Managed Risk Medical Insurance Board
September 22, 2004, Meeting

Board Members Present:	Cliff Allenby, Areta Crowell, Ph.D., Richard Figueroa, Virginia Gotlieb, M.P.H.
Ex Officio Members Present:	Jack Campana, Ed Mendoza, David Topp
Staff Present:	Lesley Cummings, Joyce Iseri, Laura Rosenthal, Janette Lopez, Tom Williams, Ernesto Sanchez, Larry Lucero, JoAnne French, Mercedes Kneeland

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

REVIEW AND APPROVAL OF MINUTES OF AUGUST 25, 2004, MEETING

A motion was made and unanimously passed to approve the minutes of the August 25, 2004, meeting.

LEGISLATIVE UPDATE

State Bill Summary

Laura Rosenthal reported there has been little action on the bills staff has been following since the last meeting. A full report will be given at the October meeting. By that time, the Governor will have acted on all bills passed by the Legislature.
Ms. Rosenthal noted that the Governor has recommended the voters reject Proposition 72, the referendum measure on SB 2 (Burton/Speier), at the November election.

Federal Update

Ms. Rosenthal reported that there has been an important development concerning the Trade Act (the “Trade Act”) of 2002. The Trade Act provided approximately $100 million funding for state high-risk pools in federal fiscal years 2003 and 2004. California would have received at least $10 million for MRMIP, but, unfortunately it did not meet the criteria for funding under the Trade Act. One reason California did not qualify is that MRMIP has a capped appropriation and periodic waiting lists, so MRMIP cannot guarantee admission to all individuals who are eligible for guaranteed issue individual market coverage under the Health Insurance Portability and Accountability Act (HIPAA). Secondly, MRMIP has a $75,000 annual cap on benefits.

Currently, there are bills pending in both the Senate (S. 2283 (Gregg)) and the House (H.R. 1110 (Towns)) that would extend high-risk pool funding through federal fiscal year 2009, expand the available dollars, and modify some of the criteria for funding. As introduced, neither bill would address California's issue, but staff has been working with the Governor's Washington, D.C., office to try to amend the bills so that California would be eligible for funding.

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

HEALTHY FAMILIES PROGRAM (HFP) UPDATE

Enrollment and Single Point of Entry Reports

Ernesto Sanchez reported that there were 681,992 children enrolled in HFP as of August 31, and 38,857 children enrolled during August. He reviewed the enrollment data regarding ethnicity, gender, the top five counties in enrollment, and the SPE statistics, including the breakdown of applications process with and without assistance (13.5% and 86.5%, respectively). He noted that applications processed without assistance has increased from last month.

Administrative Vendor Performance Report

Mr. Sanchez presented the administrative vendor (AV) performance report for August. Maximus is currently the AV for HFP and SPE. Maximus met all seven performance standards for HFP, and all four performance standards for SPE. Mr. Sanchez noted as a result of the enrollment reconciliation conducted with plans during the month of August, the AV found over 3,000 subscribers in the system who did not appear in the health plans' enrollment. These subscribers have been added to the plans' enrollment.

Lesley Cummings talked about administrative vendor performance issues brought up by Leona Butler on behalf of Santa Clara County at the August meeting. Ms. Cummings and the eligibility staff determined the complaints fall into two categories: failure to pay capitation for enrolled children, and inadequate performance in the area of eligibility determination.

Regarding capitation, plans are correct that they have enrollees on their system for whom they have not been paid. Because of these complaints, staff instituted a reconciliation process between Maximus and the plans. Not all plans have participated, but for those who did, staff found half the time the problem lay with the plans and the other half of the time it lay with the vendor. Where there are enrollees the plans have not been paid for, it appears that subscribers were disenrolled from the AV system, but not from the plans. Resolving this problem is a top priority.

Regarding inadequate performance around determination of eligibility, staff received a letter dated September 14 from Robert Sillen, Executive Director of Santa Clara Valley

Health, detailing eight problem cases, a copy of which was provided to the Board. Staff does not think these eight cases are evidence of a widespread problem. Given the short length of time between receipt of Mr. Sillen's letter and this meeting, staff has not completed an analysis of the cases. However, staff does have preliminary comments which will be made by Janette Lopez.

