Managed Risk Medical Insurance Board
July 19, 2006

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Virginia Gotlieb, M.P.H., Sandra Hernández, M.D.
Ex Officio Members Present:	Joe Munso
Staff Present:	Lesley Cummings, Denise Arend, Laura Rosenthal, Vallita Lewis, Janette Lopez, Tom Williams, Dennis Gilliam, Ruben Mejia, Mary Anne Terranova, Ernesto Sanchez, Sarah Soto-Taylor, Adrienne Thacker, JoAnne French, Jamie Yang

Chairman Allenby called the meeting to order and recessed it for executive session. At the conclusion of executive session, the meeting was reconvened.

Chairman Allenby welcomed MRMIB's new Executive Assistant, Adrienne Thacker. Lesley Cummings thanked JoAnne French, former Executive Assistant, for the work she is now doing in the Budget section.

REVIEW AND APPROVAL OF MINUTES OF MAY 17, 2006 MEETING

A motion was made and unanimously passed to approve the minutes of the May 17, 2006, meeting.

STATE BUDGET UPDATE

Tom Williams reported on how the 2006 Budget Act and accompanying trailer bill signed by the Governor on June 30 impacts MRMIB's programs. The budget reflects the Governor's efforts to expand access to health insurance for California's children. For HFP, the Budget Act includes approximately $1.1 billion to fully fund projected enrollment of 859,000 children. Some of the major changes discussed were:

- $13.4 million for incentive payments to enrollment entities (EE's) and an anticipated increase in enrollment and retention of over 13,000 children associated with the incentives. The specific incentives are a $10 increase (from $50 to $60) for each successful application submitted using the Health-e-App and an increase from $25 to $50 for each assisted annual eligibility re-determination (AER).

- $9.5 million to fund increased caseload of 12,400 children anticipated to be enrolled as a result of streamlining the initial application process.

Funding for AIM and MRMIP remain at the same levels as proposed in the May Revision.

The DHS budget includes $19.7 million the Governor added for county outreach grants to perform outreach and enrollment activities for those eligible but not yet enrolled in Medi-Cal or HFP.

The support budget includes $10.3 million to fund MRMIB's projected support budget costs, including the establishment of seven new positions. Mr. Williams detailed the functions of the 7 positions. Information on MRMIB's budget is available on the website: www.MRMIB.ca.gov

The Health Trailer Bill (AB 1807) contains several changes that impact the Board's programs. These provisions: 1) eliminate HFP eligibility for AIM-linked infants who have coverage in either Medi-Cal or employer sponsored coverage; 2) allow MRMIB to collect up to two months of the child's premium for HFP as part of the subscriber contribution required to enroll in AIM. 3) eliminate the requirement for families to pay the first month's premium as a condition of HFP enrollment; (the first month's payment will be billed after the child is successfully enrolled); 4) require the Board to report on the progress of studies being conducted regarding Mental Health and Substance Abuse services for HFP subscribers; and 5) provide the Board with emergency regulation authority to implement program changes authorized in the bill, as well as the Certified Application Assistance Incentive proposal included in the Budget.

STATE LEGISLATION

State Legislative Summary

Mary Anne Terranova reviewed the bills staff has been tracking that has either been amended or had some action taken since the last report in March. Ms. Terranova asked if there were any questions. There were none.

AB 1971 (Chan)

Laura Rosenthal presented on AB 1971 (Chan) which provides insurer financing for the Major Risk Medical Insurance Program (MRMIP). Staff has testified in support of AB 1971 which is consistent with the principles for program reform the Board has previously adopted at the March 22, 2006 meeting. AB 1971 enacts a pay or play provision under which an insurer can either guarantee issue coverage in the individual market or pay a fee to support coverage of medically uninsurable persons in MRMIP. Sufficient funds would be collected (over and above subscriber contributions and the state's $40 million in funding) to cover all persons wishing to purchase MRMIP coverage. The $75,000 annual benefit cap is eliminated and replaced with a maximum lifetime benefit of $1 million. The Department of Insurance (DOI) and Department of Managed Health Care (DMHC) would collect the premiums on behalf of the Board. There are aspects of the legislation that still need to be flushed out.

