

MATHEMATICA
Policy Research



REPORT

FINAL REPORT

Congressionally Mandated Evaluation of the Children's Health Insurance Program: A Case Study of California's Healthy Families Program

September 2012

Ian Hill

Sarah Benatar

Juliana Macri

The Urban Institute

Submitted to:

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
200 Independence Avenue, SW
Washington, DC 20201
Project Officer: Rose Chu
Contract Number: HHSP23320095642WC/HHSP23337021T

Submitted by:

Mathematica Policy Research
220 East Huron Street
Suite 300
Ann Arbor, MI 48104-1912
Telephone: (734) 794-1120
Facsimile: (734) 794-0241
Project Director: Mary Harrington
Reference Number: 06873.703

This page has been left blank for double-sided copying.

ACKNOWLEDGEMENTS

The authors would like to thank the many State officials and stakeholders in California who gave so freely of their time and insights during our site visit; this case study would not have been possible without their assistance. We would also like to sincerely thank the community-based agencies that assisted us with focus group recruitment. We are indebted to the many parents who took the time to participate in our focus groups, tell us of their experiences, and share their honest opinions about how well the Healthy Families program is meeting the needs of their children. Finally, we are grateful to our federal project officers, Rose Chu and Wilma Robinson at ASPE/DHHS, for their ongoing guidance, assistance, and advice.

This page has been left blank for double-sided copying.

CONTENTS

I.	BACKGROUND AND RECENT HISTORY	1
II.	ELIGIBILITY, ENROLLMENT, AND RETENTION.....	5
III.	OUTREACH.....	15
IV.	BENEFITS	17
V.	SERVICE DELIVERY, ACCESS, AND QUALITY OF CARE	19
VI.	COST SHARING	25
VII.	CROWD OUT	27
VIII.	FINANCING	29
IX.	PREPARATION FOR HEALTH CARE REFORM.....	31
X.	CONCLUSIONS AND LESSONS LEARNED	35
	REFERENCES	39

This page has been left blank for double-sided copying.

TABLES

II.1	Eligibility Rules, By Age and Income (as % FPL) for Medicaid and CHIP	5
II.2	CHIP and Medicaid Eligibility Policies	6
II.3	Current CHIP Application Requirements and Procedures	8
II.4	Renewal Procedures in CHIP and Medicaid	12
VI.1	Healthy Families Monthly Premiums, by Income (Effective February 1, 2009)	25
VIII.1	CHIP Allotments and Expenditures (in millions of dollars)	29
X.1	California’s Compliance with Key Mandatory and Optional CHIPRA Provisions	37

This page has been left blank for double-sided copying.

FIGURES

I.1 Number of Children Ever Enrolled in Healthy Families (1998 – 2011)..... 13

This page has been left blank for double-sided copying.

I. BACKGROUND AND RECENT HISTORY

The State of California’s Title XXI Children’s Health Insurance Program (CHIP) program is a “combination” program comprising its dominant “separate” component—*Healthy Families*—and a smaller category of children who can receive Title XXI-funded Medicaid coverage.¹ The program was launched in 1998—less than a year after the passage of the Balanced Budget Act of 1997 and the creation of the State Children’s Health Insurance Program (SCHIP, now referred to as CHIP)—and currently extends coverage to children from birth through 18 in families with income up to 250 percent of the federal poverty level. Infants and pregnant women are covered up to 300 percent of poverty. It has always been one of the largest CHIP programs in the nation; enrollment reached its zenith of just under 1.4 million children in 2009 and currently stands at just over 1 million children, largest in the U.S. (CMS, 2012).

Healthy Families (HF) was conceived in the image of private insurance, as then-Governor Pete Wilson was both an outspoken proponent of public/private partnerships and critic of Medicaid (called *Medi-Cal* in California) who saw CHIP as an opportunity to test new models of public health insurance coverage. *Medi-Cal*, at the time, was closely linked to county-based welfare eligibility systems in the eyes of the general public and reportedly carried considerable stigma. Furthermore, the program’s chronically low reimbursement rates made it unpopular with providers. Thus policymakers in both the Executive and Legislative branches aimed to build a new program that would be distinct from *Medi-Cal* and offer a more mainstream coverage product for working poor families (Hill and Hawkes, 2002). Program benefits were benchmarked against the State Employee Health Benefit Program, income-based monthly premiums were included, and a service delivery system was designed entirely with capitated managed care plans.

In keeping with this philosophy, administrative responsibility for *HF* was placed with the quasi-governmental Managed Risk Medical Insurance Board (MRMIB) and not with the Department of Health Services (now called the Department of Health Care Services—DHCS), which administers *Medi-Cal*. MRMIB, whose director reports to a board of directors which includes three appointees of the Governor and representatives of the State Senate and Assembly, is relatively small and was viewed as a more nimble, less bureaucratic agency to oversee the new program. Over the years, however, MRMIB and DHCS have worked closely with one another and aligned many policies—especially with regard to eligibility policy—so that *HF* and *Medi-Cal* can operate in a more integrated manner.

¹ Children receiving Title XXI-funded Medicaid coverage include: those who would have been eligible for Title XIX Medicaid coverage but for their parents possessing assets that exceed state eligibility limits; those enrolled in temporary coverage under the Child Health and Disability Prevention (CHDP) “Gateway” program with incomes up to 200 percent of poverty; and unborn children of income-eligible pregnant women. When *Healthy Families* was initially launched, there was also a Medicaid expansion component of the program that covered children ages 16 through 18 in families with income between 85% and 100% of the federal poverty level. This coverage was an acceleration of a federally mandated phase-in of coverage for all children under age 19 born after September 30, 1983. This phase-in was complete as of October 1, 2002, after which this group was subsumed within Title XIX.

Since 2006—the end of the study period for the previous Congressionally Mandated CHIP Evaluation—California has implemented a small number of important changes for *HF*. The program has also faced numerous serious challenges as the state endured years of dire budget conditions. Among the policy reforms, many in response to the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), *HF*:

- Engaged an External Quality Review Organization to bolster the program’s quality improvement efforts;
- Implemented a data matching process (in coordination with *Medi-Cal*) with the Social Security Administration to verify applicants’ citizenship;
- Adopted a new prospective payment methodology for reimbursing Federally Qualified Health Centers (FQHCs) and Rural Health Centers; and
- Launched a new public-access version of its online “Health-e-App” application for *HF* and *Medi-Cal*.
- Among the threats that challenged the program were:
 - A short, but significant enrollment freeze that closed *HF* to new applicants for two months in 2009;
 - Two premium increases and one increase in copayments for families;
 - A proposal by Governor Arnold Schwarzenegger to entirely eliminate *HF*, followed by another to reduce the program’s income eligibility to 200 percent of poverty; and
 - Most recently, two efforts by current Governor Jerry Brown to close down *HF* and transfer all enrolled children into *Medi-Cal*.

Not surprisingly, considerable political controversy has surrounded these various threats and, by extension, confusion among the general public over the status of *HF*. Importantly, however, federal Maintenance of Effort (MOE) rules included in the American Recovery and Reinvestment Act (ARRA) of 2009 were critical in protecting *HF* from further cuts and permitting the program to continue providing children with access to high quality care. At the time of this writing, enrollment in *HF* had declined for two consecutive years, undermining California’s progress on reducing the number of uninsured children in the state. In 2008, the most recent year for which data are available, the state had the second highest number of uninsured children in the nation—over 1 million—representing an uninsurance rate of 10.2 percent (Lynch et al, 2010), with research showing that nearly 700,000 of them are eligible for either *Medi Cal* or *HF* (Kenney et al. 2010).

All of these factors provide important context as California plans for implementation of health care reform under the Affordable Care Act. To the surprise of many and despite widespread and broad-based negative reaction to Governor Brown’s proposal to move all *HF* children into Medicaid, a last-minute budget deal between the Governor and State legislators was reached in June 2012 that will, indeed, result in the closure of the separate program and the transition of *HF* enrollees to Medicaid over the course of 2013. Transition planning was underway at the time of this publication and *HF* officials were working hard ensure that the many positive lessons learned over the 15-year lifetime of this very popular, innovative and

effective program for children and families can be preserved and transferred to the state's reformed health care system.

This case study is primarily based on site visits to California conducted in March and April 2012 by staff from the Urban Institute.² California is one of 10 States selected for study in the second Congressionally-mandated evaluation of the Children's Health Insurance Program (CHIP), called for by CHIPRA and overseen by the Assistant Secretary for Planning and Evaluation (ASPE). The report builds upon findings of the first Evaluation's case studies and highlights changes to the State programs that have occurred since 2006, with a particular focus on State responses to provisions of CHIPRA. The site visit included interviews with over 30 key informants, including State CHIP and Medicaid officials, legislators, health care providers and associations, health plans and associations, children's advocates, and community-based organizations involved in outreach and enrollment. (See Appendix A for a list of key informants and site visitors). In addition, three focus groups were conducted—in Sacramento, San Bruno, and Los Angeles—with parents of children enrolled in *HF*, including parents of children with special health care needs. Findings from these focus groups are included throughout the report and serve to augment information gathered through stakeholder interviews.

The remainder of this case study describes recent *HF* program developments and their perceived effects in the key implementation areas of: eligibility, enrollment, and retention; outreach; benefits; service delivery, quality, and access; cost sharing; crowd out; financing; and preparation for health care reform. The report concludes with cross-cutting lessons learned about the successes and challenges associated with administering California's CHIP program.

² Since our site visit was conducted before the Supreme Court ruled on the constitutionality of the Affordable Care Act, this case study report largely reflects the Healthy Families program and policy developments prior to the ruling. Where relevant, updates have been made to the extent possible.

This page has been left blank for double-sided copying.

II. ELIGIBILITY, ENROLLMENT, AND RETENTION

California’s *Healthy Families* program has long been an innovator in designing eligibility policies and procedures that facilitate children’s access to coverage, including one of the nation’s first community-based application assistance programs, a robust presumptive eligibility system, and most recently, a highly productive online application. But the program has also been challenged, at times, in coordinating its policies with those of *Medi-Cal*, smoothing operations between its single-point-of-entry enrollment vendor and the state’s 58 autonomous county Departments of Social Services (DSS) that determine *Medi-Cal* eligibility, and overcoming the long-term ripple effects of a freeze to program enrollment. This section describes California’s efforts with regard to eligibility policies, enrollment procedures, and retention.

Eligibility Policies. California’s CHIP program is officially a “combination program” under Title XXI. However, it is dominated by its separate *Healthy Families (HF)* program which extends coverage to children from birth through age 18 in families with income up to 250 percent of the federal poverty level, and infants and pregnant women with family income to 300 percent of poverty.³ California’s Medicaid program, called *Medi-Cal*, has upper income limits that vary by age, covering infants to 200 percent of poverty, children ages 1 to five up at 133 percent of poverty, and children ages 6 to 19 at 100 percent of poverty. The state’s Medicaid expansion CHIP component (M-CHIP) covers children who would be *Medi-Cal* eligible except their family assets exceed allowable limits. Income eligibility limits, by age and program, are presented in Table II.1.

Table II.1. Eligibility Rules, By Age and Income (as % FPL) for Medicaid and CHIP

	Age Categories		
	Infants	1 to 5	6 to 18
Medicaid (Medi-Cal)	200%	133%	100%
S-CHIP (Healthy Families)	300%	250%	250%
M-CHIP	*	*	*

* California uses Title XXI dollars to effectively eliminate the assets tests for children by covering children who would otherwise be *Medi-Cal* eligible except their family assets exceed allowable limits.

Beyond age and income, eligibility policies for *HF* are quite generous and well aligned with those of *Medi-Cal* (see Table II.2). Both programs offer presumptive eligibility and 12 months continuous eligibility for children (regardless of fluctuations in family income), and determine income net of various disregards. *HF* has a tiered process for verifying citizenship that allows for self-declaration with validation through a data match with the Social Security Administration and the *Medi-Cal* Eligibility System (MEDS), self-declaration with validation through State Vital Statistics data (birth records), or submission of hard copy birth documentation within two

³ Under a state plan amendment effective 2003, upper income eligibility limits for children in four counties—Alameda, San Francisco, San Mateo, and Santa Clara—are set at 300 percent of poverty under a program the state calls the County Children’s Health Insurance Program (C-CHIP). Santa Cruz County was added to this program in 2007, and withdrawn in 2008.

months of submission of an application form, if matching efforts are unsuccessful. Neither program imposes an assets test⁴ or requires a face-to-face interview when applying for coverage. California also covers legal immigrant children and pregnant women in their first five years of residence in the U.S. under both *Medi-Cal* and *HF*. All applicants are required to present income documentation and, per federal law, *Medi-Cal* provides three months of retroactive eligibility once program eligibility is established while *HF* does not.

These eligibility policies were not always so well aligned across *HF* and *Medi-Cal*; during the early years of CHIP, *Medi-Cal* included an assets test for children, required a face-to-face interview with county DSS workers, imposed more onerous verification requirements, and had only a six-month eligibility period. But one of the most important impacts of *HF*, early on, was that its more streamlined and generous eligibility policies “spilled over” to *Medi-Cal*, as policymakers recognized the benefits for families in integrating the two program’s rules (Hill and Hawkes, 2002).

Table II.2. CHIP and Medicaid Eligibility Policies

	CHIP	Medicaid	Details
Retroactive Eligibility	No	Yes	
Presumptive Eligibility	Yes, 2 months	Yes, 2 months	
Continuous Eligibility	Yes, 12 months	Yes, 12 months	
Asset Test	No	No	
Income Test	Income Net of Disregards	Income Net of Disregards	
Citizenship Requirement	Documentation requested if electronic match is not found; parents allowed 60 days to produce verification	Documentation requested if electronic match is not found; parents allowed 60 days to produce verification	SSA data match through <i>Medi-Cal</i> ’s MEDS system
Verification requirements	Yes	Yes	Require documentation of income, citizenship, and residency (<i>Medi-Cal</i> only) at the time of application
Redetermination Frequency	12 months	12 months	
In-Person Interview	No	No	

Enrollment Process. A defining characteristic of California’s enrollment process for children’s coverage is the bifurcation between *HF*’s “single point of entry” (SPE) vendor that serves to determine and renew eligibility, collect premiums, and help parents select health plans for their children, and *Medi-Cal*’s traditional reliance on the state’s 58 autonomous county DSS agencies to conduct eligibility determination and renewal. Since the inception of CHIP, State officials have

⁴ In other words, M-CHIP coverage effectively eliminates the asset test for children in *Medi-Cal*.

worked hard to coordinate and integrate the operations of these very distinct systems, and many improvements have been achieved. Still, some challenges persist.

