

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

Preamble

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

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

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

Effective Date: January 1, 2003 for C-CHIP
July 1, 2004 for AIM

Approval Date:

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

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

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

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

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

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

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

Name:	Lesley Cummings	Name:	Stan Rosenstein
Position/Title:	Executive Director	Position/Title:	Deputy Director, Medical Care Services
Department:	Managed Risk Medical Insurance Board	Department:	Department of Health Services

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

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

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

- 1.1.1. **Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR**
- 1.1.2. **Providing expanded benefits under the State's Medicaid plan (Title XIX); OR**
- 1.1.3. **A combination of both of the above.**

Introduction

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

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

- Creation of a health insurance program for children whose family incomes are above those which provide eligibility for no cost Medi-Cal up through 200% of poverty;
- Changes to the Medi-Cal system which will improve access by simplifying eligibility; and
- Coverage ~~through the Access for Infants and Mothers (AIM) program~~ of infants up to ~~12 months~~ through the age of two born to mothers enrolled in the Access for Infants and Mothers (AIM) Program whose family income is between 200-~~250%~~ 300% FPL.

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

- Chapter 623 (AB 1126 -Villaraigosa) outlines the Healthy Families insurance program which provides affordable private health insurance plans for low-income children either through a health insurance purchasing pool or an insurance purchasing credit.

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The legislation details program administration, eligibility criteria, monthly premiums, benefits, the program application process, and outreach activities;

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

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

Many children will come to Healthy Families through the Healthy Families “gateway” program, the Child Health and Disability Prevention (CHDP) program. Families of uninsured children receiving health screens from CHDP will be informed about the opportunity for health coverage. Those families wishing to pursue comprehensive coverage will be directed either to Medi-Cal or into the insurance program.

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

California will seek to ensure that children’s health plans become their medical homes by emphasizing preventive services, coordinating with programs that currently serve the uninsured and weaving quality measurement and monitoring into the fabric of the program. California will require specified performance measures in its contracts with plans and will build on these as additional measures are developed.

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

The Managed Risk Medical Insurance Board (MRMIB) will be responsible for administering the purchasing pool, the purchasing credit, and the AIM program. MRMIB has a strong commitment to providing affordable quality health care to Californians. MRMIB currently

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administers three health insurance programs: the Major Risk Medical Insurance Program (MRMIP), a program for medically uninsurable people, the Health Insurance Plan of California (HIPC), a small employer purchasing pool and the Access for Infants and Mothers (AIM) Program, a program for uninsured pregnant women and their newborns. (The state also seeks FFP for a portion of the AIM Program.)

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

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

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

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

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

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age 2, born to mothers enrolled in the AIM Program and enrolled in the Healthy Families Program.

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

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

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

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

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

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- 1.2. Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))
- 1.3. Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)
- 1.4. Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

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Implementation date: [January 1, 2003 for C-CHIP](#)
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Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

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

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

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

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

- Most children are served under the categorically needy categories (SSI/SSP and AFDC/TANF recipients).
- The Medically Needy program under Title XIX, Section 1902(a)(10)(C) provides benefits to children under age 21 who meet resource requirements and who are determined otherwise eligible.
- The Federal Poverty Level programs under Title XIX, Section 1902(l)

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

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

- For infants up to age one: family income must be at or below 200 percent of FPL, the income (between 185 percent and 200 percent) and the resources of the parents and child are disregarded.
- For children age one and under age six: family income must be at or below 133 percent of FPL.
- Presently, resources are counted for children ages 1 to 19 in the FPL program. However, state legislation has just been enacted to disregard the resources of the parents and child in the FPL program which will expand Medi-Cal coverage under Title XXI.

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

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

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

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

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

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

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

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

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

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

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

Access for Infants and Mothers (AIM). The AIM program is a public-private partnership which offers creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL. [For infants born to mothers enrolled in AIM prior to July 1, 2004, the AIM program will also provide coverage and their newborn children through the first two years of life. For infants born to mothers enrolled in AIM on or after July 1, 2004, the infants will be enrolled in the Healthy Families program.](#) AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber co-payments and contributions, while the subscriber pays two percent of their average annual income [if enrolled prior to July 1, 2004 and 1.5% of their average annual income if enrolled on or after July 1, 2004.](#) As of September 1997, AIM has provided access to comprehensive health benefits for 28,921 women and 25,735 newborns.

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

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

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

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

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

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

- DHS administers its Baby-Cal media campaign, which provides extensive outreach to pregnant women about the importance of obtaining prenatal care, and informs them that, if they have modest incomes, state programs are available to help them. With its annual \$6

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million budget, Baby-Cal uses a media campaign, operates a toll-free line which, among other things, refers callers to Medi-Cal or the AIM program (as applicable), and conducts outreach through a network of roughly 350 community based organizations (CBOs).

