MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

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(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____California_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name:	Lesley Cummings	Name:
Position/Title:	Executive Director	Position/Title:
Department:	Managed Risk Medical Insurance Board	Department:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3. ☒ A combination of both of the above.

Introduction

Shortly after enactment of the federal Children's Health Insurance Program, Governor Wilson developed a program for implementing the Initiative in California. He submitted his legislative package to the legislature in August of 1997 and the legislature worked with the Governor to enact the Healthy Families program in the last weeks of the 1997-98 legislative sessions.

With its Healthy Families Program (HFP), California seeks to expand access to health care coverage for uninsured children through:

- Creation of a health insurance program for children whose family incomes are above those which provide eligibility for no cost Medi-Cal up through 200% of poverty;
- Changes to the Medi-Cal system which will improve access by simplifying eligibility; and
- Coverage of infants up through the age of two born to mothers enrolled in the Access for Infants and Mothers (AIM) Program whose family income is between 200-300% FPL.

California's program consists of the following pieces of legislation, which are included in the plan as Attachment 2.*

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- Chapter 623 (AB 1126 -Villaraigosa) outlines the Healthy Families insurance program which provides affordable private health insurance plans for low-income children either through a health insurance purchasing pool or an insurance purchasing credit. The legislation details program administration, eligibility criteria, monthly premiums, benefits, the program application process, and outreach activities;

*Attachment 1 is a glossary of terms used in the State Plan.

- Chapters 626 and 624 (AB 217 - Figueroa and SB 903 - Lee /Maddy) enact several provisions designed to improve access to Medi-Cal for Medi-Cal eligible children; and
- Chapter 625 (AB 1572 - Villaraigosa/ Gallegos) appropriates start-up funds for the Healthy Families program.

Many children will come to Healthy Families through the Healthy Families "gateway" program, the Child Health and Disability Prevention (CHDP) program. Families of uninsured children receiving health screens from CHDP will complete a pre-enrollment application and be provided with presumptive eligibility for their children for the month of application and the following month. In addition, on the pre-enrollment application, families will be asked if they want to apply for continuing health coverage. Those families that indicate they want to apply for continuing coverage will receive a joint Medi-Cal/Healthy Families mail in application which will need to be completed and returned to the State's Single Point of Entry. Presumptive eligibility will continue for those children whose families submit an application for continuing coverage prior to the end of the second month of presumptive eligibility until a final eligibility determination is made by the Medi-Cal or Healthy Families Programs.

In the insurance program, children will receive health coverage like that provided to California's state employees under California's benchmark plan, the California Public Employees Retirement System (CalPERS). They will also receive comprehensive vision and dental coverage patterned after state employee coverage. Children with certain complicated medical conditions will receive treatment of those conditions through California's highly regarded California Children's Services (CCS) program. Similarly, children with serious emotional disturbances will receive treatment of their condition from county mental health departments. This comprehensive child focused benefits package provides children with preventive, full scope, quality health care which will help promote healthier children and, as a result, healthier families for the state of California.

California will seek to ensure that children's health plans become their medical homes by emphasizing preventive services, coordinating with programs that currently serve the

uninsured and weaving quality measurement and monitoring into the fabric of the program. California will require specified performance measures in its contracts with plans and will build on these as additional measures are developed.

The Department of Health Services (DHS) will be responsible for implementing the outreach and Medicaid changes proposed in the Title XXI state plan as well as ongoing administration of the CCS and CHDP programs.

The Managed Risk Medical Insurance Board (MRMIB) will be responsible for administering the purchasing pool, the purchasing credit, and the AIM program. MRMIB has a strong commitment to providing affordable quality health care to Californians. MRMIB currently administers three health insurance programs: the Major Risk Medical Insurance Program (MRMIP), a program for medically uninsurable people, the Health Insurance Plan of California (HIPC), a small employer purchasing pool and the Access for Infants and Mothers (AIM) Program, a program for uninsured pregnant women and their newborns. (The state also seeks FFP for a portion of the AIM Program.)

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

The AIM Program provides comprehensive health benefits for pregnant women and their infants through the age of 2 with household incomes between 200% - 300% FPL. In addition, pregnant women are not eligible for AIM if they are on Medi-Cal or have employer-sponsored coverage (unless the coverage has such high deductibles that MRMIB views the coverage as being tantamount to being uninsured). As approved in California's SPA, FFP is claimed for infants through the age of 1, born to AIM mothers with household incomes between 200% - 250% FPL.

In an effort to streamline public programs, California is in the process of modifying its AIM Program statute to change the eligibility process and benefit service delivery for infants and children up to the age of 2 born to mothers enrolled in AIM. AIM will continue to serve pregnant women with incomes up to 300% FPL. Eligibility, enrollment, plan selection and benefit service delivery through the AIM Program remain for the pregnant woman. However, infant's born to mothers enrolled in AIM will be enrolled in the Healthy Families Program from date of birth until age 2. The Healthy Families Program will conduct an annual redetermination prior to the child's first birthday to assure eligibility for the child's second year of coverage, i.e. income equal to or less than 300% FPL.

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Providing coverage to infants and children through age 2 born to mothers enrolled in AIM provides a greater selection of health plans, provides access to the CCS provider network for children with an eligible CCS condition, provides dental and vision coverage and provide families with the opportunity to have their children in the same health plan. California is in the process of combining the administrative functions of both programs into one administrative vendor. Based on an economy of scale within the Healthy Families Program, pregnant women enrolled in the AIM Program will receive: an increase in the hours of available toll free telephone support; written materials and telephone operators to support more languages; and, most importantly, seamless enrollment for the infants into the Healthy Families Program.

The legislature enacted language proposed by the Governor in his 2003-04 Budget to enroll AIM children in the Healthy Families Program. California submits this SPA to request federal approval for FFP under Title XXI up to 300% FPL for infants and children through age 2, born to mothers enrolled in the AIM Program and enrolled in the Healthy Families Program.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAMS (C-CHIP)

AB495 (Diaz) (Chapter 648, statutes 2001) authorized the MRMIB to establish a mechanism to permit county agencies, Local Initiatives (LIs), and County Organized Health System (CHOS) to utilize federal Title XXI (S-CHIP) funds not needed by the State for coverage of children or parents in the Healthy Families Program. Funds would be used to expand coverage for uninsured children with income at or below 300 percent FPL and not eligible for no cost Medi-Cal or the Healthy Families Program. California submits this SPA to implement the provisions of AB495 for Santa Clara, Alameda, San Francisco, and San Mateo Counties.

C-CHIP enrolled children will receive health coverage from a health plan that has a contract with the county to provide the services and participates in the Healthy Families Program. Health benefits are the same as in the Healthy Families Program, except for the specialized services carved out for CCS. Under the C-CHIP model, children diagnosed with an eligible CCS condition will be referred to the CCS program for a full eligibility determination, including financial eligibility. In the Healthy Families Program, enrolled children with an eligible CCS condition are "deemed" to meet the financial eligibility requirements. In C-CHIP, children that do not meet all the CCS eligibility criteria will have all their medical needs met by the health plan as occurs today under the California State Employees coverage that serves as the benchmark coverage for the Healthy Families Program. Children enrolled

in the C-CHIP will also receive comprehensive dental and vision coverage patterned after the Healthy Families Program.

C-CHIP will be administered by the counties. Application screening to assure children are not eligible for no-cost Medi-Cal or Healthy Families will be done via application assistants who are already trained in Medi-Cal and Healthy Families Program criteria. Enrollment into C-CHIP will occur by the health plan staff. To assure consistency among all the public programs, eligibility criteria are the same as in the Medi-Cal and Healthy Families Programs except that C-CHIP covers income at or below 300 percent FPL.

MRMIB is responsible for review and ongoing monitoring of each of the C-CHIP expansions to assure compliance with federal Title XXI regulations and California's approved state plan.

1.2. ☒ **Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))**

1.3. ☒ **Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)**

1.4. ☐ **Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):**

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	February 1, 2009	HFP Family Contribution Increase, Dental Benefit Cap & Vision Benefit Modification
Implementation date:	February 1, 2009	Wait List/Disenrollment Infrastructure
	January 6, 2009	AIM 6-Month Residency Requirement Elimination

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February 1, 2009	HFP Family Contribution Increase & Vision Benefit Modification
July 1, 2009	Dental Benefit Cap

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Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

According to the Current Population Survey (CPS) data analyzed by the UCLA Center for Health Policy Research, most California children currently have access to creditable health coverage. According to CPS data for 1995, 7,636,000 children had insurance coverage, with most of those (4.9 million or 53 percent of all children) having coverage through job-based insurance. In 1995, 2,345,000 (25 percent of all children) were served by Medi-Cal, the state's Medicaid program.[1] Another 124,000 children (1 percent) were covered through other public insurance such as Medicare or CHAMPUS, while 291,000 children (3 percent) had access to privately purchased insurance coverage in 1995. However, 1.6 million California children were uninsured, an estimated 17 percent of all California children.

Public Health Care Programs for Children. As was noted above, most California children obtain their coverage through private means. However, a significant number are served through public programs. The public programs under which children may get coverage include the following:

Medi-Cal. California's largest public health insurance program serving children is Medicaid (known in California as Medi-Cal).

- Most children are served under the categorically needy categories (SSI/SSP and AFDC/TANF recipients).

1 The California Department of Health Services believes that CPS data significantly underestimate the number of beneficiaries served by Medi-Cal.

- The Medically Needy program under Title XIX, Section 1902(a)(10)(C) provides benefits to children under age 21 who meet resource requirements and who are determined otherwise eligible.

- The Federal Poverty Level programs under Title XIX, Section 1902(l) provides

  benefits to children under age 19 who are determined otherwise eligible. The FPL programs are as follows:

  - For infants up to age one: family income must be at or below 200 percent of FPL, the income (between 185 percent and 200 percent) and the resources of the parents and child are disregarded.

  - For children age one and under age six: family income must be at or below 133 percent of FPL.

- Presently, resources are counted for children ages 1 to 19 in the FPL program. However, state legislation has just been enacted to disregard the resources of the parents and child in the FPL program which will expand Medi-Cal coverage under Title XXI.

California Health Care for Indigents Program (CHIP). CHIP provides funding to large counties for uncompensated hospital, physician, and other health service costs.

To be eligible for CHIP funds, counties must meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

Rural Health Services (RHS). RHS provides funding to small rural counties for uncompensated hospital, physician, and other health services costs. This is not the same as the Rural Health Demonstration Project.

To be eligible, counties must participate in the County Medical Services Program, meet their Maintenance of Effort (MOE), and provide or arrange for follow-up medical treatment for children with health problems and/or medical disorders detected through the CHDP program.

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The program contracts with the State Office of County Health Services for the rural counties' obligation to provide follow-up treatment for the conditions identified in CHDP screens.

Expanded Access to Primary Care (EAPC) Program. EAPC provides financial assistance to primary care clinics serving medically-underserved areas or populations. EAPC is funded through Proposition 99 tobacco tax monies and serves individuals at or below 200 percent of the poverty level on a sliding scale basis.

Seasonal Agricultural and Migratory Workers Health Program. This program provides financial and technical assistance to primary care clinics serving the needs of seasonal, agricultural, and migratory workers and their families. Individuals pay on a sliding scale.

California Children's Services (CCS). CCS provides funding for medical care for eligible low-income families with children with serious medical problems, such as critical acute illnesses, chronic illnesses, genetic diseases, physical handicaps, major injuries due to violence and accidents, congenital defects, and neonatal and pediatric intensive care unit level conditions. It provides physician, hospital, laboratory, X-ray, rehabilitation services, medications, and medical case management.

To be eligible, individuals must be under twenty-one years of age, have a medical condition covered by CCS, be a resident of the county, have an adjusted gross family income below $40,000 or a projected out-of-pocket medical cost greater than twenty percent of the family income.

Major Risk Medical Insurance Program (MRMIP). MRMIP provides subsidized health coverage to individuals, including children, who are denied coverage by private carriers because of a pre-existing medical condition. People who are eligible for Medicaid or Medicare cannot enroll in this program. Approximately 6% of the program subscribers are children.

Direct health services are frequently provided through community health centers, school based health centers and voluntary practitioner programs.

Access for Infants and Mothers (AIM). The AIM program is a public-private partnership which offers creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL. For infants born to mothers enrolled in

AIM prior to July 1, 2004, the AIM program will also provide coverage through the first two years of life. For infants born to mothers enrolled in AIM on or after July 1, 2004, the infants will be enrolled in the Healthy Families program. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber co-payments and contributions, while the subscriber pays two percent of their average annual income if enrolled prior to July 1, 2004 and 1.5% of their average annual income if enrolled on or after July 1, 2004. As of September 1997, AIM has provided access to comprehensive health benefits for 28,921 women and 25,735 newborns.

Uninsured Children. The CPS data indicate that the vast majority of uninsured children (1.4 million) live in families with at least one working parent. In fact, 965,000 uninsured children lived in families with at least one parent employed full-time for the entire year. Uninsured rates are highest among children in self-employed families, but

lack of insurance is also prevalent among families in which a parent works for an employer.

There are disparities in California's uninsured children's race and ethnicity as well. CPS data show that 29 percent of Latino children are uninsured, in contrast to 12 percent of Asian American children, 10 percent of non-Latino white children, and 10 percent of African American children. Furthermore, uninsured rates for children vary across geographic regions. CPS data show that 25 percent of children in Los Angeles County and 20 percent of children in Orange County are uninsured. In contrast, an average of 16 percent of children in Central Valley counties, 13 percent in San Diego County, an average of 11 percent in Riverside and San Bernardino counties, and 10 percent in the six county San Francisco Bay Area are uninsured.

CPS data estimates reflect that there are 580,000 uninsured California children whose families have incomes between 100 and 200% FPL and this might qualify as targeted low income children under Title XXI, and thus could potentially be served by the Healthy Families program. Given the sample size drawn for CPS, there are no statistically valid demographic data on this population. A copy of UCLA's analysis of the health status of children between 100 percent and 200 percent of poverty is included as Attachment 3.

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2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

California currently identifies and enrolls uncovered children who are potentially eligible to participate in public programs in several ways:

- DHS administers its Baby-Cal media campaign, which provides extensive outreach to pregnant women about the importance of obtaining prenatal care, and informs them that, if they have modest incomes, state programs are available to help them. With its annual $6 million budget, Baby-Cal uses a media campaign, operates a toll-free line which, among other things, refers callers to Medi-Cal or the AIM program (as applicable), and conducts outreach through a network of roughly 350 community based organizations (CBOs).

- California Children's Services (CCS), and Women, Infant and Children (WIC) providers identify children who may be potentially eligible for

  Medi-Cal and refer the family to the appropriate office to apply. State statute requires CCS applicants to fill out a Medi-Cal application.

- Child Health and Disability Prevention (CHDP) providers identify children who are uninsured and may be eligible for no cost Medi-Cal or the Healthy Families Program, grant presumptive eligibility in one of the two programs, and encourage families to apply for continuing coverage for Medi-Cal and Healthy Families.

- To facilitate the application process, Medi-Cal outstations eligibility workers in locations which serve large numbers of potentially eligible children, such as disproportionate share hospitals, prenatal clinics and federally qualified health centers.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The Baby-Cal campaign described in Section 2.2.1. targets pregnant women who may be eligible for participation in the AIM program. AIM also works with three community-based outreach contractors in various regions of the state to distribute informational materials via mail and at public events. AIM's contractors conduct other innovative activities such as educating insurance agents about the program, conducting a telemarketing campaign, and producing public service announcements. AIM also conducts outreach through the use of an application assistance fee paid to individuals and entities that assist families in filling out the AIM application.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. ***(Previously 4.4.5.)*** **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

The Healthy Families program consists of four components: expansions of coverage under Medi-Cal (as described in Section 2.1); establishment of a purchasing pool for children with family incomes up to 200% FPL (who are ineligible for no-cost Medi-Cal); an aggressive outreach and education campaign to make the public familiar with the availability of health coverage for the uninsured; and provision of coverage for infants under the age of 1 born to mothers enrolled in the AIM Program prior to July 1, 2004 whose family incomes are between 200-250% FPL, and infants through age 2,

born to mothers enrolled in the AIM Program on and after July 1, 2004 with family incomes between 200 - 300% FPL. This section concentrates on the insurance program and AIM as Medi-Cal's administration is in accordance with California's Title XIX plan.

Insurance Program

The insurance program will serve children whose family income falls below 200 percent FPL but who are not eligible for no-cost Medi-Cal. The program has been designed to have a smooth interface with Medi-Cal and includes a number of

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provisions to ensure that the insurance program enrolls only targeted low-income children.

Coordination with Medi-Cal:

- Under Title XXI, California will expand Medi-Cal eligibility to implement a resource disregard for children whose countable family income is at or below the appropriate FPL in the Medi-Cal program. Thus, eligibility for both programs will depend only on a family's income. Eligibility workers, CHDP providers, and other organizations assisting families will be able to use an income chart to refer children to the appropriate program.
- Healthy Families will compare its participant list against Medi-Cal's enrollment files to ensure that children do not already have creditable coverage through Medi-Cal.
- To provide families moving from Medi-Cal to Healthy Families with time to enroll in Healthy Families, the Department of Health Services will implement one month of "continued eligibility" for Medi-Cal covered children whose family income is at or below the appropriate FPL who lose eligibility for no cost Medi-Cal due to increased family income or increased age of a child.
- The Healthy Families to Medi-Cal Presumptive Eligibility (PE) Program provides children who meet certain criteria with temporary no cost Medi-Cal coverage, until the County Welfare Department (CWD) makes a final eligibility determination. At HFP Annual Eligibility Review (AER), when children are determined to have family incomes below HFP Guidelines, they are provided PE while their application is forwarded to their local CWD for a full Medi-Cal eligibility determination. PE Medi-Cal is funded under Title XIX.
- At initial application, when a child's income is determined below Healthy Families Program (HFP) guidelines, they are granted temporary Accelerated Enrollment (AE) into Medi-Cal while the application is forwarded to the local County Welfare Department (CWD) for a full Medi-Cal eligibility determination. AE Medi-Cal is funded under Title XIX, during the AE period.

Coordination with employer-sponsored coverage. The insurance program has been designed to ensure coordination with existing private coverage to reach only targeted low income children:

- The program has a coverage "firewall" -- a prohibition against covering children who have had employer sponsored coverage within 3 months prior to

applying for the Program. MRMIB is authorized to increase the length of the period to 6 months if it finds it is covering substantial numbers of children who were previously covered under employer-sponsored plans.

- The program's enabling statute prohibits insurance agents and insurers from referring dependents to the program where dependents are already covered through employer sponsored coverage.
- The program's enabling statute makes it an unfair labor practice for an employer to refer employees to the program for dependent coverage where the employer provides for such coverage or for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the Program.

Outreach. A central component to the design of Healthy Families is an extensive outreach campaign. The outreach for the new Healthy Families program is designed to be performed by CHDP providers, community-based organizations, county health agencies, and other entities that are geared to assist targeted low-income families in obtaining needed health and related services. CHDP providers will provide early medical screenings and immunizations (following Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) guidelines), grant presumptive eligibility for uninsured children under 200% of poverty in the Healthy Families and Medi-Cal programs, and encourage families to apply for continuing coverage for both Healthy Families and Medi-Cal. Healthy Families outreach will be coordinated with efforts to inform families about the enhancements to children's Medi-Cal coverage that accompany the implementation of the new Healthy Families program. As with the AIM program, entities that are likely to have contact with large numbers of children in the target population, such as school districts and day care centers, and individuals such as insurance agents will be paid a fee for assisting families in filling out the Healthy Families application. The outreach campaign is further outlined in Section 5 of this plan.

Integration of traditional and safety net providers. Counties as well as clinics and certain providers are primary sources of care for Medi-Cal beneficiaries and the uninsured, including children.

Given the critical safety net role these systems play in serving targeted children, the state will facilitate their participation in the purchasing pool. The following features are intended to assist with this process:

- MRMIB will encourage managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.
- MRMIB will allow the health plan that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium.
- County managed care systems (county organized health systems) are allowed to participate in the pool and given two years to obtain a commercial health plan license.
- MRMIB will give priority in contracting to plans with significant numbers of providers who serve uninsured children.

In summary, the Managed Risk Medical Insurance Board (MRMIB) and the Department of Health Services (DHS) have established a variety of mechanisms by which to coordinate in the administration, monitoring, and evaluation of the programs described in the plan. The mechanisms include:

- Both DHS and MRMIB report to the Secretary of the Health & Welfare Agency who can ensure that both agencies are operating under consistent policies and procedures;
- The Director of DHS, is a MRMIB Board Member. Thus, every issue before the Board is one which the Director can comment on to other Board Members and vote on. Furthermore, the Health and Welfare Agency sits on MRMIB as a ex-officio member;
- DHS and MRMIB have created a Healthy Families Core Workgroup consisting of DHS' and MRMIB's senior management. The workgroup meets every other week to ensure coordination of the program. During these meetings, workgroup members provide status reports on the various projects being implemented and discuss implementation issues;
- DHS staff has provided input to MRMIB staff on every version of the MRMIB Healthy Families regulations, as well as on the model contracts, negotiations and provided input to DHS staff on the application form common to both Healthy Families and Medi-Cal (Medicaid) for children, the outreach contract, and the outreach and media approach. MRMIB has also consulted with DHS staff on a range of issues such as Medi-Cal quality standards, Medi-Cal threshold language requirements, and the definition of traditional and safety net providers;

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- DHS has created a new high-level management position (Associate Director) to facilitate coordination of the program within and between agencies; and
- DHS staff attends MRMIB's public meetings, including board meetings, and meetings with potential vendors to explain the model contracts.

COUNTY CHILDREN'S HEALTH INITIATIVE PROGRAM (C-CHIP)

The county insurance program, similar to the Healthy Families Program, serves uninsured children whose family income does not exceed 300 percent FPL who are not eligible for no cost Medi-Cal or the Healthy Families Program and are otherwise eligible for S-CHIP funding. C-CHIP is a county based program only available in counties that have local funds allocated for its implementation.

Coordination with Medi-Cal and the Healthy Families Program. Since the C-CHIP projects are sponsored and funded from local funds, there are built in financial incentives to local counties to assure coordination with Medi-Cal and the Healthy Families Programs. More children can be covered at the county level using local dollars if they are not financially sponsoring children who could otherwise be covered by state and federal dollars.

- C-CHIP will use the same income standards and deductions as the Medi-Cal and Healthy Families Programs to assure consistency among the programs.
- C-CHIP will use a resource disregard when determining eligibility, again to assure consistency with the Medi-Cal and Healthy Families Programs.
- At the time of initial application, a Medi-Cal and Healthy Families screening will occur. Applications with children screened to Medi-Cal or Healthy Families will be submitted to the State's Single Point of Entry for processing. Counties have indicated that they will use Health-e-App, the state's internet based electronic application that provides a Medi-Cal and Healthy Families eligibility screening as the mechanism by which to assure children are not enrolled in C-CHIP in error.
- As with the initial eligibility determination, annual reviews will occur to assure continued eligibility for C-CHIP, including the Medi-Cal and Healthy Families screening.
- The State will also modify its annual review process to include forwarding applications to counties known to have a C-CHIP when a child is determined to have income above Healthy Families guidelines.

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ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

The authorizing statute for the AIM program includes the same prohibitions as mentioned above regarding insurance agent referral and unfair labor practices. It also will not provide coverage to a woman on Medi-Cal or who has employer-sponsored coverage (unless the coverage has such high deductibles that MRMIB views the coverage as being tantamount to being uninsured.)

California has historically served mothers and infants through its AIM program even if they have high deductible insurance coverage ($500 or more), because at the income of AIM mothers (200-300 percent FPL), out of pocket expenditures are so unaffordable that most mothers will be unable to use the insurance. The babies of these women may or may not have coverage once born. However, as Title XXI precludes states from serving children who have current insurance coverage, even this high deductible coverage, California will not bill the federal government under the Title XXI program to serve any infant who has access to other coverage. The AIM application asks not only whether a mother has coverage for her pregnancy, but whether that insurance will cover the infant that results from the pregnancy.

A total of 1,228 of these applicants indicated that their infants had access to other insurance coverage, 4 percent of the total application pool. California will track insured status of infants enrolled in AIM and will not claim federal financial participation for children whose mothers report the availability of health coverage for the infants. Thus, MRMIB will bill for children under age one whose family income is between 200 percent and 250 percent of FPL, for those infants born to mothers enrolled in the AIM Program prior to July 1, 2004 and who are uninsured. MRMIB will also bill for children under age two whose family income is between 200 percent and 300 percent of the FPL, for those infants born to mothers enrolled in the AIM Program on or after July 1, 2004 and who are uninsured. This second group of infants that are born to mothers enrolled in the AIM Program on or after July 1, 2004 will be enrolled in the state's Healthy Families Program. Actual claims to the federal government will be based on the data collected on infant's insurance status from the AIM application.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

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☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

Overview of the Comprehensive Healthy Families Delivery System

California's approach is to serve targeted low income children through an integrated system of care. The central component of this system is a new program to provide creditable health insurance coverage through managed care, a program which will be administered by MRMIB. MRMIB will provide managed care to targeted low-income children between ages 1 and 19, and children under age 1 with incomes between 200 and 250 percent FPL through a health insurance purchasing pool. Through the purchasing pool the state will deliver a comprehensive range of health services to targeted low income children. The state will use the power of pooled purchasing not only to obtain affordable coverage for uninsured children but also to demand high quality services for children.

