



**The California Managed Risk Medical Insurance Board**

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**Managed Risk Medical Insurance Board  
HFP Advisory Panel Meeting Summary  
February 9, 2010  
West Sacramento, California**

**Attendees:** Jack Campana, Karen Lauterbach, Leonard Kutnik, M.D., William Arroyo, M.D., Martin Steigner, D.D.S., Ellen Beck, Barbara Orozco-Valdivia, and Anastasia Gaspay

**MRMIB Staff:** Lesley Cummings, Thien Lam, Shelley Rouillard, Theresa Skewes, Niza Munoz, Jeanie Esajian, Mary Watanabe

**Introductions**

Jack Campana, Healthy Families Program (HFP) Advisory Panel Chairperson, opened the meeting by introducing himself and asking the Panel members, Managed Risk Medical Insurance Board (MRMIB) staff, and the audience to introduce themselves.

**Review and Approval of the November 10, 2009 HFP Advisory Panel Meeting Summary**

The HFP Advisory Panel accepted and approved the November 10, 2009 meeting summary.

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

Jeanie Esajian, the Deputy for Legislation and External Affairs, acknowledged that healthcare reform is still a question mark after the Massachusetts election last month. The President has recently proposed a televised bi-partisan meeting with the Democrats and Republicans, which is supposed to take place on February 25<sup>th</sup>. This is an attempt to reach agreement on healthcare reform this year. It is not known at this time if that means that this is actually going to take place – we have to wait and see what happens at this point.

Ms. Esajian referred to the reports. The first item is a letter from the National Association of Insurance Commissioners (NAIC) commenting on the changes needed to assure integrity of the insurance reforms. The second item is from the National Association of State Comprehensive Health Insurance Plans (NASCHIP). The third item is in regards to the association of state high risk pools. The fourth and final item provides a comparison of the key revisions of the House and the Senate.

To view these reports, please follow the link:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_012110/Agenda\\_Item\\_4.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/Agenda_Item_4.pdf)

Ms. Esajian directed the panel to refer to page five (5) of the comparison document. She pointed out that there is an entry for CHIP and that the House version sunsets CHIP block grant at the end of 2013, while the Senate extends CHIP block grant with additional funding through 2015.

Ms. Cummings, MRMIB Executive Director, stated that in the House version, CHIP would be replaced by two things: 1. a Medicaid expansion to 150% of the Federal Poverty Level (FPL) for all families. 2. above 150% by an insurance exchange, in which there would be subsidies for people with incomes within a certain income level (which is approximately 400% of the poverty level). Children would get coverage with their parents – either in Medicaid or in the exchange. In the Senate version, it reflects a hesitancy to insure children with their parents and it maintains a separate program for children. The exchange would then have to figure out how to incorporate this particular program in with its functions.

#### **State Budget Update**

Ms. Cummings stated that the budget is again in a deficit situation. MRMIB has fewer tools to deal with the shortfall this time around than before. The Governor is not proposing any tax increases. What he is proposing basically resolves the budget problem through reductions and with the anticipation of getting additional federal funding of about \$6.9 billion. The governor's view is that California has not been dealt with equitably by the federal government and so he is making arguments at the Congressional and Presidential level about the need to provide California with additional federal funds. He has proposed two budgets that can be viewed here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_012110/agenda\\_item\\_5\\_2010-11\\_Govs\\_Budget\\_Highlights.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/agenda_item_5_2010-11_Govs_Budget_Highlights.pdf)

The Governor's first proposal assumes that California will get \$6.9 billion in additional federal funds. What he proposes in this budget is to reduce eligibility in the Healthy Families Program from 250% FPL to 200% FPL. This cut would be made effective on May 1, 2010. This would result in approximately 200,000 children being disenrolled on May 1, 2010. The number of subscribers being disenrolled every month thereafter is about 5,000. This would require a change in statute, as the law currently says that HFP will serve children up to 250% FPL.

Ms. Cummings stated that the Governor has called for a special session for the proposals because this particular provision will take effect in the current year – with most of the savings occurring in the budget year. He has called to enact the statutory changes associated with his proposals in a special session by March 1, 2010.

Ms. Cummings mentioned that at the Board Meeting held in January, Ms. Thien Lam, Operations Division Manager for MRMIB's Eligibility Division, spoke to the Board about the tasks involved in actualizing this policy decision. Furthermore, MRMIB's Eligibility

staff and MAXIMUS colleagues will have to spend a lot of time preparing to implement the policy change that may be enacted.