- Child Health and Disability Prevention (CHDP), California Children's Services (CCS), and Women, Infant and Children (WIC) providers identify children who may be potentially eligible for Medi-Cal and refer the family to the appropriate office to apply. State statute requires CCS applicants to fill out a Medi-Cal application.
- To facilitate the application process, Medi-Cal outstations eligibility workers in locations which serve large numbers of potentially eligible children, such as disproportionate share hospitals, prenatal clinics and federally qualified health centers.

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

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

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

The Healthy Families program consists of four components: expansions of coverage under Medi-Cal (as described in Section 2.1); establishment of a purchasing pool for children with family incomes up to 200% FPL (who are ineligible for no-cost Medi-

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Cal); an aggressive outreach and education campaign to make the public familiar with the availability of health coverage for the uninsured; and provision of coverage ~~under the AIM program for~~ infants under the age of 1 born to mothers enrolled in the AIM Program prior to July 1, 2004 whose family incomes are between 200-250% FPL, and children infants through age 2, born to mothers enrolled in the AIM Program on and after July 1, 2004 ~~under the age of 1~~ with family incomes between 200 -~~250%~~ 300% FPL. This section concentrates on the insurance program and AIM as Medi-Cal's administration is in accordance with California's Title XIX plan.

Insurance Program

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

Coordination with Medi-Cal:

- Under Title XXI, California will expand Medi-Cal eligibility to implement a resource disregard for children whose countable family income is at or below the appropriate FPL in the Medi-Cal program. Thus, eligibility for both programs will depend only on a family's income. Eligibility workers, CHDP providers, and other organizations assisting families will be able to use an income chart to refer children to the appropriate program.
- Healthy Families will compare its participant list against Medi-Cal's enrollment files to ensure that children do not already have creditable coverage through Medi-Cal.
- To provide families moving from Medi-Cal to Healthy Families with time to enroll in Healthy Families, the Department of Health Services will implement one month of "continued eligibility" for Medi-Cal covered children whose family income is at or below the appropriate FPL who lose eligibility for no cost Medi-Cal due to increased family income or increased age of a child.

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

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

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

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

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

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

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

- MRMIB will encourage managed care plans to subcontract with safety net providers and require them to report annually on the number of subscribers selecting these providers.

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

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

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

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

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

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

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

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

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

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

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

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

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

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

Overview of the Comprehensive Healthy Families Delivery System

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

Many children will come to Healthy Families through a “gateway” program, the CHDP program. CHDP offers preventive health services to children under 200 percent of poverty. When children receive services from a CHDP provider, they will either be referred to Medi-Cal or to the Healthy Families insurance program. Should follow up treatment be required for a condition identified in the CHDP screen, Medi-Cal or the insurance program (depending on which program the child qualifies for) will cover the cost of care provided to children for 90 days prior to enrollment. Low income children who are ineligible for Medi-Cal or the insurance program will be referred to counties for treatment.

To meet the special needs of children, the Healthy Families program will also ensure the provision of necessary specialized services beyond those offered through the comprehensive insurance package in a coordinated manner. The CCS program and county mental health departments will address the significant needs of the minority of children whose needs may not be fully met under an insurance benefit package. The CCS program will provide case management and treatment for chronic, serious, and

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complex physically handicapping conditions, while county mental health departments will provide appropriate services to meet the needs of seriously emotionally disturbed children. Both programs will reimburse providers for these specialized services. Children receiving such services will continue to have their primary health needs served through the insurance program. Allowing those specialized services to be provided as a complement to, but outside of, the managed care setting is consistent with recent actions in the Federal budget reconciliation act which prohibit mandatory enrollment of children with special medical needs in managed care.

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

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

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

Rural health. The Department of Health Services (DHS) is authorized to operate up to five pilot programs in rural areas should the coverage provided through the insurance programs be insufficient in particular rural areas or for particular populations, such as

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migrant workers or American Indians. DHS will be meeting with stakeholders in rural areas as well as holding a public hearing in the fall of 1997 to begin to assess these issues. A final determination will be made in early 1998, after MRMIB has finished negotiations with plans for the purchasing pool and, thus, are aware of the extent of the coverage in rural areas. Should DHS, relying on the advice of the Rural Health Policy Council and the County Medical Services Program Board in evaluating the need for supplemental services, determine that supplemental services are needed, California will submit an amendment to this plan.

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

Healthy Families Purchasing Pool

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

Plan Contracting. MRMIB is authorized to contract with licensed health plans and health insurers as well as Local Initiatives approved by the Department of Health Services to provide service to Medi-Cal beneficiaries, County Organized Health Systems (COHS), and federal Health Insuring Organization demonstration projects such as Santa Barbara's COHS. Participating plans will be under the regulatory authority of California's Department of Insurance or Department of Corporations, and subscribers will be able to take any benefit grievances to those regulators. Eligibility

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grievances are appeal able to MRMIB. COHS are presently overseen by the Department of Health Services, but will be required to obtain Knox-Keene licensure within two years to participate in Healthy Families.

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

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

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

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

MRMIB traditionally contracts with health plans for two years. It continually refines and improves the requirements of the contract prior to each new contracting period. It

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will be able to incorporate in subsequent contracts the indicators of a high quality medical home once such measures have been developed.