Before turning to Ms. Lopez's remarks, Ms. Cummings said she wanted to revisit a question asked at the August meeting. Specifically, Ed Mendoza asked how staff could get objective information on whether the AV makes accurate and timely determinations. Ms. Cummings noted the following:

- Monthly reports are provided to the Board on a variety of performance measures.

- Despite reductions in personnel, eligibility staff conducted audits of processes for SPE, HFP, and AER. Maximus has submitted a plan of correction for all identified problems. Re-audits will be conducted in these three areas during the next two months.

- MRMIB's contract with the AV includes a requirement that an external entity audit the systems to assure they are working properly. Planning for this audit is underway and will begin in the next few months.

- The contract with the AV also requires its processes be certified by ISO, an international body that certifies quality assurance. Maximus has had two other programs recently certified by ISO without any problems.

Ms. Cummings said Janette Lopez, the new Deputy Director for Eligibility at MRMIB, and Michael Lemberg, the Program Director at Maximus, would next comment on what is being done to resolve the problems.

Janette Lopez preliminarily reviewed the eight cases received from Ms. Butler. Three of the eight errors were made by the previous AV, and three had been processed correctly by Maximus. Further, the cases given by Santa Clara were ones that occurred early in the transition (when there were admitted problems) and have been previously brought to the Board's attention. The cases were all old—none more recent than May 2004, and shed no light on whether there are issues that exist now. She said Ms. Butler's report at the August meeting that 80% of Health-e-Apps were being lost appears to be based on anecdote. Ms. Lopez indicated that staff has not seen any evidence of current systemic errors.

Michael Lemberg told the Board Maximus takes seriously its responsibility to HFP. While the current performance report shows Maximus has kept the promise it made at the June meeting to improve, they are still not satisfied. Actions they have taken to continue improving include:

- Adding two more health plan liaison staff, a research analyst, and two business analysts to help with the reconciliation process,

- Redesigning they way they process Health-e-Apps,

- Creating an automatic process to link up supplemental paperwork with an application within the first day, which will be implemented by the end of the month,

- Re-organizing some of their call center units and adding a quick response team to escalate calls and provide better response from supervisors, and

- Improving the process for processing applications to ensure HFP is completed within seven days and SPE is accomplished within four days.

He said Maximus is as anxious as MRMIB to solve the continuing problems with incomplete applications. Maximus appreciates the feedback from health plans and advocates. It helps them identify issues. They feel the external audit mentioned by Ms. Cummings will also help identify areas in need of improvement.

Dr. Crowell asked Ms. Lopez if the audits staff conducted gave a sense of the level of accuracy of how applications are being processed. Ms. Lopez replied that overall staff does have the sense that processing is accurate. This is not to say that there is never a mistake—and those show up in appeals. She reviews every single appeal that leaves MRMIB. It is her opinion that accuracy is very much at an acceptable level.

Mr. Mendoza added that there are bound to be human errors, making it impossible to have a perfect system. He sees the issues as a temporary phenomena---since July he has heard things are improving. He asked if the automated monitoring systems were sensitive enough to pick up systemic issues before they reach problematic levels. Ms. Lopez replied that staff is working with Maximus to identify systems to track the different types of “problem areas” they hear about from advocates and subscribers. She said it is also time to go back and re-audit the previously audited areas to assure that past problems have been resolved.

Mr. Mendoza asked if Ms. Lopez monitors a complaint line. She replied that she does, plus she conducts bi-weekly updates to track if problem trends are developing as well as progress on issues being resolved. Mr. Lemberg has been working with the Covering Kids Commission and county staff. A common complaint is that it takes too long to process an application. Ms. Lopez indicated that staff needs to educate the community on MRMIB’s process. Staff developed a flow chart to explain the process and show why it can legitimately take up to two months to enroll a child. Dr. Crowell asked when staff plans to conduct the next series of audits. Ms. Lopez said the plan is to audit SPE in October, then HFP, and, finally, AER.

Chairman Allenby called for public comments.