Healthy Families' longstanding vendor, MAXIMUS, has been under contract with MRMIB since 2004 to conduct both SPE screening and *HF* administration. All applications are submitted on California's joint *Healthy Families/Medi-Cal for Children* application, which has been in use for roughly a dozen years. It is relatively short—4 pages⁵—and is made available in 12 languages.⁶ (This and other application requirements and procedures are summarized in Table II.3.) All applications—which can be submitted by mail, online, or taken over the phone by the SPE's call center staff (who have capacity in all 12 languages)—are reviewed for content and completeness. Applications for children who appear to be *HF* eligible are processed by MAXIMUS in an average of 7 days—4 days for SPE screening and 3 days for eligibility review and processing. Vendor officials reported that over two-thirds of applications are typically incomplete and missing income or other documentation; in such cases, staff follow up with families to secure required verification and complete the process. In the early years of CHIP, families were required to submit their child's first month premium as a condition of eligibility, and were also required to choose a health plan before enrollment could be completed. Today, these rules have been relaxed; *HF* grants coverage to eligible children and then follows up with parents for premium payments and plan selection after the fact, when necessary.

Importantly, applications reviewed by the SPE for children that appear to be eligible for *Medi-Cal* are forwarded via overnight mail to the family's county of residence. (County DSS agencies retain sole authority to grant *Medi-Cal* eligibility in California.) First, however, these children are granted temporary coverage—called “accelerated enrollment”—until their formal *Medi-Cal* eligibility is determined. Parents of such children are sent a notice by the SPE informing them of this transfer and temporary coverage, and are advised to wait for further contact from the county regarding their child's eligibility. The SPE has no further contact with these applications (or families) beyond this point, and no electronic tracking system has ever been established to monitor the status of these applications. Federal law permits up to 45 days for the processing of Medicaid applications, and key informants told us that operations across California's counties are quite variable, with some taking the full 45 days (or longer) to process applications and others completing the process more quickly. Early in the program's history, many child advocates complained about counties' performance, described the hand-off of applications from the SPE to the counties as “falling into a black hole,” and expressed frustration at the inability to track processing status and with seemingly high numbers of applications that were lost. Today, though some frustration with the process persists, many fewer lost and delayed applications are reported.

A second defining characteristic of California's enrollment system is its long-standing use of community-based application assistors. The state was one of the first to adopt such an approach, and designed Certified Application Assistance to “put teeth” into its outreach efforts and enhance

⁵ The application booklet is a total of 12 pages, the 4-page application and 8 pages of instructions and related information.

⁶ The application is available in English, Spanish, Arabic, Armenian, Chinese, Farsi, Hmong, Khmer/Cambodian, Korean, Russian, Tagalog, and Vietnamese.

the program’s ability to enroll “hard to reach” families (Hill and Hawkes, 2002). MRMIB contracted with numerous “master trainer” entities who trained staff of Enrollment Entities (EEs), such as community-based organizations (CBOs), providers, and health plans, as well as individuals (including insurance brokers) in how to administer and complete the joint CHIP/Medicaid form, collect verification, and submit applications to the SPE. CAAs were initially paid a \$25 finder’s fee for every successful application; this rate was quickly raised to \$50 when state officials were told by enrollers that the lower fee was not nearly sufficient to cover the time it took to administer the application. CAAs could initially only administer the joint program application in paper form, but over the years, electronic/online versions were developed with the support of philanthropic foundations⁷ and made available for use by CAAs and county eligibility workers. (One version of the form, called Health-e-App, is basically an online replication of the HF/Medi-Cal for Children form; the other, called One-E-App, is a more ambitious effort (not available statewide or to the general public) that can be used to determine eligibility for a broad range of health, food, income support, and other public programs.⁸)

Table II.3. Current CHIP Application Requirements and Procedures

Form	
Joint Application with Medicaid	Yes ⁹
Length of Joint Application	12 pages: 4 pages of application, 8 pages of instructions, disclaimers, and additional information
Languages	English, Spanish, Arabic, Armenian, Chinese, Farsi, Hmong, Khmer/Cambodian, Korean, Russian, Tagalog, Vietnamese
Application Requirements	
Age	Yes – birth certificate required within 2 mos. of application
Income	Yes – documentation required at the time of application
Deductions	Yes – documentation required at the time of application
Social Security Number	No – not required for Healthy Families
Citizenship	Yes – documentation requested at the time of application, but program administratively verifies citizenship after the fact
Enrollment Procedures	
Express Lane Eligibility	No
Mail-In Application	Yes
Telephone Application	Yes
Online Application	Yes – Health-e-App
Hotline	Yes
Outstationed Application Assistors	No – only available in the Medicaid program
Community-Based Enrollment	Yes – Certified Application Assistants (CAAs) provide enrollment support

⁷ The California Health Care Foundation and The California Endowment, for example, were instrumental in supporting the development of *Health-e-App*.

⁸ One-e-App is not overseen by the State or *HF* program.

⁹ California uses a “joint application” in the sense defined by the federal CHIP regulations, i.e., a *HF* application that also screens for *Medi-Cal* eligibility (42 CFR section 457.301); when a child is screened as potentially eligible for *Medi-Cal* and his or her application is transmitted to the child’s county, at that point the form then is used to apply for *Medi-Cal* as well.

CAAs interviewed for this case study described a fairly consistent process for conducting their work. Most perform an initial “pre”-screen over the phone (or in the field, if they’ve met a parent at a health fair, for example), talking with parents about their income, family size, and their child’s health insurance status. They then schedule an appointment to meet (usually at

the CAA’s office) and formally complete the joint program application, and describe the items that parents need to bring to this appointment (including pay stubs for the most recent 45 days, proof of address, and the child’s birth certificate and Social Security number (if available)). At the appointment, the application is completed, either in paper form or online—depending on the preference of the CAA and/or their affiliation with an organization that uses one of the state’s online forms—and then submitted to the SPE. In total, the interview takes about 45 minutes, according to CAA staff. Interestingly, some CAAs reported that, if the family they are working with seems clearly to be *Medi-Cal* eligible, they will mail (or hand-deliver) the application directly to the county DSS office, rather than to the SPE. This, staff explain, is done to bypass the triage performed by the SPE and avoid the possibility that the family’s application might fall into the “black hole” when it is forwarded by the SPE to the county.¹⁰ Unanimously, CAAs described how families greatly appreciate the assistance they receive, alleviating them of the confusion and concern over filling out forms that they perceive as quite challenging and difficult for families to complete.

Focus Group Findings: Enrollment

Parents enrolled their children in Healthy Families on their own, with help from Certified Application Assistors (CAAs), by mail or online. With the exception of self-employed parents, most commented that the process was quite easy. But the help of CAAs was universally praised and highly valued.

“It was pretty easy. I have this [CAA] here in this clinic...she did everything for me.”

“I made an appointment with [the CAA] who went over the whole program and what’s covered. [She] was very nice...and helped me with the application and guided me, because I didn’t know what to do.”

“I was a bit skeptical in the beginning. I didn’t know what could be offered to me. But once I was given the phone number, the representative was a blessing in the skies.”

“Anytime I have a question, I call [my CAA] and she’s very responsive. She even calls me and asks me how things are going!”

“[My CAA] is on my speed-dial!”

“I just called...and they sent me an application, and I just filled it out and turned it in. And then they accepted me right away!”

“I did [the online application] three months ago. I didn’t have to send anything...it was a surprise.”

“Initially I just printed the paper and filled out the form. But the problem with me is that we are self-employed, there is no way to tell our income. And that’s where we met [our CAA], and she helped us with that.”

Several parents had heard of HF’s enrollment freeze, and their comments highlighted the uncertainty it created.

“I called the phone number...and they said they’re not accepting any more new applications! Then I have to wait and for two years I’m paying cash to doctors. Then I call again and they said, ‘Okay, you can come now.’”

“I was surprised...I did hear that they were closing it down.”

“It was back in 2008 or 2009...I heard that they were going to stop it, and I needed to hurry up and get in before they did.”

¹⁰ In these cases, however, children cannot benefit from “accelerated enrollment;” only children referred by the SPE to the counties are granted this temporary coverage.

At its height, the CAA program had upwards of 24,000 assistors working across the state, and the system was largely credited with fueling California's rapid and successful enrollment growth under both *HF* and *Medi-Cal*. However, CAA fees fell victim to budget pressures and state funding was eliminated in the mid-2000s, and key informants reported that many fewer individuals and organizations now provide application assistance across the State. However, some CAAs expressed the opinion that the fees were never sufficient or reliably paid, and these groups have instead worked to secure other sources of funding for application assistance. Other CBOs or providers have simply continued the effort on their own, without external funding, believing it to be core to their missions to serve the disadvantaged. Despite the elimination of state funding, EEs and CAAs throughout the state can still complete the necessary certification through a free, Web-based training provided by the State.

California does have a Presumptive Eligibility system that supports both *HF* and *Medi-Cal*. The system is called the "CHDP Gateway;" CHDP is the state's EPSDT program and it stands for Child Health and Disability Prevention. Under the "Gateway," CHDP providers serving uninsured children administer a five-question form to reach a preliminary assessment regarding whether the child may be eligible for *HF* or *Medi-Cal*.¹¹ If they are deemed as such, the provider registers the child as presumptively eligible for a two-month period, and the parent is instructed to complete the full program application to obtain ongoing coverage. The provider also receives reimbursement for the visit, based on the presumptive determination. The CHDP Gateway has been extensively used across California; for example, it provided short-term coverage to just over 600,000 children in 2005-2006 (Teare et al. 2007).

California does not have a federally approved Express Lane Eligibility (ELE) process. Ironically, the state was the first in the nation to explore the potential of ELE and launched pilot projects in several counties (some of which are still in operation) using information from the National School Lunch Program as a proxy for *Medi-Cal* eligibility. The pilots, however, resulted in high rates of "false positives," that is, responses of interest from parents who already had Medicaid coverage. As a result, the ELE pilots were largely not found to be efficient producers of new enrollees (Cousineau and Wada, 2006). Some of the ELE pilots continue to operate in California, but the state has not pursued a formal State Plan Amendment to add ELE to its programs.

In a new development, a "public access" version of the *Health-e-App* was launched in December 2010¹² and now permits anyone to apply for coverage on their own, via the Internet. The *Health-e-App* automatically checks for errors, omissions, and the relevance of application questions, so applicants can avoid mistakes and see only questions that apply to them. Applicants can also electronically submit required documentation and payment of a *HF* premium (if applicable). Like all other *HF/Medi-Cal for Children* applications, the public access *Health-e-App* is submitted to the SPE for review and screening. Remarkably, without any advertising or outreach, the public access *Health-e-App* accounted for about 4,000 *HF* applications per month

¹¹ State-only funds are also used to provide CHDP services to uninsured undocumented children if they are known to the MEDS system.

¹² A Spanish language version was also launched in January 2011.

throughout 2011 and was associated with a 14 percent increase in total applications submitted to the SPE in 2011 compared to 2010. Combined, public access *Health-e-Apps* and CAA-assisted online applications accounted for 42 percent of all applications submitted that year (a much larger share than the 26 percent that online applications represented in 2010) (Foster, 2012). Early evidence suggests that online applications were more likely to be complete and accurate than paper applications (64 percent vs. 61 percent), and also more likely to result in coverage (73 percent vs. 58 percent) (Foster, 2012). (Of note, CAA-assisted online applications continue to have the highest completeness rate—79 percent—and the highest rate of resultant coverage—87 percent.) Key informants were almost unanimous in their excitement and support for the public access *Health-e-App*, though some child advocates expressed concerns over the system’s security and potential for breeches of privacy and confidentiality.

Renewal. California has not shown as much innovation with its systems for redetermining eligibility for *HF* and *Medi-Cal* and, according to many informants, could improve and streamline its renewal policies to facilitate more continuous coverage for children. As summarized in Table II.4, both programs utilize an active renewal process and do not use passive, automatic, or ex parte renewal for any populations. Nor do *HF* or *Medi-Cal* permit “rolling renewal” when families come in contact with the system off-cycle and could benefit from an update of their coverage status. There is no online version of the renewal application available.¹³ No self-attestation of income is permitted at renewal, either, as both programs require families to update and resubmit income documentation. *HF* does, however, pre-print its renewal application form with family information provided on the initial application (though *Medi-Cal* does not, and simply sends families blank forms at renewal).

Despite this lack of data-driven, automated methods, California has built in numerous steps designed to maximize the chances that families renew coverage without interruption. For *HF*, the SPE mails out the Annual Eligibility Renewal (AER) packet 75 days before each child’s eligibility anniversary. A reminder card is then mailed 45 days before coverage expires to all families who have not submitted their renewal application. Finally, SPE staff place up to five phone calls to non-responders in an effort to ensure child coverage does not lapse.

Focus Group Findings: Renewal

Some parents found the renewal process simple enough to complete on their own. But others had problems, and many relied on their CAA to help them through it.

“The renewal is super easy. They do make it very user friendly.”

“When it comes to renewals, sometimes there [are] these little things that become big...problems and you’ve got to call [the CAA].”

“Every time it’s time to renew the contract, [my CAA] has it ready.”

“She’s amazing...she helps you with everything. I just had my renewal, and it took me five minutes to do it w/ her.”

“It was crazy, because...I only had a day or two to renew, and I had heard that if you don’t renew, it’s...hard to get back in. So after work, I came in...and talked to [the CAA], and she just filled out the paper and said, ‘Here you go, ma’am!’”

CAAs and health plans reported that they, too, are highly engaged with the *HF* and *Medi-Cal* renewal process. CAAs described how they keep “tickler files” on their clients and will

¹³ In the period since our site visit, California implemented a new online renewal application.

typically call parents at their children's 11th month of coverage to see if they've received AERs for their children and to encourage them to respond. They also invite families to come in if they have any questions or need help with completing the renewal application. According to CAAs, large proportions of their clients do, indeed, seek help with completing the AER, citing their desire to make sure all paperwork is done properly. Health plans, who acknowledge a direct incentive for keeping children continuously enrolled, more often have electronic files that notify staff when child enrollees are up for renewal, and may send out their own reminder letters and notices to families, followed by reminder calls as coverage expiration dates approach.