Many children will come to Healthy Families through a "gateway" program, the CHDP program. CHDP offers preventive health services to children under 200 percent of poverty. Prior to receiving services from a CHDP provider, families of uninsured children will complete a pre-enrollment application and be provided with presumptive eligibility for their children for the month of application and the following month. In addition, on the pre-enrollment application, families will be asked if they want to apply for continuing coverage through Medi-Cal or Healthy Families. Those families interested in continuing coverage, will receive a joint Medi-Cal/Healthy Families mail in application which will need to be completed and returned to the State's Single Point of Entry. Presumptive eligibility will continue for those children whose families submit an application for continuing coverage prior to the end of the second month of presumptive eligibility until a final eligibility determination is made by the Medi-Cal or Healthy Families insurance program. Should follow up treatment be required for a condition identified in the CHDP screen, Medi-Cal or the Healthy Families insurance program (depending on which program the child qualifies for) will cover the cost of care provided to children during the period of presumptive eligibility. Low income

children who are ineligible for Medi-Cal or the insurance program will be referred to counties for treatment.

To meet the special needs of children, the Healthy Families program will also ensure the provision of necessary specialized services beyond those offered through the comprehensive insurance package in a coordinated manner. The CCS program and county mental health departments will address the significant needs of the minority of children whose needs may not be fully met under an insurance benefit package. The CCS program will provide case management and treatment for chronic, serious, and complex physically handicapping conditions, while county mental health departments will provide appropriate services to meet the needs of seriously emotionally disturbed children. Both programs will reimburse providers for these specialized services. Children receiving such services will continue to have their primary health needs served through the insurance program. Allowing those specialized services to be provided as a complement to, but outside of, the managed care setting is consistent with recent actions in the Federal budget reconciliation act which prohibit mandatory enrollment of children with special medical needs in managed care.

To promote a smooth interface between Healthy Families and Medi-Cal, Medi-Cal will be enhanced through a resource disregard for children in the federal poverty level program, accelerated coverage for all children under 100 percent of the federal poverty level, and an additional one month of continued eligibility to allow children whose families become ineligible for Medi-Cal time to become enrolled in the insurance program. In addition to program integration, these features will promote greater coverage of children who are already eligible for, though not enrolled in, Medi-Cal. Under this Medicaid expansion, children without health insurance will receive their coverage under Title XXI funding. Children with health insurance will receive their coverage under Title XIX funding with the applicant's other health coverage requirements being applied.

The Healthy Families Program (HFP) grants Accelerated Enrollment (AE) into Medi-Cal when children are income screened below the HFP guidelines at initial application. These children's applications are forwarded to the local County Welfare Department (CWD), and these children are provided with temporary no cost Medi-Cal coverage while the CWD makes a final eligibility determination. AE Medi-Cal is funded under Title XIX.

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The Healthy Families Program (HFP) grants Presumptive Eligibility (PE) Medi-Cal for children when a family's income is determined below the HFP guidelines at Annual Eligibility Review. PE provides the family with temporary no cost Medi-Cal, while their application is under review by their local County Welfare Department (CWD), for a final Medi-Cal eligibility determination. PE Medi-Cal is funded under Title XIX.

Targeted low income children under age 1whose mothers are enrolled in AIM prior to July 1, 2004 and whose families have incomes between 200-250% of federal poverty level will be served through the AIM Program, under a purchasing pool arrangement similar to the Healthy Families purchasing pool. In addition, children under the age of 2 whose mothers are enrolled in AIM on or after July 1, 2004 and whose families have incomes between 200-300% of federal poverty level will be served through the Healthy Families Program. As such, the Healthy Families Program will redetermine eligibility prior to the child's first birthday. Prior to the child's second birthday, the Healthy Families Program will redetermine eligibility for the S-CHIP Healthy Families Program. If at year two, the household income exceeds that of the Healthy Families Program, 250% of the federal poverty level, the child will be informed about C-CHIP if applicable.

The authorizing statute for Healthy Families also requires the state to assess the need for specialized services in two additional areas: rural health and substance abuse.

Rural health. On December 21, 1999, the US Department of Health and Human Services approved a state plan amendment which included supplemental rural health services. The supplemental services, referred to as the Rural Health Demonstration Projects, were established to improve access to health care services for medically underserved and uninsured populations in rural areas and special populations who have rural occupations (farm workers, loggers, etc.). At the inception of the Rural Health Demonstration Projects, $6 million ($2.038 million State General Fund, and $3.962 million FFP) in augmentation was authorized in state law to develop and enhance existing health care delivery networks through contract amendments with participating HFP health, dental and vision plans. This augmentation addressed geographic access barriers and access barriers for special population subscribers enrolled in the HFP.

In the recent state budget act, the source of state funds for the Rural Health Demonstration Projects has changed. The Tobacco Tax and Health Protection Act of

1988, as added by Proposition 99, established the Cigarette and Tobacco Products Surtax fund. These funds are to be allocated for use in tobacco education and tobacco use prevention programs, tobacco-related disease research, environmental protection and recreational resource enhancement programs, and health care services for low-income, uninsured Californians. MRMIB was appropriated Proposition 99 funds in the State's 2003 Budget Act and authorized in State law (Chapter 161, Statues of 2003) to use these funds as the match to draw Title XXI SCHIP funds for the Rural Health Demonstration Projects.

Substance abuse. The authorizing statute directs MRMIB, in consultation with the Department of Alcohol and Drug Programs, to assess the feasibility of providing supplementary services for substance abusers. The core benefit package includes those services made available to state employees, but some have argued that additional services are necessary for the target population. MRMIB will report to the legislature on the need for additional services by April 15, 1998. The state will submit an amendment to this plan if it wishes to expand substance abuse services.

Oral health. California will use S-CHIP funds, within the 10 percent of the federal S-CHIP administrative cost ceiling expenditures, for other child health assistance to address the epidemic of early childhood caries in the State. The funds will be used for a special oral health initiative designed to increase utilization of dental services among low income, uninsured children ages birth to 5 years of age. The initiative will be conducted in partnership with the California First 5 Children and Families Commission (First 5 Commission) for a 3 year period. The First 5 Commission forged this partnership to leverage the resources of an existing dental services delivery system serving of 700,000 children in California.

Some health and dental plans participating in the HFP will be funded, through contract amendments, to develop innovative methods to increase the awareness about the importance of preventive oral health among parents and caregivers of young children and reduce the incidence of early childhood caries. The initiative does not change the benefits that will be provided to all children enrolled in the Healthy Families Program (see Attachment 6), but will allow participating health and dental plans to develop innovative ways of delivering these benefits.

There are 21 innovative projects that selected health and dental plans will implement to provide one or more of the following services.

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- Case Management/Individual Oral Health Education Services – Oral health professionals will provide one-one-one oral health education to parents of young children and will follow-up with families to ensure that parents keep their children's dental appointments, and/or schedule needed follow-up care after receiving their preventive dental visit. Follow-up services will also serve to reinforce the health education patients receive during their dental visit. Health education and follow-up services will be designed to meet the cultural and linguistic needs of the families served. Some follow-up and health education services will be provided in the home.

- Innovative Preventive Services – Primary care providers will form special partnerships with dental providers to ensure that young children are receiving appropriate dental screenings and referrals for treatment. Some projects will use innovative preventive techniques, such as fluoride varnishes, to facilitate the prevention of early childhood tooth decay.

- Mobile Dental Vans – these will circulate among pre-schools to provide dental screenings, parent/child education, and ensure that children screened are linked with a "dental" home.

The health and dental plans selected for this project will coordinate their projects with school readiness sites in California. These sites are areas that are served by schools with the lowest academic performance index. It is estimated that over 800 children are estimated to reside in thee areas, with 85 percent of these children living in low income households. Thus, these projects will serve predominately low-income children.

The Oral Health Project ended in December 2006.

Poison Treatment Advice And Prevention. California will use CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states, to support the California Poison Control System (CPCS). CPCS provides daily, 24-hour emergency telephone treatment advice, referral assistance, and information to manage exposure to poisonous and hazardous substances. The CPCS answers poisoning emergency calls from the general public 24 hours a day, 365 days each year at no charge. At all times, a Specialist in Poison Information (SPI) is available to manage cases and Certified Specialists in Poison Information (CSPI) manage cases and direct Poison Information Providers. The service is provided to all communities, including underserved and

indigent populations, in over 150 languages and via telecommunications devices for the deaf and hearing impaired (TDD)**.**

The call center receives approximately 220,000 calls per year involving someone ingesting poison and other hazardous substances. Nearly 40% of all calls relate to children age 0-18 with annual household incomes of $55,000 or less (250% FPL for a family of 4). Another 10% of calls are for children 0-18 with incomes up to $65,000 (250% FPL for a family of 5). Children under the age of 5 account for the majority of poison exposures. In addition to calls regarding exposure, another 90,000 calls are for information and are considered preventive. Of these calls, 64% are for children age 0-18 in families with incomes at $55,000 or less, and another 12% for families with incomes up to $65,000.

Poison center public education programs direct attention and resources to "identified at-risk populations". In California, the targeted at-risk populations are Latinos, African Americans, and children born to low income parents. Of California's 2.5 million children under the age of 5 (2002 U.S. Census), approximately 750,000 live in poverty. African-Americans and Latinos are California's largest at-risk groups.

A line of consumer-based educational materials has been developed in Spanish using research findings with target audiences. Materials are culturally relevant, take into consideration health literacy levels and clearly illustrate and describe poison center services. Chinese, Korean, Vietnamese, Tagalog, Hmong, Russian and Armenian brochures have also been developed. Materials are customized and culturally relevant to each group.

A Community Health Worker Initiative directs efforts to the "hardest to reach" and "at highest risk" populations. Community health workers deliver the CPCS message through group education sessions, community health fairs, and local events, as well as informally, though one-on-one outreach in their neighborhoods, churches, and community gatherings

CPCS advertises the national public toll free number and its own TTY toll free number in both the white pages and the "customer guide" (usually appearing on page 2) of all California telephone directories. Listings placed with the major local phone companies (SBC, Verizon) are applied to each directory they publish in California. CPCS also places these listings in the smaller rural phone company, as well as

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independent community directories.

Healthy Families Purchasing Pool

Delivery System. For the majority of eligible families, MRMIB will offer access to health plans through a subsidized consumer choice purchasing system. The pool will be built around the concepts used successfully by organized purchasers such as the California Public Employees Retirement System (CalPERS) and HIPC -- price competition among managed care health plans, family choice of plans, performance based contracts with plans, and reliance on existing private sector delivery systems. In the purchasing pool, many of the same health plans and networks available in the employer market will be available to beneficiaries, providing broad access to health care providers. Most of the plans participating will be health maintenance organizations (HMOs), but it is possible that one or more preferred provider organizations (PPOs) will also participate. PPO's participate in several of MRMIB's programs and are a particularly effective means of providing coverage in areas with little or no penetration by HMO's.

Plan Contracting. MRMIB is authorized to contract with licensed health plans and health insurers as well as Local Initiatives approved by the Department of Health Services to provide service to Medi-Cal beneficiaries, County Organized Health Systems (COHS), and federal Health Insuring Organization demonstration projects such as Santa Barbara's COHS. Participating plans will be under the regulatory authority of California's Department of Insurance or Department of Corporations, and subscribers will be able to take any benefit grievances to those regulators. Eligibility grievances are appeal able to MRMIB. COHS are presently overseen by the Department of Health Services, but will be required to obtain Knox-Keene licensure within two years to participate in Healthy Families.

To assure that health care providers currently serving low income families are given the opportunity to participate in the program:

- MRMIB will encourage private managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.
- MRMIB will allow the health plan in each county that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium.

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- County managed care systems (county organized health systems and Local Initiatives) are allowed to participate in the pool and, in the case of COHS's, given two years to obtain licensure as private health plans.
- MRMIB will give priority in contracting to plans with significant numbers of providers who serve uninsured children.

Plan Contracting Process. The process that MRMIB will use to contract with health plans will be the process it uses to contract with health plans under its three existing programs. MRMIB will first adopt (emergency) regulations detailing the eligibility, benefits and appeals process for the program. It will then issue model contracts, one for the administrative function, and one each for health, dental, and vision plans, which specify MRMIB's contracting requirements. The model contracts issued by MRMIB serve as the basis of negotiations with all vendors. These contracts will contain numerous requirements, ranging from quality standards, participation of safety net providers, communication standards, grievance procedures, and manner of payment. Many of the provisions will be aimed at developing a medical home for children. These provisions include:

- Performance standards regarding provision of health promotion service, such as immunizations;
- Requirements that families receive ID cards, evidence of coverage documents, and physician and hospital directories on the effective date of coverage;
- Requirement to report on grievances; and
- Requirements to publish materials in specified languages.

MRMIB traditionally contracts with health plans for two years. It continually refines and improves the requirements of the contract prior to each new contracting period. It will be able to incorporate in subsequent contracts the indicators of a high quality medical home once such measures have been developed.

Both the regulations and the model contracts will be adopted in public session by MRMIB after the public has had the opportunity to testify on them. Once the model contracts are adopted, MRMIB staff will meet with any and all potential contractors. Those interested in participating will be required to submit signed contracts, together with their price for services, at a certain time. MRMIB staff will review contracts for compliance with requirements and MRMIB will select contractors offering the state the best value. MRMIB can select as few or as many health, dental, and vision plans as it deems appropriate and is not constrained to select the lowest bidder(s).

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MRMIB has a reputation for expeditious implementation of the programs it administers. Each of the three existing MRMIB programs opened for enrollment within nine months of enactment of authorizing legislation. Mindful of the urgent needs of California's uninsured children, MRMIB has adopted a similarly aggressive schedule for enrollment to the pool.

Administration. The purchasing pool and purchasing credit components of the program will be privately administered under the oversight of MRMIB. A mail-in application process will be used, and eligibility determination will be completed within an estimated ten days. The application (intended to be as similar as possible to a planned redesigned Medi-Cal application for children) will be designed to verify the income eligibility of families and to screen them for access to employer sponsored coverage as well as coverage under no cost Medi-Cal. As is done in the AIM program, income eligibility will be verified using copies of last year's federal income tax forms or current year wage stubs. A random sample of applications will be audited using the Income Eligibility Verification System (IEVS) on an on-going basis to ensure the fiscal integrity of the program.

The administrative contractor will be responsible for eligibility determination, premium collection, transmission of enrollment information to health plans, and printing and mailing of application materials.

In addition, an application assistance payment will be made to entities able to refer large numbers of children to the program. The types of entities anticipated to be authorized by MRMIB for receipt of the fee include state maternal and child health contractors, school districts, parent-teacher associations, Healthy Start sites, county health departments, county welfare offices, licensed day care operators, and insurance agents or brokers. A flat fee of $50 will be paid to the referring entity for every family that is determined to be eligible for and enrolled in the program.

Quality Oversight. Consistent with its administration of its three existing programs, the MRMIB will look to the state regulatory entities to assure the basic quality of health plans with regard to financial stability, adequacy of network, and appropriateness of medical policy. In addition, to ensure that a health plan becomes a child's medical home, the best practices available for quality improvement and monitoring will be adopted. Such performance standards could include assuring the accessibility of services (such as wait time for appointments) and the delivery of

preventive treatments (such as improvements in the percentage of children that are fully immunized by age two).

Coordination with Other Programs. MRMIB will encourage all plans to develop protocols to screen and refer children needing services beyond the scope of the program's benefit package to public programs providing such services and to coordinate care between the plan and the public programs. This could include the regional centers for the developmentally disabled, county substance abuse programs and local education agencies.

MRMIB will also be coordinating eligibility with the state Medi-Cal program by referring children who appear to be eligible for Medi-Cal to the county for follow-up. MRMIB and Medi-Cal are also assessing the feasibility of using the same application form for both programs so that applications could simply be mailed for processing.

The application assistance fee, which MRMIB will pay for referrals of eligible children, is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, PTA's and county maternal and child health contractors.

Outreach Efforts. A statewide outreach effort will be launched to inform parents about the child health services offered through programs such as Healthy Families and Medi-Cal. The outreach program will use mass media, toll free phone lines, community based organizations, and coordination with other state and local programs to deliver messages that are culturally and linguistically appropriate. (See Section 5 for a more detailed description of the outreach activities.)

Child Health and Disability Prevention Program

To maximize access, continuity of care, and ease of administration, the existing CHDP program which provides preventive health screening examinations for children with family incomes of less than 200 percent of the federal poverty level will be integrated into the design of the Healthy Families program. CHDP is a logical point of entry for the target population to be served for many reasons:

- Targeted low income children eligible under Title XXI currently access preventive health services offered through CHDP;
- CHDP providers are likely to be the providers in the child health insurance plans and serve as the "medical home" for children enrolled in plans; and
- Integrating CHDP as a component of Healthy Families provides the new program with acceptability and credibility for providers and families.

To assure that uninsured children in the target population are enrolled in comprehensive health, dental and vision services, California will provide presumptive eligibility in the Medi-Cal and Healthy Families Program on site at the CHDP provider offices. The Medi-Cal Program has already submitted a state plan amendment to CMS that expands the entities qualified to determine presumptive eligibility for children under age 19 to include CHDP providers. This state plan was approved by CMS on May 7, 2003 and was implemented in the Medi-Cal Program July 1, 2003. Presumptive eligibility coverage will begin on the month of the pre-enrollment application. Once presumptive eligibility has been established for either Medi-Cal or the Healthy Families program, children will receive services through the Medi-Cal fee-for-service delivery system for both Medi-Cal and Healthy Families. This state plan amendment requests approval for Title XXI funding for those Healthy Families benefits used by children screened Healthy Families eligible based on the information provided on the pre-enrollment application. As of April 1, 2003, the Healthy Families Program no longer pays for services related to health, dental or vision care needs identified prior to Healthy Families enrollment, also referred to as the "90 day retroactive eligibility".

A streamlined system has been developed in which uninsured children seeking services with a CHDP provider will be provided presumptive eligibility. Families will receive a Medi-Cal Benefits Identification Card (BIC) for each child granted presumptive eligibility. On the pre-enrollment application, families will indicate whether they want to apply for continuing coverage. Those families that do not indicate an interest to apply for continuing coverage will be provided coverage under the presumptive eligibility beginning the month of the pre-enrollment application and ending the following month. Families that indicate they do want to apply for continuing coverage will be sent a joint Healthy Families/Medi-Cal mail in application to complete and return to the State's Single Point of Entry (SPE). For coverage to continue, the State's SPE must receive the joint application before the end of the second month of presumptive eligibility. For families that opt for continuing coverage, coverage will remain in effect until a final eligibility determination is made

by either the Healthy Families or Medi-Cal program. Children eligible for the Healthy Families program will be enrolled in a Healthy Families contracted health plan as selected by the family. Appropriate referral will also be made to the CCS program if the problem identified through the screening examination appears to be a CCS eligible condition. To ensure continuity of care whenever possible, referrals for treatment services will be made to providers in the Healthy Families insurance plan which the family has chosen. During the period between application and enrollment, the county CHDP program can assist with identification of providers, scheduling appointments for identified health care needs, coordination of services, and completion of the application form.

Specialized Services

Mental Health. A basic benefit package of mental health services will be provided by the health care plans. This basic package for mental health treatment includes 20 outpatient visits, and 30 inpatient mental health days per year. While it is anticipated that the great majority of the mental health needs of children will be met under the insurance benefit package, it is recognized that some seriously emotionally disturbed children will require more specialized mental health services. Consistent with the treatment of similarly situated privately insured populations, these children are eligible for specialized mental health services through the county mental health system of care. Children with serious emotional disturbances (estimated at between 3-5% of the general population) will be referred by the health care plan to the county mental health program for treatments, pursuant to a Memorandum of Understanding (MOU) between the two organizations for any needed additional mental health services.[2] The

2 *Definition of Serious Emotional Disturbance from Welfare and Institutions Code:* "For the purposes of this part, 'seriously emotionally disturbed children or adolescents' means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of he Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of he following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of he following occur:
(I) The child is at risk of removal from home or has already been removed from the home.
(II) The mental disorder and impairments have been present for more than six months or are likely to

required MOU will formalize this important arrangement. (The description of services available is in Attachment 6.) The county mental health program will coordinate the delivery of mental health and other health services with the health care plan for those children who meet the criteria of serious emotional disturbance.
County mental health programs will provide mental health treatment services directly or through contracts with private organizations and individual providers. The requirements for provider selection and quality improvement for these mental health services will be consistent with those used for the Medi-Cal program for a similar population.

California Children's Services Program. Integrating the CCS program into Healthy Families is a logical way to ensure that uninsured low income children with serious health conditions will continue to have access to a program highly respected by the medical community because of its focus on high quality care. Children with chronic, serious, and complex physically handicapping conditions are best served by systems and programs which have been organized specifically to serve them. It is important that care not be disrupted and that continuity and quality of services be maintained. With these goals in mind, plans will be required to refer CCS-eligible children to the CCS program for the treatment of CCS-eligible conditions.

CCS, the Title V designated program for children with special health care needs, provides medical case management and payment for health care services for those children with eligible medical conditions who live in families with annual incomes below $40,000. Coverage is, and will be, limited to coverage of the specific condition. The program establishes standards for approval of inpatient hospital facilities and pediatric specialty and subspecialty providers delivering care to eligible children. The program also has an extensive system of special care centers located at tertiary medical centers at which multispecialty, multidisciplinary teams deliver coordinated inpatient and outpatient care to children with chronic medical conditions. The centers include cardiac, chronic pulmonary disease, hematology and oncology, myelomeningocele, hemophisia, sickle cell, renal, infectious disease/immunology, hearing and speech, metabolic disorders, inherited neurologic disease, limb defect,

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continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code." [For the purposes of the Child Health Initiative, the age range will be expanded to age 19 years].

gastroenterology, craniofacial anomalies and endocrinology. The program also approves neonatal intensive care, pediatric intensive care, and pediatric rehabilitation units.

CCS program staff determines the appropriate source of health care for eligible children, assist families in accessing care, and identify other needs of the child and family that could impact the care of the eligible condition.

The services to treat the CCS eligible medical condition of a child enrolled in Healthy Families will not be the responsibility of the contracting health plan in which the child is enrolled. The CCS program will continue to authorize the medically necessary services to treat the condition using the program's regulations, policies, procedures and guidelines in determining the appropriateness of providers, and the necessity for services. CCS will expand the systems of communication that have been instituted to work with Medi-Cal managed care plans that have CCS services "carved out" from their capitation rate. Local CCS programs carefully coordinate the authorization and delivery of specialty and subspecialty services with the primary care provider to which the child is assigned.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

Delivery System. Service delivery in the C-CHIP will be provided by health plans contracted by the county. These health plans are health maintenance organizations and also contract with MRMIB to participate in the Healthy Families Program. Having these same plans available is an asset to families in that they may assume continuity of care should they go from enrollment in the C-CHIP to Healthy Families and visa versa.

Administration. The C-CHIP will be administered by the county. The health plans will be directly responsible for final C-CHIP eligibility determinations, enrollment in the LI or COHS, distribution of written materials including correspondence, billing statements, Evidence of Coverage booklet, and premium collection, etc. MRMIB will oversee program activities to assure compliance with federal Title XXI regulations. MRMIB has reviewed the following materials to provide this assurance:

- The C-CHIP application, to assure that all necessary data is collected.
- Policies and procedures for determining eligibility (including citizenship/immigration status) and enrollment, documentation requirements,

appeals processes, and enrollee protections such as continued enrollment during an appeal.
- All C-CHIP template correspondence to be used in communicating with the applicants.

Medi-Cal

As part of the Healthy Families program, the state enacted a number of changes to Medi-Cal designed to ease the entry of Medi-Cal eligible children into the Medi-Cal system and establish a more consistent eligibility standard for children. Specifically the state enacted legislation to:

- Disregard resources of the parent and child, for children between ages 1-19 in the Federal Poverty Programs, thereby expanding coverage under Title XXI for children whose families meet Medi-Cal's income standards but who have not met its resource standards;
- Provide one month of continuous eligibility to be used by families who no longer qualify for no share of cost Medi-Cal to transition to Healthy Families private insurance;
- Require development of a simplified Medi-Cal form which can be mailed in; and
- Make eligible for Medi-Cal at 100% or less of FPL, children under age 19 who were born before September 30, 1983 (children age 14-19). This means that children aged 6-19 will be eligible at 100% or less of FPL.

Funding for children who meet the criteria above who are uninsured will be funded by Title XXI while funding for children with private coverage will be by Title XIX.

The delivery system for targeted low income children served by Medi-Cal will be consistent with the existing Title XIX state plan. The appropriate Title XIX state plan amendments are included with this proposal. See Attachment 4.

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

The AIM program provides creditable coverage to pregnant women (who do not qualify for no-cost Medi-Cal) with incomes between 200 percent and 300 percent of FPL and their newborn children (if the woman was enrolled in AIM prior to July 1,

2004) through the first two years of life. Eligibles from confirmed pregnancy through birth will receive coverage through the AIM program.

AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. Because Medi-Cal currently serves infants under 1 year of age through 200 percent of FPL, infants through age 1 up to 250 percent of poverty served by AIM fall within the income range of targeted low income children. Consistent with the C-CHIP projects, the same income disregards will be applied to children born to mothers enrolled in AIM through age 2. AIM's delivery system and contracting standards are virtually identical to that of Healthy Families' purchasing pool described above. Nine health care service plans participate in AIM, which offers statewide coverage, and the vast majority of all beneficiaries are offered a choice of two plans in each region (three in Los Angeles County).

MEDI-CAL

The Medi-Cal Program, administered by the California Department of Health Services, provides services through contracts with various health plans as well as a fee for service environment with payments made directly to providers of service. Eligibles from confirmed pregnancy through birth in households with incomes at or below 200 percent of FPL who are not eligible for federally funded non-emergency services will receive coverage through the Medi-Cal Program.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Health Insurance Programs

MRMIB will contract with managed care plans which will receive a specified amount per enrollee per month.

Virtually all of the plans will be regulated by California's Department of Corporations (DOC) under a body of law - the Knox-Keene Act - established specifically for

managed care plans.[3] The Knox-Keene Act prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards. Specific Knox-Keene requirements include:

- *Medical decision making.* The Knox-Keene Act requires medical services to be sufficiently separate from administrative and fiscal management so that medical decisions are not unduly influenced by fiscal concerns. DOC conducts an onsite medical survey at least every three years. Plans have physician medical directors responsible for medical decision making and directing quality assurance programs.

