

**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.

Effective Date:

December 19, 2007
January 6, 2009
February 1, 2009
July 1, 2009

Wait List/Disenrollment Infrastructure
AIM 6-Month Residency Requirement Elimination
HFP Family Contribution Increase & Vision Benefit Modification
Dental Benefit Cap

Approval Date:

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

(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, 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.*

- 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.

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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.

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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.

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

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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.

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

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**No changes to
Sections 2 and 3
therefore pages 8
through 36 are not
included.**

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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.

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: Children from ages 0 to 19 will be served within the insurance program. Infants ages 0-1 enrolled in the AIM Program if they are born to mothers enrolled in AIM before July 1, 2004. Infant’s ages 0-2 born to mothers enrolled in AIM on or after July 1, 2004.

4.1.3. Income: Presumptive eligibility will be granted to eligible uninsured children in families with household income between 100-200% FPL that receive a health screen or immunizations by a CHDP provider. Income levels for continuous enrollment in the Healthy Families Program is between 100-200% FPL for the insurance program and 200-300% for infants and children through age 2, born to mothers enrolled in AIM. Medi-Cal uses specific exemptions from income, as is detailed in California’s Title XIX State plan. In determining eligibility for Healthy Families, Medi-Cal income exemptions will be applied and all income over 200% FPL but less than or equal to 250% FPL will be disregarded in calculating household income. If the income exemptions and income disregard reduce income to 200% or less FPL, the child will meet the Healthy Families Program income criteria. In determining eligibility for C-CHIP, Medi-Cal income exemptions will be applied and all income over 200% FPL but less than or equal to 300% FPL will be disregarded in calculating household income. If the income exemptions and income disregard reduce income to 200% FPL or less and the child is not otherwise eligible for the Healthy Families Program, the child will meet the C-CHIP income criteria.

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

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Income levels for the AIM Program include household incomes between 200-250%FPL for infants 0-1 born to mothers enrolled in the AIM Program prior to July 1, 2004; and, 200-300%FPL for infants and children through age 2, born to mothers enrolled in AIM on or after July 1, 2004.

- 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.
- 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. Pregnant women 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

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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.

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), unless the employer contribution for dependent(s) is less than \$10, if they are an inmate in a public correctional institution or if they are a patient in an institution for mental illness.
- 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.

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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 provided 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.

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.

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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 which the administrative vendor will verify using copies of the past year's federal income tax forms, or current year wage stubs.

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

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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.

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

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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 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

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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 Board 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.

When a waiting list is implemented, the program will continue to receive new applications; no eligibility determination will be made until adequate funding becomes available.

However, these applications will be screened to the state Medicaid program (Title XIX), for those children who appear to be eligible for Medi-Cal. The State's Single Point of Entry will forward these applications to the applicant's local county welfare department for a Medi-Cal eligibility determination. Each family whose child is placed a waiting list will be notified by letter of this placement. In addition, the notification letter will contain information about where the family may apply for either Medi-Cal, Medi-Cal with a Share of Cost Program, County Children's Health Insurance Program or Kaiser Permanente Child Health Plan.

If the State is using a waiting list, children will be placed on the wait list in the order in which their applications were 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. 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.

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If establishing a wait list is insufficient to ensure operation within allotted expenditures, the MRMIB Board at a public meeting will determine 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 Reviews (AER). These subscribers will also be placed on the waiting list, until sufficient funding is available to cover program expenditures and their application receipt date will be based on their AER disenrollment date. However, children with chronic conditions through California Children's Services (CCS) are exempt from AER disenrollment and will continue their enrollment in the HFP.

If the 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 begin enrolling children who were disenrolled at their AER, in the order of their AER disenrollment date on the waiting list. When all children who were disenrolled at their AER have been removed from the waiting list, eligibility will then be assessed for the additional wait listed children, in the order their application was received.

Only if 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.

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

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 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,

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the new insurance program and Medi-Cal will be substantially similar in terms of eligibility determination criteria.

DHCS 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.

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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)

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.

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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)

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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, DHCS 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.

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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))**

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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.¹

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.