Table II.4. Renewal Procedures in CHIP and Medicaid

	Renewal Requirements	
	CHIP	Medicaid
Passive/Active	Active	Active
Ex-Parte	No	No
Rolling Renewal	No	No
Same Form as Application	No - separate for CHIP and Medicaid	No - separate for CHIP and Medicaid
Preprinted/Pre-populated Form	Yes	No
Mail-In or Online Redetermination	Mail-In and online	Mail-in
Income Documentation Required at Renewal	Yes	Yes
State Administratively Verifies Income	No	No
Other Verification Required	No	No

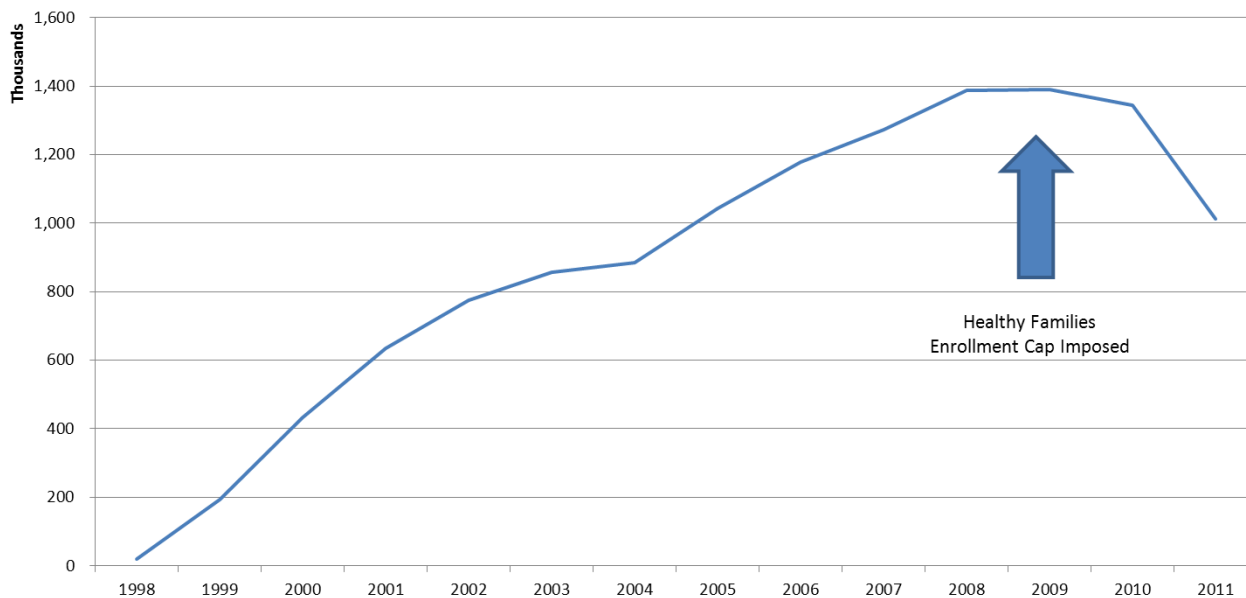
State data show that *HF* perennially achieves about a 75 percent retention rate. Most informants agreed that this rate was acceptable, but far from optimal, and hoped that more emphasis and innovation could be brought to bear in the future so that more children could receive continuous coverage.

Discussion. While key informants were generally positive about the *HF* eligibility process, they were also concerned about recent enrollment trends, expressing some confusion as well as various theories about why program enrollment had declined in recent years. As seen in Figure I.1, *HF* enrollment steadily climbed over its first 11 years, reaching a high of just under 1.4 million (ever enrolled) children in 2009. In the two years since, however, total enrollment has slipped to just over 1 million, a precipitous decline of over 25 percent.

Many informants saw the 2009 enrollment freeze (which lasted just two months, from July through August) as the pivotal point in this trend, saying that the program “never recovered” from the event. These individuals describe how the freeze caused considerable confusion among families over whether or not the program was permanently closed, and also shook families’ confidence in the program’s ability to provide stable, long-term coverage for their kids. Since outreach monies had been cut, State officials had no means for ‘advertising’ that the program was still reopened. While CAAs did their best to spread accurate information, the distinct lack of formal outreach before, during, and after the freeze was cited as problematic; solid, reliable

information about the freeze and when it was lifted was never systematically made public, perpetuating a circumstance where rumors about the program could persist.

Figure I.1. Number of Children Ever Enrolled Each Year in Healthy Families (1998 – 2011)



Source: SEDS.

Other informants, however, point to the fact that 2009 coincided with the immediate aftermath of the Great Recession and speculated that *HF* enrollment declines could be explained by the fact that many working families, previously eligible for *HF*, may have experienced job losses and/or income reductions that resulted in their subsequently qualifying for *Medi-Cal*. (*Medi-Cal* enrollment did, indeed, increase in 2010 but decreased in 2011.)

Enrollment declines aside, key informants were unanimous in their praise for the state's CAA system and continue to believe that, despite the elimination of direct funding from the state, the strategy is largely responsible for the state's successful track record in enrollment. CAAs, coupled with the SPE enrollment vendor and the recent public access *Health-e-App* have decoupled health program enrollment from the county system for many residents and steadily reduced levels of stigma that were attached to the receipt of public health coverage in years past. Consumers and CAA staff described at length how helpful the process was for families daunted by the prospect of completing application and renewal forms, and state and SPE officials pointed out that applications are vastly more likely to be complete and accurate when they are filled out with the assistance of CAAs, versus being completed by individuals, unassisted.

Along with providing community-based application assistance, California has adopted enough other the simplification strategies to meet the basic threshold for qualifying for CHIPRA performance bonuses (including 12-month continuous eligibility, no asset test, no in-person interview, joint application with Medicaid, and presumptive eligibility). Unfortunately, however, the state has not been able to achieve the enrollment growth targets in Medicaid established by CHIPRA, and have therefore not qualified for a bonus, to date. This fact was

frustrating for state officials, as they believe large states with successful past track records for enrollment are at a disadvantage when it comes to posting further dramatic enrollment growth.

Renewal appears to be the policy area where California has considerable room for improvement. The state has taken little advantage of new strategies to automate renewal, and has not appreciably improved retention rates in a decade.

Finally, the prospect of health care reform under the Affordable Care Act (discussed in more detail in Section IX, below) holds implications for enrollment in *HF* and *Medi-Cal*. California is at the forefront of efforts such as UX2014,¹⁴ which is designing a modern, integrated, data-driven eligibility portal for the health insurance exchanges and Medicaid expansions to come. Such efforts hold promise to create more seamless, convenient, and user-friendly enrollment systems for consumers and could reap significant benefits for children, families, and single adults in California.

¹⁴ A multi-state effort, supported by a number of philanthropic foundations.

III. OUTREACH

Due to chronic budget pressures, California has not directly funded outreach since before the start of the study period of 2006 to 2012. Funding for mass media campaigns was the first area to be cut back in the early 2000's, followed by support for community-level efforts. Finally, funding for CAA fees was eliminated in 2005.

This lack of support for outreach is notable given the early years of *Healthy Families* and the state's prior impressive investment in an aggressive, multi-faceted outreach campaign. With over \$20 million invested between 1998 and 2001, the *Healthy Families* and *Medi-Cal for Children* brands were jointly marketed via statewide advertising and a toll-free information hotline. The campaigns used the slogans "A Healthier Tomorrow Starts Today" and "For Your Family's Health". To complement this broad marketing strategy, roughly \$6 million were budgeted to support community-based efforts, including Outreach Contracts with upwards of 70 local organizations and schools. California also pioneered its aforementioned CAA program, which paid "finder's fees" (first \$25, then \$50) to CBOs and brokers who submitted successful applications; within four years of the launch of *HF*, nearly 24,000 CAAs were actively assisting families with completing the joint *HF/Medi-Cal for Children* application (Hill and Hawkes, 2002).

As state funding for outreach disappeared, philanthropic foundations, not-for-profit health plans, and other organizations have stepped in to maintain public awareness and outreach for children's public coverage programs. Across the state, such organizations have often funded Children's Health Initiatives (CHIs) in well over half the counties in California, supporting community-based outreach and application assistance, as well as numerous *Healthy Kids* coverage programs (Stevens et al, 2007).¹⁵

As described above, despite the loss of CAA fees, CBOs, FQHCs, and other community groups and providers have continued to conduct outreach and application assistance on their own—relying on external grants or administrative funds—seeing the activities as core to their mission of helping disadvantaged children and families. For

Focus Group Findings: Outreach

Parents reported hearing about Healthy Families from a broad range of sources, including medical providers, schools, county DSS workers, friends, and health plans.

"I heard about it from school...they gave something out."

"My provider told me. I heard it was affordable, low cost."

"My husband lost the work...that's when my friend told me [about Healthy Families] and said, 'Oh, you can go there, maybe you qualify.' So I went there!"

example, among those interviewed for this study, *Covering Kids* is a Sacramento-based municipal organization that works with over 50 partners, including schools, to distribute program materials and help parents complete *HF/Medi-Cal* applications and renewal packets. Spreading the message "Assistance with Free or Low-Cost Health Coverage," the group supports itself in

¹⁵ *Healthy Kids* programs are modeled after *Healthy Families* (in terms of benefits and cost sharing) yet extend coverage to children in low-income and working poor families that are ineligible for CHIP or Medicaid, primarily due to citizenship status.

part by drawing federal Medicaid administrative match against its own public expenditures. In San Francisco, the *NICOS Chinese Health Coalition* employs lay health workers who target immigrant communities and their providers to raise awareness of *HF/Medi-Cal* and assist families with enrollment and renewal of coverage. In Los Angeles, *Maternal and Child Health Access* uses funding from the CHI of Greater Los Angeles to support its Children's Health Outreach Initiative (CHOI), a project that has supported CAA training and direct assistance across downtown neighborhoods for 15 years.

CHIPRA Outreach Grants have also been critical in infusing federal monies to support outreach; in the most recent Cycle II, California-based organizations received five total grants amounting to nearly \$5 million in funding. For example, the California Primary Care Association is using its grant to increase the number of CAAs working in FQHCs and to conduct trainings in targeted communities to help outreach staff reach uninsured Latino children. Meanwhile, the Los Angeles Unified School District's grant is being used to expand outreach and application assistance capacity in 13 school-based wellness centers across the city, and also to build and strengthen links to local providers so that school-age children have improved access to health care.

Health plans were reported as continuing low-level outreach efforts as well, most often around annual open enrollment periods in July and August of each year. These efforts comprise distributing information and materials about their plans and other coverage options to current and potential enrollees, and asking families to make any changes for the coming year before the end of open enrollment. Community Provider Health Plans (discussed in more detail below), however, in keeping with their mission as safety-net providers, often place greater emphasis on community outreach than their for-profit counterparts. The San Francisco Health Plan, for example, employs a staff of four *Promotoras* who conduct "street" outreach across the city to find families with uninsured children, as well as 12 dedicated CAA staff that provide application assistance at the plan's numerous health centers. Similarly, the Health Plan of San Mateo contracts directly with groups like the San Bruno Resource Center to conduct "inreach" to its clients seeking housing, employment, or other assistance, inquiring about their health insurance status and helping individuals and families apply for available programs, including *Medi-Cal*, *Healthy Families*, *Healthy Kids*, and *the Kaiser Child Health Plan*.

One new investment by MRMIB involves use of social media to more effectively engage with consumers. Specifically, *HF* now maintains a presence on both Facebook and Twitter and routinely distributes news, program updates, and health tips to its friends and followers.

Overall, key informants had mixed, but mostly negative opinions about the state's lack of investment in outreach for *HF*. Some acknowledged that the program brand was very well known and that statewide marketing was probably no longer as critical. But most stakeholders—including state officials, child advocates, community agencies, and providers—felt strongly that outreach was missed during the recent Great Recession when working families losing jobs could have benefited from information about available coverage through *HF* and *Medi-Cal*. In addition, the lack of information before, during, and after the 2009 enrollment freeze perpetuated confusion surrounding the program's availability and status, according to informants, and a clear message that *HF* was open for business after the conclusion of the freeze was never broadcast.

IV. BENEFITS

The *Healthy Families* benefit package is benchmarked to California’s state employee health benefits package, known as the California Public Employees Retirement System (CalPERS). Since program inception, however, the package has included many key enhancements beyond CalPERS, including comprehensive dental and vision coverage. Today, a broad range of benefits are covered by *HF*, including preventive care, prenatal care, doctor visits, dental and vision care, basic mental health and behavioral healthcare, hospital stays, prescription drugs, and emergency care. As will be discussed in more detail below, benefits for children with special health care needs are administered by the California Children’s Services (CCS) program under a “carve out” arrangement; covered services range from simple orthopedic procedures to care for a broad range of chronic conditions, such as cancer. Responsibility for mental health is shared between *HF* health plans and each county’s mental health system; health plans are responsible for providing all mental health benefits except for those required by children with Serious Emotional Disturbances (SED), who are served by county mental health systems.

Since California’s CHIP benefit package was already quite generous, very few changes came about as a result of the passage of CHIPRA. The CHIPRA requirement for mental health parity caused no changes to the scope of covered benefits but did result in efforts to eliminate limits on the number of covered inpatient days and outpatient visits. The dental mandate under CHIPRA led the program to eliminate a \$1,500 annual cap for dental care. Several informants noted that dental coverage is broader under *HF* than in most private insurance plans.

Key informants consistently spoke highly of the package of benefits available to children under *HF*, calling it both “broad” and “comprehensive.” Advocates and community-level respondents said that, with few exceptions, enrollees are “very satisfied” with what is offered by the program and they had not heard complaints about services not being covered. These findings echoed those of the previous CHIP evaluation (Hill and Hawkes, 2002). Focus group participants seemed generally quite happy with the benefits they were receiving.

Only a handful of key informants expressed concern that *HF* recipients are not guaranteed access to the more complete set of benefits and protections available under the EPSDT program—a benefit to which *Medi-Cal* recipients are entitled. Though EPSDT theoretically provides *Medi-Cal* members with access to a wider range of services, most informants expressed the opinion that the two programs’ benefits were virtually the same, and that benefits provided to *HF* enrollees through arrangements such as the CCS wrap-around helped ensure that children with chronic conditions and disabilities receive the care they need. One advocate pointed out

Focus Group Findings: Benefits

Parents reported that Healthy Families covered all of the medical services their children needed. Some described it as comparable to private insurance.

“I didn’t see a difference [between private insurance benefits and Healthy Families benefits].”