Leona Butler, Santa Clara Health Plan, said she hopes this demonstrates to the Governor the need for a Board. She acknowledged staff for their quick response to concerns she presented at last month's meeting. Regarding Mr. Sillen's letter, she acknowledged information was a couple of months old because of time it took to compile it. The health plan received an e-mail from Maximus yesterday showing the number of subscribers erroneously reinstated in HFP that will be dropped next month. Santa Clara estimates it is currently owed $100,000 for subscribers they are carrying. She reiterated MRMIB staff is working hard and doing their best given their small size. Presentation of issues that need to be resolved is not meant as a criticism of staff. Staff is working hard but there is an inadequate number to keep on top of the issues.

Manjusha Kilkarni, National Health Law Program/Health Consumer Alliance, said their collaborative provides application assistance to thousands of individuals. They sent a letter to Irma Michel on May 4 outlining the problems they encounter with enrollment into HFP which included recommendations. They appreciate the cooperation they have received from MRMIB staff, but felt they needed to bring to the Board's attention problems that are systemic. While staff has been responsive, they believe the issues need to be resolved at the initial stages at the AV level. Applications are not being processed in a timely manner, mistakes in processing applications and making income determinations result in eligibility errors, they cannot get through to a live person on the phone, they are unable to talk to a supervisor, and information is inaccurate and/or inconsistent. MRMIB lacks a process for dealing with appeals. On some, there has been no response at all from the AV. MRMIB staff works with advocates to resolve individual cases—but the problems are systemic. Advocates are most concerned for those subscribers who do not have advocate representation. They believe there are many applicants who just give up. The problems need to be resolved as expeditiously as possible. They would support legislation to increase staff resources, and establish an appeals division specialist position.

Brooke Heymach, Legal Aid Society of San Mateo County, said they are also concerned about the length of time MRMIB takes to process applications. MRMIB has a huge backlog of appeals. CAAs report problems with the accuracy of eligibility determinations, and the number of applications that get lost causing the applicant to re-apply. She gave two case histories. She recommended CAAs be able to talk to a supervisor in order to prevent the appeals process, or to an appeals specialist when an appeal becomes necessary. Chairman Allenby asked Ms. Heymach to provide Ms. Cummings and Ms. Lopez with her notes on the specific cases.

Celia Valdez, Maternal and Child Health Access, said the problems they are experiencing are current as well as cases going as far back as January. She gave some case histories. Families have been treated rudely by AV staff and told they could not speak to supervisors. The only way they have been able to resolve problems is by working with MRMIB staff. Chairman Allenby asked Ms. Valdez to provide staff with her notes on the specific cases.

Joanne Marzan, Children Now, requested that CAAs be authorized to speak on behalf of families. Ms. Lopez said staff is working with Maximus, the Covering Kids Coalition, and 100% Campaign in this regard. Ms. Marzan said they believe the current performance report is not accurate. They would also support legislation to increase MRMIB's staff. Chairman Allenby asked Ms. Marzan to provide staff with her notes on the specific cases.

Nina Maruyama, Alameda Alliance for Health, gave two case histories that reflect current problems. They have been experiencing long delays in getting families enrolled and difficulty with the AER process. Chairman Allenby asked Ms. Maruyama to provide staff with her notes on the specific cases.

Gerri Nunez, San Joaquin County Health Plan, said renewals are a major problem area. The plan uses trained CBOs who have tried working with Maximus with unsatisfactory results, whereas a satisfactory outcome is achieved with Ernesto Sanchez within three weeks. She acknowledged Mr. Sanchez and his staff for the high level of customer service. She would like to see the same level of customer service at Maximus so that all children get enrolled quickly and efficiently. She hears a lot about communication problems and rudeness. The situation would be improved if authorized representatives could get information from the AV. She offered their support in achieving that goal.

Dr. Crowell said it is very distressing whenever a child is unable to get health insurance coverage. She appreciated the efforts people made in identifying problems.
Mr. Mendoza opined that the problems may not be a result of the AV transition, but due to a system overwhelmed with the volume of applications and the lack of application assistance. Ms. Lopez replied that it would be a good suggestion for the AV to have their staff go through training similar to what MRMIB staff received to help with the human aspect of enrolling families. Chairman Allenby said since application assistance is not available to the degree it has been in the past, MRMIB needs to get creative in finding other ways to provide application assistance, such as involving health plans. Ms. Lopez remarked that utilizing children's advocacy groups to distribute the authorized rep form will help reduce the issues presented. Mr. Campana said an audit will help shed light on the cause of the problems. He agreed that staff is overwhelmed and urged that resolving the problems remain a priority.