- *Basic health care services*. Knox-Keene plans must provide the following basic services: physician services, inpatient and outpatient services, diagnostic and therapeutic lab and radiologic services, home health care, preventive health care, and emergency health care, including ambulance and out-of-area coverage. In addition, there are a number of statutory mandates to provide or offer specific benefits.

- *Accessibility of services.* DOC must review and approve provider networks and contracts. Primary care services must be within 30 minutes or 15 miles of the enrollees' residence or workplace. Regulations require at least one primary care provider (FTE) for every 2,000 enrollees as guideline. DOC may require more providers depending on the area, population density, and other factors. Different requirements may apply in rural or medically underserved areas. DOC assures reasonable access to ancillary services and tertiary care.

- *Quality assurance*. Plans must have quality assurance programs to review quality of care, which includes as one component a utilization review system. Regulations require a program directed by health providers to review the quality of care being provided, and to identify, evaluate and remedy problems related to access, continuity and quality of care, utilization and monitoring of plan providers.

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3 Plans regulated by the Department of Insurance are also eligible to participate in the health insurance program as are county organized health systems which are overseen by the Department of Health Services under rules set forth in the Title XIX plan.

- *Financial viability*. Plans must file quarterly and annual financial statements and other financial reports. Plans must meet "tangible net equity" requirements and a financial and administrative audit is conducted at least every three years to monitor plan financial viability.

- *Consumer protection*. Plans must maintain internal grievance procedures for plan enrollees and appeals may be made to DOC if grievances are not resolved to the enrollees' satisfaction. DOC reviews and approves plan contracts, disclosure forms, marketing materials and advertising to be sure that consumers receive fair and accurate information.

In addition to the Knox-Keene statutory and regulatory requirements for all health plans, MRMIB has developed a number of features for its programs to assure that enrollees are receiving needed health care. A number of these are discussed in Section 7. However, two features associated with the purchasing pool should be pointed out here:

- *Purchasing Pool Structure*. MRMIB will use a purchasing pool structure under which families can choose from among a number of health plans available in their area. Once a year, the program will have an open enrollment period in which families can change health plans for any reason, if they so choose.

  This "vote with your feet" feature means that enrollees dissatisfied with their health plan can easily change to another -- and likely will even be able to switch to one that also includes their own provider. Thus, health plans must work to satisfy their enrollees if they hope to attract and keep large numbers of enrollees.

- *Risk Assessment/Risk Adjustment*. MRMIB is one of the country's leaders in developing and operating a risk assessment/risk adjustment (RARA) mechanism. One of the purposes of RARA is to provide fiscal relief to plans that have attracted a disproportionate share of higher risk enrollees. This mitigates the incentives that a health plan may have to avoid (or provide inadequate treatment to) a higher risk person or population because they will be high cost. Stated alternatively, it seeks to assure that plans with a higher than average risk mix of enrollees have the resources needed to serve their population. MRMIB has successfully operated a RARA mechanism in the

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HIPC since 1995 and intends to implement such a mechanism in the Healthy Families pool.

Child Health and Disability Prevention Program

The CHDP program, an entity that provides for presumptive eligibility in the Healthy Families and Medi-Cal programs, will serve as an initial screening and treatment entity for Healthy Families and Medi-Cal eligible children, and will develop and distribute medical guidelines for health assessments which CHDP providers use as guidance for the CHDP examinations. Duplicate copies of the health assessment reports are submitted by the providers to the appropriate county CHDP program. The program uses the copies to assist with referrals as needed to assure treatment was provided and to assess the quality of the exams done by individual providers. The state CHDP program analyzes statewide data on the health assessments to determine if children are receiving appropriate preventive health services.

Specialized Services

California Children's Services Program. CCS is a medical case management program. Program staff determine the appropriate source of health care for eligible children, assist families in accessing care and identify other needs of the child and family that could impact the care of the eligible condition. The program prior authorizes payment of funds for medically necessary services to treat the child's eligible condition and for hospitalized children, does concurrent reviews. This authorization is based on the program's regulations, policies, procedures and guidelines. The program also approves pediatric intensive care units and refers only to specialists meeting standards established by the program.

Mental Health. The county mental health program has responsibility for case coordination and authorization of services to treat serious emotional disturbances. Utilization management requirements for this program will be consistent with those used for the Medicaid program for a similar population and described in the Title XIX plan.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

Health Plan Regulatory Oversight. These plans are regulated by the Department of Managed Health Care, previously the Department of Corporations, under the Knox-

Keene Act. The Knox-Keene Act, as previously stated, prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards.

Specialized Services.

California Children's Services Program. Children who are enrolled in the C-CHIP and diagnosed with an eligible CCS condition will be referred to the CCS Program for an eligibility determination based on CCS eligibility criteria: CCS eligible condition, residence within the county, and income within CCS financial guidelines. Children not eligible for CCS services shall receive their medically necessary services via the health plan delivery system like the California State Employees system that serves as the benchmark. C-CHIP eligible children do not have deemed financial eligibility for CCS services; AB495 requires that expansion services be provided without state expense.

Medi-Cal

The expanded Medi-Cal services provided under Title XXI will be provided in accordance with the routine utilization review procedure used in the Medi-Cal program consistent with the Title XIX state plan. The amendments to the Title XIX state plan that allow for these services can be found in Attachment 4.

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

AIM, like the Healthy Families purchasing pool, operates in a managed care environment. The utilization controls used in the program are like those discussed in the above section on the purchasing pool.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

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4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ **Geographic area served by the Plan:** The S-CHIP plan is available statewide. The C-CHIP is available in Santa Clara, Alameda, San Francisco and San Mateo counties.

4.1.2. ☒ **Age:** a) From confirmed pregnancy to birth.
b) From 0 through age 1 enrolled in the AIM Program if they are born to mothers enrolled in AIM before July 1, 2004
c) From 0 through age 19.

4.1.3. ☒ **Income:** a) For eligibles from confirmed pregnancy through birth, 0-300% FPL (using an income disregard).
b) For eligibles from 0 through age 1 (enrolled in the AIM Program if they are born to mothers disenrolled in AIM before July 1, 2004), 200-300% FPL (using an income disregard).
c) For eligibles from 0 through age 2 (if born to a mother enrolled in the AIM Program on or after July 1, 2004), 200-300% FPL (using an income disregard).
d) For eligibles from 0 through age 19, 100-250% FPL (using an income disregard)
e) Presumptive eligibility is only available to eligibles from 100-200% FPL who receive health a screen or immunization from a CHDP provider

4.1.4. ☐ **Resources (including any standards relating to spend downs and disposition of resources):** The insurance program has no resource requirements. Consistent with this approach, California will waive the resource Medicaid requirements for all children in the Federal Poverty Level program under Medi-Cal. The C-CHIP will also waive resource requirements consistent with other public programs.

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4.1.5. ☒ **Residency (so long as residency requirement is not based on length of time in state):** Children must be residents of California. They must also meet the citizenship and immigration status requirements applicable to Title XXI. Eligibles from confirmed pregnancy covered under the AIM Program must be residents of California. Eligibility for C-CHIP will require residency within the county that sponsors an expansion program and meet the citizenship and immigration status requirements applicable to Title XXI.

4.1.6. ☐ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):**

4.1.7. ☒ **Access to or coverage under other health coverage:** Children are ineligible for the Healthy Families and C-CHIP insurance programs if they have been covered under employer sponsored coverage within the prior 3 months (with certain exceptions described in Section 4.4.4) or if they are eligible for (no cost) Medi-Cal or Medicare coverage.

4.1.8. ☒ **Duration of eligibility:**

- Presumptive eligibility begins on the first of the month in which a CHDP pre-enrollment application is completed, and continues for the following month. In addition, on going presumptive eligibility will continue for those children whose families submit a Healthy Families/Medi-Cal application to the State's Single Point of Entry prior to the end of the second month of presumptive eligibility. For those families that submit the joint application prior to the end of the second month of presumptive eligibility, their children will continue to be presumptively eligible until a final eligibility determination is made. An annual eligibility determination for on going Healthy Families is made. Medi-Cal will establish one month bridging eligibility for children whose family income increases beyond Medi-Cal's eligibility threshold for no-cost Medi-Cal coverage, but does not exceed Healthy Families limits. Infants aged 0-1 in the AIM Program are determined eligible at the time their pregnant mother enrolls and will be redetermined prior to the child's first birthday for continued eligibility. C-CHIP eligibility is for

twelve months, at which time an annual eligibility determination will occur.

For individuals who declare on the joint application that they are United States (U.S.) Citizens/Nationals or Lawfully Residing children are granted two (2) months of presumptive eligibility at the time of application to provide documentation of status for continued enrollment in the HFP. If valid documentation is provided within two (2) months of enrollment into the HFP, the eligibility period continues for the full 12 months. If the documentation is invalid, these children will be disenrolled from the HFP at the end of two (2) months.

4.1.9. ☒ Other standards (identify and describe):

- Enrollment in the insurance program and AIM will be limited to the number of children that can be served within appropriated funds. Children may be subjected to placement on a wait list or disenrollment at the Annual Eligibility Review process, if the MRMIB Board determines that HFP is unable to operate within appropriated funding.

- To be eligible for the insurance program, families must enroll all of their children, and to remain enrolled in the insurance program, families must make their premium payments.

- Children are ineligible for the insurance program if they are eligible for any California Public Employees' Retirement System Health Benefits Program(s) (CalPERS), unless the employer contribution for dependent coverage is less than $10 per family per month. If a paystub indicating CalPERS membership is received, the HFP then determines or solicits additional information if needed to determine the employer's contribution towards dependent children's benefits to ensure that these children are truly eligible for the HFP. In addition, if an applying child is an inmate in a public correctional institution, or if they are a patient in an institution for mental

illness, they are also ineligible for the HFP. The HFP application includes a declaration that must be signed addressing all the above eligibility exceptions.

- At the time of application, children enrolled in C-CHIP cannot be eligible for no cost Medi-Cal or the Healthy Families Program.

- To be eligible for AIM, families must agree to pay 1.5% of the family's gross income.

- Eligibles receiving coverage in the Medi-Cal Program and claimed under Title XXI are those not currently (prior to submission of this SPA) eligible for federally funded non-emergency health care services from confirmed pregnancy through birth.

- Eligibles receiving overage in the AIM Program and uninsured will be claimed under Title XXI. Insurance status is collected on the AIM application and hence easily identifiable.

- As of January 1, 2010, individuals who declare on the joint application that they are United States Citizens/Nationals must comply with citizenship and identity requirements described in Section 6036 of the Deficit Reduction Act (DRA) and Section 211 of the Children's Health Insurance Reauthorization Act for CHIP eligibility. Funding for these children is from Title XXI.

- Lawfully Residing children enrolled in the Healthy Families Program (HFP) are required to provide valid documentation.

  While enrolled in the HFP, these lawfully residing children are eligible for funding under Title XXI, however will be subjected to re-verification of documentation at the Annual Eligibility Review (AER) process, to the extent necessary to ensure continued valid status.

4.1.10 __X___Check if the State is electing the option under section 214 of the

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible individuals lawfully residing in the United States:

(1) "Qualified aliens" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

(2) Citizens of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who have been admitted to the United States (U.S.) as non-immigrants and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;

(3) Individuals described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of status. These individuals include:

(a) Individuals currently in temporary resident status as Amnesty beneficiaries pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);

(b) Individuals currently under Temporary Protected Status pursuant to section 244 of the INA;

(c) Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended, as well as pursuant to section 1504 of Pub. L. 106-554;

(d) Individuals currently under Deferred Enforced Departure pursuant to a decision made by the President; and

(e) Individuals who are the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

(4) Individuals in non-immigrant classifications under the INA who are permitted to remain in the U.S. for an indefinite period, including the following who are specified in section 101(a)(15) of the INA:

- Parents or children of individuals with special immigrant status under section 101(a)(27) of the INA as permitted under section 101(a)(15)(N) of the INA;
- Fiancées of a citizen as permitted under section 101(a)(15)(K) of the INA;
- Religious workers under section 101(a)(15)(R);

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- Individuals assisting the Department of Justice in a criminal investigation as permitted under section 101(a)(15)(U) of the INA;
- Battered aliens; and
- Individuals with a petition pending for 3 years or more as permitted under section 101(a)(15)(V) of the INA.

Lawfully Residing children enrolled in the Healthy Families Program (HFP) are required to provide valid documentation. While enrolled in the HFP, these Lawfully Residing children are eligible for funding under Title XXI, however will be subjected to re-verification of documentation at the Annual Eligibility Review (AER) process, to the extent necessary to ensure continued valid status.

X _____The State elects the CHIPRA section 214 option for children up to age 19
_____ The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

4.1.10.1___X__ The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

Under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, eligible qualified Lawfully Residing children will be funded under Title XXI. If the documentation has expired, during their twelve (12) full months of HFP enrollment, they will be subjected to re-verification of documentation at the Annual Eligibility Review (AER) process, to ensure their status remains valid and they are still eligible for funding under Title XXI. If the documentation has expired, after being enrolled, and can not re-verify their status remains valid, they will be disenrolled on the last day of their anniversary month.

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4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

Presumptive Eligibility

Effective July 1, 2003, families of uninsured children seen during a CHDP health screening visit will complete a pre-enrollment application. Eligible children will be granted presumptive eligibility and will receive a Medi-Cal Benefits Identification Card (BIC) to access services in the Medi-Cal fee-for-service delivery system. Presumptive eligibility will be granted beginning the first of the month in which the pre-enrollment application was completed, and continue through the following month. In the pre-enrollment application, families will also be asked if they want to apply for continuing coverage in the Healthy Families or Medi-Cal programs. Families that indicate yes will be sent a joint Healthy Families/Medi-Cal mail in application. For presumptive eligibility to continue, the State's Single Point of Entry must receive the joint Healthy Families/Medi-Cal application prior to the end of the second month of presumptive eligibility. For those joint Healthy Families/Medi-Cal applications received prior to the end of the second month of presumptive eligibility, presumptive eligibility will continue until a final eligibility determination is made. All services provide under presumptive eligibility will be in the Medi-Cal fee-for-service delivery system but paid for by Title XIX or Title XXI as appropriate. California will only claim Title XXI funding for Healthy Families benefits already approved in California's state plan.

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For individuals who declare on the joint application that they are United States Citizens/Nationals or Lawfully Residing children are granted two (2) months of presumptive eligibility at the time of application to provide documentation of status for continued enrollment into the HFP. If their documentation is provided within two (2) months of enrollment into the HFP, the eligibility period continues for the full twelve (12) months. If the documentation is invalid, these children will be disenrolled from the HFP at the end of their two (2) months of presumptive eligibility enrollment. Funding for these children during this presumptive eligibility period is funded by Title XXI.

Prior to granting presumptive eligibility, California will screen applications against the Medi-Cal Eligibility Database System (MEDS) to assure that ineligible children are not granted presumptive eligibility. Children ineligible for presumptive eligibility are those already enrolled in Medi-Cal and Healthy Families, and children known to MEDS to have a confirmed ineligible immigration status.

Insurance Program

MRMIB will contract with a private company to conduct eligibility determinations, premium collection, payment of the application assistance fee and other enrollment functions. This is the same process that it uses for MRMIB's two existing programs.

Families will fill out a simple application and mail it with accompanying supporting documents to MRMIB's enroller. The application/enrollment brochure will be published in English, Spanish, Arabic, Armenian, Chinese, Farsi, Hmong, Khmer/Cambodian, Korean, Russian, Tagalog, Vietnamese and any other languages designated by the Department of Health Care Services. Families with questions about the form will be able to call the administrative vendor through a toll free number. Families will be able to speak to the administrative vendor's staff in English or Spanish, and may communicate via other languages through a telephone translation service. MRMIB is authorized to pay certain agencies and individuals such as insurance agents and parent-teacher organizations an application assistance fee for assisting a family with a successful application. The supporting documents that families send to the enroller will include documentation of income, ensuring that applying children are income eligible for the HFP. The HFP uses a s thorough process to verify income and citizenship/residency, including requiring copies of the past year's federal income tax forms, or current wage stubs and a U.S, birth certificate or other documentation demonstrating legal immigrant status. The HFP income

documents must be for either the most recent tax return or a pay period ending in the last 45 days.

The administrative vendor will review the application within a 10 day time frame and either return it to the applicant for additional information, enroll the child(ren) in a purchasing pool health plan. Coverage under the purchasing pool plan will begin 10 days after the application has been determined complete.

On behalf of a child not yet born, families may apply for Healthy Families Program coverage up to three months prior to the expected date of delivery. The infant's 12-month period of eligibility will begin within 13 days after MRMIB receives a notice of the birth. Families that apply for coverage of an infant up to three months prior to birth and experience a change in income prior or after the infant's birth may apply for no-cost Medi-Cal. California will not begin covering children under age 1 in Healthy Families until October 1, 1999, or 90 days after the enactment of the 1999-2000 state budget.

Eligibility will be continuous for 12 months and reestablished annually, unless a child is otherwise made ineligible.

Enrollment in a Health Plan. Families will select their children's health plans when applying for the program. When families are seeking coverage through the purchasing pool, they will choose from among the plans participating in their geographic area. The number of plans from which families can choose will vary depending on the geographic area, as there are fewer managed care plans available in rural areas. In the state's population centers, MRMIB expects families to be able to choose from between 10-15 health plans, dropping down to one or two plans in the most rural parts of the state.

Descriptions of each health plan will be included in the program's handbook. In the description each plan will list its toll free numbers and describe how families can get copies of its provider directories and evidence of coverage documents. The application and enrollment materials will be available in English, Spanish, and any other threshold language designated by the Department of Health Care Services.

MRMIB will provide participating families with an annual open enrollment period during which time they may choose to switch plans.

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COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

In Santa Clara, Alameda, San Francisco and San Mateo County, the Local Initiative (LI) or County Organized Health System (COHS) will administer the local insurance expansion programs. Since the LI or COHS health plan is the only health plan available in each C-CHIP project, there are no issues related to steerage. The LI and COHS staff will be responsible for eligibility determinations even though state trained application assistants will be used to identify eligible children, assist in completing applications and screening children for the appropriate program: no cost Medi-Cal, Healthy Families or the C-CHIP. The LI and COHS will also be responsible for premium collection, program enrollment and distribution of health plan materials.

Applications received by C-CHIP that include children potentially eligible for no cost Medi-Cal or the Healthy Families Programs will be forwarded to California's Single Point of Entry for processing. Because of obvious incentives, we believe a quality screening will occur since the Medi-Cal and Healthy Families Programs are state and federally funded while the C-CHIP will be county and federally funded. Counties will want to stretch local dollars and still meet objective of reducing the number of uninsured children within the county.

In establishing local expansion programs, the C-CHIPs have adopted the same Healthy Families eligibility rules, including documentation requirements. To assure compliance with the federal screen and enroll requirement, the C-CHIP will use Health-e-App, California's web based application. In using Health-e-App, certified application assistants working with the local C-CHIPs will enter the same data as required on the joint Medi-Cal/Healthy Families mail in application. Once this is completed, Health-e-App has a calculate feature that includes a Medi-Cal, Healthy Families, or C-CHIP eligibility screening. The eligibility rules used in Health-e-App are the same as those used in California's Single Point of Entry (SPE). When children are preliminary screened to Medi-Cal or Healthy Families, the certified application assistant merely presses the submit key and the application is electronically submitted to the SPE. Health-e-App also generates a fax cover sheet for the applicant to use when faxing their income documentation. When children are preliminary screened to the local C-CHIP, the family can elect to submit the application for the State to do a final eligibility determination or print the application as evidence that an acceptable screen and enroll assessment was made so that the children can be enrolled in the local C-CHIP. The C-CHIPs have established their own applications, although most

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resemble the one used by the Healthy Families Program. Applications are processed and an eligibility determination made within thirty (30) days.

Medi-Cal

Eligibility will be established and enrollment continued in a manner that is consistent with the state's Title XIX plan.

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

Families fill out a four-page application and mail it, with accompanying supporting documents, to MRMIB's administrative vendor. Applications are available in English and Spanish. The supporting documents families send include documentation of income which the administrative vendor verifies using copies of the past year's federal income tax forms, or current year wage stubs.

MAXIMUS reviews the application within a 10 day time frame and either requests additional information from the applicant or enrolls the pregnant woman in the purchasing pool health plan selected by the woman. Coverage under the purchasing pool plan begins 10 days after the application has been determined complete.

Eligibility is determined once -- at time of application to the program-- and continues for 60 days post partum, for the mother and up to the child's second birthday for children born to mothers enrolled in the AIM Program prior to July 1, 2004. For children born to mothers enrolled on or after July 1, 2004 eligibility is determined at the time of the mother's application to the AIM Program and again before the child's first birthday and annually thereafter. Upon notification of birth, the infant will be enrolled in the Healthy Families Program. Prior to the child's first birthday, the Healthy Families Program will conduct an annual redetermination for the child's second year of coverage. Prior to the child's second birthday, the Healthy Families Program will redetermine eligibility for the S-CHIP Healthy Families Program. The state seeks FFP for the health care costs of the child up to age two for children with family incomes between 200% and 300% of poverty.

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☐ **Check here if this section does not apply to your state.**

If the MRMIB determines that sufficient funds are not available to cover the estimated cost of program expenditures and it is necessary to limit enrollment, MRMIB will place children on a waiting list until adequate funding becomes available to resume enrollment. This determination will be made in a public meeting, pursuant to State law. The MRMIB will notify the Center for Medicare and Medicaid Services prior to implementation of a waiting list in writing (by email, fax, letter or other appropriate means).

The public will be notified of a potential waiting list through the MRMIB's Board meetings. MRMIB will hold a Board meeting to facilitate public discussion of the insufficient funds for the estimated program expenditures. The Board will also notify the public of insufficient funds and institute a waiting list. MRMIB Board meeting dates and agenda items are posted on the MRMIB website and made available to the public ten (10) days in advance, to comply with California public meeting law requirements. In addition, the MRMIB website is updated to reflect any program changes and newsletter articles are updated for our community partners. Each new applicant family affected by the waiting list will receive notification in writing.

a. **When a waiting list is implemented**, the program will continue to receive new applications; however, no eligibility determinations will be made until adequate funding is available. Placement on the waiting list is only for new applications to the HFP. New applications will be screened at the Single Point of Entry (SPE) for Medi-Cal, California's Title XIX Medicaid program and the State's SPE will forward these applications to the applicant's local county welfare department for a Medi-Cal eligibility determination. Siblings and newborns of current enrollees and children formerly eligible for No-Cost Medi-Cal who apply for the HFP are considered new applicants and are subject to the waiting list. Each new applicant family whose child is placed on the waiting list will be notified by letter. In addition, the notification letter will contain information about where the family may apply for other potential coverage (e.g., Medi-Cal).

b. **If the State is using a waiting list**, children will be placed on the waiting list in the order in which their applications were received based on the date the application was received. If MRMIB determines that sufficient funds are available to cover some or all children on the waiting list, the Healthy Families Program will review the applications for children on the waiting list in the order their application was received.

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c. **When children are removed from the waiting list**, each family will receive a notification letter, informing them that sufficient funding is now available for the enrollment of their child and requesting that the family complete a pre-printed application, updating any changes and information to determine eligibility for enrollment into the Healthy Families Program. When the pre-printed application and other updated documentation is received, the State's Single Point of Entry will screen the application based upon income eligibility to either the Healthy Families Program or the state's Medi-Cal program. If the family does not reply within seventeen (17) calendar days, as noted on the pre-printed application, the application will be denied for being incomplete. If the family submits the information after the requested due date the child may be placed back onto the waiting list, in the order in which the new application is received.

If the MRMIB further determines that establishing a waiting list is insufficient to ensure operation within allotted expenditures, the MRMIB will make this determination at a public meeting and will announce that it is necessary to disenroll subscribers from the Healthy Families Program at the end of the month of their anniversary date, following their Annual Eligibility Review (AER). MRMIB Board meeting dates and agenda items are posted on the MRMIB website and made available to the public ten (10) days in advance, to comply with California public meeting law requirements. In addition, the MRMIB website is updated to reflect any program changes and newsletter articles are updated for our community partners. Each family affected by AER disenrollments will receive notification in writing thirty (30) days prior to disenrollment. These subscribers will also be placed on the waiting list until sufficient funding is available to cover program expenditures. The subscriber child's effective date on the waiting list will be the date of his or her disenrollment from the HFP. However, children with chronic conditions through California Children's Services (CCS) who are CCS eligible solely by virtue of their HFP eligibility are exempt from AER disenrollment and will continue their enrollment in the HFP.

If MRMIB later determines sufficient funds are available to cover some or all eligible subscriber children, the Healthy Families Program will stop disenrolling children during the AER process and begin enrolling subscriber children back into the program in the following manner: The Healthy Families Program will first reassess eligibility of the applications of children who were disenrolled at their AER, in the order of their effective dates on the waiting list, starting with those who have the earliest effective date. When all children who were disenrolled at their AER have been removed from the waiting list, eligibility will then be assessed for the additional waitlisted children, in the order of their effective dates on the waiting list.

If only a waiting list is implemented, children who have current enrollment in the Healthy

Families Program will remain enrolled, so long as they continue to meet all eligibility criteria and remain current with premium payments.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

In the Medi-Cal program, California will implement a resource disregard for children in the Federal Poverty Level program. In the insurance programs, MRMIB will use ~~income~~ resource disregards similar to Medi-Cal's to ascertain whether a child should be a Medi-Cal or Healthy Families enrollee. Once it is clear that a child is not Medi-Cal eligible, his or her gross family income, will be reviewed to determine whether the child is Healthy Families eligible. Thus, the new insurance program and Medi-Cal will be substantially similar in terms of eligibility determination criteria.