“I had [private] insurance with Kaiser; I think it was the same [as with Healthy Families].”

With regard to dental care, however, some gaps were identified and one participant a bad experience with a provider that pushed her to receive a service that was not covered by HF.

“I know that the braces, they would not cover the braces, so basically we decided not to do that.”

“We took [my daughter] to the doctor and she had some cavities, and the doctor told me to get her silver fillings which I wouldn’t have to pay for. But then the dentist started arguing with me, saying she should get the white fillings...”

that *HF*'s dental coverage omitted cosmetic orthodontia, and a pediatric provider explained that CHIP's lack of participation in the Vaccines for Children program meant that providers had to purchase and store vaccines in order to serve *HF* children, a costly and inconvenient endeavor.¹⁶ But overall, stakeholders interviewed for this case study spoke very highly of the benefits package available to children enrolled in *HF*, calling it nearly the equivalent of that of *Medi-Cal*, and "comparable" or "better" than what one would receive through private insurance.

¹⁶ Healthy Families providers are not eligible for Vaccines for Children. Reimbursement for immunizations is included in Healthy Families rates paid to health plans.

V. SERVICE DELIVERY, ACCESS, AND QUALITY OF CARE

From its inception, the *Healthy Families* program has worked to deliver high quality services to children exclusively through prepaid managed care arrangements. Most of California's 58 counties have an HMO option for *HF* enrollees, but some more rural areas are forced to rely on Exclusive Provider Organizations (EPOs) in order to gain network adequacy for members. In contrast to *HF*, *Medi-Cal* managed care has emerged more slowly over the past decade, with 50 percent of the state's *Medi-Cal* population now enrolled in managed care plans. Expansion of *Medi-Cal* managed care into rural counties is ongoing and the subject of current debate in the state legislature. Still, nearly half of California counties remain Fee for Service (FFS) only. Key informants reported that, despite these structural differences, *HF* and *Medi-Cal* network alignment has steadily improved in recent years. However, they also estimate that upwards of 40 percent of children in *HF* are enrolled in health plans that do not widely participate in *Medi-Cal*.

Service Delivery and Payment Arrangements. All *Healthy Families* members must enroll in a managed care plan and receive comprehensive medical and mental health services through their plan's network. The *HF* program contracts with 22 health plans statewide. In addition to commercial health plans, including Kaiser and Anthem Blue Cross, MRMIB contracts with nearly all Local Initiative Plans and County Organized Health Systems in the state. Local Initiative (LI) plans were developed with the emergence of Medicaid managed care in California, and are essentially county-sponsored health plans that are governed by an independent commission appointed by the county board of supervisors. County Organized Health Systems (COHS) are publicly sponsored health plans that serve the entire *Medi-Cal* population in a specific county or group of counties. LI and COHS plans account for approximately 30 percent of eligible *HF* enrollment statewide and 60 percent of eligible *Medi-Cal* beneficiaries (Reilly, Wunsch, and Krivit 2010). Premiums for LI and COHS plans are typically slightly lower than for commercial plans (and more affordable for consumers), which may contribute to their market share.

HF managed care system and approach is relatively straightforward. MRMIB individually negotiates its contracts with health plans that participate in *HF* and a single contract is signed with each plan for that plan's operations. Negotiated capitation rates are proprietary, but the rates for *HF* are generally perceived to be higher than for *Medi-Cal* (one informant speculated that plans typically receive approximately \$100 PMPM for *HF* versus \$75 PMPM for *Medi-Cal*). These differences may be less evident for providers, however, since some health plans report that they blend reimbursements, and providers thus receive the same rates for treating children in either program. Perhaps more important than the fees, however, are differences in administrative burdens. MRMIB's paperwork requirements were described as considerably less than those of the DHCS, and can have a big impact on provider willingness to participate.

In contrast to *HF*, Medicaid managed care in California is quite complex. California has three models of Medicaid managed care in the state:

1. The two-plan model offers enrollees the option to choose between the Local Initiative plan operating in their county and a competing commercial plan. Fourteen counties, covering three million Medi-Cal beneficiaries, offer the two-plan model.
2. County Organized Health Systems cover fewer than one million individuals in 14 counties. Nearly all Medi-Cal recipients in a COHS county are enrolled in that county's health plan.
3. Geographic managed care (GMC) is in place in two counties (Sacramento and San Diego), in which DHCS contracts with several commercial plans to ensure an adequate network and ample choice for members residing in those areas.

Medicaid managed care has expanded in California over the past decade, though its reach is considerably more limited than is *HF*. At the time of this writing, roughly the same mix of public and commercial health plans participate in *Medi-Cal* as do in *HF*, with Kaiser, one of the largest plans serving *HF* enrollees being the most notable exception. Kaiser offers coverage to nearly 20 percent of *HF* beneficiaries, with particularly strong penetration in Northern California, but has only 3 percent of the *Medi-Cal* market. Similarly, Anthem BlueCross offers its broad network for *HF* recipients in 53 of the 58 counties, but contracts with *Medi-Cal* in only 12 counties. These differences contribute to discontinuities between the two programs. As noted earlier, more than 40 percent of *HF* recipients are enrolled in plans with limited or no *Medi-Cal* coverage.

As noted above, health plans are responsible for all medical care, as well as comprehensive behavioral health care, for California's CHIP recipients. Treatment for children with serious emotional disturbances (SED), however, is carved out as a responsibility of county mental health departments. Similarly, children with disabilities or chronic conditions that would qualify them for the state's Title V/Children with Special Health Care Needs program have their specialty care carved out and delivered by the California Children's Services (CCS) program. Dental and vision care are also not the responsibility of health plans; rather, MRMIB contracts with six dental plans and three vision plans to serve *HF* members statewide. Dental contracts are all pre-paid and risk based at the plan level. Payment arrangements between plans and providers, however, vary. Initially, *HF* members are required to enroll for two years in a dental managed care organization (DMO) modeled on the state employees' plan, in which the providers are at risk. This was implemented in 2010 as a cost control measure, as many new *HF* members present with significant unmet dental needs. After two years—a point at which unmet need has typically been addressed—members then have the option to transfer to an EPO. In the EPOs, providers receive fee-for-service reimbursement, though the plans are still paid on a capitated basis.

Access to Care. Children enrolled in *HF* are perceived to have broad access to care across California. Furthermore, *HF* is perceived to offer better access to care than *Medi-Cal*. This is in part attributed to the program's provider networks and reimbursement structures, which are managed care statewide for *HF* while *Medi-Cal* remains FFS in half the state. Moreover, *Medi-Cal* reimbursement rates typically are lower than for *HF*, affecting the willingness of some plans (and their providers) to participate. Access to specialty care, however, can be more problematic for enrollees in both programs.

Dental access in *HF* is sufficient statewide with a robust network of providers, according to key informants. One noted that dental coverage in *HF* is better than the coverage employees of dental plans receive. This is in contrast to *Denti-Cal*, *Medi-Cal*'s fee-for-service dental benefit, which experiences perennial challenges with access and accountability. One dental plan noted that provider fees for *Denti-Cal* are 20 percent lower than for *HF*, impacting dentists' willingness to take patients. The impacts of this difference are borne out in utilization rates; between 65 and 75 percent of all *HF* enrollees receive at least one dental service each year (a rate comparable to children with private coverage), and only 30 percent for *Denti-Cal* recipients do so.

Although services for seriously emotionally disturbed (SED) children and children with special health care needs (CSHCN) are carved out of both the *Medi-Cal* and *HF* packages to ensure that these children have adequate access to systems of care specially designed to meet their needs, in reality both carve-out arrangements have significant problems. Simply put, health plans have a built-in incentive to refer children with special health or behavioral needs to the carve-out program, and the resulting separation of primary and specialty care services often results in fragmentation of the delivery of care. Several informants also pointed to chronic shortages of pediatric sub-specialists and child psychiatrics, especially in rural areas of the state.

Mental and behavioral health services in California are undergoing a transition, as the State Department of Mental Health is being phased out, and responsibility is being transferred to DHCS. This shift is primarily administrative, as autonomous counties have already been providing mental health services to the SED population. Capacity for providing these services, however, varies considerably from county to county. As a result, one informant noted, families are often skeptical of services delivered by the county mental health system and will therefore often refuse SED referrals. In response to CHIPRA's mental health parity requirements, MRMIB is taking an active role to bring the county mental health systems into compliance. Informants pointed to the field-based nature as a strength of the system. By relying on case management and outreach to schools, counties are equipped to provide services in areas where providers are scarce. This helps to mitigate specific provider shortages, such as pediatric psychiatry, which has been identified a "largely urban profession," resulting in significant gaps in rural areas.

Shortages of pediatric specialists impact recipients of publicly funded health care in California. A recent survey of *Medi-Cal* members found that fewer than half of *Medi-Cal* recipients report that it is easy to find a specialist (California Healthcare Foundation 2012). *HF* enrollees likely experience similar constraints when seeking specialty care, given state rules that require all physicians that participate in CCS, the carve-out for children with special health care needs, to also be registered *Medi-Cal* providers. CCS covered services range from fractures to treatment for chronic medical conditions including cancer and cystic fibrosis. Approximately 180,000 children in the state are covered by CCS, 15 percent of those are *HF* members, 75 percent are on *Medi-Cal*, and the remainder have no insurance or are under-insured.

By virtue of being carved out, primary and specialty care coordination can pose significant challenges. Stakeholders involved with the mental health and CCS systems acknowledged that shared responsibility for providing carved out services (between health plan and the county

mental health department in the case of mental health, and between the health plan and CCS in the case of complicated medical conditions) can result in disputes regarding who is responsible for paying for which services, especially when referrals are not made in a timely manner or a patient is receiving a mixture of primary care and specialty services across multiple levels of the health care system. In an attempt to address this limitation, the state is pursuing a Section 1115 waiver to pilot a program with a handful of health plans to explore the benefits of retaining CCS services within the health plans' capitated contracts.

Quality of Care.

California has several ongoing quality improvement efforts underway for *HF*.

With the passage of CHIPRA, MRMIB gained an additional tool for legislatively requiring plans to share encounter and claims data with the state for the purposes of quality oversight, an acquisition that was previously resisted. With this, MRMIB hired an external quality review organization in 2011 to conduct quality evaluations of each individual plan that contracts with *HF* as well as a statewide performance evaluation report. Health plans that contract with MRMIB currently track and must report on the following HEDIS measures:

Focus Group Findings: Access to Care

Most parents were satisfied with the plans and providers serving their children, saying they felt respected and that they thought the care obtained was high quality. When they had a provider they didn't like, changing providers was easy. Access to nurse advice was highly valued. A number of parents who obtained care at a large clinical site expressed frustration over long waits for care. Opinions of dental care were more mixed, however.

"I like this clinic a lot. I know, sometimes you have to wait a little bit. But I guess it's a priority for me because...of the attention they get here and the quality of the time they give you...."

"If I do get an appointment in the morning, I'll probably be out of here by 2:00pm or 3:00pm. They take long."

"That's why I don't mind waiting, because the doctors, they're really good. They check her from head to toe, and that's good."

"[At Kaiser], they have a nurse 24/7...you can call them...they will take the call if it's the middle of the night and your child is sick. They'll take care of you right then."

"[Changing my doctor] was just a matter of a phone call."

"I experienced more limited choices when I applied for dental care for my child."

Several parents with children with chronic illnesses said they enjoyed open access to needed specialists.

"When my daughter started having problems with her eyes, I called [the clinic], and they told me the doctor needs to check her before they can refer her. So I just took her to Children's Hospital and they took her right in."

"They told me, 'If she starts having symptoms, just take her to the emergency room.' And she called and said 'Mom, I'm seeing spots.' So I called [the clinic] and they said, 'Take her straight over.'"

Several parents talked about the importance of continuity of care, across plans and providers. These comments provide important context for policymakers considering the Governor's proposal to transfer HF children to Medi-Cal.

"When I worked for the state, I had full coverage and went to Kaiser. So it was nice, once we got involved with Healthy Families that we did not have to change anything. We are going to the same doctor, same clinic, same coverage. Everything was the same!"

"[Continuity is important], because once the doctor knows the child and the history...you feel very comfortable with the doctor."

One parent described her experiences with Medi-Cal in considerably more negative terms.

"I had a...different...experience with Medi-Cal. I think it was not as much like medical insurance...I felt that I was being treated as a lower income person, basically. But when I started to have HF, I didn't feel it at all. It was just like everyone else."

- childhood immunization status,
- adolescent immunization status,
- lead screening in children,
- child and adolescent access to primary care
- well-child visits in the first 15 months of life
- well-child visits in years 3-6
- adolescent well care visits
- use of appropriate medications for asthma
- appropriate treatment for upper respiratory infections
- appropriate testing for children with pharyngitis
- chlamydia test in women (16-18)
- identification of alcohol and other drug services
- mental health utilization

In addition, MRMIB, in collaboration with the Center for Health Care Strategies, launched a dental quality improvement program called *Healthy Smiles-Healthy Families* in 2010. This effort seeks to promote preventive oral health among low-income children. The state will also receive \$100,000 from DentaQuest to support its efforts to promote oral health among *HF* recipients.

This page has been left blank for double-sided copying.

VI. COST SHARING

As described above, the *Healthy Families* program was designed to mirror private, employer-sponsored insurance. As such, it has always included cost sharing in the form of monthly premiums and copayments for selected services. To minimize the financial burden on families, policymakers strived to set cost sharing at low, affordable levels, while still creating a sense of shared responsibility and ownership among families (Hill and Hawkes, 2002). There is no cost sharing for children enrolled in *Medi-Cal*, per the federal Medicaid statute.

Since the inception of the program, there have been only three premium increases. The first didn't occur until 2005. Then, facing mounting severe budget pressures, policymakers enacted two further premium increases in 2009 (effective in February and November of that year). These last increases more than doubled premiums for some families, with monthly amounts increasing by \$7 per child in families with incomes between 150 percent and 200 percent of poverty, and by \$9 per child for families with incomes between 200 and 300 percent of poverty. Premiums for the lowest income families were not raised, however, and monthly family maximums that vary by income help to mitigate the total out-of-pocket premium burden that families face. Copayments also increased for families in these income categories, from \$5 per visit to either \$10 or \$15 (depending on the service) for non-preventive health, dental, and vision services and prescriptions (100% Campaign, 2010). (Copayments are not imposed on preventive services.) The Brown Administration has introduced legislation to increase premiums and copayments once again, but the plan is being challenged as a violation of federal Maintenance of Effort rules.