¹ See Chollet, Deborah J., Birnbaum, Michael and Sherman, Michael J. of the Alpha Center, “Deterring Crowd-Out in 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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- 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.
- 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**

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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

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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

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population in the past years. These efforts have been statewide and as such are also made on behalf of the C-CHIP counties.

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**No changes to
Sections 5, 6 and 7
therefore pages 56
through 93 are not
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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.

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.

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.

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The Family Value Packages will have the following monthly premiums - or “family contribution amounts”:

Family Value Package	
Above 100-150% FPL	
One child	\$ 7
Two or more children	14
Above 150-200% FPL	
One child	12 9
Two children	24 18
Three or more children	36 27
Above 200-250% FPL	
One child	17 15
Two children	34 30
Three or more children	51 45

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.

Plans charging rates to the program which are higher than the costs of the designated Family Value Package will be available to families, but they are expected to pay the cost differential as well as the premiums specified above. Example: If two health plans sought to participate in the Program, one at a rate of \$50/month and the other at a rate of \$58/month, to enroll in the more expensive plan a family would have to pay its premium as well as the \$8/month cost differential.

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

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Above 100-150% FPL		
One child	\$ 4	
Two or more children		8
Above 150-200% FPL		
One child	9 6	
Two children	18 12	
Three or more children	27 18	
Above 200-250% FPL		
One child	14 12	
Two children	28 24	
Three or more children	42 36	

If the Community Provider Plan is not among the lowest priced plans available to subscribers, families will also have to pay the difference between the cost of the lowest price plan and the Community Provider Plan. For example: If the Community Provider Plan cost \$58/month and the Family Value Package was at \$50/month, the family would have to pay the \$8/month cost differential, as well as the premiums above.

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

MRMIB will disenroll families that fail to make their family contribution. Where a family has failed to make payment for 60 days and MRMIB has provided a 30 day notice to the family, in writing, of the fact that payment is late, the subscriber will be disenrolled effective the last day of the second month. Children disenrolled pursuant to this section will not be eligible for reenrollment until all past due premiums are paid during the past 12 months.

Family Contribution Sponsors

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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

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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% ~~200%~~ FPL through 250% FPL. The new HFP Category C premiums are \$ 14 ~~\$12~~ - \$17 ~~\$15~~ per month per child with a maximum of \$42 - \$51 ~~\$45~~ 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 ~~\$12~~ per month per child with a maximum of \$42 ~~\$36~~ 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 ~~\$108~~ per child per year. Like the Healthy Families Program, San Francisco County also has a discount program. When an applicant pays \$126 ~~\$108~~ per child per year, this is equivalent to \$14 ~~\$12~~ per child per month with three months free.

Santa Clara County charges monthly premiums at \$14 ~~\$12~~ per child per month with a maximum of \$42 ~~\$36~~ 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 ~~\$36~~ per child; this is equivalent to Healthy Families Program's \$14 ~~\$12~~ 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

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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.

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.

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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

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or after July 1, 2004 will be enrolled in the Healthy Families Program and subject to the cost sharing requirements.

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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.

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

- 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)**

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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.

*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 \$19,801	\$1,050 \$990	\$144 \$108	\$394 \$358	1.9% 1.8%	131
2 children	\$26,401 \$24,901	\$1,320 \$1,245	\$288 \$216	\$716 \$466	2.7% 1.9%	120
3+children	\$31,801 \$30,001	\$1,590 \$1,500	\$432 \$324	\$824 \$574	2.6% 1.9%	203

*Dollar amounts are based on April 1, 2008 ~~6~~ 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

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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,

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 \$26,401	\$1,400 \$1,320	\$204 \$180	\$454 \$430	1.6%	189
2 children	\$35,201 \$33,205	\$1,760 \$1,660	\$408 \$360	\$658 \$610	1.9% 1.8%	220
3+children	\$42,401 \$40,009	\$2,120 \$2,000	\$612 \$540	\$862 \$790	2.1% 2%	251

*Dollar amounts are based on April 1, 2008 6 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
	\$33,001	\$1,650	\$144	\$430	
2 children	\$44,001	\$2,200	\$336	\$586	322
	\$41,509	\$2,075	\$288	\$610	
3 children	\$53,001	\$2,650	\$504	\$682	393
	\$50,005	\$2,500	\$432	\$790	

*Dollar amounts are based on April 1, 2008 6 FPL

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

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ACCESS TO INFANTS AND MOTHERS (AIM) PROGRAM

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

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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.