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

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

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

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

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

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that is determined to be eligible for and enrolled in the program.

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

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

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

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

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

Child Health and Disability Prevention Program

To maximize access, continuity of care, and ease of administration, the existing CHDP

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

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

To assure that uninsured children in the target population move smoothly into enrollment in either the Healthy Families or Medi-Cal programs, California will adopt a form of limited retroactive eligibility. Once enrolled in one of the programs, a child will be provided 90 day retroactive eligibility to the date of the screening visit for payment for services related to health, dental or vision care needs identified at the initial visit. The cost of these services will be reimbursed on a fee for service basis (at Medi-Cal rates) during the period from application to enrollment and will be paid by Medi-Cal for children enrolled in Medi-Cal and by MRMIB for children enrolled in the insurance program.

A streamlined system will be developed which will provide for identification of eligibility for Healthy Families or Medi-Cal at the time of a health screening so that providers have a mechanism for delivering care and receiving payment. The services available during this period of retroactive eligibility will be specified in regulation. Appropriate referral will also be made to the CCS program if the problem identified through the screening examination appears to be a CCS eligible condition. To ensure continuity of care whenever possible, referrals for treatment services will be made to providers in the Healthy Families insurance plan which the family has chosen. During the period between application and enrollment, the county CHDP program can assist with identification of providers, scheduling appointments for identified health care needs, coordination of services, and completion of the application form.

Specialized Services

Mental Health. A basic benefit package of mental health services will be provided by the health care plans. This basic package for mental health treatment includes 20 outpatient visits, and 30 inpatient mental health days per year. While it is anticipated that the great majority of the mental health needs of children will be met under the

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insurance benefit package, it is recognized that some seriously emotionally disturbed children will require more specialized mental health services. Consistent with the treatment of similarly situated privately insured populations, these children are eligible for specialized mental health services through the county mental health system of care. Children with serious emotional disturbances (estimated at between 3-5% of the general population) will be referred by the health care plan to the county mental health program for treatments, pursuant to a Memorandum of Understanding (MOU) between the two organizations for any needed additional mental health services.² The required MOU will formalize this important arrangement. (The description of services available is in Attachment 6.) The county mental health program will coordinate the delivery of mental health and other health services with the health care plan for those children who meet the criteria of serious emotional disturbance. County mental health programs will provide mental health treatment services directly or through contracts with private organizations and individual providers. The requirements for provider selection and quality improvement for these mental health services will be consistent with those used for the Medi-Cal program for a similar population.

California Children's Services Program. Integrating the CCS program into Healthy Families is a logical way to ensure that uninsured low income children with serious health conditions will continue to have access to a program highly respected by the medical community because of its focus on high quality care. Children with chronic, serious, and complex physically handicapping conditions are best served by systems and programs which have been organized specifically to serve them. It is important

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

- (A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - (I) The child is at risk of removal from home or has already been removed from the home.
 - (II) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
- (B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
- (C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code." [For the purposes of the Child Health Initiative, the age range will be expanded to age 19 years].

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that care not be disrupted and that continuity and quality of services be maintained. With these goals in mind, plans will be required to refer CCS-eligible children to the CCS program for the treatment of CCS-eligible conditions.

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

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

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

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

Delivery System. Service delivery in the C-CHIP will be provided by health plans contracted by the county. These health plans are health maintenance organizations and also contract with MRMIB to participate in the Healthy Families Program.

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Having these same plans available is an asset to families in that they may assume continuity of care should they go from enrollment in the C-CHIP to Healthy Families and visa versa.

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

- The C-CHIP application, to assure that all necessary data is collected.
- Policies and procedures for determining eligibility (including citizenship/immigration status) and enrollment, documentation requirements, appeals processes, and enrollee protections such as continued enrollment during an appeal.
- All C-CHIP template correspondence to be used in communicating with the applicants.

Medi-Cal

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

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

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

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

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

The AIM program provides creditable coverage to pregnant women with incomes between 200 percent and 300 percent of FPL and their newborn children through the first two years of life. AIM is administered by MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. Because Medi-Cal currently serves infants under 1 year of age through 200 percent of FPL, infants through age 1 up to 250 percent of poverty served by AIM fall within the income range of targeted low income children. [Consistent with the C-CHIP projects, the same income disregards will be applied to children born to mothers enrolled in AIM through age 2.](#) AIM's delivery system and contracting standards are virtually identical to that of Healthy Families' purchasing pool described above. Nine health care service plans participate in AIM, which offers statewide coverage, and the vast majority of all beneficiaries are offered a choice of two plans in each region (three in Los Angeles County).