Table VI.1 illustrates that families with income between 100 and 150 percent of poverty pay either \$4 or \$7 per child, with a family monthly maximum of \$14. (Families pay the lower of these two premiums if their children are enrolled in their County's Community Provider Health Plan, and the higher amount if their children enrolled with another plan.) Families with income between 150 and 200 percent of poverty pay either \$13 or \$16 per child per month, up to a family maximum of \$48, and these premiums increase to either \$21 or \$24 per child for families with income between 200 and 300 percent of poverty, up to a family monthly maximum of \$72.

Table VI.1. Healthy Families Monthly Premiums, by Income (Effective February 1, 2009)

Income Level	Premium/Month	Family Max/Month
100-150% FPL	\$4 or \$7 /child	\$ 14
150-200%	\$13-16 /child	\$ 48
200-300%	\$21-24 /child	\$ 72

Providers are responsible for collecting copayments and retain the money they collect as part of their payment. Federal CHIP legislation requires that total annual cost sharing not exceed 5 percent of family income, and in California state legislation has further limited total per family out-of-pocket costs to a maximum of \$250. Members are responsible for keeping track of their out-of-pocket costs through the so-called "shoebox" method of saving receipts. *HF* officials have devised a policy that can save families money while also making payment easier. Specifically, if families pay three monthly premiums at once, they receive their fourth month of coverage for free.

Overall, most key informants viewed *HF* cost sharing as affordable for families, even in light of 2009's premium and copayment increases. Health plans could not point to any evidence that premium costs were causing families to disenroll at renewal, and providers did not believe that service use had

decreased as a result of copay increases. SPE officials, in fact, said that they typically receive feedback from parents that the program is very affordable and some still say they would rather pay for *HF* than be enrolled in *Medi-Cal* for free. Yet stakeholders did note that the timing of declines in *HF* enrollment does coincide with cost sharing increases, while also acknowledging that many other confounding factors likely explain or contribute to the drop, including the enrollment freeze, the lack of support for outreach, and the likelihood that the recession had caused many previous *HF* enrollees to become newly qualified for

Medi-Cal. Many thought that families "find a way to pay" for *HF* because they recognize its value and because the coverage allows them to "sleep better at night." And, as was the case during the first SCHIP evaluation, California informants often suggested that families appreciate having responsibility for paying for a portion of their insurance coverage, noting that it contributes to a family's sense of pride, and helps them feel like it's not a "welfare program." To be sure, cost-sharing increases were controversial, according to MRMIB officials, especially in the context of the recession. But they also acknowledged that the increases were the "last, best option" for controlling costs in the face of severe budget pressures and increasing threats to the very survival of the program.

Focus Group Findings: Cost Sharing

Premiums and copayments were described by parents as affordable and fair, especially when compared to private insurance. None reported that premium increases had caused undue hardship or made them consider dropping coverage. Some parents experienced challenges with the process of premium payment, but others appreciated the discounts they received for paying multiple months in advance. Copayments did not pose a barrier to service use among focus group participants.

"It is a good value."

"Oh, it's like the cost of going to the movies!"

"It's still okay [after the premiums increased]...especially compared to what I've paid for health care when I was working..."

"The first payment was kind of hard because I had to call. [But now they] deduct the monthly payment from my bank account."

"No, [premiums] are okay. And you...get a discount. If you pay up three months, they give you a discount. They give you the fourth month free."

"I get mine automatically taken out [of my bank account], and then I get like a 25% discount."

"Once I get my tax return...that's the first check I write, to Healthy Families...for the whole year...and I get three months free."

"I owed like \$8, and it was like for two months. But they didn't cut me off...they give you a grace period on your bill."

"[Copays] are not a problem...I don't have to think twice."

"I think it's great to have a lower copayment that's affordable. We're talking about \$10, \$15, \$20...in my opinion, it's affordable."

VII. CROWD OUT

California has had several policies in place since the start of the program to address concerns that the creation and expansion of publicly subsidized programs like *Healthy Families* would “crowd-out” private, employer-sponsored insurance. First, MRMIB monitors the health insurance status of all applicants for the program, asking the following questions:

- Does this person have other health, dental or vision insurance? (Yes/No)
- Did this child have health insurance through someone’s job in the last three months? (Yes/No)
- If yes, write the date it ended and check reason below (Options include: Lost job/Job status changed/Moved and no insurance available/All employees’ benefits ended/Death, divorce or legal separation/COBRA ended/Other)

Second, it imposes a 3-month waiting period for any child who is covered by private insurance at the time of application. Finally, MRMIB imposes legal obligations upon employers and insurers to not alter their coverage policies in response to CHIP. There is no waiting period required for Medi-Cal.

Regardless of these safeguards, few stakeholders interviewed for this case study regard crowd out to be a significant problem in California. One formal study, conducted in 2002, confirmed this perception finding the incidence of crowd-out to be very low (approximately 8 percent), and mostly occurring among lower-income families that reported they could no longer afford employer-sponsored coverage for both themselves and their children (Hughes et al, 2002). The study also found no evidence of employers referring families to the *HF* program. Community application assistants voiced similar observations; while they reported occasionally encountering families with private insurance who wanted to apply for the lower-cost *HF* program, they also said these families were mostly not willing to drop that insurance to sign up for *HF* and did not want to risk their children “going bare” for three months.

This page has been left blank for double-sided copying.

VIII. FINANCING

With the passage of the CHIPRA, federal funding for the program was extended through 2013. The Affordable Care Act then extended that funding for two more years, through 2015. CHIPRA set new total annual allotments for the program and also revised the formula for calculating State-specific allotment amounts. This new method for determining State allotments was designed to account for States' actual and projected spending, adjusting for inflation and child population growth, rather than focusing on each State's share of uninsured/uninsured low-income children, as was previously the case. Drafters of the rule changes believe that it will lead to more appropriate distribution of CHIP funds at the beginning of each year and avoid the need for massive re-allocations of funds from States unable to spend their allotment at the end of each year.

During its early years, *HF* received larger allotments than it could spend. But during the years preceding CHIPRA, allotments had not kept up with the program's growing enrollment and spending, and the state had to rely on re-allocations of unspent funds from other states at the end of several fiscal years. With the passage of CHIPRA and implementation of the new formula, however, California's CHIP allocation increased substantially, nearly doubling from 2008 to 2009 (see Table VIII.1). The state's FY 2012 allotment was over \$1.3 billion. The State's share of funding for *Healthy Families* is 35 percent, which has been consistent since the program's inception.

Table VIII.1. CHIP Allotments and Expenditures (in millions of dollars)

FFY	Federal Allotment	Federal Expenditures	Federal Matching Rate
2005	\$667.4	\$760.0	65
2006	\$646.7	\$1,150.9	65
2007	\$790.8	\$980.7	65
2008	\$789.1	\$1,259.3	65
2009	\$1,552.9	\$1,193.9	65
2010	\$1,629.2	\$1,186.8	65
2011	\$1,254.9	\$1,280.8	65
2012	\$1,314.3	\$1,251.6	65

Sources: Kaiser Family Foundation, State Health Facts 2012; Center for Children and Families, Georgetown University Health Policy Institute, 2009a, 2009b, 2012; California CARTS 2009, 2010.

With significant state budget crises in California in recent years, *HF* has increasingly been under threat. As mentioned above, California imposed an enrollment freeze in 2009, and several proposals to reduce upper income eligibility limits and eliminate the program have been presented to the legislature over the past several years. Until this past summer, *HF* had been able to weather these threats with minimal damage, thanks to federal Maintenance of Effort requirements established by the ARRA. But a recent budget deal reached by Governor Brown and State legislators would shift all *HF* enrollees into *Medi-Cal*, as will be discussed in more detail, below.

This page has been left blank for double-sided copying.

IX. PREPARATION FOR HEALTH CARE REFORM

California has been a leader in preparing for implementation of the Affordable Care Act. In 2010, the state was first in the nation to enact legislation creating a health insurance exchange (HIX) under then-Governor Arnold Schwarzenegger. Passage of exchange legislation entitled the state to annual federal grants of \$1 million for up to five years. MRMIB has been actively involved with discussions and planning for the state's enrollment and eligibility system, as well as selecting a contractor to lead statewide outreach efforts. In addition, the state implemented its "Bridge to Reform Demonstration" under a Section 1115 waiver renewed in November 2010. This Medicaid waiver is anticipated to allow California to leverage \$10 billion in federal funds between November 2010 and October 2015 to promote access and support infrastructure development throughout the state (Dutton and Lam, 2011).

California is also one of a small number of states seriously considering implementation of a Basic Health Program (BHP) under the Affordable Care Act. In studying the option, the state has engaged several experts to evaluate the feasibility and benefits of adopting a BHP. California's innovation also extends to technology; in planning for reform implementation, the state is one of 17 that have partnered to collaborate on developing a tool (UX2014) to help consumers navigate state health insurance exchanges (California Health Care Foundation, 2012).

Recently resolved was the debate over a proposal by Governor Brown to shift all kids enrolled in *Healthy Families* into *Medi-Cal*. A portion of these children—those in families with income between 100 percent and 133 percent of poverty—were to be shifted to Medicaid in 2014 as required by the Affordable Care Act, but the Governor's proposal was to go beyond this group to move virtually all *HF* enrollees into the program. Proponents of the proposal—primarily the Office of the Governor and state *Medi-Cal* officials, as well as county social services directors—argued that the move would simplify the state's array of public coverage programs, promote seamlessness for children who move between *Medi-Cal* and the HIX, and potentially streamline enrollment and eligibility determination for low-income children. In addition, moving children into *Medi-Cal* would entitle them to Title XIX protections, including services without cost sharing, and Early Periodic Screening Diagnosis & Treatment benefits. The shift would also expand the reach of the vaccines for children (VFC)

Focus Group Findings: Health Care Reform

Many parents had heard about health care reform, but knew few specifics about what this meant for them.

"I heard about it, but I really don't know how it's going to work..."

"I've heard about it. If they do something like [Healthy Families], you know, I'm willing to pay for that kind of coverage."

"I think I've heard about it...and one of my concerns is the quality of the doctors and the quality of the care. We came from Ukraine, and the insurance was available to everybody, but the quality of medical services was nothing even close to compare with what we have here."

purchasing program in the state.¹⁷ Potential cost savings, however, were the primary motivation behind the Governor’s proposal. Estimates of between \$60 million and \$90 million would be saved each year by shifting all *HF* enrollees to *Medi-Cal*. A large portion of these savings would be derived from the lower reimbursement rates *Medi-Cal* pays its health plans and providers, compared to *HF*. Children’s advocates, however, have pointed out that transitioning *HF* into *Medi-Cal* could cost the state more money because of the higher federal matching rate the state receives for *HF* and the elimination of a tax on *Medi-Cal* managed care plans that was expected to bring in \$180 million this year.

At the time of our site visit, the vast majority of key informants interviewed for this case study were against the proposal to shift all children from *HF* to *Medi-Cal*. These informants were primarily concerned that children’s access to care would suffer, that continuity of care would be disrupted, and that the efficient, effective, and transparent administration of MRMIB would be lost. They further pointed out that, particularly for children who reside in portions of the state without *Medi-Cal* managed care, access for *Medi-Cal* beneficiaries is a significant challenge. The Governor’s proposal did include a provision for expanding *Medi-Cal* managed care statewide. However, as noted above, about 35 percent of children in *HF* are enrolled in health plans that do not widely participate in *Medi-Cal*, and some reside in counties with no managed care options available in *Medi-Cal*. This transition would therefore result in care discontinuities for almost 400,000 *HF* recipients. Lastly, key informants argued that, while the *HF* program has succeeded in streamlining a fairly straightforward enrollment process through its SPE vendor, *Medi-Cal* eligibility determination is still the purview of county DSSs. These individuals expressed concern that shifting all *HF/Medi-Cal for Children* applications to the counties (which are already overwhelmed and under-staffed) could result in significant enrollment delays and abandon a well-functioning system for one that has continuously met with complaints. At the time of this writing, the state’s counties utilized three different, and largely incompatible, eligibility systems.

A compromise proposal had been put forth by child advocates that would have moved only those *HF* enrollees with family income between 100 percent and 133 percent of poverty—referred to as the “bright line” group—into *Medi-Cal* in the near term. The majority of informants with whom we spoke favored this approach, as it assuaged their concerns over potential negative transition effects and promoted a “go-slow” approach with a group of children that would have been required to move to *Medi-Cal* in 2014 anyway. The compromise proposal also would allow California’s HIX to take shape and be better judged as a potential alternative to *Medi-Cal* for higher-income children currently enrolled in *HF*, as well as their families. A coalition of more than 40 organizations released a statement in May 2012 endorsing the transition of the “bright line” children, and the state legislature is expected to act on the proposal during the 2012 session (Dorn, 2012).

However in June, faced with a grave budget impasse, the Governor and legislature agreed to adopt the proposal to virtually do away with the *HF* program and move all children in families

¹⁷ *Medi-Cal* providers have access to the Vaccines for Children program, but *Healthy Families* providers have to pay up front for vaccines and store them—which can be quite costly—although they are reimbursed for immunizations by *HF* health plans.

with income through 250 percent of the federal poverty level into *Medi-Cal*.¹⁸ The first phase of this transition will begin in January 2013, when approximately 415,000 children enrolled in managed care plans that also participate in *Medi-Cal* will move to that program. The second phase, beginning in April 2013, will move roughly 249,000 children who are enrolled in a managed care plan that is subcontracting within the *Medi-Cal* program. The third group of *HF* children who will move, numbering approximately 179,000 and starting in August 2013, will be those who are enrolled in a managed care plan that does not participate in *Medi-Cal*, but live in a county where an alternative *Medi-Cal* managed care plan exists. The final transition group will be the roughly 43,000 *HF* children living in more rural parts of the state who are enrolled in a managed care plan, but who will have to transition into *Medi-Cal* fee-for-service because there is no managed care alternative available; this fourth phase begins in September 2013. The plan, at the time of this writing, had not received federal approval and such approval will be contingent on the state being able to demonstrate that access to care will not be significantly adversely effected.