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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 disenrollment. 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))**

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- 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)

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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.
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.

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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.

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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.

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:

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- 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.
- 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.

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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.

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:

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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.

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**

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- 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.

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- 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)**

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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

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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 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

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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

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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 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.

~~In order to provide adequate prior public notice of the family contribution increase that will occur July 1, 2005 and comply with Section 457.65(b) through (d), the Healthy Families Program is taking a two-pronged approach. There are approximately 100,000 families (180,000 children) whose family income is above 200% and equal to 250% FPL. Each of these families will receive an initial notification of the upcoming family contribution increase in the annual open enrollment packet and a notice that they will be receiving additional information in the coming months. The open enrollment family contribution increase notification is included in the packet cover page, the applicant letter and shows the specific increase in family contribution on the plan selection page for those affected families. The open enrollment packets are sent out in early April annually.~~

~~Of the 100,000 families, approximately 20,000 families are scheduled to go through the Annual Eligibility Review (AER) process in April, May and June 2005 and will be sent a second notification informing them that the AER process will determine whether or not they will be impacted by the upcoming family contribution increase. The notice will inform families of the family contribution increase for families with incomes above 200% FPL. The remaining 80,000 families will be sent their second notification informing them of the increase and providing them a mid-year review form. The mid-year review form is a preprinted form that includes the family income that the program has on file. The form provides the families the opportunity to submit updated income documentation to the program to demonstrate that their family income has decreased and therefore should not be subject to the increase in family contribution. In order to efficiently distribute and process the second group mailing,~~

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~~the mailing will be done in four separate mailings over two months (April & May 2005).~~

~~The program is also taking additional steps to assure adequate public notice of the increase in family contributions for families with income above 200% and equal to 250% FPL. Enrollment Entities and Certified Application Assistants in the local communities will be notified through the monthly newsletter and users of the electronic application will be notified through an electronic update message when logging on to the system. The local community partners can assist families in completing the mid year review form and the AER packet. Also, a separate and dedicated toll free line has been established to assist families with the mid year review process and track the families effected by the family contribution increase. Additionally, program regulations to implement the family contribution increase were presented at two public Board meetings on January 26, 2005 and March 2, 2005.~~

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 four program budget sheets, the first reflects the current approved SCHIP Budget Plan, the second reflects the updated SCHIP Budget Plan including costs for the school based outreach conducted by the Connecting Kids Project effective March 18, 2005, the third reflects the updated SCHIP Budget Plan including the HFP family contribution increase to be effective July 1, 2005, and the fourth reflects the updated SCHIP Budget Plan including costs for both the HFP family contribution increase and the school based outreach. The non-Federal share for the Connecting Kids Project is from funds derived from a private philanthropic foundation, David and Lucile Packard Foundation, a non-healthcare foundation.

The increase in administrative costs between FFY 2005 and FFY 2006 is primarily due to the restoration of the Certified Application Assistance payments listed under

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Outreach/Marketing costs. The total increase in administrative costs attributable to the Connecting Kids Initiative is less than \$200,000 in FFY 2005 and FFY 2006. Therefore the increase in administrative costs is not all attributable to the Connecting Kids Project.

One hundred percent of the non-federal share of project funds for the Connecting Kids Project is derived from a private philanthropic foundation, David and Lucile Packard Foundation, a non-healthcare foundation.

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).

The budget for the program for FFY's 1998, 1999 and 2000 is detailed on the chart below. The following pages document the assumptions used in estimating expenditures. These estimates reflect our best assumptions at this point in time, related to projected costs for the Healthy Families program. These estimates should be used for planning purposes and will be updated, if needed, once final decisions have been made for inclusion in the state budget scheduled for release in early January. In addition, the state and local funds reflected as proposed state match are subject to appropriation by the Legislature as well.