Ms. Cummings also noted that there is a particular wrinkle as it affects children's needs that have severe health conditions because it is the case with the California Children's Services Program (CCS). CCS has an income eligibility of \$40,000 maximum. However, for children who are enrolled in HFP, there is an income exemption that was made in state law. Even if family income is above \$40,000, a child enrolled in HFP is entitled to CCS. So these children would not only lose their HFP insurance, but their CCS eligibility for their chronic condition as well.

The budget presumes that once again, MRMIB will receive \$81 million from California First 5 Commission, even though First 5 never committed to give the funds again for the next budget year. The budget also presumes that the MCO tax (the Medicaid Managed Care tax that was enacted by AB 1422 – that is providing MRMIB with funding in the current year) is continued through the budget year. On this point, CMS had communicated to California that they really did not think it was appropriate to draw down federal funds via this mechanism, and they have directed MRMIB to stop doing so by September 1, 2010. However, they have recently said that they are not going to raise the issue with the state until they promulgate regulations in 2011. So currently, MRMIB is in good standing with the MCO tax in the budget year. Ms. Cummings referred the panel to the handout. The handout shows what MRMIB is currently assuming in terms of revenues.

Ms. Cummings also pointed out that on page 2 of the budget highlights, #2, as it shows the premium increases for subscribers.

Dr. Ellen Beck, director of Community Education, asked Ms. Cummings for an update on staffing.

Ms. Cummings responded that, to date, what is proposed regarding MRMIB staffing is as follows: the Governor has proposed a 5% pay reduction for state employees. He has also proposed for state employees to contribute an additional 5% to the cost of their retirement. Also, he is asking each department to increase their salary savings rate by 5%, which means that the department will have to hold positions vacant for a longer period of time. The Governor has also said that the furlough days will be ending on July 1, 2010 and the three new proposals previously mentioned would replace the furloughs. Currently, MRMIB is under direction to implement the salary savings increase.

### **State Legislation**

Ms. Esajian addressed Agenda Item 5, the State Legislation Report. She called the panel's attention to the handout included in their packet. Ms. Esajian stated that she would really like to focus on two items mentioned in the handout: AB 1653 and SB 311. Assembly Bill 1653 by Assembly member Jones is expected to be heard the following week. The bill would extend for an additional six months – the quality assurance fee that AB 1383 imposed on specific hospitals. MRMIB is currently watching the bill and what action is taken.

SB 311 by Senator Alquist is the CHIPRA Implementation bill that was held in fiscal committee because of its fiscal impacts. It stayed in the fiscal committee until it expired on January 22<sup>nd</sup>. This bill can be resurrected if needed. MRMIB is going to be faced at some point with the need to move CHIPRA Implementation.

For more details about this report, please follow the link here:

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_012110/Agenda\\_Item\\_6a\\_Legislative\\_Summary\\_regular\\_session.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/Agenda_Item_6a_Legislative_Summary_regular_session.pdf)

## **6. Healthy Families Program**

### **a. CHIPRA Implementation**

**Ms. Cummings stated that the handout had not been updated since mid-December and some changes have been made since then.**

#### **i. Federal Claiming Change**

The first change is regarding Title XXI. DHCS discontinued claiming Title XXI and began claiming against Title XIX. This has already been implemented and therefore completed. The main affect is that there is less call on Title XXI dollars.

#### **ii. Citizenship Documentation**

The second change is the citizen documentation requirement that extends the Medicaid citizenship documentation requirements to CHIP. Medicaid collects social security numbers (SSN) and that is mandatory for them. In HFP, SSN's are not collected, as it is also optional for CHIP. What this provision states is that applicants must submit documentation to prove citizenship and providing certification of their identity as well. The Department of Health Care Services (DHCS) is moving ahead with implementation of a SSN match with the Social Security Administration to verify citizenship and identity. HFP is not implementing this provision at this time. However, MRMIB is working to create a match with the Department of Public Health's vital statistics birth records – where submitting a birth certificate would not needed because the state already has that information on file.

HFP is currently working on modifying the application so parents may attest to the identity of their child. MRMIB is allowing the attestation to the identity of the child through the declaration process on the application, which is similar to what Medi-Cal does.