Ms. Rosenthal introduced Deborah Kelch of the Assembly Health Committee. Ms. Kelch thanked the Board for supporting this challenging legislation and acknowledged the staff for all of its efforts. Ms. Kelch noted that it is critical for legislation to be enacted that ensures that medically uninsurable people are able to purchase coverage. As the Board is aware, Blue Cross/Blue Shield and Kaiser developed a fairly straightforward proposal for financing this coverage, consistent with the approach used in many other states. However, it quickly became apparent that due to some California specific barriers, the measure had to be constructed as a pay or play mechanism with carriers that choose not to play having to pay a fee. The pay or play mechanism in the bill is controversial with carriers because it requires guaranteed issuance if a plan does not pay the fee. Proponents are trying to develop a different pay or play alternative that does not rely on the guaranteed issuance approach. Ms. Kelch said she is optimistic that she, MRMIB staff, the legislature, and the carriers can work together to enact this legislation this year. She expressed concern that the Administration had yet to weigh in on the bill, but noted that enactment this year is critical given that there is already a waiting list of uninsured people. And it is not at all certain that Blue Cross would be willing to continue in the program under the existing terms.

Chairman Allenby commended Ms. Kelch for her excellent work. He thanked her and asked her to convey the Board's thanks to Assemblywoman Chan.

Note: The following item was taken out of sequence.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Blue Cross Presentation on Disease and Case Management

At the last Board meeting Blue Cross presented its proposal for enacting insurer assessments for MRMIP. One element of the BC proposal was for MRMIP subscribers to participate in disease management programs. Dr. Crowell asked that Blue Cross describe its disease and case management programs at this meeting.

Chad Westover from Blue Cross provided an overview of key indicators that provide success in case management and disease management. Mr. Westover then introduced Mary Beth East, M.P.H., Director of Health Services for Blue Cross' state-sponsored business. Ms. East reviewed in detail the hand-out she provided. She stressed the most significant factor in successful disease management is the relationship between the physician and patient. Disease management looks at common health issues, such as asthma or diabetes. Case management takes into consideration environment and extenuating circumstances and looks at the person as a whole. An important goal of disease management is self-care skills for a chronic disease, encouraging adherence to nationally accepted clinical practice guidelines and promoting an interactive approach between the physician and patient toward chronic disease management.

Chairman Allenby asked Ms. East to comment on the differences in disease management programs done in fee-for-service plans vs. managed care plans. She

replied that BC has a program that it uses in the Medi-Cal managed care environment and that a number of the elements are very transferable. It is a hybrid model integrating care management and disease management.

Dr. Crowell stressed the importance of treating the whole person as Ms. East described, especially with children. It mirrors what the mental health system is trying to implement in terms of severe cases. So many diseases have co-morbidities and it is important for someone to be attentive to the whole picture. Ms. Gotlieb said the statistics on utilization were fascinating. She asked if there was any data on cost savings associated with the studies. Ms. East said there are cost savings, particularly when treatment is diverted to the primary care provider's office. Ms. East stated she did not have that data with her, but that it is available.

Chairman Allenby asked if there were any questions or comments.

Ms. Cummings asked how the program intersects with the care provided under the CCS program. Ms. East replied that BC nurses collaborate with CCS. Blue Cross is still responsible for the vaccinations, etc. Chairman Allenby suggested that implementing disease/case management in broader lines of business would require consultation with both physicians and patients. Chairman Allenby thanked Ms. East for her presentation.

INTERAGENCY AGREEMENT WITH THE DEPARTMENT OF HEALTH SERVICES FOR TITLE XXI REIMBURSEMENT OF HEALTHY FAMILIES PROGRAM INFORMATION IN THE CALIFORNIA HEALTH INTERVIEW SURVEY.