DHS and MRMIB are developing a joint application for children's Medi-Cal and Healthy Families, and will add two questions on resources to the Medi-Cal only form of the joint application to assess whether children are eligible for the program because the State no longer performs an asset test. These questions do not provide sufficient information for identifying those children. We would suggest establishing a threshold amount above the Title XIX income eligibility, in which families within the threshold amount would then be asked qualifying questions beyond the two that were proposed, so as to further detail their resources. We believe this approach would provide you with the necessary information to properly account for the newly eligible children.

Resource Disregard. California will follow federal law that precludes certain income from being counted in determining eligibility for federally means tested programs and will not count this income. In determining Healthy

Families eligibility, California will not count income from the following sources:

- Disaster Relief Payments (federal disaster and emergency assistance and comparable assistance provided by State and local governments and disaster assistance organizations;
- Per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands;
- Agent Orange Payments;
- Title IV Student Assistance;
- Energy Assistance Payments to Low Income Families;
- Relocation Assistance Payments;
- Victims of Crime Assistance Payments;
- Spina Bifida Payments; and
- Any other federal income deduction required for a federal means tested program.

Some federal income deductions, such as Earned Income Tax Credit and Japanese Reparation Payments, apply only to certain federal programs and not all federally means tested programs, including Title XXI. In cases where the income deduction does not apply to Title XXI, this income will be counted.

Further, the Healthy Families program will share eligibility files with Medi-Cal on an ongoing basis to check for children enrolled in both programs.

Employer Sponsored Insurance Coverage. The application will ask parents about their access to employer sponsored insurance coverage. Children who have been covered under such coverage in the prior 3 months will be determined ineligible.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

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All county expansion programs included in this state plan amendment proposes to follow the same screening procedures at the initial and annual eligibility review as those followed in the Healthy Families Program. Rules on income disregards, resource disregards and the three month separation period from employer sponsored insurance coverage all apply to C-CHIP enrollees. Initial applications and annual review applications that include a child who is applying for C-CHIP coverage but who may be eligible for no cost Medi-Cal or the Healthy Families Program will be forwarded to the State's Single Point of Entry for processing.

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

The program serves women whose family income is too high for Medi-Cal and who do not have employer sponsored coverage. The AIM administrative vendor verifies the income eligibility of families by reviewing income information submitted by families, either the previous year's federal income tax forms or current year wage stubs. Families eligible for no-cost Medi-Cal are denied AIM enrollment. If a family indicates, on the AIM application that it has coverage through an employer, that application is not approved, unless the employer provides a separate maternity only deductible or copayment greater than $500. California will not claim Federal Financial Participation for these women.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

California is currently assessing whether it is possible to develop an application form which can be used both for Healthy Families and Medi-Cal for pregnant women and children. Until that form is developed (and its development determined to be feasible), such families will be notified of their potential eligibility for Medi-Cal and how to apply when their Healthy Families application is returned to them.

The state's outreach and community based organization activities will be coordinated between Medi-Cal and the insurance program. These efforts will aim to assist families in applying for the program under which they qualify,

with a goal of directing families to the correct program at the point of first contact, in recognition that CBOs are often the health system's first contact with uninsured families with income under 200% FPL.

The state also intends to rely heavily on the state's CHDP program as an access point into coverage. CHDP providers will screen the children for eligibility into Medi-Cal or Healthy Families and assist families in filing applications for the appropriate program.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

Even though each of the C-CHIP's has created their own application, they were all modeled after the joint Medi-Cal/Healthy Families application hence the C-CHIP applications contain the same questions and have the same look and feel. As a result, the State's Single Point of Entry processing center will have the necessary information to make an eligibility determination. Once a child is determined Healthy Families eligible, the applicant will be contacted for a health plan selection.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Establishment of California's Single Point of Entry (SPE)

The SPE, run by the Healthy Families administrative vendor, was established to 1) create a centralized location for the joint mail-in Healthy Families/Medi-Cal for Children applications to be received; and, 2) screen eligible children to Healthy Families or Medi-Cal as appropriate. The benefits that have resulted from the State's SPE are assuring compliance with the federal screen and enroll requirement, applying consistent eligibility criteria when conducting the Medi-Cal eligibility screen; streamlined application and enrollment process for families, and a central point of contact for county eligibility workers.

Application Process:

Applicants mail the joint mail-in application directly to the SPE. The SPE first screens all applications for no-cost Medi-Cal eligibility, and then routes

the applications to either the County Welfare Department (CWD) or HFP as appropriate.

When applications are sent to Medi-Cal from the SPE and the children are determined to be ineligible for no-cost Medi-Cal due to income considerations or updated information, the CWD returns the application to the SPE with a transmittal form to indicate why the person is ineligible for no-cost Medi-Cal. The SPE has on-site liaison staff that is proficient in Medi-Cal eligibility criteria and can evaluate whether the information received or forwarded from the county is sufficient to forward directly to HFP. The SPE liaison staff work directly with county staff on those applications in which the information forwarded to the SPE is not sufficient to support a definitive eligibility determination. This quality improvement effort has increased the standardization of eligibility determinations and reduced the unnecessary flow of applications between programs.

The State has further streamlined the enrollment process by providing alternatives to the standard joint mail-in application. A Medi-Cal application (MC 210) or the Medi-Cal Annual Redetermination form with a Notice of Action (NOA) and supporting documentation, is acceptable for use as an application for the HFP. Consistent with this policy, DHS has issued a letter, which instructs counties to forward the applications of no-cost Medi-Cal ineligible persons to the HFP. Applications that are initiated at or mailed to the county directly and determined to have children ineligible for no-cost Medi-Cal because income exceeding the Medi-Cal limits are forwarded to the SPE for a HF determination. These applications are forwarded with a transmittal form, NOA, and supporting documentation as available.

Medi-Cal Redetermination Process:

At the time of a Medi-Cal redetermination, if a child is determined to no longer be eligible for no-cost Medi-Cal because of income, the CWD forwards a transmittal, notice of action, and the supporting documentation to the HFP for a determination. Moreover, the SPE, MEDS, and the HFP administrative vendor's internal data systems interface. If a Medi-Cal or HFP enrollee has an income change before his/her redetermination and requests a redetermination to establish eligibility for the other program, each program has the ability to

forward (or receive) information and supporting documentation. This information and process can be used to establish eligibility and maintain seamless health coverage.

Since the HFP's inception, the State has provided a "one-month bridge" which is a transition period for those children living in families with incomes that no longer qualify them for no-cost Medi-Cal. The one-month bridge continues the child's coverage for an additional month while the HPF makes an eligibility determination and the child is enrolled. Each person enrolled in a Medi-Cal health plan will continue his or her enrollment in the same health plan during the one-month bridge.

C-CHIP Application Process:

The C-CHIP projects will not be using the state's Single Point of Entry for application submissions and screening. The applications used by the C-CHIP counties have been modeled after the Healthy Families Program so that each county has all required information to do an appropriate eligibility determination. Application assistance is provided by local State Certified Application Assistants who submit applications to the state's Single Point of Entry for children assessed eligible for Medicaid and Healthy Families and submit applications to the local health plans for C-CHIP enrollments. In addition, the state has modified Health-e-App, the web based Medi-Cal and Healthy Families application to include eligibility screening for C-CHIP as well.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

California will include provisions to minimize the potential for employers or individual employees do not drop their current dependent coverage to take advantage of subsidized coverage. Such "crowd out" seems to be a potential consequence of making available subsidized coverage for children. However, given that several researchers have found that crowd out is not a serious concern when subsidized programs are limited to children, the state is not sure how big a danger crowd out might actually be.[4]

4 See Chollet, Deborah J., Birnbaum, Michael and Sherman, Michael J. of the Alpha Center, "Deterring Crowd-Out in

Nonetheless, we believe that the measures we have adopted in our authorizing statute are among the best approaches to prevent crowd out. Features to avoid crowd out include:

- Establishes a coverage "firewall" -- a prohibition against covering children who have had employer sponsored coverage within 3 months prior to applying for Healthy Families. MRMIB is authorized to increase the length of the period to 6 months if it finds that Healthy Families is covering substantial numbers of children who were previously covered under employer-sponsored plans.

- The state has established exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of the Program. These include, but are not limited to:

  - Loss of employment due to factors other than voluntary termination.
  - Change to a new employer that does not provide an option for dependent coverage.
  - Change of address so that no employer sponsored coverage is available.
  - Discontinuation of health benefits to all employees of the applicant's employer.
  - Expiration of COBRA coverage period.
  - Coverage provided pursuant to an exemption authorized under subdivision (I) of Section 1367 of the Health and Safety Code.

- Establishes copayments for non-preventive services.

- Prohibits insurance agents and insurers from referring dependents to the program where dependents are already covered through employer sponsored coverage. Violation of the provisions would constitute unfair competition under the Business and Professions Code.

Public Insurance Programs: State Policies and Experience" (October 1997); Children's Defense Fund, "Fears That Employers Coverage Will Fall If Uninsured Children Are Helped Are Exaggerated" (November 1997); and Center for Health System Change *Issue Brief No. 3*, "Medicaid Eligibility Policy and the Crowding-Out Effect" (October 1996).

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- Makes it an unfair labor practice for an employer to refer employees to the program for dependent coverage where the employer provides for such coverage.

- Makes it an unfair labor practice for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the Program.

- Directs MRMIB to develop participation standards that minimize "crowd out".

- Directs MRMIB to monitor applications to determine whether employers or employees dropped coverage to participate in the program.

MRMIB will monitor applications to determine whether employers or employees have dropped coverage to participate in the program. Specific monitoring strategies that the Board will consider include the use of a third party evaluator, and subscriber or employer surveys to measure the extent to which crowd-out has occurred.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

The C-CHIP projects will adopt the same provisions as the Healthy Families Program to minimize the potential for employers or individual employees to drop their current dependent coverage to take advantage of subsidized coverage.

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☒ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

This is not an issue for infants born to mothers enrolled in the AIM Program as those infants would not have previously had employer sponsored coverage.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

One of the Healthy Families eligibility rules used in the C-CHIP projects is that a child cannot have had employer sponsored insurance within the past 90 days. This question is asked on the application. In addition because there is only one health plan available within each of the four counties, the health plan will check its enrollment database to see if the child has prior employer sponsored coverage within the past 90 days prior to enrolling in C-CHIP.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5. Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

The provision of child health assistance to low income children who are American Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C.1603(c) (Section 2102)(b)(3)(D) or who are Alaska Natives (as defined in the Alaska Native Claims Settlement Act, 43 U.S.C. 1601), will be assured through the following procedures:

- Technical assistance by the state American Indian Health Program, Federal Indian Health Services, and tribes in tracking of services to American Indians.

- Inclusion of American Indian ethnicity using the federal definition on the application form for tracking purposes.

- Targeted statewide outreach media campaign and outreach activities through contracts with selected community based organizations providing services to American Indian children to assure that American Indian families are aware of the program throughout the state and to assist children in enrolling in the Healthy Families Program.

- Provision of training to local American Indian clinic staff for outreach and referral to the Healthy Families program.

- Use of the 30 American Indian primary care clinics (which are CHDP providers) to screen low income youth, provide initial treatment and referral either to Medi- Cal or Healthy Families.

- Provision to exempt American Indian and Alaska Native families, that meet the cost sharing waiver requirements, from monthly premiums and benefit copayments. This exemption will be made only when an AI/AN provides acceptable documentation showing proof of his/her AI/AN status. Acceptable documentation for the applicant or the child includes:

    1. An American Indian or Alaska Native enrollment document from a federally recognized tribe; or
    2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; or
    3. A Certificate of Indian Heritage from an Indian Health Service facility operating in the State of California.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

California has made significant efforts to educate entities, clinics, state Certified Application Assistants, and the general population regarding the

Healthy Families Program including targeted outreach to the AI/AN population in the past years. These efforts have been statewide and as such are also made on behalf of the C-CHIP counties.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

The state recognizes the importance of outreach to families of children likely to be eligible for assistance under the Healthy Families Program to inform families of the availability of coverage and to motivate them to enroll. California will undertake a multifaceted approach to outreach to meet these goals. California will secure a $20 million annual outreach contract with a private entity, which will conduct a media campaign and subcontract with community based organizations and other entities to directly identify and assist potential enrollees to Medi-Cal and the new Healthy Families insurance program. The state will also use a pre-enrollment process and application assistance fee to outreach to beneficiaries, as well as reduce barriers such as complicated enrollment forms which may impede beneficiaries from participating. In addition, California will engage in a provider education effort in support of its outreach campaign, as providers are a vital link to the subscriber community. California believes this multi-pronged outreach strategy will motivate the families of targeted low income children to enroll them into the subsidized health insurance programs that California has available to them.

The Department of Health Services (DHS) is recognized nationally as a leader in social marketing and public awareness campaigns and will be responsible for outreach for both the Medi-Cal and Healthy Families' insurance programs. Pursuant to Section 14067 of the Welfare and Institutions Code, DHS will develop and conduct a community outreach and education campaign to help families learn about and apply for Medi-Cal and the newly authorized health insurance program. The outreach campaign will target families of children who are currently eligible for Medi-Cal but not enrolled in the program, as well as targeted low income children who will be newly eligible for the Healthy Families Program. DHS will administer the outreach contract because of its extensive experience conducting similar outreach efforts, including the BabyCal campaign which focuses on prenatal care for both, the

Medi-Cal and AIM programs, the statewide anti-tobacco campaign, and the Partnership for Responsible Parenting which aims to reduce teen and unwed pregnancy.

The outreach efforts for the Healthy Families and Medi-Cal programs will be modeled after similar Departmental campaign efforts such as BabyCal. Under BabyCal, DHS conducts education and outreach programs to low- income pregnant women who may be eligible either for Medi-Cal or AIM. DHS targets its message to low-income uninsured women who are then referred to the appropriate program. DHS will also rely on its experience conducting beneficiary education and outreach for its Medi-Cal managed care efforts, including the importance of using materials and messages that are appropriate to the target populations' comprehension levels, languages, and cultures.

DHS and MRMIB are committed to meeting the requirements of Title VI of the Civil Rights Act of 1964 by ensuring that non-English speaking persons are included in outreach, media and enrollment activities. Below we describe how DHS will address outreach to non-English speaking populations and how MRMIB will address access to enrollment materials for these populations.

DHS Outreach & Media Contractor

DHS will contract with a private marketing firm to administer the statewide outreach campaign. Outreach efforts will consist of two main strategies to enroll uninsured children into the Title XXI funded programs as quickly as possible. The first is a traditional multi-media approach. DHS will implement a variety of targeted outreach strategies, such as English and Spanish advertising on TV, radio, outdoor billboards, transit ads, posters, pamphlets, fliers, and other promotional items. Additionally, collateral materials in ten threshold languages will be printed and distributed, and the state may incorporate additional threshold languages into the media campaign as the program matures. California will also use print media to educate providers who are a key link to the target population.

The outreach message will be simple. The target population will be informed about the importance of preventive care, the value of insuring children before they become ill and that health care programs for the uninsured are available. Potential beneficiaries will be advised to call a toll-free phone number for more information. DHS has used a similar approach though its administration of the BabyCal campaign, a $6 million annual effort which educates pregnant women of the importance of prenatal care. The DHS' toll free line directs low and modest income pregnant women to Medi-Cal or to the Access for Infants and Mothers (AIM) Program to assist them in obtaining coverage for their pregnancies. The multi-media approach

is intended to effectively and quickly notify the broad public about Healthy Families and Medi-Cal's availability to cover children.

The second facet of the outreach strategy is a community outreach effort to complement the statewide media campaign. The community outreach effort will entail distribution of print material and promotional items developed under the media component as well as work at the individual level to explain to families what must be done to obtain health insurance and all steps needed to see a health care provider. The DHS outreach contractor will coordinate a number of community-based initiatives to educate potentially eligible applicants about the program and to assist potential applicants in the application process, and will partner with entities working directly with target populations. The existing infrastructure of public health programs already serves a high proportion of families with targeted low income children, as do other entities such as community-based organizations and schools. Thus, in overseeing the campaign, DHS will coordinate with, seek input from, offer comprehensive training to, and partner with entities and programs including (but not limited to): MRMIB and its contracting health plans; the California Department of Education; county health departments; Women, Infants, and Children (WIC) program agencies; Child Health and Disability Prevention (CHDP) providers; primary care clinics; school-linked health services, such as Head Start and Healthy Start programs; and community based organizations that deal with potentially eligible families and children.

Community based organizations, public health programs, and other entities will play a key role in the state's outreach and education efforts given their community orientation and focus, as well as their ability to provide culturally and linguistically appropriated services to California's diverse target population. Furthermore, these programs and organizations are a vital link to families of targeted low income children who may not be otherwise reached through the statewide media campaign, such as farm worker families and immigrant communities, among others. By allocating a significant portion of its outreach resources to this local effort, California will better ensure that it educates potential beneficiaries from diverse cultural and ethnic populations in the state, and will target families that -- through a media campaign alone -- may not be motivated to enroll in the Healthy Families insurance program or in Medi-Cal.

In implementing the Outreach and Media contracts for both Medi-Cal and Healthy Families, DHS, through its outreach and media contractor, RS&E, will:

- Translate the joint Medi-Cal/Healthy Families application pamphlet into ten threshold languages: English, Spanish, Cantonese, Russian, Farsi, Cambodian,

Laotian, Hmong, Vietnamese, and Armenian. Counties with high populations in other languages will do further form translations as they currently do for the existing Medi-Cal form;

- Maintain a toll-free outreach number with operators who speak English and Spanish and who have access to the AT&T translation services for all other languages;
- Place outdoor advertising in the threshold languages wherever at least 1,000 Medi-Cal recipients in a given zip code speak one of the languages.
- Develop outreach print materials in the ten threshold languages, including material to be published in newspapers and periodicals published in the ten threshold languages;
- Conduct radio and TV spots in English and Spanish; and
- Recruit a diverse cultural, linguistic and geographic mix of CBO's to assist applicants, focusing particularly on those with an existing relationship with subpopulations of the target group. The CBO's will help ensure that the target populations can access program information and assistance.

Healthy Families Administrative Vendor

MRMIB is aware that its program needs to serve the linguistic and cultural needs of California's diverse population. In fact, MRMIB anticipates that as many as 60 percent of children who will be served by Healthy Families will be Latino. The Model Contract for the administrative vendor requires the vendor to:

- Describe how the organization will approach communicating effectively with a linguistically diverse population;
- Print Health Families specific information included in the application packet (the joint application and Healthy Families brochure) in the 10 threshold languages;
- Translate all Healthy Families Program materials into ten Medi-Cal threshold languages in year one. MRMIB will reevaluate this strategy during the program's second year to assess if Medi-Cal's threshold languages are appropriate for Healthy Families;
- Maximize the availability of non-English written materials, per the requirements of Section 7290 of the Government Code. This statute requires that a state agency make non-English languages available to the extent that 5 percent or more the population being served speaks a particular language. The Board's review of the primary languages spoken by the 113,117 statewide

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share-of-cost Medi-Cal enrollees between the ages of 1-18 during the sample month of January, 1998, shows the following: English, 52,062; Spanish, 55,585, Vietnamese, 1,567; Cantonese, 1,225; Tagalog, 423; Korean and Russian, 217 each; Hmong and Laotian, 128. Based on this review, the Board's administrator would publish materials in English and Spanish. The Board has decided to exceed the requirements of Government Code Section 7290, at least for the first year;

- Assure that all translated materials are an accurate and culturally sensitive translation of the English version. The vendor must have two independent readers verify the accuracy of each translation. The contract specifies that the vendor must have application package and other materials available in all threshold languages by June 1, 1998 or be subject to liquidated damages;
- Have trained English and Spanish speaking staff on site between 8 AM and 8 PM weekdays and have the capability to provide telephone services via a translation service for all other languages in the threshold languages identified above; and
- Establish a Network Information Service for subscribers which, among other data, will list languages spoken at each provider's office.

Overall, in its oversight of the outreach contract, DHS is committed to the following:

- Focus group testing to ensure quality and understanding of communication materials with target population.

- Ongoing and frequent involvement of stakeholders. Such stakeholders include, but are not limited to: community based organizations (CBO's), members of the target population, providers, public health programs, advocacy groups, and the Department of Social Services, which is leading the State's welfare reform efforts.

- Development of linguistically appropriate informing materials in up to ten threshold languages as appropriate.

The collaborative strategy to initiate a large state-wide media campaign with significant emphasis on local community-based involvement will effectively spread the message that:

- preventive services like those provided through comprehensive, child focused health insurance is important to keep children healthy; and

- California has programs, like Medi-Cal and Healthy Families, which can help families become a part of a medical home.

Beyond administering the outreach contract, DHS will ensure that staff at the state and county level will be well trained to respond to inquiries from and provide progress reports to CBO's, advocacy groups, the legislature, and other interested parties, to enroll eligible children, and to ensure that providers are involved early on in the process. In addition, outreach efforts will be coordinated with existing state efforts to outstation eligibility workers at federally qualified health centers (FQHC's) and disproportionate share hospital (DSH) facilities.

The outreach effort will also be targeted to business coalitions, such as the Chamber of Commerce, to ensure that employees are aware of the new programs for uninsured children. Messages to employers will emphasize that the programs are for children presently uninsured and will detail the various statutory sanctions (described in Section 4.4.4) to deter employers from dropping dependent coverage.

While DHS will undertake the efforts outlined above, MRMIB will conduct a number of corresponding efforts to outreach to uninsured families whose children may be eligible for the insurance program. MRMIB will begin by starting a pre-enrollment process. From now until the program begins, MRMIB will be keeping a list of all potential beneficiaries who contact them expressing interest about the program. When all enrollment materials become available, MRMIB will mail enrollment materials to all applicants on their mailing list.

To complement the media campaign, the State will fund an extensive grass roots outreach effort using pay for performance reimbursement of local individuals and entities. The grass roots effort is based on a "people helping people" model in which a broad range of individuals and entities are trained to assist families with the joint Medi-Cal/Healthy Families application.

Funding for application assistance fees paid to CBO's will come from DHS. Funding of fees paid to health care providers and insurance agents will come from MRMIB. All funds will be administered through Runyon, Saltzman & Einhorn (RS&E). Through RS&E, training sessions and continuing education courses will be offered to representatives of local entities. These community organizations include local health departments, licensed day care operators, schools, faith based organizations, community clinics, and insurance agents. The training will provide participants with skills in assisting families to complete the joint application.

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Upon successful completion of the training, the representatives of the organizations will be authorized to conduct training sessions with other persons in their organization. The organization's trainer will have to certify which employees have completed the training and attest to understanding program rules and regulations. Agent/brokers can be trained via a course for which continued education units (CEU's) are available. RS&E will develop the curriculum for the training as well as conducting the training sessions.

Once a person is certified as trained, he or she is eligible to assist applicants (for both Medi-Cal and Healthy Families) and bill for the assistance fee. The fee will only be paid after verification of enrollment. The fee will be paid no more often than once for any child/family in any given twelve month period and will also be available for case assistance provided during the annual requalification.

When a CBO, provider, or agent's bills for the $25, the person providing the assistance will sign a certification that they did not assist the family in health plan selection nor violate any of the State's other requirements. In the Medi-Cal program, conflict of interest is not problematic because choice of health plan is an entirely separate process that occurs after eligibility has been determined by the county. The joint application form being developed for Medi-Cal and Healthy Families contains an item for designation of health plan for the Healthy Families Program portion of the application exclusively. Further, since the state will be requiring the assisters to certify that they understand program rules and regulations, the state will be able to prosecute any assister that does make plan recommendations.

DHS will establish an outreach working group to advise RS&E, the Department, and MRMIB on the efficacy of its outreach and education strategy. Healthy Families will monitor program experience to ensure compliance with program rules, particularly those related to conflict of interest, by having the administrator ask the applicant at the time of the welcome call (10 days after enrollment) whether anyone attempted to refer the applicant to a given health plan. In addition, DHS and MRMIB will assess the experience of this approach over time to determine if it is meeting its goals of facilitating the enrollment of eligible families into Healthy Families and Medi-Cal. Finally, we would note that a Medi-Cal specific outreach and education effort, focused on children who are uninsured but Medi-Cal eligible, will be conducted. This campaign will operate under the same principles and strategies as the Healthy Families Program campaign.

In addition to pre-enrollment, MRMIB may also provide a $50 one-time application assistance fee for entities and individuals that assist beneficiaries applying for the Healthy Families Program. MRMIB successfully uses an application assistance fee in two of its

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existing programs, MRMIP and AIM. The purpose of the fee is to provide an outcome based financial incentive to organization/person who come into regular contact with the target population. Use of the application assistance fee is particularly important as it is the way by which MRMIB creates an incentive to encourage participation from a large number of community organizations who have contact with uninsured children.

MRMIB will pay the application assistance fee only for those beneficiaries who are successfully enrolled into the insurance program. Such entities, which are certified by MRMIB, are broadly defined as groups which have potential outreach capabilities to educate and enroll targeted applicants into the Healthy Families Program. They include, but are not limited to, Parent Teacher Associations, insurance agents and brokers, WIC clinics, community clinics, and county welfare departments. MRMIB certifies entities and individuals who are able to collect the application assistance fee, to ensure proper oversight of the efforts and avoid potential marketing abuses associated with the fee. Providing a $50 assistance fee will give entities an incentive to inform, educate, and help enroll all potential beneficiaries.

In creating the Healthy Families state plan, the state is making an extensive effort to reach out to and receive input from the public. Comments and suggestions made by various public agencies have helped California to develop and shape its outreach strategies. The Health and Welfare Agency hosted two forums in October to receive input from the public on implementation of the Healthy Families Program. In addition to the open forums, DHS conducted a series of meetings with stakeholder groups to obtain input on Healthy Families outreach efforts. The groups included community-based organizations, counties, program agencies, advocates, health plans, and providers. These meetings have helped create an open dialogue between interested parties on this important issue of mutual concern.