#### **iii. Medicaid Managed Care Standards**

Ms. Cummings stated that application of certain Medicaid managed care standards to CHIP fails to recognize the fact that there are states with non-entitlement programs. The application of the Medicaid managed care rules to CHIPRA is complicated and increased state costs.

The first rule requires CMS to approve existing HFP contracts with the managed care plans. MRMIB is still unsure of what this means. Another provision gives HFP subscribers the right to disenroll from their health plan and go into some other kind of coverage, a "second option." Currently, there are eight counties with only one health plan. MRMIB has two options. The first is to pay a significant rate increase to another plan to enter the eight counties. This would be viewed darkly by the plan that is already present in those counties, unless that plan also gets a significant rate increase. The second option (which is the option that MRMIB is currently pursuing) is using the Medi-Cal Fee-For-Service (FFS) Network. DHCS would have to incorporate the change into its system, which will take time. It also requires statute changes and has fiscal consequences.

Another Medicaid managed care standard requires states to develop and implement a quality assessment and improvement strategy that includes contracting with an External Quality Review Organization (EQRO).

Ms. Cummings reiterated that HFP is not an entitlement. There will be significant costs incurred to follow the managed care standards. MRMIB considered applying for a quality demonstration grant offered through CHIPRA. However, CMS requires the health plans to report all twenty-four proposed core quality measures. MRMIB could not participate because the plans currently report only eleven measures. It would cost plans to report all the measures, and the state has no funds for these costs.

Shelley Rouillard, Benefits Quality and Monitoring Division Deputy Director, stated that MRMIB received a grant from the David and Lucile Packard Foundation for about \$49,000 which MRMIB will use to hire a consultant to assist MRMIB in the process of developing a quality strategy and EQRO solicitation. There are certain activities an EQRO is required to conduct, one of which is performance improvement projects conducted by plans.

Ms. Cummings stated that the good thing about the application of the managed care rules through CHIPRA is that plans must submit encounter and claims data. MRMIB now has the authority that had eluded the department to create this encounter database system. The bad news is that CHIPRA only authorizes collection of encounter and claims data as of July 2009. MRMIB wants to go back to July 2007 because it takes eighteen months for claims and encounter data to be complete.

Ms. Cummings stated there are provisions in the contract with MAXIMUS to develop an encounter and claims system and do analysis of the plan data submitted.

#### **iv. Dental Coverage**

Ms. Cummings mentioned that dental coverage became a mandated benefit under CHIPRA (previously it had been optional). Vision remains optional. The federal government has a construct of designating a benchmark or creating a

“Secretary Approved” plan. MRMIB staff has had discussions with CMS on whether the current dental benefits satisfies the CHIPRA regulations. Of course, any requirement that would increase dental costs will be problematic.

**v. Mental Health and Substance Abuse Treatment Parity**

In regards to Mental Health and Substance Abuse Parity, Ms. Cummings stated that MRMIB concluded that in order to conform to parity, MRMIB had to ensure a child would receive services for treatment of SED. If a county determined that a child had SED and the county Mental Health Department was not able to serve that child, then the plans would continue to be responsible for ensuring the child received needed services.

MRMIB has inserted clarifying language to that effect in the health plan contracts for 2010-2011. MRMIB does not expect there to be any increased costs because this is the way the system is supposed to work now. The plans have argued that it would provide a county with an incentive not to serve a child with SED. Board staff did not concur with this assessment. In order to comply with CHIPRA requirements, there will be no limit on in-patient or out-patient mental health or substance abuse treatment. Staff is presenting regulations to implement the change at the March Board Meeting.

**vi. Prospective Payment System for FQHC and RHC**

Ms. Cummings discussed application of the Prospective Payment System (PPS) to CHIP services and stated that this is another feature of Medicaid that was drafted into CHIP; again, without regard to the fiscal consequences to the states. In Medicaid now, rural health and federally qualified health centers are paid what is called a “prospective payment rate” which is roughly equal to their costs. In Medicaid managed care, the health plans are required to pay clinics in the same manner as they pay other network providers. Then the Department of Health Care Services gives an additional interim rate to the clinics, reflecting that fact that their costs are higher than what they are paid by the managed care plans. At the end of the year, an audit is done to confirm the clinics’ actual costs and then payment reconciliation occurs. The federal law states that MRMIB has to start paying FQHCs and rural health centers using the prospective payment system. It will obviously increase costs. MRMIB is in the process of figuring out what the fiscal costs may be. There will have to be a state law change that gives MRMIB authority to do the change. The implementation date would be January 1, 2011.