Dennis Gilliam asked for Board approval of the interagency agreement with the Department of Health Services for increased access and input into UCLA's California Health Interview Survey (CHIS). A motion was made and unanimously passed to approve the agreement.

MODIFICATION OF CONTRACT DELEGATION

Laura Rosenthal asked for Board approval of a modification to the contract delegation authority the Board adopted at its May 17 meeting. The version approved at that meeting contained an editing error. The correction clarifies that the Board will continue to approve inter-agency agreements with expenditures in excess of $200,000. A motion was made and unanimously passed to approve the modified contract delegation authority.

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry (SPE) Reports

Sarah Soto-Taylor asked if there were any questions regarding the written enrollment reports. There were none.

Administrative Vendor Performance Report

Janette Lopez discussed the June administrative vendor (AV) report for HFP and SPE. MAXIMUS is the AV for both of these programs. There were a few standards MAXIMUS did not meet in June. Ms. Lopez introduced Michael Lemberg, HFP's Program Manager from MAXIMUS, to explain why the standards were not met.

Mr. Lemberg indicated there had been a catastrophic equipment failure on June 8. A special device on the network, which is comprised of over 100 hard drives, is supposed to never go down. One drive went bad and corrupted all the other drives. The data from the June 8 equipment failure could not be restored, causing 1600 production hours to be lost that day. Over the course of the next two weeks, MAXIMUS staff worked 1700 hours of overtime to recreate the work lost when the system failed. Things were back on track within 3 days.

Chairman Allenby asked Mr. Lemberg what MAXIMUS' plans are to ensure this does not happen again. Mr. Lemberg replied that the interim solution was to archive files on a different server while he is reviewing options for the permanent solution. Ms. Gotlieb asked what caused this system failure. Mr. Lemberg replied that a vendor who was on-site analyzing the problem identified it as a software failure. A patch has been installed. Ms. Gotlieb asked Ms. Cummings if there was feedback from any subscribers. Ms. Cummings said she was not aware of any. Mr. Lemberg added that this was fairly invisible to subscribers. There was a slight delay in the processing of applications.

Enrollment Entities/Certified Application Assistants (EE/CAA) Reimbursement

Ernesto Sanchez provided an update on EE/CAA reimbursements. He noted that the program almost has as many CAA's now as it did before fees were eliminated. The Board was pleased.

Appeals/Program Review Workload Update

Ms. Lopez updated the Board on the progress in reducing the appeals/program review backlog. She reminded the Board that in January there was a backlog of 1400 cases, 80% of which were program reviews. Her goal had been to clear the backlog by the end of June. Staff have been working exceeding hard, but did not quite clear the backlog by the end of June. There are fewer than 200 cases remaining; half of which the analysts intend to complete by July 31. Ms. Lopez acknowledged Caroline Castaneda, Wendi Dodgin, Thien Lam, Larry Lucero, and Kathi Dobrinen -- along with all the Eligibility analysts and support staff who assist in responding to these inquiries.

Ms. Lopez highlighted the Eligibility Division's accomplishments in the last twelve months and detailed its future workload. Charts provided by Ms. Lopez illustrated the volume of appeals and program reviews from September 2004 through June 2006, showing an average of 188 per month in the past six months. Both staff and MAXIMUS have noticed a decline since May 2005. Ms. Lopez emphasized that staff has

consistently stayed on top of the current appeals and continues to work weekends. Dr. Crowell asked when the back log is expected to be completed. Ms. Lopez replied by the end of the month.

Advisory Panel Update

On behalf of Jack Campana, the Panel Chair who was unable to attend the meeting, Ms. Lopez summarized the HFP Advisory Panel meeting held May 3, 2006. She noted that Mr. Campana asked that she defer presenting the Panel's recommendations on allowing dentists to use general anesthesia in the office. He will present this to the Board at the next Board meeting.