Sources of the non-Federal share of plan expenditures will be the state funds for all program elements except for:

- County mental health which will be matched by local funds;
- California Children's Services (CCS) which will be matched by General Fund and local funds;
- Child Health and Disability Prevention program (CHDP) which will be matched by General Fund and local funds.
- The California Children and Families Commission (CCFC) is a state entity which was established through a ballot initiative in 1998. The CCFC's source of funding is a special tax on cigarettes and other tobacco products. The CCFC's expenditure of funds and ongoing activities are overseen by the Governor and state Legislature.
- C-CHIP implementation. The source of funds vary by county and are detailed below:

1. Santa Clara: Proposition 10 (County Tobacco Settlement) Funds, and City of San Jose will provide their Tobacco Settlement funds that are directly allocated to them.

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2. Alameda: Proposition 10 (County Tobacco Settlement) Funds.
3. San Francisco: Proposition 10 (County Tobacco Settlement) Funds, and City/County General Funds. The specific sources of City/County General Funds include: property taxes, business taxes, and other local taxes.
4. San Mateo: Proposition 10 Funds, and County General Funds. The specific sources of County General Funds include: the Solid Waste fund, and the Peninsula and Sequoia Healthcare Districts. The Districts are formed and operated pursuant to the Local Health Care District Law (California Health and Safety code Sections 32000et seq.). The Districts are financed by a property tax this is assessed on property owners within their catchments areas and the Districts will use these tax receipts only (rather than any rental or investment income).

Start Up Costs. It is not possible for the percentage of administrative costs be as low as ten percent of expenditures until a sizeable number of children have been enrolled. In fact, the estimates below indicate that the percentage of administrative cost will not decline to ten percent until the second FFY of operation. The Federal government must fully participate in the costs to start-up state programs if the children’s health insurance program is to succeed nationally.

MRMIB will implement a uniform system for determining costs in accordance with Office of Management and Budget (OMB) circular A-87, “Cost Principles for State, Local, and Indian Tribal Governments.” To ensure proper determination of allowable costs, all costs charged to Title XXI will be reviewed to ensure that they are necessary, reasonable, adequately documented, and properly reconciled. Additionally, MRMIB will establish periodic review of our cost structure to ensure that operating costs are properly allocated among the appropriate federal and state programs.

For example, personal service costs, i.e., salaries and wages and employee benefits, will be properly documented and certified to ensure proper allocation to Title XXI. Specifically, MRMIB is implementing a time reporting system that uses detailed activity reports and monthly certifications to document and account for the total activity of each employee and for time charged to Title XXI and/or the three existing state programs.

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Indirect costs will be determined according to cost objectives and program goals. Using OMB A-87 guidelines, its supplements, and checklists, we will develop a comprehensive cost allocation system that clearly defines the nature of the costs, i.e., direct or indirect.

Currently, the operating costs of MRMIB's three existing state programs are separately tracked and reported in the state accounting system. All administrative contracts are assigned separate control numbers for proper tracking and reporting of financial activities related to their respective programs.

DHS has in place a program cost accounting system, CALSTARS, which tracks and allocates direct and indirect costs in accordance with Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." This system uses a clearly defined set of program cost account codes, object (type of cost) codes and fund source codes to support the accurate allocation of benefit costs, as well as administrative and overhead costs, among all programs, including Title XXI accounting as well. A key component of this system is the Indirect Cost Rate Plan (ICRP) which is reviewed and approved by HCFA. The ICRP process applies a predetermined, approved-budget-based, percentage rate to direct salary and benefit costs in order to allocate departmental and statewide overhead (executive and administrative support) uniformly to all direct programs and fund sources.

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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

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the estimate of the number of children eligible for HFP to account for the fact that income deductions would not be applied for the HFP2.

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.³

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.
- 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

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.

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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 DHCS 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.
- 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.

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- 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.

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

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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.

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.

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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

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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 for 1999, 2000 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 15 through 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

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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

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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.

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

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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.

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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.

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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.

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.

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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.

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 be 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 the activities necessary to expand Medi-Cal health coverage for low-income uninsured children, and provide education and outreach activities.

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No changes to Section 10, 11 and 12, therefore pages 138 through end of document are not included.

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