HF officials have been hard at work to plan for this difficult transition. They continue to be concerned about enrollees' access to care, pointing out that simply because a health plan participates in both *HF* and *Medi-Cal* does not guarantee that the provider networks offered by the plan for the two programs are identical. And broader questions remain about the extent to which providers currently serving *HF* enrollees will be willing to continue serving these children at lower *Medi-Cal* rates. These officials remain committed to ensuring that the design of *HF*, designed to provide low-income children with reliable access to high-quality pediatric care is not lost as implementation of the Affordable Care Act progresses.

¹⁸ Infants enrolled in the AIM Program (Access for Mothers and Infants) in families with income between 251 percent and 300 percent of poverty will remain in a state-funded portion of Healthy Families. This population currently makes up less than three percent of current enrollees. All children over age one in these families would be eligible to participate in the state's health insurance marketplace.

This page has been left blank for double-sided copying.

X. CONCLUSIONS AND LESSONS LEARNED

From any number of perspectives, the *Healthy Families* program can be considered a success. Policymakers set out to create a separate program modeled more closely after private insurance than Medicaid, and in that they succeeded based on *HF*'s 14 years of bi-partisan political support, and wide popularity among consumers, providers, and health plans. Program designers worked hard to design innovative, streamlined enrollment systems, and based on California's successful track record in enrolling uninsured children, they achieved that objective. MRMIB also wanted to provide enrolled children with access to a broad set of health plans and providers across the state, and stakeholders generally believe that the program has accomplished this, with regard to both medical and dental care. (Comments by parents participating in focus groups underscore how much value they see in having health insurance for their children.)

Yet, despite its popularity, *HF*'s very existence has been under threat for several years in light of California's precarious state budget situation. Massive perennial deficits have persuaded two administrations—one Republican and one Democratic—to propose moving all *HF* enrollees into the less costly *Medi-Cal* program. In spite of strong resistance from a broad range of advocates, providers, and health system stakeholders, these efforts finally prevailed in June 2012 and the state will begin transitioning *HF* children to *Medi-Cal* in January 2013.

Despite this outcome, stakeholders were unanimous in stating that the many valuable lessons learned from *HF* regarding how to reach out to, enroll, and care for children must be preserved and incorporated into *Medi-Cal* and other new systems that follow it as California continues to implement the Affordable Care Act. Some of these key lessons include:

- ***Community-based application assistance is a critical tool for enrolling hard-to-reach populations.*** As described in this case study, California was a leader in designing a strategy that succeeded in coupling outreach with enrollment, giving community agencies and workers the skills and authority to complete program applications and assist parents with this often complex process. Stakeholders are convinced that the CAA system has been critical in supporting consistent, strong enrollment in *HF*, and was also instrumental in boosting enrollment of eligible children into *Medi-Cal*. As evidence of its support and effectiveness, many foundations and other entities continued to fund CAA activities after state funding was cut, and many agencies and providers chose to conduct the function with their own resources. Stakeholders also believe that some form of CAA will persist under health reform to help families navigate the process of finding and enrolling into coverage.

- **More generally, simplified and streamlined eligibility rules work.** As was the case with so many CHIP programs across the nation, HF embraced numerous eligibility simplification strategies from the outset and these strategies were, over time, adopted by Medi-Cal. These efforts, coupled with an effective SPE enrollment vendor, improvements in county DSS operations, and most recently, the addition of a public-access online application, have resulted in a more user-friendly system for families that facilitates, rather than complicates, enrollment. Most recently, HF has also made much-needed progress with simplifying renewal by making an online version of its renewal application available to consumers.

- **Strong benefits coverage and access to care—both medical and dental—can be achieved through statewide contracts with a broad range of public and private health plans.** The HF benefits package was described as nearly the equivalent of Medi-Cal's. Furthermore, HF has constructed a statewide managed care network that appears to be providing generally strong access to care for children. Dental care, too, is delivered through managed care arrangements. Simple statewide contracts and fair

reimbursement were attributed to HF as key factors in building these broad service delivery systems. In the opinion of many stakeholders, HF networks outperform their Medi-Cal counterparts with regard to access. And distinct difference between the two programs' networks persist, making seamless transfer between the two programs difficult for families whose circumstances change, thus leading to disruptions in continuity of care. This problem will be crucial to monitor in 2013 as HF children are transitioned to Medi-Cal.

Focus Group Findings: Implications of having health insurance

Parents were unanimous in their appreciation of having coverage for their children. Many contrasted their current situation to a time when they did not have health insurance.

"[Having insurance for my child] is peace of mind."

"You don't have to worry if you have the money or not to take them to the doctor."

"It makes a lot of difference, because you don't have to worry about how much you are going to spend. It helps you a lot in life..."

"It gives me security... Every week I'm worrying about how am I going to get groceries or how am I going to pay my rent. But I don't have to worry about [health coverage]."

"It's definitely peace of mind. It's like VISA—it's priceless."

"If my business goes up or down, I don't have to worry. At least she's covered, you know?"

"You can actually go home and you can sleep well, because you don't have to worry about what might happen."

"I would have been homeless a year ago when she went to the hospital. It was one day, and it was about \$85,000. I don't know what I would have done [without Healthy Families]."

"What attracted me to the program...is that they don't have the preexisting condition exclusion when you apply. When you normally apply for health insurance there's always that preexisting condition that would exclude you from getting insurance...or a waiting period. It didn't happen like that with Healthy Families."

"[When my child was uninsured] whether I took him to the doctor...depended on what I thought it was, if it was serious or not...because you have to pay."

"When I tried to go to the pharmacy and see how much it would cost, it was like \$100 or something, and I said, 'I can't afford that!'"

"Private was more expensive; we were paying like \$200 a month."

"We had a \$50 copayment even though we were paying hundreds and hundreds of dollars a month!"

- ***Given its many strengths, HF was not dramatically impacted by CHIPRA provisions.*** As illustrated in Table X.1, the state has complied with mandatory changes (such as adding medically necessary orthodontia and paying FQHCs based on Medicaid prospective payment methods) and has adopted many other optional provisions related to coverage of legal immigrant children and pregnant women and development of more rigorous quality monitoring methods.

Table X.1. California's Compliance with Key Mandatory and Optional CHIPRA Provisions

Provision	Implemented in California?
Mandatory CHIPRA provisions	
Mental health parity required for States that include mental health or substance abuse services in their CHIP plans by October 1, 2009	Yes
Requires States to include dental services in CHIP plans	Yes
Medicaid citizenship and identity documentation requirements applied to Title XXI, effective January 1, 2010	Yes
30-day grace period before cancellation of coverage	Yes
Apply Medicaid prospective payment system to reimburse FQHCs and RHCs effective October 1, 2009	Yes
Optional CHIPRA provisions	
Option to provide dental-only supplemental coverage for children who otherwise qualify for a State's CHIP program but who have other health insurance without dental benefits	No
Option to cover legal immigrant children and pregnant women in their first 5 years in the United States in Medicaid and CHIP	Yes
Bonus payments for those implementing five of eight simplifications	No – Have implemented five of eight simplifications but are not eligible because have not surpassed threshold for Medicaid enrollment
Contingency funds for States exceeding CHIP allotments due to increased enrollment of low-income children	TBD
CHIPRA Outreach Grants	Yes
Quality initiatives, including development of quality measures and a quality demonstration grant program	In development

FQHC = Federally qualified health center; RHC = rural health clinic.

- ***Nominal premiums and copayments do not appear to pose barriers to access and use.*** Always controversial, cost sharing can discourage families from enrolling in a program or using its services, if rates are too high or imposed on families with too little income. But in the case of *HF*, a strong majority of stakeholders believe that cost sharing levels are fair, affordable, and well-targeted, even after two premium increases were enacted after 2009. Families, too, expressed comfort with the amounts they were asked to pay, and even pride in being able to contribute to the cost of their care.

California has aggressively planned and prepared for implementation of the ACA and in this planning considered the potential elimination of its *Healthy Families* program. Despite strong and broad-based support for the program, policymakers did decide to abandon the separate program and will begin transitioning *HF* enrollees into *Medi-Cal* beginning in January 2013. Though State officials mourned the decision, referring to it as the “end of an era,” they remain committed to working so that the numerous principles and strengths of *HF* are carried over to the next generation of reformed Medicaid and subsidized programs so that children will receive optimal care and access.

REFERENCES

- The 100% Campaign. “Low-Income Children On Healthy Families Could See Premiums Increase at Twice the Rate of Anthem Blue Cross’ Massive Premium Hikes.” March 9, 2010. <http://www.100percentcampaign.org/publications/>
- California Health Care Foundation, “Unveiling Enroll UX 2014 Design: Welcome to Coverage, A new standard for public and private health insurance enrollment.” <http://www.chcf.org/media/press-releases/2012/designing-a-new-standard-for-enrollment>
- Centers for Medicare & Medicaid Services (CMS), CHIP Statistical Enrollment Data System (SEDS) as of February 18, 2011, verified and provided by CMS. 2011 data accessed on May 14, 2012.
- Cousineau, Michael and Eriko Wada, *Express Lane Eligibility Project, Evaluation Report* (Los Angeles: USC Division of Community Health, July 2006).
- Dorn, Stan. “The Future of Healthy Families: Transitioning to 2014 and Beyond.” Washington, DC: The Urban Institute, February 2012.
- Foster, Leslie. “Health-e-App Public Access: A New Online Path to Children’s Health Coverage in California.” Mathematica Policy Research, Inc. with support of the California Health Care Foundation and the David and Lucile Packard Foundation. Research Brief 1, March 2012.
- Hill, Ian and Corrina Hawkes. “Congressionally Mandated Evaluation of the State Children’s Health Insurance Program: Site Visit Report—The State of California’s Healthy Families Program.” Washington, DC: The Urban Institute, November 2002.
- Hughes, Dana Hughes, DrPH, January Angeles, MPP, Erik Stilling, PhD. “Crowd-Out in the Healthy Families Program: Does it Exist?” Institute for Health Policy Studies, University of California, San Francisco: August 2002. http://www.mrmib.ca.gov/mrmib/HFP/HFP_Crowd-Out_Study_Dana_Huges_2002.pdf
- Kaiser Family Foundation, State Health Facts 2012; Center for Children and Families, Georgetown University Health Policy Institute, 2009a, 2009b, 2012; California CARTS 2009, 2010.
- Kenny, Genevieve, and *Health Affairs*, 2010
- Lynch, Victoria, Samantha Phong, Genevieve Kenney, and Juliana Macri. *New National and State Estimates from the 2008 American Community Survey*. Princeton, NJ: The Robert Wood Johnson Foundation. August 2010. <http://www.rwjf.org/files/research/67668.pdf>

Reilly, Tim, Bobbie Wunsch and Steven Krivit. "California's Local Community Health Plans: A Story of Cost Savings, Quality Improvement, and Community Leadership 2010." The California Endowment, January 2010.

http://www.pachealth.org/docs/100054_CAE_LocalCommunityHealthPlans_7.pdf

Stevens, Gregory D., Kyoko Rice, and Michael R. Cousineau. Children's Health Initiatives in California: The Experiences of Local Coalitions Pursuing Universal Coverage for Children. *American Journal of Public Health*: April 2007, Vol. 97, No. 4, pp. 738-743. doi: 10.2105/AJPH.2006.088690

Teare, Catherine, Len Finocchio, and Victoria Martin-Young. "Connecting Kids to Health Coverage: Evaluating the Child Health and Disability Prevention Gateway Program." The California Healthcare Foundation. August 2007.
<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ConnectingKidsToHealthCoverageEvaluationOfCHDP.pdf>.

APPENDIX A

SITE VISITORS AND KEY INFORMANTS

This page has been left blank for double-sided copying.

California Site Visit

March 26 – 30 and April 11 – 12, 2012

Site Visitors

Urban Institute

Ian Hill
Sarah Benatar
Juliana Macri

Key Informants: Sacramento

MRMIB

Janette Casillas
Tony Lee
Jeanie Esajian
Ellen Badley
Irma Michael

Department of Health Care Services (DHCS)

Rene Mollow
Len Finocchio

California State Assembly

Dr. Richard Pan

Anthem Blue Cross

Norma Durand
Leslie Porras
Steve Melody

California Children's Services (CCS)

Louis Rico
Dr. Marianne Dawson

California Primary Care Association (CPCA)

Deborah Ortiz

California Medical Association

David Ford

County Mental Health Directors Association (CMHDA)

Don Kingdon

Cover the Kids

Kelley Bennett-Wofford
Joil Zhong
Juan Malespin

Delta Dental

Sheryl Brewer
Brandi Christian

MAXIMUS Lane Adams

Dale Ramey
Kathi Prudhomme
Michael Lemberg

Western Center on Law and Poverty

Elizabeth Landsberg

Key Informants: San Francisco

North East Medical Services

Christina Ng

NICOS Chinese Health Coalition

Corinna Liew

North Peninsula Neighborhood Services Center

Audrey Magnusen
Alex Parada

San Francisco Health Plan

John Gurgrina
Nina Maruyama
Kersti Adams
Jackie Parra
Johanna Alvarez
Wendy Li

Key Informants: Los Angeles

Maternal and Child Health Access

Lynn Kersey

The Children's Partnership

Wendy Lazarus

Eisner Pediatrics
Dr. Deborah Lerner
Carl Coan

Kaiser Permanente
Gwendolyn Leake-Isaacs
Christine X Nelson
Susan D Fleischman
Teresa R Stark

This page has been left blank for double-sided copying.

APPENDIX B

ALABAMA STATE APPLICATION

This page has been left blank for double-sided copying.



Free and Low-Cost Health Care for Children and Pregnant Women

A healthier tomorrow starts today!

Free and low-cost health care, including:

- Preventive Care
- Prenatal Care
- Doctor Visits
- Vision/Dental Care
- Mental Health
- Prescriptions
- Hospital Stays
- Emergency Visits

See Inside

How to Apply 2
 Application AI-A4
 Need Help? 3
 Family Size & Income . . 4
 Pregnant? 5
 Other Questions 6
 Notices 7

This application is available in:
 Spanish, Vietnamese, Chinese,
 Korean, Russian, Armenian, Farsi,
 Khmer, Hmong, Arabic and Tagalog
 Español, Việt Ngữ, 中文, 한국어,
 Русский, Հայերեն, فارسی,
 Գաղտնի, Hmoob, العربية, Tagalog

MC 321 HFP (rev. 07/10)
 Instructions

Apply now for Medi-Cal and Healthy Families.

Follow these steps:

- ① Fill out the application inside.
- ② Send us copies of the documents listed on page 2.
- ③ If you are pregnant, see page 5.
- ④ Sign and mail the application.