Health Plan Assistance With Incomplete Applications

Janette Lopez reviewed the actions the AV takes in order to complete applications, as provided for in its contract. She provided details such as the criteria for when applications at the SPE are forwarded to Medi-Cal or HFP, and for both SPE and HFP, the number of follow-up calls made to the applicants, the various times and days of follow-up calls, the information required in order to complete an application, the length of time within which to process an application, and what happens when the application is not successfully completed.

At the last meeting, Hellan Dowden proposed that MRMIB send incomplete applications to the health plan designated on the application so that the designated health plan could assist in completing the application. The proposal was based on practices in the State of New York. Research conducted by staff shows that New York's model is very different from California's. Instead, of an administrative vendor (AV), the health plans New York contracts with are responsible for enrollment. At the inception of HFP, advocates, community-based organization, and health plans expressed concerns about having the health plans perform AV functions. The state decided not to use a health plan for enrollment to ensure that the process would be objective.

Ms. Lopez discussed further concerns about Ms. Dowden's proposal, some of which include substantial changes to the AV contract, extensive system changes, health plan contract changes, HIPAA considerations, statewide implementation, and that the complexity, technology and time involved exceeds MRMIB's resources. Staff recommended that rather than implement the proposal patterned after New York, MRMIB continue with the systems already in place to complete new applications—but engage health plans in ensuring that subscribers complete the annual eligibility process. These systems are in place and, since the subscriber is enrolled with the plan, avoids HIPAA issues.

Chairman Allenby referred to the 40 minutes of public comments regarding incomplete applications, and the fact that there may never again be the application assistance there once was. While the perspectives may differ between the insurance industry and the advocates, any offers of assistance deserve serious consideration.

Ms. Gotlieb expressed concern about the staffing issues and potentially more problems being created with a new system. She said it would be preferable to resolve the problems that have been identified.

Ms. Dowden said she made the proposal because 86% of the applicants do not have advocates. She asked for the opportunity to meet with the Board, the AV, and staff to further discuss letting health plans chosen by the applicant assist the applicant in completing their enrollment.

Leona Butler suggested clarifying the issue before trying to offer assistance. The question is why so many applications are incomplete. Income documentation is the largest reason for incomplete applications, which was true even when there was much more assistance from CAAs. Mr. Figueroa agreed staff should meet with Ms. Dowden to discuss the issues further. He also expressed concern that adding an additional party to the transaction could create another potential for more problems. He suggested reviewing the results of the audits to learn what changes need to be made.

Ms. Cummings noted that Ms. Dowden and staff do not share the same view that if a person designates a plan on an incomplete application that provides sufficient authority under HIPAA. Ms. Rosenthal added that an individual can authorize an advocate to

assist, but an application cannot be passed onto a health plan without giving health plans contractual obligations to perform duties that include HIPAA requirements.

The Board agreed they are all troubled by the drop in enrollment. They directed that resolution to the issue of incomplete applications be given high priority.

Draft Health, Dental, and Vision Plan Contracts for 7/1/05 through 6/30/08 and Rural Health Demonstration Projects for 7/1/05 through 6/30/07

Joyce Iseri said HFP was last reprocured in 2000. The new reprocurement is for a three-year period starting July 1, 2005. It is being opened up to new plans. Today's draft is still incomplete in some respects. It is being given to the plans to provide them opportunity for comments. She acknowledged the following staff who have worked to develop the new procurement document: Vallita Lewis and her staff in the Benefits division; Mauricio Leiva, who worked on the rural health demonstration project; Dennis Gilliam; Janette Lopez; and Laura Rosenthal.