**vii. Performance Bonus**

Ms. Cummings stated that the performance bonus for increased enrollment is for Medicaid only even though the analysis looks at both CHIP and Medicaid enrollment data. Ms. Lam stated that California applied for a performance bonus and met the required standards, but based on the bonus formula, California did not receive a bonus payment.

**viii. Enhanced FMAP for Interpretation and Translation**

Ms. Cummings mentioned the availability of the enhanced FMAP for translation or interpretation services. CMS has said that this would not be applicable to health plan costs because their costs are already covered through the capitated rates. However, the costs associated with creating the HFP application and translating it would be eligible for this enhanced rate. MRMIB estimates the savings is minimal.

**ix. Express Lane**

The Express Lane option is essentially about enrollment into Medicaid, so this does not apply to HFP. DHCS has been skeptical about the advantages of an Express Lane option given the experience that it had with this via the School Lunch Program which promoted Medicaid, through most of the children were already enrolled in Medicaid.

Ms. Lam states that MRMIB does accept the National School Lunch Program (NSLP). NSLP applications were for children who did not qualify for no-cost Medi-Cal and that information is forwarded over to MRMIB. The volume of applications that MRMIB receives through NSLP is extremely small per month.

Ms. Cummings stated that MRMIB is creating an electronic application available to the public. Ms. Lam mentioned that this will be a phased approach. What MRMIB is anticipating is to have the Health-E-App (which is currently only limited to Enrollment Entities and CAA's who can access it) available for public use. The English version should be available in June of this year. MRMIB is anticipating rolling out a Spanish version of Health-E-App in July. Then MRMIB will be working on other ways in which families will be able to submit their forms to the department (such as continued enrollment forms, the AER's, Add-A-Person forms, etc.). This additional component will be completed in phase three by August.

**x. Legal Immigrant Children and Pregnant Women**

Ms. Cummings stated that MRMIB had submitted a SPA to cover these populations. These costs have already been added to the budget for the current year to defer state general fund costs.

**xi. Outreach**

CMS has funded three entities for outreach in California. They were entities with rather small application volumes.

**xii. Federal Annual Report**

CMS has not provided guidance on what additional information will be required for inclusion in the State's Annual Report.

**xiii. PERM**

Ms. Cummings announced that MRMIB got incredibly good results in the last PERM audit because of the performance of MAXIMUS. MRMIB is currently waiting for regulations to be promulgated because the department wants to make an argument that states that performed so well should be off the hook for several years.

For more information about CHIPRA implementation, please follow the link here: [http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_121609/Agenda\\_Item\\_6.h\\_CHIPRA\\_Impacts\\_Implementation\\_Chart.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_121609/Agenda_Item_6.h_CHIPRA_Impacts_Implementation_Chart.pdf)

**b. Premium Discount Project**

Ms. Rouillard introduced Margie Powers, the consultant working on the Premium Discount Project.

Ms. Powers stated that currently, the plan that has the most TSN providers in its network gets designated the Community Provider Plan (CPP). Three lists are developed to identify who those TSN providers are. There is a hospital list, a clinic list and a CHDP provider list. The hospital list is pretty good; MRMIB receives hospital data from OSHPD. Over the last couple of years, the clinic data MRMIB receives from Medi-Cal has been deteriorating because the list of clinics is based on FFS Medi-Cal claims. In the Medi-Cal managed care counties, there are very few claims for clinics that serve children. Similarly, with CHDP providers in Medi-Cal managed care counties, there are not many FFS claims so the data that MRMIB receives does not include many of the providers, so the data is inadequate.

MRMIB decided to undertake the project because it wants a fair and equitable process for determining which plans gets the premium discount and prefers one that would utilize data that MRMIB has control over. The staff as well as the Board is interested in incorporating quality performance into the designation process. Ms. Powers stated that through her research, she has been finding that plans do not want to do this.

Mary Watanabe, MRMIB Research Specialist, mentioned that the clinic list is worth 45% of the total plan score. The clinic list is the only list that is not weighed by either the number of children or the number of services provided.

