it illustrates the larger confusion.

In closing, Ms. Hardy stated she was pleased that vacancies on the HFP Advisory Panel are being filled and she indicated that advocates will continue to watch the transition of the Panel to DHCS closely to ensure it is incorporated into the existing structures within DHCS so there is a coherent plan to obtain stakeholder input on the Medi-Cal Program from advocates, consumers and different groups. Jack Campana thanked Ms. Hardy for her remarks and said they were appreciated.

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

The document provided on the Update on Transitioned Children to the Medi-Cal Program is located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_5.b\\_Update\\_on\\_Transitioned\\_Children\\_to\\_MediCal\\_Prg.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_5.b_Update_on_Transitioned_Children_to_MediCal_Prg.pdf)

#### Transition versus Disenrollment Statistics

Ms. Casillas reported on Agenda Item 5.c, the Transition versus Disenrollment Statistics. She noted that, sadly, HFP enrollment was down to just over 32,000, which was similar to enrollment during HFP's first year of implementation.

The report on Transition versus Disenrollment Statistics can be found here:  
[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_5.c.\\_Transition\\_vs\\_Disenrollment\\_Statistics.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_5.c._Transition_vs_Disenrollment_Statistics.pdf)

### Call Center Report

Ms. Casillas reported on Agenda Item 5.d, the Call Center Report. Calls for August numbered nearly 5,000. However, an update earlier the day of the Board meeting showed 7,400 calls for August; this is consistent with the July phone call volume of almost 8,900. She noted that these callers would have been families of children who were transitioned on August 1.

The Call Center Report can be found here:  
[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_5.d.\\_HFP\\_Call\\_Center\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_5.d._HFP_Call_Center_Report.pdf)

### Updated Schedule of Subscriber Notices

Ms. Casillas reported on Agenda Item 5.f, Updated Schedule of Subscriber Notices. The latest updates to the document are the Phase 4A reminder notice, which went out on August 1. For Phase 4B, the 90-day notice went out on August 1. The reminder notice for Phase 4B is to be determined, but it should go out 30 days in advance of the transition, on or about October 1.

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

The Updated Schedule of Subscriber Notices is located here:  
[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_5.f.\\_Notices\\_Schedule\\_8-21-13\\_brd\\_mtg.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_5.f._Notices_Schedule_8-21-13_brd_mtg.pdf)

### **EXTERNAL AFFAIRS UPDATE**

Jeanie Esajian reported on Agenda Item 7, the External Affairs Update. Media inquiries since the last Board meeting were from *The Sacramento Business Journal*, The California Healthcare Foundation Center for Health Reporting, *California Health Line*, *The Associated Press* and *The Ventura County Star*. These news outlets inquired about the transition of HFP subscribers to Medi-Cal, the transition of California PCIP subscribers to the federally-run PCIP, MRMIB surveys on health quality in HFP and the future of MRMIP. She noted that a representative sampling of the coverage was provided to the Board in its packet.

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

The External Affairs Update is located at:  
[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_7\\_082113.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_7_082113.pdf)

## **STATE LEGISLATION**

Jordan Espey reported on Agenda Item 8, State Legislation. No bills have been added to the report since the last meeting. However, seven bills were amended. One of those, SB 28, no longer requires MRMIB to provide information on Pre-Existing Condition Insurance Plan subscribers to Covered California. SB 800 now provides for the transfer of certain MRMIB employees to DHCS or the California Health Benefits Exchange if their functions were to cease.

Since the State Legislation report was written, AB 50 was substantially amended and now contains a number of provisions related to enacted Special Session bills on Medi-Cal expansion. Additionally, AB 617 is now a two-year bill and SB 239 passed out of the Assembly Health Committee on the previous day. Mr. Espey reported that September 13 is the last day for each house to pass bills.

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

The State Legislation Report can be found here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_8\\_Legislative\\_Summary\\_8-21-2013.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_8_Legislative_Summary_8-21-2013.pdf)

## **PRE-EXISTING CONDITION INSURANCE PLAN (PCIP) UPDATE**

### **Update on Transition of California PCIP Subscribers to Federally-Administered PCIP**

Ms. Casillas reported on Agenda Item 9.a, Update on Transition of California PCIP Subscribers to Federally-Administered PCIP. MRMIB staff continues to work on individual cases of enrollment, claims or premium issues brought to its attention by the Centers for Medicare and Medicaid Services. Misdirected premiums are being sent to CMS, and MRMIB is providing monthly reports of newborns delivered in the program.