In a similar vein, MRMIB holds bi-monthly public meetings to solicit public input in its decision-making process for Healthy Families, and will use a 14 member Advisory Board to receive further constructive feedback. MRMIB mails out drafts of regulations and model contracts to its extensive mailing list and solicits public testimony on the drafts prior to finalizing them. Throughout the implementation process, DHS and MRMIB will continue communication with interested groups to solicit feedback pertaining to California's outreach efforts.

One consistent theme that has emerged from public discussions thus far is the importance of reducing barriers to enrollment as a means of conducting outreach. In the past, long and complex forms may have intimidated and deterred potential applicants from enrolling in state health insurance programs. To ensure the greatest amount of applicants will enroll in either

the state's Medi-Cal or new insurance programs, all application materials will be simplified to make the process as easy and "applicant friendly" as possible. Recognizing that documenting assets for the purposes of determining eligibility for Medi-Cal is time consuming and burdensome for many applicants, and thus may act as a barrier to enrollment, California will disregard resources for children in the Medi-Cal federal poverty level programs. This allows DHS to significantly simplify the Medi-Cal application for children. Like the AIM program, MRMIB will also use a simple mail-in application for the new insurance program. Furthermore, DHS and MRMIB are in the process of determining whether a joint application between Medi-Cal and the new Healthy Families insurance program will simplify the application and enrollment procedure.

Another matter of importance is the development of outreach and enrollment materials that are appropriate to the populations' reading comprehension levels, languages, and cultures.

DHS will create a toll free number to increase public awareness about Medi-Cal and the new insurance program. To ensure that this toll free line is accessible to the broadest array of Californians, DHS is exploring the use of multi-lingual prompts and operator assistance to help facilitate easier access to information and services. To ensure that application and enrollment materials are understandable to the target population, DHS will use the entity which has assisted in the development and translation of enrollment material for Medi-Cal managed care.

Finally, public affairs officials of both DHS and MRMIB will provide information to health care providers, business coalitions and other targeted groups about the new health insurance programs by submitting brief program descriptions and implementation time lines in various magazines, bulletins, and journals. For example, the December 1997 Medi-Cal Quarterly Newsletter and the January 1998 Medi-Cal Monthly Bulletin will have articles featuring the Healthy Families program. The State of California will feature key aspects of the Healthy Families Program on its state home page on the Internet, and MRMIB will require that its administrative vendor establish and maintain a Healthy Families web site. This will provide the general public an overview of the new policy, specific programs within Healthy Families, and contact names and locations for more detailed information, complementing the comprehensive outreach efforts under the outreach contractor.

Outreach Time Line:

October 1997:	Begin public comment on regulations
November 1997:	Release RFP for outreach contractor

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December 1997:	Release of Medi-Cal quarterly newsletter
January 1998:	Initial release of monthly Medi-Cal bulletin
February 1, 1998:	Award contracts to outreach contractor
February 1, 1998:	Toll free information launched
February 18, 1998:	Radio, collateral and outdoor advertising launched
March 1, 1998:	Medi-Cal enhancements in place (resource disregard, 100% expansion)
June 1, 1998:	Program enrollment materials available
June 1, 1998:	Medi-Cal enhancement in place (one month continued eligibility)
July 1, 1998:	First children enrolled in insurance program

*MRMIB's pre-enrollment process occurs from now until enrollment begins.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

The local C-CHIP will use state trained application assistants at community organizations, county welfare staff and the Healthy Families Program to "get the word out" about the availability of the C-CHIP. Application assistants in the community today are aware of the county sponsored programs and currently provide assistance in getting children enrolled in the programs. The Healthy Families administrative vendor has been provided with phone scripts that identify counties with expansion programs in order to refer families to if they are residents of that county and are ineligible for the Healthy Families Program because of excess income. We are in the process of modifying procedures with the Healthy Families administrative vendor to request the families' permission to forward these applications to the local programs.

CONNECTING KIDS TO HEALTHCARE THROUGH SCHOOLS

Continuing with the state's approach of outreach to families of children likely to be eligible for assistance under the Medi-Cal or Healthy Families Programs is the Connecting Kids to Healthcare through Schools Project (Connecting Kids). Connecting Kids serves as a resource for schools; state and local level partners; community based organizations; and other organizations that are involved in promoting health coverage for uninsured families. Its goal is to increase schools involvement in promoting enrollment, retention and utilization of children's services in healthcare coverage programs by providing the skills and tools necessary to effectively conduct school outreach efforts related to: 1) the Healthy Families Program; 2) Medi-Cal for Families; and 3) County-CHIP.

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The Connecting Kids project is a unique partnership between the state and the David and Lucile Packard Foundation. The David and Lucile Packard Foundation was created in 1964, by the co-founder of the Hewlett-Packard Company and his wife. The foundation is based on the belief that America is home to a unique type of organization dependent upon private funding and volunteer leadership and by using private funding for public purposes, programs of this type channel the personal commitment of millions of individuals who participate as volunteers or donors. The Foundation focuses in three key program areas: 1) the Conservation and Science Program; 2) the Population Program; and 3) the Children, Families and Communities Program. Upon David Packard's death in 1996, the Foundation was named the beneficiary of a major portion of his estate whose wealth was generated from the company that he co-founded. The Foundation, now in its forty-first year continues to support organizations that are committed to its mission including providing access to health insurance for all children that ensures them appropriate healthcare. It is a private philanthropic foundation, not a healthcare foundation. Attached are the Foundation's Audited Financial Statements for 2003 & 2002, for your convenience.

The David and Lucille Packard Foundation, via the Public Health Institute (PHI), provide a contracted employee (Judith Torres) using philanthropic grant funds. The PHI is an independent, nonprofit organization dedicated to promoting health, well-being and quality of life for people through California, across the nation and around the world. The PHI serves as a fiduciary agent for the grant proposal. The PHI offers comprehensive administrative and programmatic resources, including technical support, program design, funding development, grant and contract management, corporate legal counsel, staff recruitment, employee benefit and administrative support. The PHI is made up of highly qualified professionals with extensive nonprofit and business experience within the field of public health. The PHI provides support for programs, including resource development and planning, grant and contract management, human resources administration, financial and accounting services, and in-house counsel.

Connecting Kids' activities include promoting healthcare coverage programs at statewide and local meetings and conferences related to schools and school-related organizations; providing technical assistance on marketing techniques and outreach strategies; maintaining and updating a Connecting Kids website with information, resources and links to other relevant websites; providing collaborative outreach with local Children and Families Commissions and Regional Children's Health Projects; and providing school districts/schools and county offices of education with camera ready outreach materials to help facilitate school-based outreach.

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Obesity Prevention Campaign

California will contract with a private marketing firm to embark on a new advertising campaign aimed at increasing awareness of the long-term impacts of overweight and obesity in young children while inspiring positive change in family eating and physical activity habits. The campaign will likely include two general market and two Spanish language TV ads, five radio ads (one general market, two African American, and two Spanish), and possibly radio or print ads in one or more Asian languages. The campaign may also provide the SCHIP toll free number for families with uninsured children to call, have questions answered, and even apply by phone.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)

6.1.1.2. ☒ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

California will use the CalPERS state employee benefit package as the benchmark coverage health. It will provide enhanced services beyond the benchmark package, including comprehensive dental and vision coverage, screening and initial treatment services through the CHDP program and treatment services for severely ill children in a non managed care delivery system. Uninsured children granted presumptive eligibility by a CHDP provider will be provided these same benefits during the

period of presumptive eligibility as well. For a full benefits description, see Attachment 6.

Attachment A, a copy of Article 3 of the AIM program regulations, details of the benefits of the Access to Infants and Mothers' (AIM) program. However no abortion benefits will be provided under this state plan for eligibles receiving prenatal coverage through the AIM Program for the Medi-Cal Program.

Attachment B, from our actuarial consultant Leslie Paters of Cooper's and Lybrand, states that the AIM benefit package is at least equivalent to the health benefits coverage used for our benchmark plan.

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☒ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

Attachment A, a copy of Article 3 of the AIM program regulations, details the benefits of the Access to Infants and Mothers' (AIM) program. The benefits of the AIM Program for infants born to mothers enrolled in AIM prior to July 1, 2004 include comprehensive health and do not include dental or vision benefits.

Attachment B, from our actuarial consultant Leslie Paters of Cooper's and Lybrand, states that the AIM benefit package is at least equivalent to the health benefits coverage used for our benchmark plan.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida;

Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1. ☐ Coverage the same as Medicaid State plan

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☒ Coverage that includes benchmark coverage plus additional coverage

California will provide enhanced services beyond the benchmark package, including comprehensive dental and vision coverage, screening and initial treatment services through the CHDP program and treatment services for severely ill children in a non-managed care delivery system. For a full benefits description, see Attachment 6. Infants born to mothers enrolled in the AIM Program on or after July 1, 2004 will also receive the CalPERS benefits including the enhanced services.

6.1.4.5. ☐ Coverage that is the same as defined by Aexisting comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

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6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

Medicaid (M/C) services limited to emergency services and pregnancy-related services required for eligibles. These services include prenatal care and services for complication of pregnancy.

	Healthy Families Program for Children	Medicaid (M/C) Prenatal Benefits for Eligibles 0-200% FPL	Access for Infants and Mothers (AIM) Prenatal Benefits for Eligibles 200%-300% FPL
6.2.1. Inpatient services (Section 2110(a)(1))	X	X	X
6.2.2. Outpatient services (Section 2110(a)(2))	X	X	X
6.2.3. Physician services (Section 2110(a)(3))	X	X	X
6.2.4. Surgical services Section 2110(a)(4))	X	X	X
6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))		X	
6.2.6. Prescription drugs (Section 2110(a)(6))	X	X	X
6.2.7. Over-the-counter medications (Section 2110(a)(7))		X	
6.2.8. Laboratory and radiological services (Section 2110(a)(8))	X	X	X
6.2.9. Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))	X	X	X

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6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))	X	X	X
6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)	X	X	X
6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))	X	X*	X
6.2.13. Disposable medical supplies (Section 2110(a)(13))	X	X*	X
6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))		X	
6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))		X	
6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)	X		
6.2.17. Dental services (Section 2110(a)(17))	X	X***	
6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))	X	X*	X

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6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))	X	X*	X
6.2.20. Case management services (Section 2110(a)(20))			
6.2.21. Care coordination services (Section 2110(a)(21))			
6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))	X	X*	X
6.2.23. Hospice care (Section 2110(a)(23))	X	X	X
6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))		X*	
6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))			
6.2.26. Medical transportation (Section 2110(a)(26))	X	X*	X
6.2.27. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))		X*	
6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))			

* Provided if medically necessary
*** Dental services limited to emergency periodontal

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6.3. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: ***Previously 8.6***

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.;

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Describe the cost of such coverage on an average per child basis. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.**

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

The state views the use of quality standards, performance measurement information strategies and quality improvement strategies as critical ingredients to transforming access to health plan coverage from the provision of access to the creation of a medical home. Below is a description of how California will use a number of tools and strategies in the Healthy Families Program and C-CHIP to ensure health care coverage translates to meaningful access to necessary services. AIM and Medi-Cal are not addressed separately. In the case of AIM, its operations substantially parallel the Healthy Families purchasing pool. Thus the description of that pool applies to AIM. Medi-Cal is addressed in California's Title XIX plan.

Measuring Clinical Quality: The model health plan contract requires contractors to provide the state with audited clinical measures consisting of the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS) 3.0 Performance Measures as well as any age relevant HEDIS measures which are included in versions of HEDIS numbered higher than 3.0. Plans must also report the number of subscribers who received a health assessment visit within 120 days or four consecutive months after their effective date of coverage. These data must be measured or audited by an independent third party and reported annually. MRMIB may use the data to provide information to subscribers in its annual open enrollment or program application materials.

Standards Designed to Improve to Quality of Care: Health plans are required to assure that its providers will use the most recent recommendations of the American Academy of Pediatrics (AAP) with regard to recommendations for preventive pediatric health care. Annually, the plan must inform the caretakers of its enrollees of the AAP's recommended schedule of preventive care visits. The notice must be in English, Spanish and any other language which is spoken in more than 5 percent of the plan's enrollee's households.

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Quality Management Processes: The contractor must assure the State that its Quality Management processes have been reviewed and found to be satisfactory by either the National Committee on Quality Assurance, the Joint Commission on the Accreditation of Healthcare Organizations, or the State of California's Medi-Cal Managed Care Program. The contractor must also maintain a system of accountability for quality improvement activities which includes the participation of the contractor's governing body, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the process of quality improvement development and performance.

Risk Assessment and Adjustment Process: MRMIB will implement a risk assessment and adjustment (RARA) process for Healthy Families similar to that which MRMIB uses in the HIPC. MRMIB believes that risk adjustment is critical to providing quality care. RARA provides the necessary balance to the aggressive price negotiations undertaken in a purchasing pool. Through use of risk adjusted premiums, plans that provide quality services in an efficient manner accrue financial benefits. MRMIB intends to implement RARA in the third year of program operations.

Ongoing Efforts to Improve Quality Measures and Accountability: MRMIB will establish a Children's and Adolescent's Clinical Improvement Work Group. The purpose of the group is to expand the numbers of reportable clinical quality measures and develop an approach to increasing health plan's accountability for clinical quality improvements. The starting point for the work group's activities will be the December 4, 1997 report "A Clinical Quality Accountability Framework: California's Healthy Families Program" (See Attachment B), particularly the section on standardized patient satisfaction monitoring and reporting. The workgroup will meet at least quarterly and will develop recommendations for improvements to the program's quality improvement strategy by December of 1999. These recommendations would be incorporated in contracts for the contracting period July 1, 2000 through June 30, 2002. The work group may also make interim recommendations for the contract year July 1, 1999 through June 30, 2000. Health plan contractors must participate in the workgroup.

AIM Quality Assurance Measures

The AIM program relies on the quality assurance requirements of the Knox-Keene Act which regulates health plans. These requirements are detailed on pg. 20 of the state plan and include requirements governing accessibility of health services, consumer

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protection and quality assurance. Quality assurance requirements specifically require that plans have quality assurance programs, and that providers establish a program to review the quality of care being provided and identify, evaluate and remedy problems related to access, continuity of care, utilization and monitoring of plan providers.

Quality Assurance Measures for Programs Not Under MRMIB's Purview

County Mental Health Programs: County mental health programs are overseen by the state Department of Mental Health. The requirements for quality assurance will be those used for Medi-Cal beneficiaries under the Short Doyle Medi-Cal program. In addition, DMH is developing a performance outcome system for children with serious emotional disturbance.

Quality Management Systems for Short-Doyle Medi-Cal: The following is a description of the quality management system which is used for specialty mental health services under the Short-Doyle Medi-Cal program. The Department of Mental Health requires each local county mental health department to have a Quality Management Program. The components of this program are described in the paragraphs below. The Department conducts a review of access and quality of care at least once every 12 months and issues reports to each county detailing findings, recommendations and corrective action as appropriate. The Department performs its monitoring function by inspecting or auditing facilities, management systems and procedures, books, record (including the Quality Management plan), grievance/complaint logs and data.

Quality Management Definition: Quality Management as established in the Short-Doyle Mental Health system is an integrative process that links knowledge, structure and processes together to assess and improve quality. Quality Management processes are those activities that the county mental health department undertakes to improve the quality of clinical care, clinical services, and consumer services. Each county's quality management program includes a written quality management plan, a quality improvement committee with designated health care professionals with substantive management and clinical experience and a specific active role for practitioners, providers, consumers and family members.

Quality Management Plan: At the local level, the quality management program coordinates performance monitoring activities including client and system outcomes, utilization management, credentialing and monitoring of providers, assessment of

beneficiary and provider satisfaction, clinical records review and resolution of beneficiary grievance and fair hearing and provider appeals. The methodology for these functions is detailed in the county's local Quality Management Plan.

Each local mental health department must set standards and establish systems to monitor the following:

- Timeliness of routine mental health appointments;
- Timeliness of services for urgent conditions;
- Access to after hours care; and
- Responsiveness of the county's toll free 24 hour telephone.

Additionally, at least once each year counties survey for beneficiary and family satisfaction and review the numbers and types of beneficiary grievances. Fair hearings and requests to change persons providing services are evaluated at least annually.

The local mental health department also identifies meaningful clinical issues relevant to its beneficiaries for assessment and evaluation. These issues always include a review of the safety and effectiveness of medication practices and may include other important clinical issues such as procedures and interventions used to respond when an individual is potentially suicidal.

Quality Improvement Committee: Each county, through their Quality Improvement Committee, also establishes quantitative measures to assess performance. Some of these indicators are monitored for the entire population and could include length of stay in inpatient facilities, recidivism, and total number of acute psychiatric bed days. Examples of measures which are specific to children include number of youth and children involved in the juvenile justice system.

Documentation Standards: Clinical documentation required in client records includes physical condition, presenting problem and relevant conditions, medications, mental health treatment history, use of alcohol, tobacco, and other drugs, mental status and five axis diagnoses. A complete developmental history is required for children and youth. Treatment plans must include specific observable or quantifiable goals, proposed type of intervention and estimated duration of intervention as well as documentation of the client's agreement with and participation in the plan. Regular

progress notes must include appropriate signature and timely documentation of relevant aspects of client care, clinical decisions and interventions.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

Insurance Programs. MRMIB will monitor quality standards in the purchasing pool and voucher programs through:

- Analysis and trending of reports from health, dental and vision plans. MRMIB staff will collect and analyze a variety of reports generated by participating plans, regulatory entities, and external review organizations to monitor the quality of care received and to focus plan efforts on areas needing improvement. These reports include:

  - Benefit Grievances: Benefit grievances filed by Healthy Families subscribers with participating plans. Participating plans will be contractually required to report benefit grievances once a year. These reports will be shared with subscribers who request the information. In addition, MRMIB will track any publicly available information on the number and type of benefit grievances filed by all subscribers enrolled in a participating plan (Department of Corporations reports all benefit grievances filed with plans annually). Grievance information will be used by MRMIB to identify plan performance needing improvement and to form the basis of future performance standards.

  - Regulatory Entity Reports: MRMIB will work with the state's two health insurance industry regulatory entities (the Departments of Insurance and Corporations) to assure that all publicly available data on health plan performance is known to MRMIB.

  - Enrollment and Disenrollment Reports: These reports will be generated by the program's administrative contractor and used by MRMIB as an early warning system of problems with a particular plan or medical group.

- Implementation of a risk assessment/risk adjustment process to minimize any financial incentives health plans may have to attempt to enroll healthier than average enrollees. While some observers view risk adjustment mechanisms in solely financial terms, MRMIB believes that inclusion of risk adjusted premium payments to plans is the single most important activity that MRMIB can undertake to assure the quality of care. MRMIB has been a pioneer in the risk adjustment field. In the HIPC, MRMIB currently oversees one of the nation's few operational risk adjustment processes. MRMIB believes that risk adjustment provides the necessary balance to the aggressive price negotiations undertaken in collective purchasing arrangements such as a purchasing pool. Through use of risk adjusted premiums, plans that provide quality services in an efficient manner would accrue the greatest financial benefit. MRMIB intends to seek philanthropic funding for development of a child focused risk assessment methodology. MRMIB intends to implement such a methodology in the third year of program operation. Implementation of risk assessment/adjustment in the third year of program operations will permit MRMIB to develop an understanding of the health risk based issues in children's health care and provide time to assure that all stakeholders are able to participate in development of the methodology.

- Monitoring the accreditation status of participating plans by entities such as the National Committee for Quality Assurance (NCQA). MRMIB intends to provide accreditation status information to parents to assist them in selecting a health, dental and vision plan.

MRMIB will identify the quality indicators to be used for the purchasing pool plans as follows:

- The specific indicators to be tracked will focus on child or adolescent specific outcome measures, such as the immunization status of two year olds. To the extent feasible, MRMIB intends to utilize the audited HEDIS measures generated by the California Cooperative HEDIS Reporting Initiative (CCHRI). CCHRI is a collaborative effort of purchasers, providers and plans who are committed to produce audited performance data on health plans which can be compared across plans

and tracked over time. The health plans participating in CCHRI represent 95% of the commercially enrolled California health maintenance organization population. At present, the only audited child-specific HEDIS measure being collected by CCHRI is the immunization status of two year olds. Until audited measures are available, MRMIB will collect unaudited health plan reported information on other HEDIS child and adolescent based measures. MRMIB anticipates that the number of indicators collected during each contract period will expand as the field of outcome based quality measurement matures and as health plan's ability to produce data increases in response to purchasers demands.

- Each of the contacts between MRMIB and participating health, dental and vision plans will contain specific performance objectives. In developing these objectives, MRMIB will be guided by oral and written testimony received during the program development process, and by advice provided by the Healthy Families Advisory Panel. These standards may relate to clinical, access, or customer service based standards of quality. Those standards which are adopted by MRMIB will be included in contracts with participating health, dental and vision plans. The performance measures will be adopted by MRMIB in December of 1997 and will be included in each of the Model Contracts (health, dental and vision). The Model Contracts are the documents from which MRMIB will negotiate agreements with each of its plan partners. While MRMIB has not yet determined the specific performance measures for each of the contracts, the purchasing power of the Healthy Families Program subscriber base will provide MRMIB with significant ability to influence plan behavior.

CHDP. The Healthy Families gateway program, CHDP, reimburses for periodic health assessments and immunizations for children and adolescents under 21 years of age eligible for Medi-Cal and for those 19 years of age and under whose family's income is 200 percent of the federal poverty level or below. Through its administration of the CHDP and CCS programs, the Department of Health Services will use a variety of approaches to monitor quality standards. The state CHDP program is responsible for developing standards for the care delivered in a complete health assessment, including those components required by the EPSDT program (dental, nutrition, vision

and hearing screening). In general, the standards of the American Academy of Pediatrics serve as the basis for preventive services standards. The program distributes Health Assessment Guidelines to enrolled CHDP providers (physicians, medical clinics, medical groups, and certified pediatric or family nurse practitioners) to provide a framework for the quality of care to be delivered during an assessment, including appropriate screening methodologies and specific tools. The local CHDP program is responsible for enrolling providers, both those who wish to provide health assessments and those who wish to deliver complete health care, if they meet the criteria outlined in Section 6860 of Title XXI. It also identifies providers who may be providing substandard services and can require corrective action in order to continue program participation.

Specialized Services. The CCS program develops standards for provider participation under the authority of Section 123925 of the Health and Safety Code. Providers, from individual pediatric specialists and sub-specialists to hospital inpatient facilities, wishing to participate in the program apply to have their qualifications reviewed and assessed. CCS state program staff perform on-site review of hospital facilities and special care centers that includes the determination of the appropriateness of the professional staff delivering care to CCS-eligible children and the quality of the health care provided (generally through the review of medical records).

The CCS program staff authorizes paneled and approved providers to deliver services to eligible children. CCS case management, through its prior authorization requirements, can insure that children with serious physically handicapping conditions are receiving health care services from the appropriate type and level of provider.

The requirements for provider selection, quality improvements systems and documentation that are used for a similar population in the Medi-Cal program will be required of county Mental Health Plans under this program. In addition, California has been a national leader in the implementation of a performance outcome system for children with serious emotional disturbance. Children with serious emotional disturbance receiving Mental Health Plan services under Title XXI will be included in this effort. Families will be able to work with the Mental Health Plans on a formal or informal basis to resolve problems.

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COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

MRMIB will monitor quality standards in the C-CHIP projects through:

- Analysis and trending of reports from health, dental and vision plans. MRMIB staff will collect and analyze a variety of reports generated by participating plans, regulatory entities, and external review organizations to monitor the quality of care received and to focus plan efforts on areas needing improvement. These reports include:

  - Benefit Grievances: Benefit grievances filed by Healthy Families subscribers with participating plans. Participating plans will be contractually required to report benefit grievances once a year. These reports will be shared with subscribers who request the information. In addition, MRMIB will track any publicly available information on the number and type of benefit grievances filed by all subscribers enrolled in a participating plan (Department of Corporations reports all benefit grievances filed with plans annually). Grievance information will be used by MRMIB to identify plan performance needing improvement and to form the basis of future performance standards.

  - Regulatory Entity Reports: MRMIB will work with the state's two health insurance industry regulatory entities (the Departments of Insurance and Corporations) to assure that all publicly available data on health plan performance is known to MRMIB.

- Monitoring the accreditation status of participating plans by entities such as the National Committee for Quality Assurance (NCQA).

- The specific indicators to be tracked will focus on child or adolescent specific outcome measures, such as the immunization status of two year olds. To the extent feasible, MRMIB intends to utilize the audited HEDIS measures generated by the California Cooperative HEDIS Reporting Initiative (CCHRI). CCHRI is a collaborative effort of purchasers, providers and plans who are committed to produce audited performance data on health plans which can be compared across plans

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and tracked over time. The health plans participating in CCHRI represent 95% of the commercially enrolled California health maintenance organization population. At present, the only audited child-specific HEDIS measure being collected by CCHRI is the immunization status of two year olds. Until audited measures are available, MRMIB will collect unaudited health plan reported information on other HEDIS child and adolescent based measures. MRMIB anticipates that the number of indicators collected during each contract period will expand as the field of outcome based quality measurement matures and as health plan's ability to produce data increases in response to purchasers demands.

7.1.2. ☒ Performance measurement

MRMIB will measure performance of purchasing pool plans through three strategies:

- Collaboration on performance measures with other large purchasers such as CalPERS and the Pacific Business Group on Health (PBGH). MRMIB is a member organization of PBGH. Using the purchasing power of the Healthy Families subscriber base, MRMIB intends to collaborate actively with other large purchasers to encourage the health plan and provider communities to move more quickly to identify and expanded set of clinical quality indicators.