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

Health Insurance Programs

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

Virtually all of the plans will be regulated by California's Department of Corporations (DOC) under a body of law - the Knox-Keene Act - established specifically for managed care plans.³ The Knox-Keene Act prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes

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

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fiscal solvency requirements and quality assurance standards. Specific Knox-Keene requirements include:

- *Medical decision making.* The Knox-Keene Act requires medical services to be sufficiently separate from administrative and fiscal management so that medical decisions are not unduly influenced by fiscal concerns. DOC conducts an onsite medical survey at least every three years. Plans have physician medical directors responsible for medical decision making and directing quality assurance programs.
- *Basic health care services.* Knox-Keene plans must provide the following basic services: physician services, inpatient and outpatient services, diagnostic and therapeutic lab and radiologic services, home health care, preventive health care, and emergency health care, including ambulance and out-of-area coverage. In addition, there are a number of statutory mandates to provide or offer specific benefits.
- *Accessibility of services.* DOC must review and approve provider networks and contracts. Primary care services must be within 30 minutes or 15 miles of the enrollees' residence or workplace. Regulations require at least one primary care provider (FTE) for every 2,000 enrollees as guideline. DOC may require more providers depending on the area, population density, and other factors. Different requirements may apply in rural or medically underserved areas. DOC assures reasonable access to ancillary services and tertiary care.
- *Quality assurance.* Plans must have quality assurance programs to review quality of care, which includes as one component a utilization review system. Regulations require a program directed by health providers to review the quality of care being provided, and to identify, evaluate and remedy problems related to access, continuity and quality of care, utilization and monitoring of plan providers.
- *Financial viability.* Plans must file quarterly and annual financial statements and other financial reports. Plans must meet "tangible net equity" requirements and a financial and administrative audit is conducted at least every three years to monitor plan financial viability.
- *Consumer protection.* Plans must maintain internal grievance procedures for plan enrollees and appeals may be made to DOC if grievances are not resolved to the enrollees' satisfaction. DOC reviews and approves plan contracts,

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disclosure forms, marketing materials and advertising to be sure that consumers receive fair and accurate information.

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

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

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

- *Risk Assessment/Risk Adjustment.* MRMIB is one of the country’s leaders in developing and operating a risk assessment/risk adjustment (RARA) mechanism. One of the purposes of RARA is to provide fiscal relief to plans that have attracted a disproportionate share of higher risk enrollees. This mitigates the incentives that a health plan may have to avoid (or provide inadequate treatment to) a higher risk person or population because they will be high cost. Stated alternatively, it seeks to assure that plans with a higher than average risk mix of enrollees have the resources needed to serve their population. MRMIB has successfully operated a RARA mechanism in the HIPC since 1995 and intends to implement such a mechanism in the Healthy Families pool.

Child Health and Disability Prevention Program

The CHDP program, which will serve as an initial screening and treatment entity as well as a referral source for Healthy Families and Medi-Cal eligible children, develops and distributes medical guidelines for health assessments which CHDP providers use as guidance for the CHDP examinations. Duplicate copies of the health assessment reports are submitted by the providers to the appropriate county CHDP program. The program uses the copies to assist with referrals as needed to assure treatment was

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provided and to assess the quality of the exams done by individual providers. The state CHDP program analyzes statewide data on the health assessments to determine if children are receiving appropriate preventive health services. Treatment services will be limited to services for which a need was identified in the health assessment. CHDP will develop prior authorization procedures for high cost services. CHDP will respond to requests for prior authorization within 72 hours so that treatment is not delayed.

Specialized Services

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

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

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

Health Plan Regulatory Oversight. These plans are regulated by the Department of Managed Health Care, previously the Department of Corporations, under the Knox-Keene Act. The Knox-Keene Act, as previously stated, prescribes rules for the organization of health maintenance organizations and other managed care entities. It specifies plan standards, marketing rules, and consumer disclosure requirements. It also establishes fiscal solvency requirements and quality assurance standards.

Specialized Services.

California Children's Services Program. Children who are enrolled in the C-CHIP and diagnosed with an eligible CCS condition will be referred to the CCS Program for an eligibility determination based on CCS eligibility criteria: CCS eligible condition, residence within the county, and income within CCS financial guidelines. Children

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not eligible for CCS services shall receive their medically necessary services via the health plan delivery system like the California State Employees system that serves as the benchmark. C-CHIP eligible children do not have deemed financial eligibility for CCS services; AB495 requires that expansion services be provided without state expense.

Medi-Cal

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

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

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

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

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

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

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

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

4.1.3. Income:

Healthy Families Program:

Income levels for the Healthy Families insurance program is between 100–200% FPL. Medi-Cal uses specific exemptions from income, as is detailed in California’s Title XIX State plan. In determining eligibility for Healthy Families, Medi-Cal income exemptions will be applied and all income over 200% FPL but less than or equal to 250% FPL will be disregarded in calculating household income. If the income exemptions and income disregard reduce income to 200% or less FPL, the child will meet the Healthy Families Program income criteria.

County Children’s Health Insurance Program (C-CHIP):

In determining eligibility for C-CHIP, Medi-Cal income exemptions will be applied and all income over 200% FPL but less than or equal to 300% FPL will be disregarded in calculating household income. If the income exemptions and income disregard reduce income to 200% FPL or less and the child is not otherwise eligible for the Healthy Families Program, the child will meet the C-CHIP income criteria.