With the CHDP list, CHDP is based on the number of children whose county of residence is the county in which they received services. So in CHDP, MRMIB ends up with providers on a county list that are from outside of that county, but they are weighed based on the number of children who have received services. CHDP is 35% of the total score. Historically, MRMIB has had minimal appeals to the lists. Last year, MRMIB received over 700 appeals and those were just ones that the plans were able to put together in the amount of time that they had. So far this year, MRMIB has received over 1,100 appeals that needed to be reviewed. There were several plans that chose to not participate because they did not have enough staff to research and it was not worth their efforts. Needless to say, MRMIB has had significant issues with just developing the lists.

Ms. Rouillard asked the panel: Do you think T&SN should be part of the designation process?

Ms. Cummings mentioned that her goals for this project are to reduce the amount of staff resources that are spent through this process because no one is going to give the department new staff. Another goal is to develop funds for this project because currently, no one is going to give MRMIB money for quality incentives.

Ms. Orozco-Valdivia suggested using HEDIS scores, as Medi-Cal does in its auto-assignment process, as the basis for awarding the premium discount. She also suggested that the premium discount should be awarded to the Medi-Cal managed care plan that receives the auto assignment in those counties where there are Medi-Cal managed care plans.

Several members of the Panel agreed that quality should be the basis for the premium discount.

There was discussion about obtaining HEDIS data on a regional, rather than a statewide basis. Dr. Kutnik stated that there are 18 counties where the data would be from a single county, but others are statewide. Ms. Rouillard noted that this was a proposed contract amendment that was taken out of the model 2010-11 contract due to increased plan cost to report regional HEDIS data.

Dr. Arroyo felt that quality should expand beyond just HFP; for example, having a broader initiative for quality across state programs.

Dr. Beck expressed reluctance to eliminate the reduced premium altogether. She suggested incorporating quality and possibly taking a hiatus from the CPP for one year to figure out how to do it differently. She also suggested incentivizing parents to bring their children in for well child visits.

Dr. Kutnik stated quality should have a significant role in the process. He didn't think that MRMIB could completely take T&SN out of the formula.

Ms. Orozco-Valdivia asked about including CAHPS results. Ms. Rouillard responded it raises the problem about statewide data being used to calculate results in a specific county and the local plans' concerns about being compared to statewide plans.

Dr. Beck suggested it may be the time to shift staff's role for a year to change the statute and develop outcomes measures for the premium discount process.

Ms. Cummings noted that CMS has recently published core performance measures and states are working on figuring out what the right measures are.

Dr. Beck suggested a plan could get the premium discount if it scored well in some percentage of measures, such as 15 out of 22.

Dr. Arroyo asked if the data relative to HEDIS was reliable. Ms. Rouillard responded that it was. Ms. Rouillard suggested that if a plan wants to compete in a certain county that it report HEDIS data for that county.

Ms. Cummings noted that currently default enrollment in HFP is to the plan designated the CPP. Medi-Cal defaults enrollment to the plan with the highest score based on an algorithm that includes quality performance.

Ms. Gisella Gomez from CalOptima asked about the original intent of the CPP designation. Ms. Rouillard responded that it was to incentivize the plans to offer a choice of providers to HFP members that included T&SN providers.

Dr. Beck stated MRMIB needs to have county data. Ms. Rouillard responded that perhaps MRMIB needs to wait until it has encounter data from all the plans. At that point, a county by county analysis could be done.

### **c. HFP Plan Contract Language**

Ms. Rouillard stated that every year, MRMIB presents model plan contracts to the Board. It gives plans the opportunity to comment on potential changes to the contract. In November and December of 2009, MRMIB tried to find a balance between increasing plan accountability and quality – while not increasing costs significantly because there will not be any additional funds for plans.

After the November meeting, plans made a lot of comments about the proposed contract language. MRMIB held a conference call with the plans prior to the December meeting and made changes to the contract as a result. Ms. Rouillard highlighted the provisions that ended up in the contract, some of the issues that the plans had with what MRMIB was proposing, and why certain proposals did not end up on the contract.

Regarding mental health, plans had a big concern with the language to implement parity. From staff's perspective, it does not change the way HFP works currently, but there has been a lack of clarity between the law, regulations and plan contracts. So MRMIB is trying to bring all of these into alignment so that there is consistency in the policy statement about services to treat children with SED.