- Requiring all participating health plans to submit yearly results of the latest version of the Health Employer Data Information Set (HEDIS). As mentioned above, audited HEDIS results will be used when available.

- Establishing contractual agreements with participating plans obligating them to submit the results of standardized subscriber satisfaction surveys. While the exact survey instrument has not been determined, the instrument used by the NCQA will be evaluated for its applicability to the issues of importance to children and adolescents.

MRMIB will evaluate and select a means to enforce plan performance related to the performance standards. Enforcement can take one of several approaches. These include using either a fiscal (or enrollment) penalty based system in which plans are penalized when MRMIB identifies a deficiency, or a performance target based system in which plans agree to put a percentage of their premium at risk if they do not achieve the predetermined performance levels.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

The volume of children in C-CHIP, coupled with the short term duration of the funding makes it infeasible to set up separate performance measures. However, the C-CHIP projects are modeled consistent with the Healthy Families Program and the health plans delivering the C-CHIP services are the same health plans. Thus, the information produced for the Healthy Families program plans will be reflective of the performance for C-CHIP.

7.1.3. ☒ Information strategies

MRMIB will use the following information strategies to improve and assure the quality of service provided through the Healthy Families Purchasing Pool Program:

- The Healthy Families Program brochure/application will include an easy to read chart summarizing the program benefits. Participating plans will be required to distribute to all subscribers a detailed description of covered benefits and exclusions in their Evidence of Coverage Document (EOC), a list of physicians and hospitals available in their network (Directories) and an identification card for subscribers to use to access services. Through its contractual relationships with plans, MRMIB will require the provision of these documents to families no later than the effective date of coverage. In addition, all plans participating in the Healthy Families program will be required to make EOCs available on a pre-enrollment basis to those families wishing to review the coverage documents in detail prior to selecting a health plan.

- The Healthy Families Program brochure/application will include a section where all participating plans will have the opportunity to respond to a standardized set of topics of interest to families when selecting a plan, such as a description of the plan's provider network, how language support services are accessed, the plan's view of why a family should want to select the plan, and how approval for specialty care is handled in the plan. The exact list of issues will be developed by MRMIB using input received at MRMIB public meetings, available market research, and in consultation with the Healthy Families Advisory Panel.

- The Healthy Families Program brochure/application will include a chart comparing responses to commonly asked questions. These questions will be generated using input received at the MRMIB public meetings, available market research, and in consultation with the Healthy Families Advisory Panel. These may include answers to questions such as:

    - How many times can a child change their primary care physician in one benefit year?
    - Does the plan require physicians to prescribe pharmacy products from a list of drugs (a formulary) approved by the plan?
    - What is the total number of primary care physicians in the plan?

- MRMIB's experience in purchasing health benefits for small employers and their employees' families through HIPC shows that most families want to know the plans that include the child's physician when selecting a plan. To respond to this consumer need the Healthy Families Program will create a Provider Information Service. The Provider Information Service will be modeled on the Physician Super Directory developed by MRMIB for its small employer purchasing pool. It will include a listing of the pediatricians, family practice and general practice doctors, clinics/medical groups and hospitals that will be available through Healthy Families participating health plans. Additional information will include languages spoken in the

physician's office, the gender of the physician, and if the physician is accepting new patients. The Provider Information Service will be available to families as they make their initial health plan choices and again at each annual open enrollment.

- MRMIB will require all plans providing services to Healthy Families program subscribers to prominently display in their Evidence of Coverage documents the grievance procedures of the plan and the plan's regulatory entity's toll free phone number.

- Application/enrollment materials will be available in English, Spanish, and other threshold languages designated by the Department of Health Services. Staff answering the toll-free number used by the administrator of the program will speak English and Spanish and have access to translator services for other languages.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

The county LI and COHS will provide to its enrolled members a detailed description of covered benefits, exclusions, and grievance procedures in their Evidence of Coverage (EOC) booklet.

7.1.4. ☒ Quality improvement strategies

All of the approaches described under quality standards, performance measurement, and information strategies will be used by MRMIB to encourage quality improvement by participating plans. This will be done through five strategic approaches. These are:

- Keeping up to date on developments in quality improvement, including any indicators that may be developed regarding the high quality medical home;

- Feeding back information to plans to help them understand their own performance over time and how they compare to other plans providing services to Healthy Families Program subscribers;

- Enforcing of contractual provisions which link quality based measures to plan performance;

- Increasing plan performance targets over time; and

- Providing quality based information to families. This final approach empowers the consumer to punish or reward plans with enrollment based on the value each family places on the quality standards.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

The volume of children in C-CHIP, coupled with the short term duration of the funding makes it infeasible to set up separate indictors to assess the quality of the services. However, the C-CHIP projects are modeled consistent with the Healthy Families Program and the health plans delivering the C-CHIP services are the same health plans. Thus, the information produced for the Healthy Families Program will be reflective of the quality of services provided for C-CHIP.

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

The enabling statute for the Healthy Families program requires MRMIB to contract with a broad range of health plans in providing services to subscribers participating in the purchasing pool. MRMIB has used this strategy in contracting for health services in the HIPC and currently contracts with 20 health plans that provide HIPC subscribers access to 84% of California's licensed practicing physicians. The Healthy Families Program will similarly contract with a large number of health plans to maximize enrollee choice of plans and providers within their communities.

The program has also been structured to encourage participation of traditional and safety net providers who have been serving many of the low-income uninsured. The program components to encourage participation are detailed in Section 3.

MRMIB will also take a number of steps to monitor access to covered services. Some of these are:

- MRMIB will monitor the ongoing status of health plans with their regulators to assure quality services are available to subscribers.

- MRMIB will use plan enrollment and disenrollment reports as a early warning signal of access problems with a health plan. All families choosing to switch their child from one health plan to another will be surveyed to find out why they are requesting a plan change. This survey will alert MRMIB staff to family concerns regarding access to specialty care, wait time for appointments, provider network instability or other access related barriers.

- CHDP and CCS services are monitored through authorization of services and claims review by county CHDP and CCS programs. County staff can serve an important role in training, and review of service provision.

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

The State is undertaking three steps to assure and monitor access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations.

1) Through contracts, all health plans are required to provide preventive services in accordance with recommendations from the American Academy of Pediatrics and immunizations in accordance with the American Committee for Immunization Practices (ACIP). Health plans are also required on an annual basis to inform enrollees of the schedule for receiving preventive and immunization services and on the availability of these services (which include well baby, child and adolescent care, and childhood and adolescent immunizations).

2) The State issues an annual member guide to Healthy Families enrollees. This member guide includes a schedule for well-visits and immunizations for babies, young children and adolescents.

3) The State monitors access to preventive services using HEDIS. Each year health plans report the number of children receiving well visits and immunizations. The State compares plan reports to national guidelines and benchmarks to determine deficiencies. Plans with deficient performance compared to all plans in the program are asked to submit a corrective action plan. The State is currently exploring minimum performance thresholds which will be implemented with the July 1, 2004 contracts.

The State assures that the monitoring efforts used for Healthy Families will be used for C-CHIP.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

California state law contains specific requirements for access to services, including emergency services. These requirements can be found in Health and Safety Code, Section 1367 and California Code of Regulations, Sections, 1300.67.2 and 1300.67.2.1. All plans operating in California are subject to these requirements. The State regulator of managed care organizations, the Department of Managed Health Care, enforces this law.

In addition to State law, the State uses several methods to monitor access to services. The State collects information on the number of specific Healthy Families enrollee grievances each plan has received, and the number of enrollee complaints the State had directly received. The plan grievances and enrollee complaints are categorized and patterns of complaints among the plans are reviewed periodically.

The State requires plans to submit annual performance measures, using HEDIS, which provides information on the delivery of well care and immunizations. The State is currently developing an infrastructure that collect encounter/claims data from participating health plans. Encounter/claims data collected from plans will enable the State to track utilization patterns among plans and compare these patterns against publicly available benchmarks. This infrastructure will be administered under the 2004 Administrative Vendor contract.

The State also conducts an annual consumer satisfaction survey of families which address their experience with their health plan. The survey instrument used (CAHPS) requests information on access to care and the ability of members to get the care they needed quickly.

Through the county contracts with the State, counties will be required to submit utilization data on preventive and emergency services and grievances from C-CHIP enrollees. Due to the limited number of C-CHIP enrollees in each county, counties will not be required to conduct consumer surveys. However, if a county opted to conduct a survey the county would be requested to submit the result to the State for information only. Results from any survey would not yield valid results.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

To meet the special needs of children, Healthy Families will ensure the provision of necessary specialized services beyond those offered through the comprehensive insurance package in a coordinated manner. The California Children's Services (CCS) program will address the significant needs of the minority of children whose needs may not be fully met under an insurance benefit package. The CCS program will provide case management and treatment for chronic, serious, and complex physically handicapping conditions. Coverage is and will be limited to coverage of the specific condition. The program establishes standards for the approval of inpatient hospital facilities and pediatric specialty and subspecialty providers delivering care to eligible children. The program also has an extensive system of special care centers located at tertiary medical center at which multispecialty, multidisciplinary teams deliver coordinated inpatient and outpatient care to children with chronic medical conditions. The centers include cardiac, chronic pulmonary disease, hematology and oncology, myelomeningocele, hemophisia, sickle cell, renal, infectious disease/immunology, hearing and speech metabolic disorders, inherited neurologic disease, limb defect, gastroenterology, craniofacial anomalies and endocrinology. The program

also approves neonatal intensive care, pediatric intensive care, and pediatric rehabilitation units.

The program staff determines the appropriate source of health care for eligible children, assist families in accessing care, and identify other needs of the child and family that could impact the care of the eligible condition.

The services to treat the CCS eligible medical condition of a child enrolled in Healthy Families will not be the responsibility of the contracting health plan in which the child is enrolled. The CCS program will continue to authorize the medically necessary services to treat the conditions using the program's regulations, policies, procedures, and guidelines in determining the appropriateness of providers, and the necessity for services. CCS will expand the systems of communication that have been instituted to work with Medi-Cal managed care plans that have CCS services "carved out" from their capitation rate. Local CCS programs carefully coordinate the authorization and delivery of specialty and subspecialty services with the primary care provider to which the child is assigned. This program will reimburse providers for these specialized services. Children receiving such services will continue to have their primary health needs serviced through the insurance program. Allowing those specialized services to be provided as a complement to, but outside of, the managed care setting is consistent with recent actions in the Federal Budget Reconciliation Act (BBA 1997) which prohibit mandatory enrollment of children with special medical needs in managed care.

The State expects that approximately 2 percent of children enrolled in the HFP will be eligible for CCS services. On an annual basis the State will review the number of active HFP cases in the CCS program. The State will also require participating plans to report the number of referrals they have made to the CCS program each quarter. The State will also use the HEDIS CAHPS survey to monitor access and quality of these services. This survey has a special module to address the satisfaction and experiences of families which children who have chronic conditions.

The state will include in its C-CHIP contracts a requirement to report the number of active C-CHIP/CCS cases and the number of children referred to the CCS program. Of those children enrolled in C-CHIP, some will qualify for CCS services based on CCS eligibility requirements whereby services for the

qualifying CCS eligible condition will be provided by CCS. In those cases where a family does not qualify based on CCS eligibility requirements, the medically necessary services will be provided by the C-CHIP health plan. California's State Department of Managed Healthcare licensure requirements includes adequacy of network including specialists covered services not available in network must be covered out of network.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

California state law contains specific requirements for health plan utilization review, including prospective, retrospective, and concurrent review. State law also requires independent medical review of health plans decisions concerning medical necessity. These requirements, found at Health and Safety Code Section 1367.01 and 1374.30 et seq., are designed to ensure that the prior authorization process does not present an undue barrier for continuity and access to care.

The State assures that this method will also be implemented under the C-CHIP program.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

There is no cost sharing requirements for children enrolled in presumptive eligibility under S-CHIP. There is no cost sharing requirement for eligibles from confirmed pregnancy through birth (0-200% FPL). For eligibles from confirmed pregnancy through birth in households with income 200-300% FPL, there is a family contribution of 1.5% of the families' annual income.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1. ☒ **YES**
8.1.2. ☐ **NO, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

Purchasing Pool Premiums

*Family Value Package***.** MRMIB will designate one or more "Family Value Packages" (FVP's) in each geographic area. The FVP is the combination of health, dental, and vision plans which offer the best prices to the program. MRMIB has the ability to designate a range of prices as the "lowest" cost value to the state. The exact range will be designated by MRMIB in the program regulation process. Only plans that fall within the FVP range may be purchased in the program

The family contribution amounts have been increased for highest income families pursuant to the 2008 State budget trailer bill, (Chapter 758, Statutes of 2008) which takes effect on February 1, 2009 for families with income above or greater than 150 % - and less than or equal to 250% FPL. Please refer to the attached income charts demonstrating this.

Above 100-150% FPL	
One child	$7
Two or more children	$14
Above 150-200% FPL	
One child	$12
Two children	$24
Three or more children	$36
Above 200-250% FPL	
One child	$17
Two children	$34
Three or more children	$51

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Families who prepay three months of premiums will not have to pay a premium for the fourth month. Families who use recurring electronic fund or credit card transfers receive a 25% discount on monthly family contributions.

Community Provider Plan. MRMIB will also designate a "Community Provider Plan" by geographic area. This is the plan in the area with the highest percentage of traditional and safety net providers. These packages will have the following monthly base premiums:

	Community Provider Plan
Above 100-150% FPL	
One child	$4
Two or more children	$8
Above 150-200% FPL	
One child	$ 9
Two children	$18
Three or more children	$27
Above 200-250% FPL	
One child	$14
Two children	$28
Three or more children	$42

If the family selects other than the Community Provider Plan, the family therefore has a higher premium.

Again, families that pay 3 months of premiums in advance will receive the fourth month free. Families who use recurring electronic fund or credit card transfers receive a 25% discount on monthly family contributions.

Disenrollment for Non-Payment of Premium

California will disenroll families effective the last day of the second consecutive month that they fail to make their family contribution payments. Each family that fail to make their monthly family contribution payment is 30 days late on the payment, will receive a notice stating they are 30 days past due and that their child (ren)'s coverage will end at the end of the 60 day period, if the full family contribution payment is not received. Families will receive another notice at 45 days prior to the end of their 60 day past due period, informing this is a final past due notice. The 45 day notice contains a continued enrollment form, where families can request the HFP to keep their coverage in effective, while the program reviews any disputes the family has regarding their past due payments. After the 45 day notice, the family will receive the 60 days in arrears billing notice informing them the total amount due and again reminding them of the upcoming disenrollment date. When a family has failed to make payment for 60 days after receiving the three advanced notices the subscriber will be disenrolled effective the last day of the second consecutive month (60 days). At the end of the 60 day period, the family will receive a disenrollment notice, stating their coverage has ended. Children disenrolled pursuant to this section will not be eligible for re-enrollment until all past due premiums are paid during the past 12 months.

Family Contribution Sponsors

The first 12 months of an applicant's premium may be paid by a Family Contribution Sponsor. A Family Contribution Sponsor must register with MRMIB by completing and returning a Family Contribution Sponsorship Registration Form and receiving a sponsor identification number. The following persons or entities are not eligible to be a Family Contribution Sponsor:

1. a person that is a health care, dental care or vision care provider that participates in the Healthy Families Program or an organization composed primarily of or controlled by such persons,
2. an entity, including governmental, school, non-profit and charitable organizations, that is, or that operates, an institution or facility that is a health care, dental care or vision care provider that participates in the Healthy Families Program,

3. a participating plan,
4. any person or entity acting on behalf of or representing a person or entity identified in (1) through (3) above.

Family Contribution Sponsors must certify that they are not ineligible under 1 of the 4 categories listed above. For each applicant being sponsored, the Family Contribution Sponsor shall submit payment for 12 months of family premiums and the completed and signed Family Contribution Sponsorship Form with the Healthy Families Application. No premium adjustments for a sponsored family will be made during the first 12 months in the program. MRMIB may disqualify a sponsor if it determines that the sponsor has violated or encourage an applicant to violate program rules.

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

Subscribers enrolled in the AIM Program prior to July 1, 2004 pay premiums equal to 2% of the families annual income for coverage of the pregnant woman and the infant through age one. An additional $100 is charged for the second year of the infant's life. Subscribers enrolled in the AIM Program on or after July 1, 2004 will pay premiums equal to 1.5% of the families' annual income for coverage of the pregnant woman and upon birth, the infant will be enrolled in the Healthy Families Program. Once enrolled in the Healthy Families Program, infants will be subject to the standard cost sharing requirements of the program. [Note: The state seeks FFP for infants up to age one who were born to mothers enrolled in the AIM Program prior to July 1, 2004 with family income between 200-250% FPL and for infants up to age two with family income between 200-300% FPL.]

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

Effective February 1, 2009, a premium increase in the HFP impacted families above 150% FPL through 250% FPL. The new HFP Category C premiums are $14 - $17 per month per child with a maximum of $42 - $51 per family. San Francisco, San Mateo, Santa Clara and Alameda County health plans are the designated community provider plan (CPP) in the Healthy Families Program and therefore their Healthy Families Program premiums are $14 per month per

child with a maximum of $42 per family in Category C. As in the Healthy Families Program the C-CHIP offers a premium discount option. If three months of premiums are paid in advance, the fourth month is free. The three county C-CHIP Programs use the HFP Category C premiums and increased their premiums to the HFP Category C levels as of February 1, 2009.

San Francisco County charges annual premiums at $126 per child per year. Like the Healthy Families Program, San Francisco County also has a discount program. When an applicant pays $126 per child per year, this is equivalent to $14 per child per month with three months free.

Santa Clara County charges monthly premiums at $14 per child per month with a maximum of $42 per family per month. As in the Healthy Families Program, subscribers of Santa Clara County's Healthy Kids Program can pay three months in advance and get the fourth month free.

San Mateo charges a quarterly premium of $42 per child; this is equivalent to Healthy Families Program's $14 per child per month. San Mateo County also offers the same discount program. If three quarter's premiums are paid in advance the fourth quarter is free.

Alameda County has not yet implemented their participation in C-CHIP.

San Francisco, San Mateo and Santa Clara Counties offer a Sponsorship Program or family contribution assistance program. The funding for sponsorship for San Mateo and Santa Clara Counties is derived from the local Tobacco Tax dollars being invested in their C-CHIP project. Funding for sponsorship for San Francisco County is derived from County funds being invested in their C-CHIP project. Families are informed about sponsorship by the Certified Application Assistants, annual renewal form, the families Welcome Letter when enrolled in C-CHIP and in the letter advising the family that they are delinquent on the monthly premiums. Families enrolled in their C-CHIP program can apply for sponsorship at any time during their enrollment. An eligibility specialist reviews the request and approves as appropriate. All requests for sponsorship due to financial hardships are approved. The duration of sponsorship varies, as it begins from the time the request is approved until the annual renewal occurs, which is often a 12-month period.

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8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

No coinsurance. Copayments are summarized below and described in more detail in Attachment 6.
Health Coverage

MRMIB will establish copayment levels in amounts that reflect the copayment levels for the state's selected benchmark plan, the Public Employee's Retirement System. However, no copayments will be charged for prenatal, well baby, well child or immunization services or benefits. Further, the amount of copayments a family will pay in a given year is limited to $250, as opposed to the $1,500 annual copayment maximum in the benchmark plan. Copayment amounts are detailed by benefit in the description of benefits in section 6.2 of this application. The copayment for most services (office visits, prescriptions) is $5.00.

Dental and Vision Coverage

MRMIB will establish co-payment levels in amounts that reflect the co-payment levels for the plans made available to state employees through the Department of Personnel Administration. No copayments will be required for preventive and diagnostic services, including dental exams, teeth cleaning, X-rays, topical fluoride treatments, space maintainers and sealants. Copayment amounts are detailed by benefit in the description of benefits in Attachment 6.

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

Infants born to mothers enrolled in the AIM Program prior to July 1, 2004 do not have copayments. Infants born to mothers enrolled in the AIM Program on or after July 1, 2004 will be enrolled in the Healthy Families Program and subject to the cost sharing requirements.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

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Copayments under the C-CHIP projects range from $5 - $15 when required for health, dental, and vision benefits. Attachment 6 provides a detailed description of the benefits provided and the related copay.

8.2.4. Other: N/A

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

The public will be notified of Healthy Families' cost-sharing requirements, including differences based on income, in the Program's application, enrollment materials and program regulations. Copays will also be listed in plan disclosure documents such as Evidence of Coverage (EOC) documents provided to each family. Agencies and individuals who help families with their application will also be familiar with the program's cost-sharing requirements and be able to communicate them to families when discussing the program.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

Families applying for C-CHIP will be informed about the cost sharing requirements from the C-CHIP application, enrollment materials, and the same individuals conducting outreach; the local state trained application assistants, county social service staff, and the health plan staff. In addition, cost sharing information is included in the members Evidence of Coverage booklet which is mailed to each family when a child within the household is enrolled.

Any changes to the cost sharing requirements would be presented in public forums and also require review and approval by the State's Department of Managed Health Care prior to implementation. The public forums vary by county however all of them have confirmed that community input would be solicited. The various types of public forums include Health Plan Board meetings, Health Plan Commission meetings, local Prop 10 Commission meetings, and the Children's Health Initiative Coalition Oversight Board.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

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8.4.1. ☒ **Cost-sharing does not favor children from higher income families over lower income families.** **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ **No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations.** **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3. ☒ **No additional cost-sharing applies to the costs of emergency medical services delivered outside the network**. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5 Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42 CFR 457.560(b) and 457.505(e))**

HEALTHY FAMILIES INSURANCE PROGRAM

Premiums

Table 1: HFP Premium Contributions for Families below 150% FPL

California will ensure that the annual aggregate cost-sharing for a family with incomes less than 150% FPL is less than that required by Section 1916(b)(1) and Section 1916(2)(3) as is required under Title XXI. The maximum monthly premium charge for Healthy Families insurance program is consistent with the standards established under Section 447.52 of Title 42 of the Code of Federal Regulations (CFR). Healthy Families' premiums for families below 150% are $7 per child per month (with a maximum family contribution of $14 per family per month). Table 1 below demonstrates that the maximum premium payments for a family at 100% FPL under Healthy Families (Column II) falls within the maximum monthly charges established under Section 447.42 of Title 42 CFR.

I.	II.	III.	IV.
Family Size	Income of a Single Parent Family at 100% FPL + $1*	Premium Contribution	Medicaid Maximum Monthly Charge (Unadjusted for Inflation)**
1 child	$1,167	$7 mo. / $84 yr.	$19 mo./ $228 yr.
2 children	$1,467	$14 mo. / $168 yr.	$15-$16 mo./ $180-$192 yr.

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*Dollar amounts are based on April 1, 2008 FPL.
**Source: Code of Federal Regulations, Section 447.52 of Title 42

Table 2: Aggregate Cost Sharing for Families Above 150 – 200% FPL for HFP

California ensures that the annual aggregate cost-sharing for a family does not exceed 5% of a family's income as is required by Section 2103(3)(B) of Title XXI. Healthy Families' premiums are established in statute, along with a limit of $250 on the total copayments which would be required of a family annually. The table below demonstrates that the maximum cost sharing falls well within the 5% annual cap. Although dental and vision benefits are optional in SCHIP, this table shows how many such visits a child could have before exceeding the limit. Table 2 demonstrates the aggregate cost sharing for families above 150% FPL up to and including 200% FPL,

I	II	III	IV	V	VI	VII
Family Size	Annual Income of a Single Parent Family @ 150% FPL +$1*	5% Ceiling	Annual Premium Contribution**	Annual Premium + $250 Family Cap on Health Copays	Percentage of Annual Income	Number of Dental and Vision Visits for Non-Preventive Services Needed to Exceed Ceiling
1 child	$21,001	$1,050	$144	$394	1.9 %	131
2 children	$26,401	$1,320	$288	$538	2.0%	156
3+children	$31,801	$1,590	$432	$682	2.1%	182

*Dollar amounts are based on April 1, 2008 FPL.
**Dollar amounts do not include premium discounts for pre-payment. If included, it would reduce the premium contribution amounts by 25%.

Table 3: Aggregate Cost Sharing for Families Above 200% FPL for HFP

California ensures that the annual aggregate cost-sharing for a family does not exceed 5% of a family's income as is required by Section 2103(3)(B) of Title XXI. Healthy Families' premiums are established in statute, along with a limit of $250 on the total copayments which would be required of a family annually. The table below demonstrates that the maximum cost sharing falls well within the 5% annual cap. Although dental and vision benefits are optional in SCHIP, this table shows how many such visits a child could have before exceeding the limit. Table 3 demonstrates the aggregate cost sharing for families above 200% FPL up to and including 250% FPL,

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I	II	III	IV	V	VI	VII
Family Size	Annual Income of a Single Parent Family @ 200% FPL + $1*	5% Ceiling	Annual Premium Contribution**	Annual Premium + $250 Family Cap on Health Copays	Percentage of Annual Income	Number of Dental and Vision Visits for Non-Preventive Services Needed to Exceed Ceiling
1 Child	$28,008	$1,400	$204	$454	1.6%	189
2 children	$35,201	$1,760	$408	$658	1.9%	220
3+children	$42,401	$2,120	$612	$862	2.0%	251

*Dollar amounts are based on April 1, 2008 FPL.
**Dollar amounts do not include premium discounts for pre-payment. If included, it would reduce the premium contribution amounts by 25%.

Copays. Healthy Families sets health benefit copayments at $5, the lowest priced copayments available on the private market in California today. A copayment level of $5 is reasonable for families with incomes below 150% FPL for a number of reasons. First, Healthy Families will charge no copays for any preventive services, and no family will be required to pay any copayments after it has contributed $250 annually. Also, Healthy Families will not charge any copay for institutional services, in contrast to Medicaid law which allows a 50% copayment for the first day of institutional care. Finally, Title XXI requires that cost sharing not exceed an amount that is "nominal" under Medicaid law, with appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The maximum copayment for a service costing over $50 is $3 under Medicaid law and was established in 1978. When adjusted for 1996 using the California Consumer Price Index (CPI), that copayment level rises to over $7, well above the $5 copay proposed by California.