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ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

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

- 4.1.4. **Resources (including any standards relating to spend downs and disposition of resources):** The insurance program has no resource requirements. Consistent with this approach, California will waive the resource Medicaid requirements for all children in the Federal Poverty Level program under Medi-Cal. [The C-CHIP will also waive resource requirements consistent with other public programs.](#)
- 4.1.5. **Residency (so long as residency requirement is not based on length of time in state):** Children must be residents of California. They must also meet the citizenship and immigration status requirements applicable to Title XXI. [Eligibility for C-CHIP will require residency within the county that sponsors an expansion program and meet the citizenship and immigration status requirements applicable to Title XXI.](#)
- 4.1.6. **Disability Status (so long as any standard relating to disability status does not restrict eligibility):**
- 4.1.7. **Access to or coverage under other health coverage:** Children are ineligible for the [Healthy Families and C-CHIP](#) insurance programs if they have been covered under employer sponsored coverage within the prior 3 months (with certain exceptions described in Section 4.4.4) or if they are eligible for (no cost) Medi-Cal or Medicare coverage.
- 4.1.8. **Duration of eligibility:** Annual eligibility determination for Healthy Families. Medi-Cal will establish one month bridging eligibility for children whose family income increases beyond Medi-Cal's eligibility threshold for no-cost Medi-Cal coverage, but does not exceed Healthy Families limits. Infants aged 0-1 in the AIM Program are determined eligible at the time their pregnant mother enrolls [and will be redetermined prior to the child's first birthday for continued eligibility.](#)

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C-CHIP eligibility is for twelve months, at which time an annual eligibility determination will occur.

4.1.9. ☒ Other standards (identify and describe):

- Enrollment in the insurance program and AIM will be limited to the number of children that can be served within appropriated funds.
- To be eligible for the insurance program, families must enroll all of their children, pay the first month's family contribution, and (if selecting coverage through the purchasing pool) agree to remain in the pool for at least six months, unless other coverage is obtained and demonstrated. To remain enrolled in the insurance program, families must make their premium payments. Those who fail to do so will be disenrolled and not allowed to apply again for six months. However, state law stipulates that MRMIB may waive the six month exclusionary period of disenrollment for good cause.
- Children are ineligible for the insurance program if they are eligible for any California Public Employees' Retirement System Health Benefits Program(s), if they are an inmate in a public correctional institution or if they are a patient in an institution for mental illness.
- At the time of application, children enrolled in C-CHIP cannot be eligible for no cost Medi-Cal or the Healthy Families Program.
- To be eligible for AIM, families must agree to pay 2% of the family's gross income plus \$100 at the child's first birthday (~~\$50 discount if the child's immunizations are up to date on their first birthday~~). The child's mother must have lived in California for at least six months prior to applying for coverage under the program.

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

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- 4.2.1. ☒ **These standards do not discriminate on the basis of diagnosis.**
- 4.2.2. ☒ **Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.**
- 4.2.3. ☒ **These standards do not deny eligibility based on a child having a pre-existing medical condition.**

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

Insurance Program

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

Families will fill out a simple application and mail it with accompanying supporting documents to MRMIB's enroller. The application/enrollment brochure will be published in English, Spanish, and any other languages designated by the Department of Health Services as a "threshold" language for the Medi-Cal program. Families with questions about the form will be able to call the administrative vendor through a toll free number. Families will be able to speak to the administrative vendor's staff in English or Spanish, and may communicate via other languages through a telephone translation service. MRMIB is authorized to pay certain agencies and individuals such as insurance agents and parent-teacher organizations an application assistance fee for assisting a family with a successful application. The supporting documents that families send to the enroller will include documentation of income eligibility which the administrative vendor will verify using copies of the past year's federal income tax forms, or current year wage stubs. The administrative vendor will audit a random sample of applications on an ongoing basis using the IEVS system to confirm income information. The Systematic Alien Verification System (SAVE) or an appropriate alternative will be used to verify immigration status.

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

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

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

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

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

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

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

In Santa Clara, Alameda, San Francisco and San Mateo County, the Local Initiative (LI) or County Organized Health System (COHS) will administer the local insurance expansion programs. Since the LI or COHS health plan is the only health plan available in each C-CHIP project, there are no issues related to steerage. The LI and COHS staff will be responsible for eligibility determinations even though state trained application assistants will be used to identify eligible children, assist in completing

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applications and screening children for the appropriate program: no cost Medi-Cal, Healthy Families or the C-CHIP. The LI and COHS will also be responsible for premium collection, program enrollment and distribution of health plan materials.