Who can apply?

- Children under the age of 19 from low-income and working families
- Pregnant women

Children and pregnant women who do not have immigration papers may still qualify for some Medi-Cal.

How much does it cost?

Medi-Cal is free. Healthy Families is \$4 – \$24 per child, per month.

Want to know if you qualify?

It depends on your family size, income, and age of the child. See the chart on the back cover.

We can help you apply for free!

- On the phone – We can help you fill out your application on the phone.
- In-person – A trained assistant can meet with you.
- We can help you in any language!

Call: **1-800-880-5305** or TDD: **1-800-735-2929**

Monday – Friday: 8 a.m. – 8 p.m.,
Saturday: 8 a.m. – 5 p.m.

Sponsored by the State of California

Here's how to apply:

Pregnant? See page 5.

1 Fill out the 4-page application.

If you do not understand a question, or do not have any of the documents, call: **1-800-880-5305**. Or, look for the information you need on pages 3–7.

2 Send us copies of income and expense documents.

(You may be able to use other documents not listed here.)

One document for each person living in the home who has a job:

- A recent pay stub (from less than 45 days ago), **or**
- A signed, dated statement from your employer showing your gross income and how often you are paid, **or**
- Last year's federal income tax return.

One document for each person living in the home who is self-employed:

- Last year's federal income tax form with Schedules C, C-EZ, or F, **or**
- A signed, itemized profit and loss statement for the last 3 months. For a sample profit and loss statement, go to: www.healthyfamilies.ca.gov, then click on the "Downloads" tab.

If you have income from Disability, Pensions, Retirement, Social Security, Veteran's Benefits, Workers' Compensation, or Unemployment, send a copy of:

- The award letter, check, **or** bank statement showing direct deposit for the most recent payment.

If you receive or pay child support or spousal support, send a copy of:

- The court order, paycheck stub showing support deduction, receipts, or the monthly support check, **or**
- A statement from the Department of Child Support Services or the person who pays support that lists: the amount of monthly support, who the support is for, who pays for it, and who receives it.

If you pay for child day care or disabled dependent care, send a copy of:

- A cancelled check **or** receipt, **or** a signed statement from your child day care provider showing how much you pay each month.

3 Send citizenship or immigration documents for each person applying.

(Send this now or as soon as you can.)

Citizens or Nationals: Send a copy of the birth certificate, passport, certificate of U.S. citizenship or naturalization or other proof of citizenship for each person applying. We may ask you for more information later.

Non-citizens: Send proof of immigration status. Make copies of front and back sides of documents. Or send a receipt from Immigration (USCIS) showing that you have applied to replace a lost document. *Even if the person applying does not have immigration papers, you can still apply for Medi-Cal.*

4 Send **one** document per household that proves California residency.

(You may be able to use other documents not listed here.)

- A pay stub that shows your address in California, **or**
- California Driver's license or ID card from DMV, **or**
- Rent receipt or utility bill, **or**
- Proof of your child's enrollment in school.

5 Sign and Mail the Application (The application is on pages A1-A4.)

Mail your application and copies of the documents in the attached envelope. No stamps needed!

Mail it to: **Healthy Families/Medi-Cal, P.O. Box 138005, Sacramento, CA 95813-9984**

Application

Please fill out all 4 pages of this form. Print clearly.
Use black or blue ink only. Mail your completed form to:

Healthy Families/Medi-Cal
P.O. Box 138005
Sacramento, CA 95813-9984



Need Help?
Call: 1-800-880-5305

Tell us about the family member filling out this form.

① _____ / /
Last Name First Name Middle Initial Date of Birth (mo/day/yr)

② _____ ()
Home Address (Number and Street) **Do NOT use a P.O. Box – unless homeless** Apt. # Home Phone #

③ _____ ()
City County Zip Code Work Phone #

④ _____ ()
Mailing Address (if different from above) or P.O. Box Apt. # Message or Cell Phone #

⑤ _____
City Zip Code E-mail Address (Optional)

⑥ What language do you want us to speak to you in? ⑦ What language should we write to you in?

Tell us who you are applying for. (If more than 3 children, photocopy pages A1 and A2 to list other children.)

	Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
⑧ Name	Last				Pregnant women in Medi-Cal or AIM: do not fill out this part. <input type="checkbox"/> Check here to apply for Healthy Families for your baby before he/she is born. You must: <ul style="list-style-type: none"> • Be at least 6 months pregnant, • Send proof of pregnancy from your doctor or clinic with the application, and • Send proof of birth when the baby is born. (More information on page 5.)
	First				
	Middle				
⑨ Name on birth certificate (if different from name above)	Last				
	First				
	Middle				
⑩ Does the child live away from home because of school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
⑪ Home address (if different from home address in ②)					
⑫ Mailing address (if different from mailing address in ④)					
⑬ Date of Birth	____/____/____ mo day yr	____/____/____ mo day yr	____/____/____ mo day yr	____/____/____ mo day yr	
⑭ Relationship to person in ①	<input type="checkbox"/> My child	<input type="checkbox"/> My child	<input type="checkbox"/> My child	Baby's Due Date: ____/____/____	
	<input type="checkbox"/> My stepchild	<input type="checkbox"/> My stepchild	<input type="checkbox"/> My stepchild		
	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____		
⑮ Gender	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	Number of babies expected: _____	

	Child 1	Child 2	Child 3	Pregnant Woman	Unborn Child
16	Ethnicity – <i>Optional</i> (See page 6.)				
17	Birthplace County: _____ State: _____ Or foreign country: _____				
18	Social Security No. (See pages 6 and 7.) <i>This is optional if you are applying for Healthy Families or for emergency or pregnancy services.</i>				
19	U.S. Citizen or National? (See pages 3 and 7.) If No, date arrived in the U.S. ____/____/____ mo day yr				
20	Medi-Cal benefits card number (BIC), if you have it:				
21	Does this person have other health, dental or vision insurance? <i>Even if you have other health insurance, Medi-Cal may cover what your other insurance does not.</i>				
22	Did this child have health insurance through someone's job in the last 3 months? (See page 6.) ____/____/____ mo day yr <i>Check the box to tell us why health coverage ended:</i> <input type="checkbox"/> Lost job <input type="checkbox"/> Job status changed <input type="checkbox"/> Moved and no insurance available <input type="checkbox"/> All employees' benefits ended <input type="checkbox"/> Death, divorce or legal separation <input type="checkbox"/> COBRA ended <input type="checkbox"/> Other _____				
23	Does this person want to apply for Medi-Cal for medical expenses in the last 3 months? (See page 6.) <i>Medi-Cal may cover medical expenses for past 3 months.</i>				
24	Mother's Name: Last _____ First _____ Middle _____ Does this child live with the mother? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25	Father's Name: Last _____ First _____ Middle _____ Does this child live with the father? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Tear Here

If you need more space, make a copy of this page or attach another sheet.

Family Size List all other family members who live in the home. Include children under 21, stepparents, and the spouse of any teenager or pregnant woman who lives in the home. Do **not** list aunts, uncles, nieces, nephews, or grandparents. (For more information, see page 4.)

	Name	Gender	Date of Birth	How is this person related to the person in ①?
26		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ mo day yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other _____
27		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ mo day yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other _____
28		<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____ mo day yr	<input type="checkbox"/> Child <input type="checkbox"/> Boyfriend <input type="checkbox"/> Spouse <input type="checkbox"/> Stepchild <input type="checkbox"/> Girlfriend <input type="checkbox"/> Other _____

29 Is any person in the home pregnant? Yes No
If yes, who? _____ How many babies is she expecting? _____ Due Date: ____/____/____
mo day yr

Family Income List the income of **every** person listed in this application. Include child support and spousal support received. (Use a separate line for each source of income.)

	Name of person with income (Children who are in school do not have to list their income from a job.)	Source of Income (job, social security, pension, etc.)	How often is income received? (Weekly, biweekly, monthly)	How much is the income? (total gross income)	Social Security Number (Optional)
30				\$	
31				\$	
32				\$	
33				\$	
34				\$	

Tear Here

Expenses List the monthly expenses of the person in ① and the people listed above.

- 35 Child Day Care or Disabled Dependent Care
For (child or dependent's name): _____ Age: _____ Amount paid: _____
For (child or dependent's name): _____ Age: _____ Amount paid: _____
For (child or dependent's name): _____ Age: _____ Amount paid: _____
- 36 Court-ordered child support
Paid to: _____ Paid by: _____ Amount paid: _____
Paid to: _____ Paid by: _____ Amount paid: _____
- 37 Court-ordered spousal support
Paid to: _____ Paid by: _____ Amount paid: _____

Household Information

- 38 Does the person in ①, anyone listed above, or any other person in the home want Medi-Cal? . . . Yes No
If yes, who? _____ (If you answer Yes, we will contact you.)
- 39 Does any child or other person in the home have a physical, mental, emotional or developmental disability and want Medi-Cal? Yes No
If yes, who? _____ (If you answer Yes, we will contact you to see if you qualify.)
- 40 Is any person applying for coverage involved in a lawsuit because of an injury or accident? (For more information, see page 6.) Yes No
- 41 Is there more than one car in the household? (Optional) Yes No
- 42 Is there more than \$3,150 in household bank accounts? (Optional) Yes No

The health care programs may share your information unless you check below:

- 43 We will send your application to Healthy Kids or a similar county program if your child does not qualify for full Medi-Cal or Healthy Families. If you do not want us to send it, check here. *(For more information, see page 6.)*
- 44 Medi-Cal will share your child’s application with Healthy Families if your child no longer qualifies for free Medi-Cal in the future. If you do not want us to send it, check here.

Choose your Healthy Families plans:

Write the name or code of the plans you want below. To learn more about what plans are available, see the Healthy Families Handbook or call: **1-800-880-5305**. Or visit: **www.healthyfamilies.ca.gov**

45 Health Plan _____ Name Code	46 Doctor or Clinic _____ <i>(Optional)</i> Name Code
47 Dental Plan _____ Name Code	48 Dentist or Clinic _____ <i>(Optional)</i> Name Code
49 Vision Plan _____ Name Code	50 Eye Doctor or Clinic _____ <i>(Optional)</i> Name Code

Check all boxes that describe you:

- 51 Native American Indian Forestry worker Agricultural worker Working in Fishing
- If you checked any of these boxes, you may qualify for the Special Population Plan that covers your child in any California county. Look for the Plan Code for this special plan in your Healthy Families Handbook or at www.healthyfamilies.ca.gov.*

Are you (or the child applying for coverage) a Native American Indian or Alaska Native who wants free Healthy Families health care?

- 52 Yes No *If yes, see page 6.*

Healthy Families Plan Disputes

Each plan has its own rules for resolving disputes about the delivery of services and other matters. Some plans say you must use binding arbitration for disputes; others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have the dispute decided in court. To find out more about how a plan resolves disputes, you can call the plan or look in the HFP Handbook. Or go to: www.healthyfamilies.ca.gov.

Declaration and Signature *(Required)*

I declare under penalty of perjury under California state law that I have read this application, the answers provided, and the documents enclosed and, to the best of my knowledge, they are correct and true. I have read and understand the Notices, and I am making the Declarations on page 7.

Applicant signs here: _____ Date: _____

Witness signs here *(If applicant signed with a mark)*: _____ Date: _____

Authorized Representative *(If any)*: _____ Date: _____

Fill out below ONLY if a Certified Application Assistant (CAA) helped you fill out this form.

- Check this box and sign below to allow Healthy Families and Medi-Cal to speak to a representative of the Enrollment Entity (EE) listed below about the status of this Application. This permission ends when the program mails you its decision on this Application.

I certify the CAA listed below helped me complete this application. This CAA helped me for free.

Applicant Signature: _____ Date: _____

CAA# _____ EE# _____

CAA Signature: _____ Date: _____

The state will not reimburse the EE unless the CAA fills out this section completely and correctly when the application is submitted.

Tear Here

Need Help?

We can help you!

- On the phone – We can help you fill out the application on the phone.
- In-person – A trained assistant will help you apply. Some assistants can fill out your application online.
- We can help you in any language!
- *All Help is Free!*

Call: **1-800-880-5305**

TDD: **1-800-735-2929**

Can I get help on the Internet?

Yes. For more information about Healthy Families, go to: www.healthyfamilies.ca.gov

Who can apply for a child?

The child's parent, stepparent, guardian, or caregiver relative can apply. Emancipated minors can apply for themselves.

Does the child or pregnant woman have to be a U.S. citizen or National?

No. Documented and undocumented immigrants may be eligible for Medi-Cal. Some immigrants may be eligible for pregnancy and emergency services only. Others may be eligible for full Medi-Cal benefits.

For Healthy Families, a child must be a U.S. citizen, National, or qualified immigrant. For more information see the Healthy Families Handbook or go to www.healthyfamilies.ca.gov. Click on "FAQs".

Do I have to give you immigration information for everyone in my family?

No. Only list the immigration information for family members who are applying for health benefits.

Parents do not need to give their immigration information if only applying for their children.

The immigration information you give is private and confidential. We only use it to see if you are eligible. And, we do not use your immigration information to demand payment for services lawfully received.

MC 321 HFP (rev. 07/10)
Instructions

Is the information I give you private?

Yes. We only use your information to see if you are eligible or to administer the programs. See page 7.

Do I have to pay anything?

No, not for Medi-Cal.

For Healthy Families, you do not have to pay now. But, once you are enrolled, the cost is \$4 – \$24 per month for each child, up to \$72 per family. If you pay the premiums for 3 full months now, you get one month free!

What happens after I apply?

We will send you a letter to let you know which program your children may be eligible for and when coverage would begin. It can take up to 45 days to process your application.

When can I check on my application?

Call us 10 – 15 days after you mail the application.
1-800-880-5305

Will all the children in my family be in the same program?

Maybe. It depends on your family size, income and the age of each child. You may have a younger child in Medi-Cal and an older child in Healthy Families.

What if I can't send copies of the documents you need now?

The fastest way to enroll is to send all your documents now. Or send them as soon as you can. Or fax them to us at: **1-866-848-4974**

If we need more information, we will call you and send you a letter.

Family Size and Income

How do you use my personal and financial information?

We look at the size of your family and income to see if you or your children qualify for the programs. We may not count everyone as part of your family. And we may not count everyone's income. We will figure it out for you.

Who should I list as family members living in my home?