2007 Open Enrollment Update

Ms. Lopez presented an issue paper on changes to the open enrollment (OE) process. Only 5% of subscribers change plans at OE. She reminded the Board that staff had previously discussed with them a proposal to revise the open enrollment process to follow the CalPERS model of mailing subscribers a postcard instead of an entire packet and that doing so would reduce workload. Upon closer review, staff concluded that the process would actually have to remain the same and occur in the same short timeframe. Thus, there would not be a savings in staff time. The only savings would be in the cost of printing postcards instead of packets.

An alternative would be to use the Medi-Cal model in which families are allowed to change plans each month. This approach would distribute workload over the course of the year However, a contract amendment and a change in the regulations would be necessary. Staff has checked with a few plans about this approach and they expressed concern about continuity of care if families jump from plan to plan.

Dr. Hernandez asked how subscribers would get information on health plan quality if the OE process were changed. Ms. Lopez replied that there were a number of possibilities including use of the website, sending out separate letters, doing blasts to CAA's, and including information in billing statements or AER packets. Dr. Hernandez emphasized that it is very important for families to be knowledgeable about plan HEDIS scores. She did not think providing the information via the internet would be sufficient. She suggested that staff consider this aspect of the change very seriously.

Staff would like to hear the Board's opinion and comments from the public, and will bring this topic back at the September meeting.

Ms. Gotlieb expressed concern about how subscribers would be notified of changes in their health plan. Ms. Lopez said that subscribers would always be notified of any changes in plans. Everything that goes into plan contracts goes into the handbooks, which are revised annually. The Board and staff continued to discuss the various ways of revising open enrollment.

Chairman Allenby called for public comment.

Chad Westover with Blue Cross expressed concern about the impact of monthly enrollment changes on the ability of a plan to do effective disease management.

Discussion of Community Provider Plan (CPP) Designation Process

Denise Arend noted that over the last couple of years, plans have raised concerns about certain elements of the process. Staff began looking at some of those concerns after the 2006 competition was completed. She presented a paper summarizing their concerns and recommended changes. Regarding the calculation of the hospital score, local initiatives have expressed concern that allowing for credit for a hospital stay in an out-of-county hospital favors the larger plans. They and Cal-Optima also suggest that MRMIB use as its definition of traditional and safety net hospitals the same method used by Medi-Cal which awards points for HEDIS performance and for contracting with disproportionate share hospitals. Health Net, however, expressed opposition to these changes. Regarding calculation of the clinic score, some plans expressed concerns about including outpatient hospital-based clinics (Provider Type 15), some were concerned that clinics might be listed more than once, and some objected to methadone and optometry clinics being included at all.

Staff intends to circulate the issue paper to stakeholders, obtain feedback on the issues, and make final recommendations to the Board at the September meeting.

Chairman Allenby called for public comment.

Fred Richmond, Chief Executive Officer, Coalition of Orange County Community Clinics commented on the clinic methodology. His coalition, oversees 39 sites that provide 475,000 primary care services for the uninsured in Orange County. Dr. Richmond commented that between 1998 and 2004, MRMIB did not include provider type 15 when calculating the clinic scores, but that for some reason this changed in 2005. His view is that including it is inappropriate as it dilutes the weight of true clinics. Inclusion of outpatient clinics seems inconsistent with legislative intent. He indicated that he was supportive of hospital-based or hospital affiliated clinics that function as community clinics.

Richard Chambers, representing Cal Optima in Orange County, echoed Dr. Richmond's comments

Chad Westover of Blue Cross said that CPP is a great tool. Highlighting member choice is important in determining where utilization is best. He urged that health plans not be forced to limit contracting to obtain the CPP designation.

Quality Performance Improvement Project and Recognition of High Performance Health Plans

Vallita Lewis gave a brief overview of the methodology staff recently introduced to hold participating health plans accountable for their performance on four selected HEDIS quality measures: Immunizations, well-child visits, adolescent well-care visits and access to primary care providers. The overview included a description of the methodology utilized to calculate scores, rank the plans, and communicate the results.