She said MRMIB staff has asked CMS for enrollment reports on the transitioned California subscribers. CMS is generally two months behind in reporting enrollment, so the first report is anticipated in mid-September for July. This will provide a general sense of how many individuals actually enrolled in the federal program. MRMIB staff also spoke with CMS regarding transitioning subscribers' out-of-pocket expenses (the deductibles and co-pays) and whether this would be reported by state. CMS indicated that this data may not be available. Ms. Casillas said that CMS continues to receive calls from transitioned subscribers who are upset about the changes in the out-of-pocket maximum and deductibles. She reported that staff continues to work with the administrative vendor and Health Now, the third-party administrator, on a phase-out contract. Ms. Casillas said contracts would run at least through December 31, 2014, to accommodate provider and claim appeals, and other remaining activities. However, she said most activities will be concluded long before that time.

### Administrative Vendor Performance Report

Larry Lucero reported on Agenda Item 9.b, the Administrative Vendor Performance Report. The administrative vendor continued to meet performance, quality and accuracy requirements for July although enrollment in PCIP ended June 30.

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

The PCIP Administrative Vendor Performance Report is located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_9.b\\_PCIP\\_Adv\\_Vendor\\_Board\\_Report\\_July\\_2013.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_9.b_PCIP_Adv_Vendor_Board_Report_July_2013.pdf)

### Third Party Administrator Performance Report

Ellen Badley reported on Agenda Item 9.c, the Third Party Administrator Performance Report. Ms. Badley said that the vendor met all medical and pharmacy claims processing performance standards, with seven complaints received from subscribers during the month of July. Customer service calls in June totaled 7,010, but declined by approximately 60 percent for July to 2,700 calls. Call volume in August was approximately 1,000 for the first two weeks.

The majority of July calls were complaints about the transition, increased out-of-pocket costs in the federal plan or claims issues related to services received prior to the July 1 transition. The third party administrator reported that, initially, calls indicated a lot of subscriber confusion about the transition and changes, specifically about out-of-pocket costs and new deductibles for subscribers who had already met their out-of-pocket maximums or deductible.

Ms. Casillas said it now appears that, as the transition has moved forward, subscribers have a better understanding about what the transition means and those call categories are dropping off significantly.

Additionally, the third party administrator met all performance standards related to provider technical support. Provider calls decreased about 30 percent from June to July, from 7,178 calls to 4,797 calls. From August 1 to 15, there were about 2,000 calls from providers, most for the purpose of verifying benefits and eligibility. Many of the calls were transferred to the federal plan, unless they related to claims payments for services rendered before July 1. Subscriber material production and distribution was not reported because no ID cards or new member packets were mailed. Finally, there were no requests for independent external review and administrative hearings.

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

The PCIP Third Party Administrator Performance Report is located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_9.c\\_TP\\_A\\_Performance\\_Report\\_July\\_2013.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_9.c_TP_A_Performance_Report_July_2013.pdf)

## Utilization Reports

Ms. Badley reported on Agenda Item 9.d, the PCIP Utilization Reports. The quarterly report provides utilization from April 2013 through June 2013 for payments. Inpatient facility usage continues to be the largest share at 41.6 percent, followed by outpatient facilities at 30 percent. Inpatient professional services were 4.3 percent, outpatient professional services were 13 percent and prescription drugs were 10 percent.

Ms. Badley also indicated that she reviewed all the PCIP quarterly reports from the inception of the program. She indicated that inpatient facility usage has ranged from a low of 34 percent to a high of 49 percent. Each quarter, depending on how claims fell, inpatient professional services ranged from 3.5 percent to 5 percent. Prescription drugs ranged from 5.4 percent to 12.2 percent, outpatient facilities from 25 percent to 35 percent and outpatient professional services from 12.9 percent to 17 percent. She indicated that, while the numbers varied, these numbers look similar to those in the inception-to-date report.

Ms. Badley reported that the average length of stay for this quarter was seven days, up a bit from the previous quarter. The top five diagnoses by plan payment included chemotherapy, coronary arteriosclerosis and end-stage renal disease. These are the major categories occurring quarter by quarter, and in the inception-to-date report. She noted that rehabilitation appeared in the top five diagnoses for the first time. Pharmacy utilization continues to look very similar quarter to quarter; brand name drugs represent approximately 25 percent of prescriptions but drive 75 percent of the cost, and 75 percent of prescriptions are generic but account for only 25 percent of the cost.