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

In establishing local expansion programs, the C-CHIPs have adopted the same Healthy Families eligibility rules, including documentation requirements. To assure compliance with the federal screen and enroll requirement, the C-CHIP will use Health-e-App, California's web based application. In using Health-e-App, certified application assistants working with the local C-CHIPs will enter the same data as required on the joint Medi-Cal/Healthy Families mail in application. Once this is completed, Health-e-App has a calculate feature that includes a Medi-Cal, Healthy Families, or C-CHIP eligibility screening. The eligibility rules used in Health-e-App are the same as those used in California's Single Point of Entry (SPE). When children are preliminary screened to Medi-Cal or Healthy Families, the certified application assistant merely presses the submit key and the application is electronically submitted to the SPE. Health-e-App also generates a fax cover sheet for the applicant to use when faxing their income documentation. When children are preliminary screened to the local C-CHIP, the family can elect to submit the application for the State to do a final eligibility determination or print the application as evidence that an acceptable screen and enroll assessment was made so that the children can be enrolled in the local C-CHIP. The C-CHIPs have established their own applications, although most resemble the one used by the Healthy Families Program. Applications are processed and an eligibility determination made within thirty (30) days.

Medi-Cal

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

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

Maxicare Care 1st reviews the application within a 10 day time frame and either requests ~~returns it to the applicant~~ for additional information from the applicant or enrolls the pregnant woman in the purchasing pool health plan selected by the woman. Coverage under the purchasing pool plan begins 10 days after the application has been determined complete.

Eligibility is determined once -- at time of application to the program-- and continues for 60 days post partum, for the mother and up to the child's second birthday for children born to mothers enrolled in the AIM Program prior to July 1, 2004. For children born to mothers enrolled on or after July 1, 2004 eligibility is determined at the time of the mother's application to the AIM Program and again before the child's first birthday and annually thereafter. Upon notification of birth, the infant will be enrolled in the Healthy Families Program. Prior to the child's first birthday, the Healthy Families Program will conduct an annual redetermination for the child's second year of coverage. Prior to the child's second birthday, the Healthy Families Program will redetermine eligibility for the S-CHIP Healthy Families Program. (~~However, the~~ The state seeks FFP only for the health care costs of the child up to age ~~one~~ two ~~and only~~ for children with family incomes between 200% and ~~250%~~ 300% of poverty.)

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

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

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the

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state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))

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

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

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

- Disaster Relief Payments (federal disaster and emergency assistance and comparable assistance provided by State and local governments and disaster assistance organizations;
- Per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands;
- Agent Orange Payments;
- Title IV Student Assistance;
- Energy Assistance Payments to Low Income Families;

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- Relocation Assistance Payments;
- Victims of Crime Assistance Payments;
- Spina Bifida Payments; and
- Any other federal income deduction required for a federal means tested program.

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

Further, the Healthy Families program will share eligibility files with Medi-Cal on an ongoing basis to check for children enrolled in both programs. Additionally, a random sample of applications will be audited using the Income Eligibility Verification System (IEVS) on an on-going basis to verify that the incomes being reported were the incomes earned.

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

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

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

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

The program serves women whose family income is too high for Medi-Cal and who do not have employer sponsored coverage. The AIM administrative vendor verifies the income eligibility of families by reviewing income

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information submitted by families, either the previous year's federal income tax forms or current year wage stubs. Families eligible for no-cost Medi-Cal are denied AIM enrollment. If a family indicates on the AIM application that it has coverage through an employer, that application is not approved.

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

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

The state's outreach and community based organization activities will be coordinated between Medi-Cal and the insurance program. These efforts will aim to assist families in applying for the program under which they qualify, with a goal of directing families to the correct program at the point of first contact, in recognition that CBOs are often the health system's first contact with uninsured families with income under 200% FPL.

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

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

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

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children

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determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2))
(42CFR 431.636(b)(4))

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

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

Application Process:

Applicants mail the joint mail-in application directly to the SPE. The SPE first screens all applications for no-cost Medi-Cal eligibility, and then routes the applications to either the County Welfare Department (CWD) or HFP as appropriate.

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

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

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the county directly and determined to have children ineligible for no-cost Medi-Cal because income exceeding the Medi-Cal limits are forwarded to the SPE for a HF determination. These applications are forwarded with a transmittal form, NOA, and supporting documentation as available.

Medi-Cal Redetermination Process:

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

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

C-CHIP Application Process

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

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

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

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

- Establishes a coverage “firewall” -- a prohibition against covering children who have had employer sponsored coverage within 3 months prior to applying for Healthy Families. MRMIB is authorized to increase the length of the period to 6 months if it finds that Healthy Families is covering substantial numbers of children who were previously covered under employer-sponsored plans.
- The state has established exceptions to this limitation in cases where prior coverage ended due to reasons unrelated to the availability of the Program. These include, but are not limited to:
 - Loss of employment due to factors other than voluntary termination.
 - Change to a new employer that does not provide an option for dependent coverage.
 - Change of address so that no employer sponsored coverage is available.
 - Discontinuation of health benefits to all employees of the applicant’s employer.
 - Expiration of COBRA coverage period.
 - Coverage provided pursuant to an exemption authorized under

⁴ See Chollet, Deborah J., Birnbaum, Michael and Sherman, Michael J. of the Alpha Center, “Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience” (October 1997); Children’s Defense Fund, “Fears That Employers Coverage Will Fall If Uninsured Children Are Helped Are Exaggerated” (November 1997); and Center for Health System Change *Issue Brief No. 3*, “Medicaid Eligibility Policy and the Crowding-Out Effect” (October 1996).