The $250 limit does not apply to dental or vision coverage. Further, as California does not have copays for most dental services that children receive (preventive exams, cleanings, restorations, sealants, and fluoride treatments) it has lowered all other copays to five dollars. Children who meet CCS conditions will receive their services (orthodontics) from CCS without a copay. Therefore, including dental services in the $250 maximum is not needed. Very few families will have to pay a copay at all for dental services and those that do will be for a specific condition (root canal) which should have limited utilization.

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Table 4: Aggregate Cost Sharing for Families Above 250% for C-CHIP

California's approved State Plan demonstrates that the cost sharing requirements do not exceed those allowable under Title XXI. Even though the cost sharing requirements are slightly higher in the C-CHIP projects compared to the Healthy Families Program, the higher income level is commensurate with the difference. Using 250% FPL as the baseline income, Table 4 below provides an analysis of the five percent cost sharing limit compared to the highest premium that would be charged by any given county. Therefore California provides assurances that the cost sharing requirements continue to be within the allowable limits established under Title XXI. Included in the cost sharing limit California assures that the $250 copayment cap also applies to the C-CHIP projects. This is also reflected in Attachment 6 and 7.

I	II	III	IV	V	VI
Family Size	Annual Income of a Single Parent Family @ 250% FPL +$1*	5% Ceiling	Annual Premium Contribution**	Annual Premium + $250 Family Cap on Health Copays	Number of Dental and Vision Visits for Non-Preventive Services Needed to Exceed Ceiling
1 child	$35,001	$1,750	$168	$418	266
2 children	$44,001	$2,200	$336	$586	322
3 children	$53,001	$2,650	$504	$682	393

*Dollar amounts are based on April 1, 2008 FPL

**Does not include premium discounts for pre-payment. If included, it would reduce the premium amounts by 25%.

ACCESS TO INFANTS AND MOTHERS (AIM) PROGRAM

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The amount of premium charged for AIM coverage is limited to 2% of family income for women enrolled prior to July 1, 2004 and no copays are charged. The premium charged to women enrolled on or after July 1, 2004 is limited to 1.5% of family income and the infant born to these women will be enrolled in the Healthy Families Program. Infants enrolled in the Healthy Families Program will be subjected to the standard cost sharing requirements.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

The provision of child health assistance to low income children who are American Indians (as defined in section 49(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c), (Section 2102)(b)(3)(D)) or who are Alaskan Natives (as defined in the Alaska Native Claims Settlement Act, 43 U.S.C. 1601), will be assured through the following procedures:

- Technical assistance by the state American Indian Health Program, Federal Indian Health Services, and tribes in tracking of services to American Indians.

- Inclusion of American Indian ethnicity using the federal definition on the application form for tracking purposes.

- Training to local American Indian clinic staff for outreach and referral to the Healthy Families Program.

- Use of the 30 American Indian primary care clinics (which are CHDP providers) to screen low income youth, provide initial treatment and referral either to Medi-Cal or Healthy families.

- Implementation of a provision to exempt American Indian and Alaska Native (AI/AN) families that meet the cost sharing waiver requirements, from monthly premiums and benefit copayments. This exemption is implemented the same in C-CHIP as it is in the Healthy Families Program. The exemption from premiums will be made at the time of application submission when a family declares AI/AN status consistent with the documentation requirements listed below. The family will have two months to submit the required documentation to continue the premium waiver. If documentation is not submitted within two months from

enrollment, premiums will be charged prospectively. When acceptable documentation is submitted, the copayment waiver will also be applied. Acceptable documentation for the applicant or the child includes:

1. An American Indian or Alaskan Native enrollment document from a federally recognized tribe; or

2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; or

3. A Certificate of Indian Heritage from an Indian Health Service facility operating in the State of California.

- Education to Certified Application Assistants about the cost sharing exemption for AI/AN families that meet the cost sharing waiver requirements.

- C-CHIPs will provide the same cost sharing waivers as the Healthy Families Program.

- C-CHIP will include this cost sharing exemption notice in their member handbooks consistent with the Healthy Families Program.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Currently, if a program participant fails to make a payment, the next month's invoice he receives includes a 30 day past due warning. The second month's invoice includes the amount due for the previous month and the current month, the date by which payment must be remitted, and the date the coverage will end if payment is not made. If the premium is 45 days past due, a warning letter is sent to the applicant, which includes information on payment options, the disenrollment date, and an instructions on how to complete the request form for continued enrollment. If the premium has not been received on the 20th of the second month, a courtesy call is placed to the applicant. The applicant is reminded that a premium payment is due and that his or her child will be disenrolled as of the end of the month. He or she is also questioned regarding whether he or she received the notification. A last billing statement is also mailed to the applicant on the 20th day of the month, and if HFP has not received

payment by the last day of the second month, a disenrollment with appeal information letter is sent to the applicant.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

In the development of the C-CHIP projects, the counties implemented the core design of the Healthy Families Program with some variation. As such, the notification process described above for the Healthy Families Program is the minimum which occurs in the C-CHIP projects. Some C-CHIP projects send four notices prior to disenrollment and others include phone calls to the applicant prior to disenrollement. In addition, all four C-CHIP projects have established enrollee protections as required under Title XXI. These enrollee protections include continued enrollment in the program during the time an appeal disputing the decision to disenroll from the program is being reviewed.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ **State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))**
- ☒ **The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. (42CFR 457.570(b))**
- ☒ **In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing Category as appropriate. (42CFR 457.570(b))**
- ☒ **The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ **No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements.** **(Section 2105(c)(5) (42CFR 457.224)** **(*Previously 8.4.5)***

8.8.3. ☒ **No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.**
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ **Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997.** **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ **No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.** **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ **No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).** **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children:
(Section 2107(a)(2)) (42CFR 457.710(b))

California has developed strategic objectives for increasing the extent of creditable health coverage for targeted low-income children and other low-income children. These objectives are all focused toward the state's overarching concern: that the outcome of increasing the extent of creditable health coverage will significantly improve the health status of California's children. The strategic objectives are to:

1. Increase the awareness of low income uninsured families about the availability of comprehensive low or no cost health coverage for children as well as the importance of timely and ongoing care for children. Motivate such families to obtain coverage for their children.

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2. Provide a choice of health plans for families to choose from in obtaining coverage for their children.

3. Provide an application and enrollment process which is easy for targeted low-income families to understand and use.

4. Assure that financial barriers do not keep families from enrolling their children in the program.

5. Assure that health services purchased by the program are accessible to enrolled children.

6. Assure the participation of community-based organizations in outreach and education activities.

7. Encourage the inclusion of traditional and safety net providers in health plan networks.

8. Strengthen and encourage employer-sponsored coverage to the maximum extent possible.

9. Assure that enrolled children with significant health needs receive access to appropriate care.

9.2. Specify one or more performance goals for each strategic objective identified:
(Section 2107(a)(3)) (42CFR 457.710(c))

The following performance goals and measures have been identified for each of the strategic objectives defined above:

Objective 1: Increase the awareness of low income families about the availability of comprehensive low or no cost health coverage for children as well as the importance of timely and ongoing care for children. Motivate such families to obtain coverage for their children.

Performance goals:

1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.

1.2 Reduce the percentage of uninsured children in target income families that have family incomes above no cost Medi-Cal levels.

1.3 Reduce the percentage of children using the emergency room as their usual source of primary care.

Proposed measures:
California will use Current Population Survey longitudinal data as well as Medi-Cal and emergency room data as obtained by the Department of Health Services.

Objective 2: Provide a choice of health plans for families to choose from in obtaining coverage for their children.

Performance goals:

2.1 The Healthy Families insurance pool and Medi-Cal will provide each family with two or more health plan choices for their children.

Proposed measures:
California will use a quantitative evaluation of the number of health plan choices provided to Medi-Cal and Healthy Families enrollees. California will conduct an analysis by region of the demographic distribution of members by health plan in Medi- Cal and Healthy Families.

Objective 3: Provide an application and enrollment process which is easy for targeted low-income families to understand and use.

Performance goals:

3.1 Assure that Medi-Cal and the insurance program's enrollment contractor provide written and telephone services in the languages spoken by the target population.

3.2 Develop an application process that can be completed without an in-person meeting.

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Proposed measures:

MRMIB will assess its effectiveness in meeting these goals for the insurance program. MRMIB's enrollment contractor will track the percentage of insurance program applications which are approved without being mailed back for additional information, and will ensure that the average time interval between receipt of application and establishment of eligibility is no more than 10 days. By July 1, 1998, MRMIB will ensure that all enrollment materials for the insurance program are available in the threshold languages identified by DHS and that materials are available at an eighth grade reading level.

By June 1, 1998, DHS will develop a work plan for creating a simplified Medi-Cal application. By April 1, 1998, DHS will have all program enrollment materials in the threshold languages.

Objective 4: Assure that financial barriers do not keep families from enrolling their children in the program.

Performance goals:

4.1 Limit program costs to a point where cost of participating in health coverage will not exceed two percent of a family's annual household income.

Proposed measures:

California will survey uninsured persons in the target population to determine if financial barriers prevent their enrollment, and track such data longitudinally. MRMIB will also survey families disenrolling from the insurance program to assess whether cost influenced their decision to disenroll.

Objective 5: Assure that health services purchased by the program are accessible to enrolled children.

Performance goals:

5.1 Achieve year to year improvements in the percentage of targeted low income children that have had a visit with a primary care provider during the year.

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5.2 Achieve year to year improvements in the percentage of targeted low income children that have had well-child examinations at the appropriate intervals for their age.

5.3 Achieve year to year improvements in the percentage of targeted low income children who receive required immunizations by age 2 and by age 13.

Proposed measures:

California will use HEDIS measures relevant to children's service accessibility for all health plans participating in the insurance program, and participating health plans will be contractually obligated to participate in annual audited HEDIS reporting.

Objective 6: Assure the participation of community-based organizations in outreach and education activities.

Performance goals:

6.1 Insure that a variety of entities experienced in working with targeted low income populations are eligible to receive the application assistance fee for assisting families with enrollment.

6.2 Insure that a variety of entities experience in working with targeted low income populations receive subcontracts with the outreach/education contractor have input in the development of culturally and linguistically appropriate outreach and enrollment materials.

Proposed measures:

DHS will require the outreach/education contractor to allocate a percentage of resources to fund the participation of community-based organizations in the state's outreach efforts, and will require the contractor to document their participation. MRMIB will use its Advisory Board -- which includes representation from the community -- to receive external feedback on the participation of community based organizations in its use of the application assistance fee.

Objective 7: Encourage the inclusion of traditional and safety net providers in health plan networks.

Performance goals:

7.1 Achieve increases in the number of children enrolled in the insurance pool who have access to a provider located within their zip code.

7.2 Achieve increases in the number of children who have access to traditional and safety net providers as defined by MRMIB.

Proposed measures:

MRMIB will require participating plans to report annually on the number of subscribers selecting traditional and safety net providers.

Objective 8: Strengthen and encourage employer-sponsored coverage to the maximum extent possible.

Performance goals:

8.1 Maintain the proportion of children under 200 percent of FPL who are covered under an employer-based plan, taking into account decreases in coverage due to increasing health care costs or a downturn in the economy.

Proposed measures:

California will use data from the Current Population Survey to assess changes in the insurance status of targeted low income children. In addition, when determining eligibility for the insurance program, MRMIB will ask questions relating to past employer-based insurance coverage, allowing California to track the number of children who have access to employment-based coverage and to ensure that children enrolling in Healthy Families are uninsured rather than dropping employment based coverage to participate in the program.

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Objective 9: Assure that enrolled children with significant health needs receive access to appropriate care.

Performance goals:

9.1 Achieve year to year maintenance and/or improvements in the percentage of children with special health care needs with a source of insurance for primary care and specialty care.

9.2 Ensure that children with special health care needs experience no break in coverage/services as they access specialized services.

Proposed measures:

MRMIB will track the number of children with special health care needs who participate in the program. MRMIB will also monitor subscriber complaints and health plans' compliance with referral requirements.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

The volume of children in C-CHIP, coupled with the short term duration of the funding makes it infeasible to set up separate performance goals and measures. However the C-CHIP projects are modeled consistent with the Healthy Families Program and the health plans delivering the C-CHIP services are the same health plans. Thus, the information produced for the Healthy Families Program plans will be reflective of the performance for C-CHIP.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Measures are outlined in Section 9.2 above.

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Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☒ **The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**

9.3.2. ☒ **The reduction in the percentage of uninsured children.**

9.3.3. ☐ **The increase in the percentage of children with a usual source of care.**

9.3.4. ☐ **The extent to which outcome measures show progress on one or more of the health problems identified by the state.**

9.3.5. ☒ **HEDIS Measurement Set relevant to children and adolescents younger than 19.**

9.3.6. ☐ **Other child appropriate measurement set. List or describe the set used.**

9.3.7. ☐ **If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**

- **9.3.7.1.** ☐ **Immunizations**
- **9.3.7.2.** ☐ **Well child care**
- **9.3.7.3.** ☐ **Adolescent well visits**
- **9.3.7.4.** ☐ **Satisfaction with care**
- **9.3.7.5.** ☐ **Mental health**
- **9.3.7.6.** ☐ **Dental care**
- **9.3.7.7.** ☐ **Other, please list:**

9.3.8. ☒ **Performance measures for special targeted populations.**

9.4. ☒ **The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires.** **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ **The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports.** **(Section 2107(b)(2)) (42CFR 457.750)**

The state will perform the annual assessments and evaluations required in Section 2108(a) to assess its progress in meeting the performance goals and measures

identified in Section 9. Data necessary to prepare these reports will be drawn from administrative files maintained by the Healthy Families and Medi-Cal programs, the Current Population Survey, disenrollment surveys of Healthy Families Program participants, and HEDIS reports. In addition, the state intends to secure philanthropic funding for an independent third party evaluation of the Healthy Families program.

By March 31, 2000, the state will submit an evaluation that includes the elements specified in Section 2108(b) of Title XXI.

The evaluation will include an assessment of Healthy Families' effectiveness in increasing the number of children with creditable health coverage. MRMIB will evaluate its effectiveness in meeting this goal by using Current Population Survey data on the proportion of children in families with incomes below 200% FPL who are uninsured. California will also use Current Population Survey data and data collected by the Department of Health Services to assess a change in the percentage of Medi-Cal eligible children who are enrolled in Medi-Cal. In addition, California will use Current Population Survey data to estimate the extent to which Healthy Families has substituted coverage of children under 200% FPL who would have otherwise been covered through an employer.

The March 31, 2000, assessment will also include a description and analysis of the following, as required in Section 2108(b):

- Demographics of children assisted under the state plan.
- Quality of health coverage provided under the plan. As Section 7.1 demonstrates, California will use HEDIS and subscriber disenrollment data to evaluate the effectiveness of care offered through Healthy Families.
- Subsidies and cost-sharing. The state will report the amount of subsidies paid out of state and federal funds and the amount of cost-sharing paid by enrolled families.
- Service area.
- Time limits. Healthy Families offers enrolled children 12 months of continued eligibility. The state will evaluate how many children receive a full year of coverage, and if not, why coverage was dropped.
- Benefits covered and other methods used to provide health assistance.
- Sources of non-federal funding.

The March 31, 2000, assessment will also evaluate the effectiveness of other public and private programs in increasing the availability of affordable quality individual and family health insurance for children. The state will further review the coordination of its Title XXI plan with other programs providing health care and health care financing, including Medi-Cal and maternal and child health services. The state will report on changes and trends affecting the provision of health insurance and health care to children, with an analysis in health care cost indexes, changes in state demographics and income, changes in the work status of parents and the level of unemployment, and any new state legislation enacted subsequent to the plan that will affect children's health care.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

- **9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)**
- **9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**
- **9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)**
- **9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)**

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

From the beginning, California has sought to gather public input in the design of the Healthy Families program. In anticipation of developing a Title XXI children's health program, in late July and early August of 1997, the Secretary of the Health and Welfare Agency and the Director of DHS held round table discussions with interested parties and solicited written feedback from constituency groups. Governor Wilson

introduced his children's health proposal on August 27, 1997. After introduction of the plan, the Secretary of the Health and Welfare Agency held meetings with numerous stakeholder groups to obtain their feedback on the proposal. Using the Governor's proposal as a framework, the Healthy Families state legislative package (AB 1126, SB 903, AB 217, and AB 1572) was developed through a joint "Health Access" conference committee. The conference committee held several open committee meetings, during which time the public was invited to offer feedback on the Healthy Families proposal.

Since the passage of Healthy Families' enabling legislation, MRMIB and DHS staff has met with numerous interested parties to solicit feedback on the design and implementation of the state plan. Some examples of such interested parties are: the Association of California Life and Health Insurance Companies, the California Association of Public Hospitals, the California Medical Association, the California Primary Care Association, the Local Health Plans of California, the DHS Multicultural Task Force, representatives of the Private Essential Access Community Hospitals, the California HealthCare Foundation, the Los Angeles County Medi-Cal Managed Care Oversight Council, the Children's Hospital Association, the Child Health Policy Advisory Committee, and the Statewide Parent-Teacher Association.

Furthermore, California held two public forums to receive input from the community to implement its children's health program. The forums, held in Oakland on October 21 and Los Angeles on October 24, were hosted by MRMIB's Chairman, DHS' Director, and the Health and Welfare Agency's Secretary. Over 400 people attended and roughly 60 gave public testimony regarding Healthy Families implementation.

DHS has also solicited input specifically relating to the development of the Healthy Families outreach campaign through a series of eight meetings with representatives of counties, program agencies, community based organizations, advocacy groups, health plans and providers.

The public will have the opportunity to offer input as to the implementation of Healthy Families on an ongoing basis, through opportunities to provide input directly to MRMIB or through the Advisory Board established in statute. MRMIB maintains an extensive mailing list for individuals and entities who want to receive information about MRMIB. Mailing list subscribers receive agendas and minutes of Board meetings and draft regulations. MRMIB holds open meetings twice monthly, where it solicits public input on draft regulations prior to adopting them. In addition to

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receiving oral feedback from the public during MRMIB meetings, MRMIB staff distributes copies of all correspondence regarding Healthy Families implementation to all MRMIB members.

Healthy Families' enabling legislation also established a 14 member Advisory Panel to advise MRMIB. The chair of the Advisory Panel will be elected by the members and will serve as an ex officio, nonvoting member of MRMIB. The Advisory Panel will include representatives from the subscriber population, primary care clinics, disproportionate share hospitals, mental health providers, substance abuse providers, county public health providers, health plans, the education community, and the business community; physicians who are board certified in pediatrics and family practice medicine; and a representative of a family of children with special needs.

COUNTY CHILDREN'S HEALTH INSURANCE PROGRAM (C-CHIP)

MRMIB does this on their behalf by virtue that the Board has public meetings where the public can comment on the Healthy Families Program. Given the C-CHIP projects are modeled after the Healthy Families Program, the C-CHIP projects in essence reflect public comment input.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

Throughout the years, California has solicited and received input from various Indian Tribes, tribal affiliated organizations and boards on matters related to enrollment in the Medi-Cal and Healthy Families Programs as well as the development and implementation of the Healthy Families cost sharing exemption. Several activities include:

- Participation in American Indian sponsored conferences, meetings and workgroups.
- Coordinated distribution of targeted outreach materials to the American Indian population via conferences, clinics, and meetings.
- Meetings with various tribal affiliated organizations and boards to identify acceptable documentation to demonstrate tribal affiliation for families to qualify for the Healthy Families cost sharing waiver.

C-CHIP
Again, we do it on their behalf by virtue that we have done it on a statewide basis for the Healthy Families Program and C-CHIP follows the same AI/AN rules established by the Healthy Families Program.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

Initially, the public was informed of the premium and benefit change through budget hearings, legislative approval and enactment of the 2008 Trailer Bill provisions associated with the 2008-2009 Budget Act, and was again informed of those changes as well as the new waiting list and disenrollment infrastructure through promulgation of regulations in accordance with State law. Promulgation of regulations also entailed public meetings of the MRMIB Board.

In order to provide adequate prior public notice of the family contribution increase that occurred on February 1, 2009 and comply with Section 457.65 (b) through (d), the Healthy Families Program also took a two-pronged approach. There were approximately 326,618 families whose family income is greater than 150% and less than or equal to 250% FPL. Each of these families received an initial notification of the upcoming family contribution increase in the annual open enrollment packet. The open enrollment family contribution increase notification was included in the packet cover page and the applicant letter showing the specific increase in family contribution on the plan selection page for those affected families.

The open enrollment period for 2008 was held November 15, 2008 – December 31, 2008 and the plan transfer took effect on February 1, 2009. The open enrollment packet, sent to families beginning November 5, 2008, provided an option that if the family would be impacted by the premium increase they could have their premium re-evaluated, if their income has decreased. There were three (3) notices sent to each affected family with their monthly billing invoice, regarding the increase of premiums, on October 20, 2008, November 20, 2008 and December 20, 2008.

The program also took additional steps to assure adequate public notice of the increase of the family contributions for families with income greater than 150% and less than or equal to 250% FPL. Enrollment Entities and Certified Application Assistants in the

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local communities were notified through the monthly newsletter and users of the electronic application were also notified through an electronic update message when logging onto the system. Public Service Announcements were provided on the dedicated toll-free line. The HFP website was updated and, starting in November 2008, had a dedicated page regarding the increase of family contributions.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- **Planned use of funds, including --**
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.

- **Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.**

Attached are 3 budget sheets which update the Healthy Families Program budget. The non-Federal share for the Rural Health Demonstration Projects is from funds derived from a tax imposed on tobacco products through a State Proposition (Prop 99).

Payments to AIM Health Plans. AIM is administered by the MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber copayments and contributions, while the subscriber enrolled prior to July 1, 2004 pays two percent of their annual income. A subscriber (200-300% FPL) enrolled after July 1, 2004 pays 1.5% of their annual income. AIM rates paid to health plans reflect the use of bundled costs for prenatal care, delivery services, and 60 days postpartum care. These services will be claimed under Title XXI pursuant to the newly established eligibles.

Payments to Medi-Cal Program (0-200% FPL). The Medi-Cal Program, administered by the California Department of Health Services, provides services through contracts with various health plans as well as a fee for service environment with payments made

directly to providers of service. Eligibles from confirmed pregnancy through birth in household with incomes at or below 200% FPL will receive coverage through the Medi-Cal Program. Prenatal services provided from the confirmed pregnancy through birth, to those who are not eligible for the federally funded non-emergency services under the Medi-Cal Program will be claimed under Title XXI. Medi-Cal payments paid to health plans and providers reflect the use of bundled costs of prenatal care, delivery services, and 60 days postpartum care. These services will be claimed under Title XXI pursuant to the newly established eligibles.

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Healthy Families Program
Title XXI State Plan Amendment
Enrollment and Cost Assumptions
Federal Fiscal Years 1999, 2000, 2001, 2002 and 2003

CASELOAD ESTIMATE ASSUMPTIONS

HFP Monthly Enrollment – Base Program

At the time the State Plan was submitted in November 1997, Current Population Survey (CPS) data estimated that, for children ages 1 to 18 between 100 percent and 200 percent of the federal poverty level, as many as 580,000 may be uninsured, and thus could be potentially served by the Healthy Families Program (HFP). The UCLA Center for Health and Policy Research provided this estimate. An aggressive goal of 34.5% of all eligible children was adopted for the 1st year of program operation. Based on this goal, estimated monthly enrollment by the end of Federal Fiscal Year (FFY) 1998, 1999 and 2000 was 57,000, 261,000, and 501,000 respectively.

At the request of DHS, the UCLA Center for Health Policy Research conducted research in early 1997 to estimate the number of children ages 1 through 18 between 100 and 199 percent of poverty who were uninsured and ineligible for Medi-Cal. Using the March 1996 Current Population Survey (CPS), UCLA arrived at an estimate of 580,000 children in the specified age and income bracket, who were thus potentially eligible for HFP. This estimate was included in California's Title XXI State Plan, which was submitted in November 1997.

In 1998, the UCLA Center for Health Policy Research released revised estimates based on the March 1997 CPS. UCLA estimated that there were approximately 1.74 million uninsured children in California. Of those, an estimated 400,000 were eligible for HFP, and 668,000 were eligible for no-cost Medi-Cal. The 1998 estimates provided by the UCLA Center for Health Policy Research were based upon the March 1997 CPS. The authors of the UCLA estimates reduced prior estimates to reflect the number of undocumented uninsured children who are ineligible for HFP. UCLA also adjusted the data to account for the fact that some sources of income counted by CPS that are not included under HFP and MC. Furthermore, income under CPS is based upon a larger family size than is counted under HFP and Medi-Cal eligibility guidelines. These adjustments further reduced the number of children eligible for HFP and increased the number of children eligible for MC. UCLA further lowered

the estimate of the number of children eligible for HFP to account for the fact that income deductions would not be applied for the HFP[5].

In January 1999, UCLA again updated projections of the number of children eligible for HFP and MC. Basing their work on data from the March 1998 CPS, researchers from UCLA now estimate that 328,000 children are eligible for HFP and 788,000 children are eligible and unenrolled for no-cost Medi-Cal. The researchers explain the decrease in the estimated number of HFP children and the increase in MC children due to changes in the income distribution of the target population.[6]

Based on this revision and on the actual monthly enrollment through February 1999, estimated monthly enrollment is projected as follows:

	Base Program	Cost
FFY 1999	156,250 by 10/1	$ 84,886,683
FFY 2000	281,251 by 10/1	$213,608,109
FFY2001	328,000 by 10/1	$309,040,744

DMH FOR SED SERVICES

- Assumes 3% of the average annual HFP enrollment.