The number one diagnosis for the quarter was pregnancy; Ms. Badley indicated that this was a surprise. Cancer and circulatory disease were also in the top five. Chairman Allenby asked if the inclusion of pregnancy in the top five diagnoses was unique to California, or was a nationwide phenomenon. Ms. Badley said it was nationwide. Ms. Casillas said other state PCIPs reported similar findings. Ms. Casillas said that, with the average length of stay at 15 days for conditions originating in the perinatal period, one could presume these were high-risk pregnancies.

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

The PCIP Utilization Reports can be found here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_9.d\\_PCIP\\_Utilization\\_Reports.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_9.d_PCIP_Utilization_Reports.pdf)

## **MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE**

### Enrollment Report

Larry Lucero reported on Agenda Item 10.a, the Enrollment Report. During July, a total of 246 persons enrolled in the program, bringing current enrollment to

approximately 6,500, well below the enrollment cap of 7,500. Currently, no one is on the wait list, however, there are 17 applicants in the deferred enrollment process. There were no significant changes in plan or county distributions of subscribers and demographics remain unchanged.

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

The MRMIP Enrollment Report is located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_10.a\\_MRMIP\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_10.a_MRMIP_Enrollment_Report.pdf)

#### Administrative Vendor Performance Report

Mr. Lucero reported on Agenda Item 10.b, the Administrative Vendor Performance Report. The administrative vendor met or exceeded all four of the established performance standard requirements.

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

The MRMIP Administrative Vendor Performance Report is located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_10.b\\_MRMIP\\_Adm\\_Vendor\\_Perf\\_for\\_August\\_2013.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_10.b_MRMIP_Adm_Vendor_Perf_for_August_2013.pdf)

#### Updated Enrollment Estimate

Terresa Krum reported on Agenda Item 10.c, the Updated Enrollment Estimate. After a discussion with outside actuaries, MRMIB staff concluded that there are sufficient funds to maintain the enrollment cap at 7,500, which is the staff recommendation to the Board. Staff believes there are sufficient funds even though program enrollments were slightly higher and disenrollments were slightly lower. The next enrollment estimate will be in November.

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

#### Adoption of Emergency Regulations to Continue 2013 Subscriber Contribution Subsidy and Modify Calculation of Subscriber Contributions

Laura Rosenthal reported on Agenda Item 10.d, Adoption of Emergency Regulations to Continue 2013 Subscriber Contribution Subsidy and Modify Calculation of Subscriber Contributions. Ms. Rosenthal said staff is requesting that the Board adopt the emergency regulation today to continue the current subscriber premium subsidy that brings subscriber contributions or premiums down to 100 percent of market. In 2012 the Legislature passed AB 1526, authored by then Assembly Member William Monning; AB 1526 subsidized subscriber premiums down to 100 percent of market for 2013. In late 2012, the Board adopted a regulation implementing that subsidy for the calendar year 2013. This year, AB 82, the 2013 Omnibus Health Trailer Bill, continued the Board's authority

to subsidize the premiums down to 100 percent of market without an end date. The regulation package before the Board continues the subsidy of premiums down to 100 percent of market without an end date. The remaining changes make conforming technical changes to the process for calculating subscriber premiums.

She said the action requested from the Board was to adopt the Finding of Emergency and Adoption of Emergency Regulations included in Agenda Item 10.d.

A motion was made and unanimously adopted.

The MRMIP Emergency Regulations to Continue 2013 Subscriber Contribution, et al., is located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_10.d\\_MRMIP\\_Regulations.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_10.d_MRMIP_Regulations.pdf)

#### First Viewing of Emergency Regulations: Eligibility

Ms. Rosenthal reported on Agenda Item 10.e, the First Viewing of Emergency Regulations: Eligibility. Ms. Rosenthal emphasized that MRMIB is seeking public input before finalizing a decision.

The impetus for the draft regulation is that, when new marketplace rules under the Affordable Care Act and California's implementing legislation take effect in January 2014, it appears upon preliminary analysis that certain provisions of the MRMIP eligibility regulations become inapplicable, specifically, the provision under which an individual is eligible if he or she is charged a higher premium and the provision conferring eligibility based on involuntary termination of existing coverage.

Ms. Rosenthal invited members of the public who wish to discuss the draft regulation to contact her.