The methodology used to identify the highest and lowest performing plans included several components: 1) Calculating a total plan performance score based on the plan's scores on the HEDIS measures; 2) adjusting the total score by adding or subtracting points based on whether there was a positive or negative change from the prior year; 3) ranking the plans from highest to lowest based on their adjusted score and 4) identifying the highest and lowest performing plans based on whether their adjusted score was one standard deviation above or below the mean. Staff consulted with high scoring plans to identify what strategies they had used to obtain their high scores. Staff also contacted the lowest scoring plans to discuss their performance and obtain an action plan for improvement. When contacting plans with the lowest scores to discuss results, staff found that most of them had already taken proactive steps to address their low scores. Based on the preliminary 2005 HEDIS scores, several plans reported improvements as a result of the interventions implemented

The top three highest performing plans are Inland Empire Health Plan, Cal Optima, and the San Francisco Health Plan. Ms. Cummings presented the plans' representatives with a Certificate and Letter of Appreciation.

Thomas Pham accepted the award on behalf of Inland Empire, the highest scoring plan, stating that the plan is committed to serving HFP. Its score improved by almost 100 points in three years. Strategies utilized included pay-for-performance incentives with cash for providers; incentives for teen-agers including gift certificates to Best Buy, movie theater tickets and I-tunes. It also provides annual training to providers and recognizes the importance of HEDIS and CAHPS performance. Richard Chambers and Lisa Gomez accepted the award on behalf of Cal Optima, the plan with the second highest score, stating that they take it seriously that children receive services. It improved its score by 97 points. Strategies utilized included creating a provider tool kit with age specific forms, and letters to send to families for missed appointments. It also sent reminders to families to make an appointment on the member's birthday. Cia Byrnes accepted the award on behalf of the San Francisco Health Plan, the third highest performing plan. It improved its score by 116 points in the last three years. SFHP sent birthday cards with movie tickets to children and teens to encourage annual visits. It also conducted outreach at local schools. Ms. Byrnes acknowledged the providers, clinics, and staff for their dedication to the program.

Chairman Allenby commented that the Board takes quality performance very seriously. Over time it will make a difference. Dr. Crowell emphasized the improvement on quality performance may be included in the future for mental health indicators. She also directed staff to include the alcohol and drug measure in future reports. Ms. Gotlieb

commented that it is thrilling to see such successful results, especially in reaching teens.

UCSF Study on HFP Approach for Coverage of Seriously Emotionally Disturbed (SED) Children

Ms. Cummings said that UCSF's report on improving the delivery of care to children with Serious Emotional Disturbances was not yet completed and would be provided at the September meeting.

2004 County Mental Health Services for Seriously Emotionally Disturbed (SED) Children Status Report

Ruben Mejia reviewed the 2004 report on mental health services for SED children. The HFP uses two delivery systems to provide comprehensive mental health services. The health plans provide basic mental health services and medically necessary treatment of severe mental illnesses. Children with mental health issues who are suspected of being SED are referred to the county mental health department for assessment and treatment. The report provides data on the percentage of children receiving basic mental health services from plans, the percentage of children referred for SED services, the number of active SED cases reported by counties, and expenditures for SED services

Dr. Crowell was pleased to see the increase in the basic mental health services provided by the plans. Dr. Hernández asked if would be possible to learn from Kaiser what their internal rate of referral is for mental health services. Mr. Mejia said that information would be made available in the next report.

[This report can be found on the web at www.MRMIB.ca.gov under Reports/Healthy Families/Plan Performance

2003/2004 Dental Quality Measurement (HEDIS) Report

Mr. Mejia described the performance measures, reviewed the methodology used, and highlighted the results. California is one of few states providing dental care as part of the S-CHIP program and no benchmarks currently exist for the majority of dental measures discussed in the report.

Staff will contact each dental plan over the course of the next two months to discuss possible causes for scores, and to request corrective action strategies. A follow-up report will be provided at a future meeting.