The contract language specifies that the plan must develop a treatment plan to treat SED if there is a delay in the county not serving the child. This is a statutory requirement. The contract also maintains a requirement for plans to enter into a MOU with County Mental Health Departments, "to the extent feasible."

MRMIB is currently working with the County Mental Health Directors Association (CMHDA) to modify the MOU to make it clear for both plans and counties. The plans generally agree that children should get the services they need.

MRMIB currently has two staff in the Benefits and Quality Monitoring Division funded under Prop 63 to address issues and coordination between counties and plans around

services to treat children with SED. MRMIB has told the plans, if there are problems, please let us know as the department is there to help resolve those issues. MRMIB would also like to know to what extent there are problems.

With regard to CCS, MRMIB has similar language in the contracts. If a county CCS program for whatever reason cannot serve a child, then the plans need to provide the services. MRMIB is also asking the plans to report an unduplicated count of children who are receiving services from CCS. In the past, MRMIB has received data only on how many kids were referred each year, but that does not indicate the total number of children that are actually being served by CCS.

MRMIB deleted language regarding retroactive payments made by CCS. This language was removed because MRMIB does not have any authority to say how or when or if CCS is going to pay claims. Because the plans objected to this deletion, MRMIB added language that refers to a CCS policy letter that clarifies the issue. This is the basis upon which any retroactive payments would be made to plans.

Plans are also concerned about how local CCS Programs determine eligibility compared to how HFP determines eligibility. CCS Program eligibility is determined based on the child's county of residence. In the HFP, eligibility is based on a child's residence in the state. An issue came up in San Diego, where the child was a resident of the state, but the mother was a resident of another country. So CCS denied eligibility. MRMIB has a staff person who handles CCS and plan coordination activities.

MRMIB tried to include a requirement that plans report HEDIS measures by region, but it was going to cost plans too much so it was dropped from the model contract. Also in the model contract staff took to the Board in November, there were minimum performance standards. For example, there must be a certain percent of children in a health plan that received child immunization/well child visits. It was also deleted due to increased costs.

MRMIB did note that CHIPRA is going to require increased accountability for quality. The core quality measures, which are out for public comment currently, are voluntary at this point. Given the new Medicaid standards that MRMIB has to adhere to, there will be performance improvement projects and performance standards further down the line. The plans are anticipating what is coming.

The plans are going to submit Group Needs Assessments to MRMIB at the end of the benefit year (September 2011) that will address cultural and linguistic services, including access to services, the needs of the plan's population, and what the plans intend to do to address those needs. There will also be a report on plans' health education activities.

The contract also includes language about compliance with CHIPRA and as CMS guidance becomes clear, MRMIB may have to modify the contract.

Ms. Rouillard said the Board did acknowledge publicly that the contract does not make much progress around quality, but they were trying to be mindful of the costs, the

financial situation with the plans, and recognizing that there are not going to be any increased rates due to the continuing state budget deficits.

In the dental contracts, MRMIB added the CCS provision that was included in the health plan contracts. There are no changes to vision contracts.

The model contract language can be found at:

[http://www.mrmib.ca.gov/MRMIB/2010\\_11\\_Plan\\_Contract\\_Final.html](http://www.mrmib.ca.gov/MRMIB/2010_11_Plan_Contract_Final.html)

#### **d. Advisory on Committee on Quality**

Ms. Watanabe mentioned that committee members felt very strongly about maintaining the safety net provider component in the CPP designation. One of the concerns is that if MRMIB does not include safety net providers, there would not be an incentive for the plans to continue to contract with some of these providers.

At the January 28<sup>th</sup> meeting, the primary focus was on the CHIPRA core measures which were released on Dec 29<sup>th</sup> 2009. MRMIB worked through each of the measures; there are currently 24 quality measures that proposed review and comment. The comments are due on Feb 28<sup>th</sup> 2010. MRMIB currently collects 11 of the 24 core quality measures. There are 6 that the department believes could be collected. There are 7 that MRMIB does not have the ability to collect because the services are either carved out to CCS, or there are several that apply to pregnant women and the HFP currently has a very small number of pregnant teens.

When MRMIB initially established the committee, the committee members were asked to meet through 2009. MRMIB has asked the committee to meet for the next year and most of the members agreed to do so. The primary task of the committee will be to develop the quality strategy.