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subdivision (I) of Section 1367 of the Health and Safety Code.

- Establishes copayments for non-preventive services.
- Prohibits insurance agents and insurers from referring dependents to the program where dependents are already covered through employer sponsored coverage. Violation of the provisions would constitute unfair competition under the Business and Professions Code.
- Makes it an unfair labor practice for an employer to refer employees to the program for dependent coverage where the employer provides for such coverage.
- Makes it an unfair labor practice for an employer to change coverage or change the employee share of cost for coverage to get employees to enroll in the Program.
- Directs MRMIB to develop participation standards that minimize “crowd out”.
- Directs MRMIB to monitor applications to determine whether employers or employees dropped coverage to participate in the program.

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

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

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

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

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

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

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

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

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

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

The minimum employer contribution.

The cost-effectiveness determination.

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

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

- Technical assistance by the state American Indian Health Program, Federal Indian Health Services, and tribes in tracking of services to American Indians.
- Inclusion of American Indian ethnicity using the federal definition on the application form for tracking purposes.
- Targeted statewide outreach media campaign and outreach activities through contracts with selected community based organizations providing services to American Indian children to assure that American Indian families are aware of the program throughout the state and to assist children in enrolling in the Healthy Families Program.
- Provision of training to local American Indian clinic staff for outreach and referral to the Healthy Families program.
- Use of the 30 American Indian primary care clinics (which are CHDP providers) to screen low income youth, provide initial treatment and referral either to Medi- Cal or Healthy Families.
- Provision to exempt American Indian and Alaska Native families, that meet the cost sharing waiver requirements, from monthly premiums and benefit copayments. This exemption will be made only when an AI/AN provides acceptable documentation showing proof of his/her AI/AN status. Acceptable documentation for the applicant or the child includes:
 1. An American Indian or Alaska Native enrollment document from a federally recognized tribe; or
 2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; or
 3. A Certificate of Indian Heritage from an Indian Health Service facility operating in the State of California.

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

California has made significant efforts to educate entities, clinics, state Certified Application Assistants, and the general population regarding the Healthy Families Program including targeted outreach to the AI/AN population in the past years. These efforts have been statewide and as such are also made on behalf of the C-CHIP counties. **Section 5. Outreach (Section**

2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program:

(Section 2102(c)(1)) (42CFR 457.90)

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

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

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contract because of its extensive experience conducting similar outreach efforts, including the BabyCal campaign which focuses on prenatal care for both, the Medi-Cal and AIM programs, the statewide anti-tobacco campaign, and the Partnership for Responsible Parenting which aims to reduce teen and unwed pregnancy.

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

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

DHS Outreach & Media Contractor

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

The outreach message will be simple. The target population will be informed about the importance of preventive care, the value of insuring children before they become ill and that health care programs for the uninsured are available. Potential beneficiaries will be advised to call a toll-free phone number for more information. DHS has used a similar approach through its administration of the BabyCal campaign, a \$6 million annual effort which educates pregnant women of the importance of prenatal care. The

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DHS' toll free line directs low and modest income pregnant women to Medi-Cal or to the Access for Infants and Mothers (AIM) Program to assist them in obtaining coverage for their pregnancies. The multi-media approach is intended to effectively and quickly notify the broad public about Healthy Families and Medi-Cal's availability to cover children.

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

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

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

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- Translate the joint Medi-Cal/Healthy Families application pamphlet into ten threshold languages: English, Spanish, Cantonese, Russian, Farsi, Cambodian, Laotian, Hmong, Vietnamese, and Armenian. Counties with high populations in other languages will do further form translations as they currently do for the existing Medi-Cal form;
- Maintain a toll-free outreach number with operators who speak English and Spanish and who have access to the AT&T translation services for all other languages;
- Place outdoor advertising in the threshold languages wherever at least 1,000 Medi-Cal recipients in a given zip code speak one of the languages.
- Develop outreach print materials in the ten threshold languages, including material to be published in newspapers and periodicals published in the ten threshold languages;
- Conduct radio and TV spots in English and Spanish; and
- Recruit a diverse cultural, linguistic and geographic mix of CBO's to assist applicants, focusing particularly on those with an existing relationship with subpopulations of the target group. The CBO's will help ensure that the target populations can access program information and assistance.