Ms. Gotlieb expressed concern about the low scores. She suggested it might be more useful to measure initial dental visits in relation to new enrollees. Dr. Crowell expressed surprise at the low utilization of dental services noting that the Board had expected it to be a very valued benefit. She commented that in HFP's early years, dental plans had been concerned about very high utilization. Chairman Allenby noted that having only

one dental plan in the past limited enrollment. Mr. Munso pointed out that changing to a monthly open enrollment process would impact ability to track quality outcomes. Ms. Cummings agreed but noted that the measures only look at subscribers who are continuously enrolled.

Ms. Gotlieb asked if staff were concerned about adequate access to dentists. Ms. Lewis commented that part of the First 5 Commission's focus on oral health was to look at ways to improve access. She indicated that she will convene a Dental Advisory Committee to assist in identifying appropriate measures for dental services and develop strategies to improve utilization.

[This report can be found on the web at www.MRMIB.ca.gov. under Reports/Healthy Families/Plan Performance**]**

Chairman Allenby announced there will not be a meeting in August. He also recognized Soap Dowell, a former Board member, who was present in the audience.

Rural Health Demonstration Projects (RHDP) Contract Awards

Ms. Lewis said that as a result of an internal reconciliation process staff identified $2.7 million in funds available but not allocated to the RHDP. Staff requested the Board's approval to allocate the funds for six dental projects and four health projects which were detailed in a chart passed out to the Board. These projects were rated excellent during the last solicitation process completed in January 2006, but funds were not available at that time to approve the projects. Approving the projects now, rather than conducting a new solicitation, will allow for quicker allocation of the funds and implementation of new projects. They would be effective from September 1, 2006, to June 30, 2008. A motion was made and unanimously passed to award the ten RHDP contracts as presented.

CHILDREN'S HEALTH INITIATIVE MATCHING FUND

County Children's Health Insurance Program (C-CHIP) Update

Ernesto Sanchez reviewed highlights of the update on C-CHIP. Almost $278,000 in federal funds has now been drawn down for three of the four counties approved by CMS (San Mateo, San Francisco, and Santa Clara). New proposals have been received from Santa Cruz and Tulare Counties. Mr. Sanchez recognized the efforts of the following staff: Ginny Veneracion-Alunan, Kathi Dobrinen, Kristen Taylor, Srini Anne, Dennis Gilliam, and Don Minnich.

Buy-In Update

Mr. Sanchez provided the Board with an update on the buy-in project. Staff continues to work on an analysis of the CCS issue which continues to be a major barrier to implementation. Staff is looking into whether a reinsurance approach could be used to

address the problem. He noted that the work plan contains some major deliverables in September and October, notably obtaining foundation funding for implementation costs.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Ms. Soto-Taylor asked if there were any questions regarding the enrollment reports. There were none.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Ms. Soto-Taylor reported that there is no change in enrollment because of the cap. Ms. Cummings commented that the guaranteed issue pilot is still in effect and that MRMIP now has reached its maximum enrollment so the waiting list is back in place. Even with additional health plan subsidies in the pilot, the waiting list for MRMIP had to be reinstated. Ms. Gotlieb pointed out that the Chan bill (AB 1971) is of major importance.

Open Enrollment Update

Ms. Lopez said historically the purchase of AV services has been limited so that the money can be allocated mostly for benefits. There has been discussion about changing the process on open enrollment (AB 1401). However, staff recommends maintaining status quo at this time.

Federal Seed Grant Funding

Ms. Rosenthal said that last month, CMS informed staff that the MRMIP failed to qualify for federal funding because of the $75,000 annual benefit cap. MRMIP may qualify for up to $1 million in seed grant funds from CMS but would not qualify for the $4 to $8 million CMS might otherwise have awarded.

At the end of June, staff submitted an application to CMS for the $1 million grant – $250,000 for program development and $750,000 for program costs. The application states that MRMIP qualifies for funding for program costs only if the $75,000 annual cap is eliminated. Passage of AB 1971 or similar legislation would be required in order to eliminate this cap.

There being no further business to come to the Board, the meeting was adjourned.