#### **e. Benefits Review Project**

Ms. Watanabe addressed the agenda item. She stated that one of the tasks that the Board has asked staff to do is look at the HFP benefit design. MRMIB will be looking at the current benefit structure and what changes could be made to reduce program costs. MRMIB will be asking questions such as: what are the other states doing? What are possible ways that we can redesign the benefit package to achieve cost savings?

The California Health Care Foundation (CHCF) is funding this project. MRMIB hopes this will start soon. The estimated timeline is expected to run through April of this year. There will be a report to both the CHCF as well as to the Board.

#### **f. Encounter Data Project**

Ms. Watanabe stated that currently, MRMIB has 6 pilot plans that will submit their encounter and claims data starting next month. MRMIB's goal is to have all of the health plans submitting encounter data by the end of the year. MRMIB received a call from one of the dental plans last week to get them on board to submit encounter data and to get their process in place. This project will roll out in several phases starting with the pilot plans next month. The health plans will all be reporting at the end of the year and dental

plans will have until February of 2011. MRMIB is moving right along with collecting this data. However, as Ms. Rouillard mentioned, MRMIB may not be able to look at this data before July 1, 2009 unless there is a statute change. The good news is that progress is being made.

**g. Dental Quality Improvement Project**

Ms. Watanabe stated that staff has recently presented a preliminary report to the Board with all the new dental quality measures. MRMIB had several plans respond, saying that there were errors in their data submission and they have since re-submitted the data. Staff's goal is to present a final report to the Board in March. MRMIB will be working with a consultant, funded by the California Health Care Foundation, to help look at the disparities in plan performance. There are huge disparities in the "open network" versus the "capitated" plan models. MRMIB reconfigured the way the results were displayed to highlight these differences by demographics as well as overall performance in different health plan models. MRMIB will be working with the consultant to understand these differences and develop some strategies for improvement, especially in the capitated models.

**Informational HFP Reports**

To access these reports, please click on the links below the agenda item.

**a. Enrollment and Single Point of Entry Report**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_012110/Agenda\\_Item\\_8.a\\_HFP\\_Enrollment\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/Agenda_Item_8.a_HFP_Enrollment_Report.pdf)

**b. Administrative Vendor Performance Report**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_012110/Agenda\\_Item\\_8.b\\_HFP\\_Admin\\_Vendor\\_Perf\\_December\\_2009\\_Summary.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/Agenda_Item_8.b_HFP_Admin_Vendor_Perf_December_2009_Summary.pdf)

**c. Notice of HFP Advisory Panel Vacancies**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_012110/Agenda\\_Item\\_8.b\\_HFP\\_Admin\\_Vendor\\_Perf\\_December\\_2009\\_Summary.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/Agenda_Item_8.b_HFP_Admin_Vendor_Perf_December_2009_Summary.pdf)

**d. Final Adoption of Regulation Addressing Legal Immigrant Eligibility Verification (ER-4-09)**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_012110/Agenda\\_Item\\_8d\\_HFP\\_Legal\\_Immigrant\\_Eligibility\\_Verification.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/Agenda_Item_8d_HFP_Legal_Immigrant_Eligibility_Verification.pdf)

**e. Out of Pocket Maximum Report**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_111809/Agenda\\_Item\\_8.g\\_0607\\_0708\\_Out-Of-Pocket\\_Expenditure\\_Report.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_111809/Agenda_Item_8.g_0607_0708_Out-Of-Pocket_Expenditure_Report.pdf)

**8. Inter-Agency Agreement (EMSA)**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_101509/Agenda\\_Item\\_6.a\\_Board\\_Resolution\\_and\\_Summary\\_EMSA\\_IA.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_101509/Agenda_Item_6.a_Board_Resolution_and_Summary_EMSA_IA.pdf)

**9. Adoption of 2010 Rulemaking Calendar**

[http://www.mrmib.ca.gov/MRMIB/Agenda\\_Minutes\\_012110/Agenda\\_Item\\_7.pdf](http://www.mrmib.ca.gov/MRMIB/Agenda_Minutes_012110/Agenda_Item_7.pdf)

Mr. Campana asked if there were any more comments or questions. There being none, he reminds the next panel that the next meeting is May 11, 2010, and adjourns the meeting.