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

The MRMIP First Viewing of Emergency Regulations: Eligibility, can be found here: [http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_10.e\\_MRMIP\\_Regulation\\_Eligibility.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_10.e_MRMIP_Regulation_Eligibility.pdf)

#### Other Program Updates

This item was not presented to the Board.

#### **HEALTHCARE REFORM UNDER THE AFFORDABLE CARE ACT**

This item was not presented to the Board.

## **HEALTHY FAMILIES PROGRAM (HFP) UPDATE**

### **Enrollment Report**

Ernesto Sanchez reported on Agenda Item 12.a, the Enrollment Report. The July Enrollment Report showed 273 new subscribers at the end of the month, for a total of 139,000 prior to the August 1 transition. There were no major changes to the demographics. The greatest number of unavoidable disenrollments was for subscribers found to already be enrolled in Medi-Cal Program or those disenrolled as a result of 1931(b) or CalWORKS screening.

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\\_082113/Agenda\\_Item\\_12.a\\_HFP\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_12.a_HFP_Enrollment_Report.pdf)

### **Administrative Vendor Performance Report**

Mr. Sanchez reported on Agenda Item 12.b, the Administrative Vendor Performance Report. The administrative vendor met all performance standards in processing and program reviews, data transmissions and answering the toll-free line. Additionally, the administrative vendor met all quality and accuracy performance standards on determinations of annual enrollment review packets, adjudicating appeals and electronic transmissions.

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

The HFP Administrative Vendor Performance Report is located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_12.b\\_HFP\\_Adm\\_Vendor\\_Perf\\_for\\_July\\_2013.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_12.b_HFP_Adm_Vendor_Perf_for_July_2013.pdf)

### **Appointment of HFP Advisory Panel Members**

Chairman Allenby said a motion was required for Agenda Item 12.c, the Appointment of HFP Advisory Panel Members. The motion was to reappoint Ellen Beck to the Family Practice Physician position, and to newly appoint Jared Ira Fine to the County Public Health Provider position and Alice Mayall as the representative of a family with a special needs child. The motion was unanimously approved.

Mr. Campana, who serves as chair of the Board, said he was pleased with all three appointments. He noted that Dr. Beck has served on the Panel for several years and operates free clinics in San Diego for the most needy of the state's population. He said he also was pleased that the Panel member representing County Public Health Providers focused on dental issues and that Dr. Mayall had experience working on issues concerning violence.

The Appointment of HFP Advisory Panel Members document can be found here: [http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_12.c. Appointment\\_of\\_HFP\\_Advisory\\_Panel\\_Members.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_12.c_Appointment_of_HFP_Advisory_Panel_Members.pdf)

### HFP Subscriber Needs Assessment

David Bruglia reported on Agenda Item 12.d, the Cultural and Linguistic Subscriber Needs Assessment for the 2011-12 benefit year. The report details findings from the Group Needs Assessment, or GNA, which is a comprehensive assessment of subscribers that HFP plans are required to submit every five years. The last GNA was submitted in September 2011, and an update was submitted by the plans in September 2012. This update compared previous, current and ongoing activities that plans are taking to address the needs, gaps in services or any other issues raised by the GNA. This report only summarizes information submitted by the health plans. MRMIB will include key findings from the HFP dental plans GNA in the 2012 Dental Quality Report.

The GNA required plans to describe the most frequently diagnosed conditions and list the various programs they offered to reduce various disparities. The four most frequently cited conditions included diabetes, asthma or upper respiratory infections, obesity and mental health or substance abuse. Many of the health plans broke down these cited conditions by ethnic groups. One of the key findings in this report revealed that the Hispanic population was the most frequently identified ethnic group across all four conditions. This gap is expected as, historically, Hispanics have comprised nearly 50 percent of the HFP population. The report details activities that plans use or plan to use to address these conditions.

The GNA also requires plans to conduct a subscriber survey to measure how well the linguistic needs of subscribers were being met. The summary of responses to survey questions attempted to identify any issues with language barriers in communicating with their doctors or obtaining interpreting services. Results for the first five questions of the survey were included in the report, as they addressed the issues of language barriers. The remaining questions, not tabulated in the report, did not address language barriers, but measured subscriber preferences on how they obtained informational material. MRMIB staff allowed plans to modify the questions to better fit their plans; this variation led to survey responses that were too inconsistent to tabulate.