You should list:

- Any child under age 21 living at home, or away at school and claimed as tax dependent
- The birth parents, adoptive parents, or a stepparent who lives with a child you are applying for
- The pregnant woman and her unborn child (If she is married, list her husband, too.)
- The spouse of any teenager living in the home
- An emancipated minor

Do not list:

- aunts, uncles, • cousins,
- nieces, nephews, or • grandparents.

But, if any of these relatives want Medi-Cal, check "Yes" on question 38 on your application.

What if my income is too high?

Your children may still qualify because we deduct your payments for child day care, child support, dependent care, and spousal support expenses from your family income. We also deduct up to \$90 for each family member who works or receives State Disability Insurance or Workers' Compensation.

If your income is still too high, your children may qualify for Healthy Kids. See page 6.

How does child or spousal support affect my income?

If you *pay* child or spousal support, we deduct the amount you pay from your family income.

If you *receive* child or spousal support, we count the amount of support you receive, minus up to \$50 from your family income.

Do you deduct child day care or disabled dependent expenses from my income?

We deduct these expenses from your family income if:

- The person who pays for it lives in the home, and
- The adults in the home cannot provide this care because they are working or in job training.

The maximum amount we can deduct depends on the age of the person receiving care. See below:

Child under 2 years old	\$200
Child 2 years old or older	\$175
Disabled dependent (any age)	\$175

What if my income will change soon?

If you know your family income will change in the next few months because of a promotion, layoff, or other change, attach a separate sheet of paper and explain.

Example:

This month, my paycheck was for \$1000. But usually my paycheck is for \$800. Last month I got \$200 extra in overtime. There will be no overtime for the next 6 months.

What is "gross" income?

Gross income is the amount before taxes and before other deductions are taken out.

What is my gross income if I am self-employed?

We look at your profit or loss (on your Schedule C from last year or your Profit & Loss statements from the last 3 months). Then we add back your expenses for meals, entertainment and depreciation. If you lost money in any month or during the year, we will count your income as \$0 for that period of time.

Pregnant?

Medi-Cal for pregnant women includes:

- Pregnancy services (including some dental services), or
- Complete health services

How do I apply?

For pregnancy services *only*, fill out the application and send us the documents listed on page 2. If you want *complete* health services, you must also send proof of pregnancy from your doctor or clinic.

It may take up to 45 days to process your application and let you know if you are eligible.

Can I get pregnancy services sooner?

Yes. There is a special program that offers free immediate, temporary, pregnancy-related services to women who are applying for Medi-Cal. It's called *Presumptive Eligibility for Pregnant Women*. Ask your health care provider if they participate in this program.

For more information, call: **1-800-824-0088**

Will I get paid back for pregnancy services I get before my application is approved?

If your application is approved, Medi-Cal may pay you back for pregnancy services you received in the 3 months before you apply – even if the services were not from a Medi-Cal provider. But after you send in your application, you can only get paid back if you get services from an enrolled Medi-Cal provider.

What if I don't qualify for Medi-Cal?

If your income is too high for free Medi-Cal, you can apply to AIM. (AIM is short for *Access for Infants and Mothers*.)

AIM is a low-cost program for uninsured pregnant women whose income is too high to qualify for free Medi-Cal.

For more information, call
1-800-433-2611

Or go to: www.aim.ca.gov

How do I sign up my newborn if I have Medi-Cal or AIM for my pregnancy?

You do not need to fill out this application.

If you have **Medi-Cal**, contact your eligibility worker to make sure your baby is covered from birth. Or fill out a *Newborn Referral Form*. Print the form at: www.dhcs.ca.gov/formsandpubs/forms/Forms/mc330.pdf.

If you have **AIM**, your baby may qualify for Healthy Families from birth. Contact Healthy Families to report your baby's birth. Call **1-800-880-5305** or go to www.aim.ca.gov, then click on "Register Your Baby."

If I don't have Medi-Cal or AIM for my pregnancy, can I apply for Healthy Families for my baby before he/she is born?

Yes. Follow these steps:

1. Apply for Healthy Families when you are at least 6 months pregnant. Fill out this application and check the box on page A1 (in the Unborn Child column).
2. Include a statement from your doctor or clinic saying you are pregnant and your due date with your application.
3. If your baby qualifies for Healthy Families, send proof of birth within 30 days. Proof of birth is a:
 - Signed letter from the health care provider who delivered the baby or the hospital where the baby was born, or
 - Hospital certificate of birth, or
 - Birth certificate.

The proof of birth must have the baby's first and last name, birth date, place of birth, and gender.

Important! If you were not covered by AIM for your pregnancy, your baby's Healthy Families coverage starts **13 days** after we get the proof of birth.

Other Questions

What do I write for ethnicity?

Write the ethnic group that the child or pregnant woman belongs to.

Here is a list that may help:

Alaska Native	Hispanic
Amerasian	Japanese
Asian Indian	Korean
Black/African American	Laotian
Cambodian	Native American Indian
Chinese	Other Asian
Filipino	Samoan
Guamanian	Vietnamese
Hawaiian	White
Other	

What if I want full Medi-Cal but I don't have a Social Security number?

You may be able to get full Medi-Cal if you apply for a Social Security number and give it to us within 60 days.

To get a Social Security number, contact the Social Security Administration:

1-800-772-1213 (toll-free)

If you cannot get a Social Security number, you may still be eligible for pregnancy and emergency services.

What if my child used to have health insurance through someone's job, but it ended?

If you are eligible, Medi-Cal can cover you right away.

Healthy Families covers eligible children 3 months after coverage ends. If the coverage ended because of a change in job status, you moved, benefits to all employees ended, a death, legal separation or divorce, or COBRA coverage ended, you may qualify for coverage sooner.

Can Medi-Cal help me pay for past medical services?

Yes. Medi-Cal may be able to help pay for paid or unpaid medical costs you had in the 3 months before you applied. Check Yes on ② on the application.

What if I am involved in a lawsuit and I get a settlement?

If there is a legal settlement in your favor for an accident or injury and Medi-Cal covered your health care, you may have to pay Medi-Cal back for the services from the settlement.

Will Medi-Cal help me pay for medical services until my application is approved?

If you want Medi-Cal to pay, make sure your provider is an enrolled Medi-Cal provider, first. Medi-Cal may pay you back for services you get from an enrolled provider after you apply.

How do I choose my Medi-Cal health plan?

We will send you a packet. If you do not want to wait, call Health Care Options: **1-800-430-4263**. They will tell you if there are Medi-Cal health plans in your county.

Native American Indians / Alaska Natives:

If you do not qualify for free Medi-Cal, you can get Healthy Families for free. Make sure you check Yes in ⑤ on the application. You must also send one of these documents (for the parent or the child) now or within 2 months of enrollment:

- Enrollment document from your federally recognized tribe, or
- Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs, or
- A letter of Indian Heritage from a California Indian health service clinic.

What if my children do not qualify for the programs?

They may qualify for another free or low-cost health care program for children who are not eligible for full Medi-Cal or Healthy Families.

In many counties it is called the *Healthy Kids Program*. If the program in your county can accept this application, we will send it to them.

To see if your county has a Healthy Kids Program, call: **1-800-880-5305**

Healthy Families Notices

Declarations

I declare that each person I am applying for:

- Is a resident of California
- Is not in jail or in a mental hospital
- Is not eligible for Medicare Part A and Part B
- Is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program, but the employer contribution for dependent(s) is less than \$10.

I also declare that:

- All individuals listed on this Application will follow the rules of participation, the utilization review process and the dispute resolution process of the plans in which the individual is enrolled.
- I attest to the identity of each person being applied for.
- I have read and understand the *Healthy Families Handbook*. I understand what it says about each health, dental and vision plan and the benefits they offer.
- I am applying for all of my children eligible for Healthy Families, unless they are already enrolled, or unless I am only applying for myself.
- I give permission to Healthy Families to check my family income, health coverage, immigration status of the people I am applying for, and all other facts on this Application Form.
- I agree to notify the program within 30 days of any change of address of any person applied for who is accepted into the program and any change in the applicant's billing address.

Privacy

The law requires you provide the information requested to apply for Healthy Families. (Title 10, CCR, § 2699.6600) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with the agencies and plans you want to enroll in.

Citizenship and Immigration Information

The application asks you about your citizenship and immigration status. You must answer these questions. We use your answers to administer the program and to see if you are eligible. If you are a parent or guardian and are not applying for yourself, we will not share your immigration information with other agencies, including the immigration authorities. If you do not answer the questions, we may deny your application.

Ethnicity

Unless you are applying for benefits based on your Native American ancestry, you do not have to answer the questions about ethnicity.

Social Security Numbers

You do not have to provide your Social Security Number if you do not want to.

Access to Your Records

You have the right to access records maintained by the Managed Risk Medical Insurance Board that contain your personal information. To do so, contact:

Managed Risk Medical Insurance Board
Attn: HIPAA Coordinator
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695

MC 321 HFP (rev. 07/10)
Instructions

Medi-Cal Notices

Rights, Responsibilities and Declarations

I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- Ask for an interpreter.
- Ask for a fair hearing if I think a decision on my Medi-Cal case is unfair or wrong. I must ask for a hearing within 90 days after the "Notice of Action" is mailed to me. To find out about Medi-Cal fair hearings, call toll-free 1-800-952-5253.

I have the responsibility to:

- Send in a status report when the county asks me to.
- Report any changes in the information I gave on this Application Form within 10 days.
- Let the county know if a family member applies for disability benefits; is in a public institution; or gets medical care for any accident or injury caused by another person.
- Cooperate if my case is reviewed.

I declare that each person I am applying for:

- Lives in California.
- Is not getting public assistance from outside California.
- Is not in jail, prison, or any other correctional facility.

I further declare that:

- I understand that as a condition of Medi-Cal eligibility, all rights to medical support and third party payments are automatically assigned to the State of California.
- If I am not eligible for this Medi-Cal Program, I understand I may qualify for other programs and have the right to apply for them.
- If I purposely do not give needed facts, or if I give false facts, I understand benefits may be denied or ended and repayment may be required. I may also be investigated for fraud.

Confidentiality

The information you give on this Application Form is private and confidential. It will only be disclosed if required by law. (*Welfare and Institutions Code Sections 10850 and 14100.2*)

Privacy

The law requires Medi-Cal applicants answer all questions on this application not marked optional. (*Welfare & Institutions Code, § 14011 and Title 22, CCR regulations*) The personal and medical information you provide will be used only to identify you and to administer the program. This means we will share your information with federal, state, and local agencies.

Citizenship and Immigration Information

If you are applying for benefits, you must answer the questions about citizenship and immigration status. If you are a parent or guardian and are not applying for yourself, you do not have to provide your immigration information. If you are applying for full-scope Medi-Cal, we will confirm your immigration status with Immigration (USCIS) only to see if you are eligible. We will not share your immigration information with Immigration or other agencies for any other reason. Your application will be incomplete if you do not answer these questions for persons applying and we may deny your application.

Social Security Numbers

Unless you are applying for emergency or pregnancy-related benefits only, you must provide your Social Security Number. (*Welfare & Institutions Code § 14011.2 and Social Security Act §1137(a)(1)*).

Access to Your Records

You have the right to access records maintained by the Department of Health Care Services that contain your personal information. To do so, contact your county health and human services or social services office.

Free and Low-Cost Health Care:

- Preventive care
- Prenatal care
- Mental health
- Hospital stays
- Doctor visits
- Vision/Dental care
- Prescriptions
- Emergency care

Want to know if you qualify?

Send your completed application and documents right away! We can tell you if you qualify within 45 days! Find your family size, monthly income (before taxes and deductions) and age of children below to see what program the person may qualify for. You are allowed to deduct some expenses. For more information, see page 4.

Valid until 3/31/2012

Child's Age ▶	0 – 1 year or pregnant woman*	0 – 1 year old	1 – 5 years old		6 – 18 years old	
Family Size A pregnant woman = 2 people* ▼	Medi-Cal	Healthy Families	Medi-Cal	Healthy Families	Medi-Cal	Healthy Families
1	\$0 - \$1,815	\$1,816 - \$2,269	\$0 - \$1,207	\$1,208 - \$2,269	\$0 - \$ 908	\$ 909 - \$2,269
2	\$0 - \$2,452	\$2,453 - \$3,065	\$0 - \$1,631	\$1,632 - \$3,065	\$0 - \$1,226	\$1,227 - \$3,065
3	\$0 - \$3,089	\$3,090 - \$3,861	\$0 - \$2,054	\$2,055 - \$3,861	\$0 - \$1,545	\$1,546 - \$3,861
4	\$0 - \$3,725	\$3,726 - \$4,657	\$0 - \$2,478	\$2,479 - \$4,657	\$0 - \$1,863	\$1,864 - \$4,657
5	\$0 - \$4,362	\$4,363 - \$5,453	\$0 - \$2,901	\$2,902 - \$5,453	\$0 - \$2,181	\$2,182 - \$5,453
6**	\$0 - \$4,999	\$5,000 - \$6,248	\$0 - \$3,324	\$3,325 - \$6,248	\$0 - \$2,500	\$2,501 - \$6,248

* If more than one baby is expected, send a statement from your health care provider that says how many babies are expected. (This increases the family size.)

** If there are more than 6 people in your family, call: 1-800-880-5305.

Many children and pregnant women qualify.

It depends on your family size, income, and age of your child. If you do not have immigration papers, you may still qualify for some Medi-Cal.

If you do not qualify, we may be able to refer you to a low-cost county health insurance program called Healthy Kids or another program that may be able to cover your children.

It's free or low-cost.

Medi-Cal is free, including office visits.

Healthy Families is \$4 – \$24 per month for each child, up to \$72 maximum per family. Preventive services, like immunizations, are free. Other visits cost \$5 – \$15 each.

The programs let you choose a doctor or clinic. And, most counties offer a choice of health plans.

Call today — it's a free call!
1-800-880-5305

TDD: 1-800-735-2929

Monday – Friday: 8 a.m. – 8 p.m. or Saturday: 8 a.m. – 5 p.m.

Visit Healthy Families at: www.healthyfamilies.ca.gov

This page has been left blank for double-sided copying.

www.mathematica-mpr.com

**Improving public well-being by conducting high quality,
objective research and data collection**

PRINCETON, NJ ■ ANN ARBOR, MI ■ CAMBRIDGE, MA ■ CHICAGO, IL ■ OAKLAND, CA ■ WASHINGTON, DC

MATHEMATICA
Policy Research

Mathematica® is a registered trademark
of Mathematica Policy Research, Inc.