In addition to going over a few of the particulars of the draft contracts, Ms. Iseri said a model evidence of coverage (EOC) document is being introduced for the first time. Staff developed this in conjunction with the Department of Managed Health Care (DMHC). A summary of the key contract provisions of the contract can be found following the solicitation letter. In light of experiences with enrollment data, this contract will require plans to report any errors in data supplied by the AV within 45 days; otherwise the State will not be liable. In the process of amending contracts last year, the Board added a requirement that plans reconcile quarterly. The new contract will require plans to reconcile on a monthly basis.

Mauricio Leiva highlighted some of the goals and objectives of the Rural Health Demonstration Project (RHDP). This RHDP is a two-year contract for fiscal years 2005-06 and 2006-07.

The bidders' conference for both the HFP health, dental, and vision contracts and the RHDP contracts will be held on November 9, 2004. The final draft of the contracts will be presented to the Board for its approval at the October meeting, with selection of plans to occur at the March 23, 2005, meeting.

Chairman Allenby called for public comments.

Marty Martinez, California Pan-Ethnic Health Network;Jan Liu, Asian and Pacific Islander American Health Forum; and Patricia Diaz, Latino Coalition for a Healthy California, discussed their concerns around the cultural and linguistics component of the draft model contract. They said they appreciate staff's willingness to work with them and hope that their concerns are addressed in the final draft to be approved at the October meeting. They recommend a separate document for linguistic services, rather than amendments to the contract itself. The health plans they have approached have been positive to their suggestion that materials be translated into the same languages

required for Medi-Cal. They submitted a proposal to MRMIB staff for what they believe would be a more effective needs assessment based on health plans' data than the needs assessment currently in use. Mr. Mendoza commented that encounter data is the best source for needs assessment.

Open Enrollment Report

Larry Lucero reviewed the Open Enrollment 2004 Summary Report covering the period from April 15, 2003, to May 31, 2004. There are two types of surveys: one for those who are required to change plans due to service area changes, and one for those who change voluntarily. Subscribers who had been disenrolled were also included in the survey. The report compares current data to historical data going back to 1999. Mr. Mendoza, who is the Deputy Directory at DMHC, noted that the survey DMHC conducts for the commercial plans indicates that satisfaction has gone down commensurate with the rise in costs. Consumers appear to expect more as their costs increase. He said that the Board should be prepared for increased levels of dissatisfaction when premiums increase next year. Dr. Crowell remarked that HFP's percentages have not declined with the exception of dental, which continues to be problematic. Chairman Allenby asked if there were any further questions or comments; there were none.

ACCESS FOR INFANTS AND MOTHERS (AIM) UPDATE

Enrollment Report

Mr. Sanchez reported that there are currently 6,382 mothers and 13,292 infants enrolled in the program. He reviewed the enrollment data, including ethnicity, infant gender percentage, and the counties and health plans with the highest percentage of enrollment.

MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) UPDATE

Enrollment Report

Mr. Sanchez reported that there are currently 9,119 people enrolled in the program. As of September 1, 2004, there are 51 on the waiting list serving the post-enrollment waiting period. During the past month, four were disenrolled pursuant to AB 1401. The total number of 36-month disenrollments to-date is 9,848. The program remains open to new subscribers since the current enrollment is below the cap of 10,718.

Ms. Gotlieb asked if it were possible the enrollment cap would be reached in the next couple of months. Ms. Iseri replied that a new projected enrollment cap will be presented at the October meeting. The enrollment cap usually covers a 12-month period, however it is updated every six months. Chairman Allenby asked if there were any further questions or comments; there were none.

Annual Disenrollment Survey

Mr. Sanchez reviewed highlights of the 2004 MRMIP disenrollment survey. The survey is conducted in January when the largest disenrollments occur as a result of the change in premiums. Of the subscribers who responded to the survey, 46.32% indicated they obtained health coverage outside of MRMIP, and 45.59% left the program because they could no longer afford it. Chairman Allenby asked if there were any questions or comments; there were none.

Before closing the meeting, Dr. Crowell, who was unable to attend last month's meeting at which Irma Michel was acknowledged upon her retirement, expressed her gratitude to Ms. Michel for her years of service way above the call of duty. She acknowledged Ms. Michel for her outstanding dedication, boundless energy, creativity, and, above all else, her positive attitude.

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