	Cost
FFY 1999	$ 8,541,844
FFY 2000	$20,319,937
FFY 2001	$30,535,090

HFP EXPANSION ENROLLMENT ASSUMPTIONS

Use of Income Disregards up to 250% FPL and Income Deductions

- Caseload estimates assume enrollment will begin 7/99.
- Assumes 132,000 potentially eligible children with net family income under 250 percent of FPL, in addition to above estimated 328,000 base eligible children.

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5 Steve P. Wallace et al. "Technical Notes for *New Estimates find 400,000 Children Eligible for Healthy Families Program, Policy Brief 98-4*." UCLA Center for Health Policy Research. October 1998.
6 Helen Halpon Schauffler et al. "The State of Health Insurance in California, 1998." UC Berkeley Center for Health and Public Policy Studies and the UCLA Center for Health Policy Research. January 1999. Page 24.

- Of the 328,000 identified as potentially eligible, assumes 129,370 children will be enrolling in the HFP. This estimate is based on the January 1999 UCLA estimate of 132,000 children between 0-19 years old that would be eligible if income deductions and income disregards were used to determine income eligibility reduced by MRMIB's estimate of 2,630 children between 0-1 years old. The exclusion of the 0-1 age band was made because the 0-1 years children whose net family incomes (when using Medi-Cal income deductions) are below 200% FPL are eligible for free Medi-Cal and therefore are ineligible for HFP. Estimated monthly enrollment is projected as follows:

	250% Expansion	Cost
FFY 1999	5,337 by 10/1	$ 815,139
FFY 2000	48,514 by 10/1	$29,557,097
FFY 2001	87,325 by 10/1	$71,346,890

Department of Mental Health (DMH) Services for Treatment of Serious Emotional Disturbance (SED)

- Assumes enrollment will begin 7/99.
- Assumes 3% of the average annual HFP enrollment

FFY 1999	$ 428,038
FFY 2000	$ 2,689,752
FFY 2001	$ 6,533,562

Only MRMIB and DMH estimate costs for this proposal. The DHS estimates no additional costs for Child Health Disability Program (CHDP) because the program eligibility ceiling is 200% FPL and does not use income deductions in eligibility determinations. DHS also estimates minimal costs for California Children's Services (CCS).

LEGAL IMMIGRANTS POST 8/22/96
(Cost for legal immigrants are funded from 100 percent State Funds and are excluded in the budget display)

- Caseload estimates assume enrollment will begin 7/99.

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- Assumes 40,000 potentially eligible legal immigrant children will enter the United States in a five year period (or 8,000 legal immigrant children annually) based on the revised UCLA report dated 1/99.
- Assumes the 40,000 potentially eligible children will enroll over a seven year period.
- Assumes 8,000 eligible children for every 12-month period beginning 8/22/96.
- Assumes a cumulative backlog of 22,667 eligible children for the 34-month period ending 7/1/99.
- Estimated monthly enrollment is projected as follows:

	Legal Immigrants	Cost
FFY 1999	920 by 10/1	$ 133,632
FFY 2000	8,520 by 10/1	$ 4,518,707
FFY 2001	17,799 by 10/1	$12,384,323

This expansion program will be 100% State-funded (requiring no federal matching Title XXI funds) unless federal matching funds are made available by Congress.

DMH FOR SED SERVICES

- Assumes enrollment will begin 7/99.
- Assumes 3% of the average annual HFP enrollment.

FFY 1999	$ 71,844
FFY 2000	$ 480,067
FFY 2001	$ 1,275,720

Only MRMIB, CCS and DMH estimate costs for this proposal. Estimated CCS costs are $137,000 total funds. The DHS estimates no additional costs for Child Health Disability Program (CHDP).

MRMIB Payments to Health, Dental and Vision Plans. These health services costs are the estimated insurance premium costs as the served population grows over time.

Estimated payments (or premiums) for health, dental, and vision per month are: $71.50 per enrolled child per month (PCPM) for October 1998 through June 1999 and $80.08 PCPM for the period July 1999 through September 2001. For children under age 1, estimated premiums are 230.00 PCPM.

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MRMIB Offsetting Premium Payments. The total health services costs are offset by a monthly premium (or contribution) payment per child paid by the family. The administrative vendor, on behalf of MRMIB collects these premiums. These premiums will be collected by the health plan.

Estimated offset of premium payments per child per month is $5.00.

Payments for Application Assistance Fee (One time). The application assistance fee which MRMIB will pay for referrals of eligible subscribers is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, county child health and disability prevention program providers, clinics, and hospitals.

Estimated payment for application assistance fee per family is $50.00; estimated monthly enrollment by end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Case Management Costs. The cost of assisting families to maintain their child's enrollment in the HFP will be $66,995 in FFY 1999. Each HFP subscriber is re-evaluated annually prior to their anniversary date in the program to determine continued eligibility for the program. The provision of annual eligibility review by qualified application assistants helps to assure continuity of coverage for enrolled children. The maintenance of a medical home for children is a core objective for the HFP.

MRMIB Payments to Access for Infants and Mother (AIM) Health Plans. AIM is administered by the MRMIB, which contracts with the private sector to provide subsidized coverage for uninsured and underinsured women and their newborn infants through two years of age. To cover the full cost of care, California uses Cigarette and Tobacco Products Surtax Funds (Proposition 99) to subsidize subscriber co-payments and contributions, while the subscriber pays a premium amount equal to two percent of the family's average annual income. Roughly four percent of AIM enrollees have access to high deductible insurance coverage, or have insurance coverage for their children. Based on HCFA's technical guidance, MRMIB agreed not to claim Title XXI matching funds for infants enrolled with access to high deductible insurance coverage (identified through the application process), since their insured status excludes them from the definition of Title XXI's population.

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California Children's Services (CCS). The CCS Program component of the HFP reflects estimated costs of providing services for the eligible children (under 200percent of poverty) enrolled in CCS. CCS provides specialty and sub-specialty services to children with special health care needs, which require case management and authorization of services to ensure that appropriate treatment and services are provided. CCS will be responsible for all medical, dental, and vision services necessary to treat an enrolled child's CCS eligible condition in coordination with the HFP plan delivery of primary and preventative health care services.

Average cost per eligible per month is $124.00. It is also assumed that the county and state will participate equally in the match requirement.

Child Health & Disability Prevention (CHDP). Through this program, children who receive a CHDP screen will be pre-enrolled in Medi-Cal or the Healthy Families Program (HFP). Pre-enrollment will involve two months of full-scope Medi-Cal coverage, during which time the family may apply for ongoing Medi-Cal or Healthy Families Program coverage. California will only claim Title XXI funding for previously approved S-CHIP benefits. Following are the assumptions used in the cost estimate:

a) An estimated 4,300 children will be eligible for pre-enrollment into the Healthy Families Program in the 1st month of PE implementation.
b) An estimated 8,500 new children will be eligible for pre-enrollment into the Healthy Families Program in the 2nd month of PE implementation.
c) An estimated 13,000 new children will be eligible for pre-enrollment into the Healthy Families Program in the 3rd month of PE implementation.
d) An estimated 17,000 new children will be eligible for pre-enrollment into the Healthy Families Program in the 4th and ongoing months of PE implementation.

Rural Health Demonstration Projects – MRMIB & DHS. The Healthy Families rural demonstration projects were established to improve access to health care services for medically under-served and uninsured populations in rural areas, and special populations who have rural occupations (farm workers, loggers, etc.).

The MRMIB's $6 million ($2.038 million GF and $3.962 million FFP) augmentation is to develop and enhance existing health care delivery networks through contract amendments with participating HFP health dental and vision plans. This

augmentation addresses geographic access barriers and access barriers for special population subscribers enrolled in the HFP (seasonal and migrant farm workers, and American Indians).

Mental Health – For SED Services. The mental health component of the Healthy Families Program (HFP) represents the total estimated costs of providing mental health services to eligible children with serious emotional disturbance (SED) consistent with the Bronzan/McCorkadale Act. These services are provided through a single, local, public entity because the expertise and resources for serving this special needs population is currently in the county mental health programs. The HFP health plans are responsible to provide psychiatric inpatient hospital services to this population up to the limit of the benefit, which is 30 days on an annual basis. The costs associated with the basic benefit have not been included here. Medically necessary mental health services for the SED population beyond the basic inpatient benefit are the responsibility of the county mental health programs. The proportion of SED children enrolling is estimated to be three percent of the average annual HFP enrollment. Three percent is a conservative estimate of the incidence of SED based on national and state prevalence and usage data used by the Department of Mental Health (DMH) when estimating services and funding needs for the Medi-Cal population ages 0 to 21.

The estimated average cost per child per month is $229.00. The estimated monthly enrollment of children with SED in HFP for1999, 200 and 2001 is 2,965, 7,510 and 11,840 respectively.

Oral Health Demonstration Project. The Managed Risk Medical Insurance Board, in conjunction with the California Children's and Families Commission (CCFC) will provide $1 million in CCFC funds (drawing $2 million in FFP) each year for a total of $3 million a year. The total funds used for this project will be $9 million over the 3 year lifespan of the project to increase the awareness about the importance of preventive oral health among parents and caregivers of young children and reduce the incidence of early childhood caries. This funding addresses the epidemic of early childhood caries that exists in the state.

Accelerate Coverage of Children Under 100 Percent of Federal Poverty Level (FPL). The DHS 100 percent program previously provided coverage to children whose families have income in excess of the maintenance need but less than 100 percent of

poverty if they were born after September 30, 1983. In March 1998, the program was expanded to cover children under the age of 19.

The estimated average cost per child is $89 per month and the estimated number of eligible children is 15,818 averages monthly. Eligible children are expected to phase-in over 19 months. The cost estimates reflect Title XXI federal funding available for these eligible children in excess of the Title XIX federal funding. The full costs for these eligible children are included in the Medi-Cal base estimate.

Asset Waiver for Children. Resources will not be counted in determining the Medi-Cal eligibility for children eligible under the various Percentage Program limits.

The estimated average cost per child under 15 years of age is $48, and 15through 18 years of age is $89. There were 592 eligible children in February 1999. It is assumed that this population will continue to grow at a rate of 250 per month.

One Month Bridge from Medi-Cal to Healthy Families. A federally acceptable One Month Bridge Program of Title XXI funded health care for children becoming ineligible for free Medi-Cal was established by AB 2780, Chapter 310 Statutes of 1998. This program (which covers one month only) was implemented on November 1, 1998. To be eligible, families' income must be between 100 percent and 200 percent of the federal poverty level. The estimated average cost per child is $43 per month and the estimated number of eligible children, once the program is fully implemented is 8,036 per month. In February 1999 there were 471 children eligible. It is assumed that the caseload will grow at a rate of 250 per month to the total 8,036.

MRMIB Payments to Administrative Vendor. MRMIB payment to the HFP administrative vendor for eligibility determination and enrollment services are classified as administrative costs in accordance with Health Care Financing Administration (HCFA) guidelines for claiming Title XXI funds. The administrative vendor contract (contract) with Electronic Data Systems (EDS) includes final negotiated per child per month (PCPM) costs of $52.00 for the first 10,000 subscribers and $3.85 thereafter. Also included are minimal costs for the state share of transactions fees for families' cash and credit card payments, and bad check fees from the families' first month premium payments.

Statewide Outreach Campaign. The State has implemented various activities to provide information to families regarding both Medi-Cal and HFP, and to encourage

and increase enrollment of children in both programs. Full year outreach activities are estimated at $12 million annually.

Note: The Outreach budget includes the one-time application assistance fees and annual eligibility review fees.

Mental Health County Administration. This is the administrative cost portion of the Healthy Families Program county mental health funding.

Medi-Cal Conforming Costs - County Administration. This represents the total estimated cost for counties to determine eligibility for a) accelerated Coverage of Children Under 100 percent FPL; b) asset waiver for children.

EDS Costs - Fiscal Intermediary (FI). Provider reimbursement for all fee-for-service elements of expanded access is processed by EDS, the Medi-Cal Fiscal Intermediary (FI) through an automated payment system integrated with the California-Medi-Cal Management Information System (CA-MMIS). It is assumed that all providers would utilize the HCFA 1500 and UB92 standardized Medi-Cal claim forms as well as the CHDP PM 160. The current CA-MMIS models for expanded access for HFP. The CHDP system will allow assessments and the CA-MMIS will accommodate any treatment claims. Both systems require enhancements to comply with Title XXI requirements.

One Month Bridge. This is the county administration cost associated with implementation of the One Month Bridge Program described in Section I.B.5.

State Administration - MRMIB. MRMIB administers the HFP estimates health care for approximately 497,000 children of moderate income working individuals through subsidized private health insurance plans. The current state fiscal year 1999/00 budget includes authority for 28.0 positions and $3.314 million total funds ($1.342 million General Fund).

State Administration - DHS. The Department of Health Services has, in the current state fiscal year 99/00, budget authority for 12 positions and $1.268 million ($.387 million General Fund). These resources are necessary to meet requirements of the HFP legislation, conduct the activities necessary to expand Medi-Cal health coverage for low-income uninsured children, and provide education and outreach activities.

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Attached are a series of exhibits which explain how the amounts for benefits and other cost components were calculated.

Exhibit 1- Estimated enrollment and related costs for Healthy Family program benefits, premium payments, contractor payments and assistance fees.
Exhibit 2- Enrollment assumptions
Exhibit 3- Benefit cost assumptions
Exhibit 4- Average premium calculation
Exhibit 5- Basis for Title XXI-eligible Access for Infants and Mothers program costs (the AIM estimate has since been reduced by 4 percent in response to HCFA's concern that AIM covers infants with access to insurance coverage)
Exhibit 6- Basis for Title XXI-eligible California Children's Services program costs
Exhibit 7- Basis for Title XXI-eligible Child Health and Disability Prevention program costs
Exhibit 8- Basis for Title XXI- Mental Health Services benefit and associated administrative costs
Exhibit 9- Assumptions and calculations for conforming Medi-Cal program costs for accelerated coverage, asset waiver, extended eligibility and outreach program costs (First year outreach costs revised to match chaptered legislation. First year estimate for extended eligibility has been reduced because California will have to pass state clean-up legislation before it can implement extended eligibility in accordance with HCFA's parameters. Original extended eligibility estimate assumed a May 1, 1998 implementation date, while amended estimate assumes a July 1, 1998 implementation date.)
Exhibit 10- Basis for cost estimate for the Fiscal Intermediary requirements (Revised cost estimate. California will claim Fiscal Intermediary costs under Title XIX rather than seek the enhanced FFP under Title XXI)
Exhibit 11- The state budget proposal for DHS administrative staff costs (Revised cost estimate includes amount for overhead costs consistent with the HCFA-approved indirect cost rate plan and additional application printing costs)
Exhibit 12- The state budget proposal for MRMIB administrative staff costs (Revised cost estimate includes additional financial accounting and processing staff in response to HCFA draft guidelines)
Exhibit 13- Revised State Plan budget table with revised administrative cost amounts and percentage calculations

Payment to Health, Dental and Vision Plans. Current Population Survey data estimates that, for children ages 1 to 18 between 100 percent and 200 percent of the

federal poverty level, as many as 580,000 may be uninsured, and thus could potentially be served by the Healthy Families Program. These health services costs are the estimated insurance premium costs as the served population grows over time.

Estimated payment for health, dental, vision per month is $70.25; estimated monthly enrollment by the end of Federal Fiscal Year (FFY) 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Offsetting Premium Payments. The total health services costs will be offset by a monthly premium payment per child paid by the family. These premiums will be collected by the health plan.

Estimated offset of premium payments per child per month is $6.00; estimated monthly enrollment by the end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Payments to Enrollment Contractor. The Managed Risk Medical Insurance Board (MRMIB) will contract with a private company to conduct the eligibility and enrollment process. This is the same process that it uses for its three existing programs.

Estimated payment to enrollment contractor per child per month is $3.50; estimated monthly enrollment by end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Payments for Application Assistance Fee (One time). The application assistance fee which MRMIB will pay for referrals of eligible subscribers is another feature which will facilitate coordination with public and private entities. MRMIB will specify those agencies and persons in regulation after public hearing, but anticipates authorizing a wide range of entities including insurance agents, county child health and disability prevention program providers, clinics, and hospitals.

Estimated payment for application assistance fee per family is $50.00; estimated monthly enrollment by end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Payments to AIM Health Plans. AIM is administered by the MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the

full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber copayments and contributions, while the subscriber pays two percent of their average annual income.

Estimated payments to AIM health plans average $4,888,190 per year.

California Children's Services (CCS). The CCS Program component of the Healthy Families Program reflects estimated costs of providing services for the eligible children (under 200% of poverty) enrolled in CCS. CCS provides specialty and subspecialty services to children with special health care needs which require case management and authorization of services to ensure that appropriate treatment and services are provided. CCS will be responsible for all medical, dental, and vision services necessary to treat an enrolled child's CCS eligible condition in coordination with the Healthy Families Program plan delivery of providing the primary and preventative health care services.

Average cost per eligible per month is $180.50; estimated monthly enrollment by end of FFY 1, 2, and 3 is 2,048, 9,377, and 18,000 respectively. It is also assumed that the county and state will participate equally in the match requirement.

Child Health Disability Prevention (CHDP) (Without EDS Costs). The CHDP estimate reflects payment to CHDP providers for screening exams and initial follow-up treatment for new Healthy Families Program enrollees during a period up to 30 days during which their application to the Program is pending. It is anticipated the CHDP providers will be a major source of referral for the Program.

Average cost of CHDP screen for age 1-18 is $65.96 and average cost of 30-day follow up treatment is $18.50. It is estimated that 12,500 enrolled first month and 8,000 each additional month through June 1998; thereafter, 10,000 enrolled each month through June 1999.

Mental Health. The mental health component of the Healthy Kids program represents the total estimated costs of providing mental health services to children who are under 200% of poverty with serious emotional disturbance (SED) consistent with the Bronzan/McCorkadale Act. These services are provided through a single, local, public entity because the expertise and resources for serving this special needs population is currently in the county mental health programs.

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Average cost per child per month is $220.00; estimated monthly enrollment for FFY 1, 2, and 3 is 1,710, 7,830, and 15,030 respectively.

Accelerate Coverage of Children Under 100% of FPL. The 100% program currently provides coverage to children who have income in excess of the maintenance need but less than 100% of poverty if they were born after September 30, 1983. The program is being expanded to cover children under the age of 19.

Average cost per child is $89 per month; estimated number of children is 15,818 per month.

Asset Waiver for Children. Resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits.

Average cost per child under 15 years is $48, and 15-18 years is $89; estimated number of 67 children eligible is 33,935 per month.

One Month Extended Eligibility When Income Increases. All Medi-Cal Only children discontinued from Medi-Cal or given a share of cost will be given an additional month of zero share of cost Medi-Cal in order to give them time to apply for the Healthy Families Program.

Average cost per child is $43 per month; estimated number of children eligible is 52,391 per month.

Statewide Outreach Campaign. The Department will implement various activities to provide information to families regarding Medi-Cal and the Healthy Families Program.

Full year outreach activities are estimated at $12 million annually.

DMH County Administration. This is the total estimated administrative cost of providing mental health services to the eligible children.

Medi-Cal Conforming Costs - County Administration. This represents the total estimated share of cost for counties providing a) Accelerate Coverage of Children Under 100% FPL, and b) Asset Waiver for Children services.

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EDS Costs - Fiscal Intermediary (FI). Provider reimbursement for all fee for service elements of expanded access would be processed by the Medi-Cal FI through an automated payment system integrated with CA-MMIS. It is assumed that all providers would utilize the HCFA 1500 and UB92 standardized Medi-Cal claim forms as well as the CHDP PM 160. Initial analysis of the CHDP providers system could be used as cost effective model for expanded access for the Healthy Families Program. While this system will require some level of enhancement and will be contingent upon the final parameters identified for implementation, it is anticipated that these modifications can de accommodated on a timely basis.

Ongoing operational costs are estimated to be $1,444,160 annually.

State Administration - MRMIB. MRMIB will administer the Healthy Families Program, and will provide health care for approximately 580,000 children of moderate income working individuals through subsidized private health insurance plans. MRMIB is requesting 18 positions and $1.600 million ($560 thousand General Fund) in the current state fiscal year; and 21 positions and $2.156 million ($755 thousand General Fund) for the state fiscal year 1998- 99.

State Administration - DHS. The Department of Health Services is requesting 19 positions and $2.679 million ($937 thousand General Fund) in the current state fiscal year; and 19 positions and $2.836 million ($993 thousand General Fund for the state fiscal year 1998-99.

This request is necessary to meet the requirement of the Healthy Families legislation, conduct 68 the activities necessary to expand Medi-Cal health coverage for low-income uninsured children, and provide education and outreach activities.

California Poison Control System - The State of California General Fund will provide $2.95 million in funding each State fiscal year which will be used to match $5.47 million in Title XXI Federal Funds for a total of $8.42 million each state fiscal year. This is not a new source of funds under Title XXI. These funds will be used to support the California Poison Control System (CPCS).

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Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

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11.2.4. ☒ **Section 1128A (relating to civil monetary penalties)**

11.2.5. ☒ **Section 1128B (relating to criminal penalties for certain additional charges)**

11.2.6. ☒ **Section 1128E (relating to the National health care fraud and abuse data collection program)**

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

Described below is a description of California's review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. These processes reflect those in the Healthy Families Program and C-CHIP.

a) As required in 42 CFR 457.1130(a), California provides applicants and enrollees the opportunity to review eligibility and enrollment issues such as denial of eligibility; failure to make a timely determination of eligibility; and suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. These eligibility and enrollment issues are specifically included in the Healthy Families regulations, program handbook, and notification letters to applicants and enrollees. All decisions are provided in writing and all decisions which have a negative impact on an applicant or enrollee include instructions on how to appeal the decision if the applicant or enrollee believes the decision is incorrect.

b) For purposes of implementing 42 CFR 457.1170 California has determined that the first level appeal review conducted by the Appeals Unit within the administrative vendor meets the core requirements as defined in 42 CFR 457.1150(a) as an impartial review. The Appeals Unit is a distinct and

separate unit from the Eligibility Unit that makes the initial eligibility determination and is not directly involved in the matter under review.

c) Included in the program's administrative vendor contract is a section on reviewing appeals. In addressing the need for expedited review when there is an immediate need for health services, a contractual provision requires the administrative vendor to forward all appeals in need of immediate review to the Managed Risk Medical Insurance Board within five (5) business days.

d) As required in 42 CFR 457.1170, California provides enrollees the opportunity for continuation of enrollment pending the completion of review of a termination of enrollment, including a decision to disenroll for failure to pay cost sharing. Prior to disenrollment, enrollees are notified of the impending termination, the reason for such termination, and a pre-printed form in which to request continued enrollment and to provide the necessary information or explanation as to why termination should not occur. This provision of the Healthy Families Program was implemented in February 2003.

e) California already provides written notification to applicants and enrollees on all decisions made. In addition, as explained in a. and d. above, all decisions which have a negative impact on an applicant or enrollee include instructions on how to appeal the decision and request continued enrollment if the applicant or enrollee believes the decision is incorrect.

f) California provides all review decisions in writing.

g) California affirms that each applicant or enrollee has the right to represent him or herself or choose a representative, the right to review his or her file and other relevant information and the right to participate fully in the review process. In reviewing the specific requirements of 42 CFR 457.1140(d)(1)-(3) California will modify its current appeal language to include an affirmative statement regarding an applicant's or enrollee's right to representation and opportunity to review his or her records. This modification is in process with California's new administrative vendor and should be complete by March 2004. California complies with the requirement to allow an applicant or enrollee to participate fully in the review process. Any notification of an appeal able determination includes full notification of appeal rights and

instructs the applicant or enrollee that he or she can submit additional information for review.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

Participating plans are required by state law to establish and maintain a grievance system approved by the Department of Managed Health Care (DMHC). The DMHC is responsible for licensing and regulating pre-paid plans (health, dental, and vision) in California.

The plan's grievance process must provide reasonable procedures in accordance with DMHC regulations to ensure adequate consideration of grievances and provide for recertification when appropriate. Subscribers who are not satisfied with the plan's final determination or who have not received a response to their grievance with 30 calendar days, have the option of appealing to the DMHC.

DMHC will review the appeals as a standard review or as an Independent Medical Review (IMR). (The IMR allows subscribers to obtain an impartial review of any health care service eligible for coverage and payment under a health plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the services are not medically necessary). The standard review and Independent Medical Review process include a final resolution by DMHC staff or DMHC contractor that is binding on the health plan.

The patient protection provision in state law that was established for managed care enrollees in California also apply to HFP and C-CHIP subscribers since they are enrolled in licensed managed care plans. Thus, members are instructed to use their health plan's grievance process-including the DMHC's IMR process, if the subscriber has a grievance. When subscribers call MRMIB directly, MRMIB staff serves as an ombudsman assisting subscribers with the grievance process.

MRMIB requires all HFP participating plans to report benefits-related grievances once a year. In addition, MRMIB tracks all complaints directly received from subscribers, and any publicly available information on the number and type of benefit grievances

filed by subscribers enrolled in a participating plan. Grievance information is used by MRMIB to identify problem areas and to take appropriate steps towards improvements.

MRMIB complies with 42 CFR 457.1120(a)(2)(b) using the statewide review system which is required of all health care service plans operating in California, including HFP and C-CHIP participating plans. This system is enforced by the California Department of Managed Care (DMHC). The statewide review system provides an impartial review of any health care service eligible for coverage and payment under a health plan contract. The issues that are handled through this process include:

- Accessibility
- Coverage/Benefits Disputes
- Appeals of Denials of Care/Payment
- Quality of Care
- Billing and Financial
- Attitude and Service

These issues handled through the statewide review system are consistent with the issues that would otherwise be addressed by 42 CFR 457.1130(b).

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

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