In addition to the GNA, plans are required to report annually on the services they provide to meet the cultural linguistic needs of subscribers. This information was reported in the Cultural and Linguistics Report in April 2012. However, staff found that this information did not change significantly from year to year. A summary of that report is also included in the Cultural and Linguistic Subscriber Needs Assessment.

Mr. Bruglia said staff recommended that public programs serving limited English proficient individuals monitor the effectiveness of services and use focus groups and services targeted to these families. With the transition of HFP subscribers to Medi-Cal well under way, this is the final report that MRMIB will publish on the

GNA and the Cultural and Linguistics Needs Survey. During this process, staff learned several lessons, including that MRMIB strategies and tools for addressing cultural and linguistic services were developed in conjunction with the Advisory Committee on Quality and the HFP Advisory Panel. Staff recommends that policymakers and other state programs implement similar advisory groups of subject matter experts and subscriber families to assist in the development of quality improvement initiatives and outreach efforts. Staff also strongly urges reporting on compliance with cultural and linguistic requirements.

Staff found it challenging to identify the most frequently cited health risks and needs based on ethnicity or language across the plans, because plans reported from different data sources. Staff recommends consideration of standardized submissions for data related to ethnicity and language in order to facilitate future analysis.

Mr. Bruglia said MRMIB staff recognized every plan's efforts to assist the diverse populations served by HFP. Regardless of the state program that serves these subscribers, future policymakers, program administrators and plans must continue to focus on ensuring that families have access to services in a language that they understand and that is sensitive to their culture.

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

Ellen Wu commended the plans that submitted data by health conditions and by race/ethnicity. She said she was not sure what happened with the plans that were not able to submit this information. With regard to the disparities found, particularly among the Latino population, Ms. Wu said she understood that the majority of HFP subscribers were Latinos. However, she said what was needed was to look at the disproportionate ratio, and she said she did not believe that was done. She said she did not believe any conclusions could be made that the disparity seen in the Latino population was a result of their higher population numbers in HFP.

The HFP Subscriber Needs Assessment report can be found here:  
[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_12.d\\_HFP\\_Subscriber\\_Needs\\_Assessment\\_final.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_12.d_HFP_Subscriber_Needs_Assessment_final.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 13.a, the Enrollment Report. A total of 672 new AIM mothers were enrolled in July, bringing total enrollment to slightly over 5,800. Latinos continued to be the largest ethnic group in AIM. There were no

major changes in demographics and approximately 88 percent of subscribers were in the top 18 counties of enrollment.

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

The AIM Enrollment Report is located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_13.a\\_AIM\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_13.a_AIM_Enrollment_Report.pdf)

#### Administrative Vendor Performance Report

Mr. Sanchez reported on Agenda Item 13.b, the Administrative Vendor Performance Report. The administrative vendor met all performance and quality and accuracy standards for completeness and eligibility determination, data transmissions and the toll-free line.

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\\_082113/Agenda\\_Item\\_13.b\\_AIM\\_Adm\\_Vendor\\_Perf\\_July\\_2013\\_Summary.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_13.b_AIM_Adm_Vendor_Perf_July_2013_Summary.pdf)

#### Adoption of Emergency Regulations to Implement Statutory Requirements Concerning Modified Adjusted Gross Income (MAGI) and Disenrollment at End of a Month

Mr. Sanchez presented Agenda Item 13.c, the Adoption of Emergency Regulations to Implement Statutory Requirements Concerning Modified Adjusted Gross Income (MAGI) and Disenrollment at End of a Month. The regulations enact a number of statutorily mandated changes, including the methodology of establishing income eligibility for AIM using Modified Adjusted Gross Income (MAGI) and changing the disenrollment date to end of the month in which the 60<sup>th</sup> day postpartum occurs rather than the 61st day after delivery.

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

A motion to adopt the Finding of Emergency and Adoption of Emergency Regulations contained in Agenda Item 13.c was unanimously approved by the Board. Ms. Rosenthal noted that MAGI is required by federal law and AB 82, which was this year's Omnibus Trailer Bill. Additionally, end-of-month disenrollment is required by ABX1-1, a Special Session bill enacted this year.

The AIM Emergency Regulations to Implement Statutory Requirements Concerning MAGI, et al., are located here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_082113/Agenda\\_Item\\_13.c\\_AIM\\_MAGI\\_Regulations.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_082113/Agenda_Item_13.c_AIM_MAGI_Regulations.pdf)

Other Program Updates

No Other Program Updates were presented to the Board.

The meeting was adjourned at 12:14 p.m.