Healthy Families Administrative Vendor

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

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

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Board's review of the primary languages spoken by the 113,117 statewide share-of-cost Medi-Cal enrollees between the ages of 1-18 during the sample month of January, 1998, shows the following: English, 52,062; Spanish, 55,585, Vietnamese, 1,567; Cantonese, 1,225; Tagalog, 423; Korean and Russian, 217 each; Hmong and Laotian, 128. Based on this review, the Board's administrator would publish materials in English and Spanish. The Board has decided to exceed the requirements of Government Code Section 7290, at least for the first year;

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

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

- Focus group testing to ensure quality and understanding of communication materials with target population.
- Ongoing and frequent involvement of stakeholders. Such stakeholders include, but are not limited to: community based organizations (CBO's), members of the target population, providers, public health programs, advocacy groups, and the Department of Social Services, which is leading the State's welfare reform efforts.
- Development of linguistically appropriate informing materials in up to ten threshold languages as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

In addition to pre-enrollment, MRMIB may also provide a \$50 one-time application

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assistance fee for entities and individuals that assist beneficiaries applying for the Healthy Families Program. MRMIB successfully uses an application assistance fee in two of its existing programs, MRMIP and AIM. The purpose of the fee is to provide an outcome based financial incentive to organization/person who come into regular contact with the target population. Use of the application assistance fee is particularly important as it is the way by which MRMIB creates an incentive to encourage participation from a large number of community organizations who have contact with uninsured children.

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

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

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

One consistent theme that has emerged from public discussions thus far is the

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importance of reducing barriers to enrollment as a means of conducting outreach. In the past, long and complex forms may have intimidated and deterred potential applicants from enrolling in state health insurance programs. To ensure the greatest amount of applicants will enroll in either the state's Medi-Cal or new insurance programs, all application materials will be simplified to make the process as easy and "applicant friendly" as possible. Recognizing that documenting assets for the purposes of determining eligibility for Medi-Cal is time consuming and burdensome for many applicants, and thus may act as a barrier to enrollment, California will disregard resources for children in the Medi-Cal federal poverty level programs. This allows DHS to significantly simplify the Medi-Cal application for children. Like the AIM program, MRMIB will also use a simple mail-in application for the new insurance program. Furthermore, DHS and MRMIB are in the process of determining whether a joint application between Medi-Cal and the new Healthy Families insurance program will simplify the application and enrollment procedure.

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

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

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

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Outreach Time Line:

October 1997: Begin public comment on regulations
November 1997: Release RFP for outreach contractor
December 1997: Release of Medi-Cal quarterly newsletter
January 1998: Initial release of monthly Medi-Cal bulletin
February 1, 1998: Award contracts to outreach contractor
February 1, 1998: Toll free information launched
February 18, 1998: Radio, collateral and outdoor advertising launched
March 1, 1998: Medi-Cal enhancements in place (resource disregard, 100% expansion)
June 1, 1998: Program enrollment materials available
June 1, 1998: Medi-Cal enhancement in place (one month continued eligibility)
July 1, 1998: First children enrolled in insurance program
*MRMIB's pre-enrollment process occurs from now until enrollment begins.

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

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

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

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

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

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

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

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

California will use the CalPERS state employee benefit package as the benchmark coverage for its health insurance coverage to Healthy Families members [and for infants born to mothers enrolled in the AIM Program on or after July 1, 2004.](#)

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

The C-CHIP projects will provide the same comprehensive benefit package as that of the Healthy Families Program, with a few exceptions, to its enrollees. The exceptions to the benefit package include:

- Children enrolled in C-CHIP and diagnosed with a CCS eligible condition will be referred to CCS for a full eligibility determination. If the child is determined CCS eligible, CCS will provide services to treat the CCS condition. If the child is not CCS eligible, the health plan shall provide all medically necessary services including the treatment of the CCS condition as is true under the benchmark coverage.

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

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

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

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

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

[The C-CHIPs will provide the same comprehensive benefit package as that of the Healthy Families Program, with a few exceptions, to its enrollees. The exceptions to the benefit package include:](#)

- [Children enrolled in C-CHIP and diagnosed with a CCS eligible condition will be referred to CCS for a full eligibility determination. If the child is determined CCS eligible, CCS will provide services to treat the CCS condition. If the child is not CCS eligible, the health plan shall provide all medically necessary services including the treatment of the CCS condition as is true under the benchmark coverage.](#)

6.1.3. **Existing Comprehensive State-Based Coverage;** (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] **Please attach a description of the benefits package,**

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

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

- 6.1.4.1. Coverage the same as Medicaid State plan**
- 6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration project**
- 6.1.4.3. Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population**
- 6.1.4.4. Coverage that includes benchmark coverage plus additional coverage**

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

- 6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage**
- 6.1.4.6. Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)**
- 6.1.4.7. Other (Describe)**

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

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limitations) (Section 2110(a)) (42CFR 457.490)

(For a full benefits description, see Attachment 6 and 7)

- 6.2.1. **Inpatient services** (Section 2110(a)(1))
- 6.2.2. **Outpatient services** (Section 2110(a)(2))
- 6.2.3. **Physician services** (Section 2110(a)(3))
- 6.2.4. **Surgical services** Section 2110(a)(4))
- 6.2.5. **Clinic services (including health center services) and other ambulatory health care services.** (Section 2110(a)(5))
- 6.2.6. **Prescription drugs** (Section 2110(a)(6))
- 6.2.7. **Over-the-counter medications** (Section 2110(a)(7))
- 6.2.8. **Laboratory and radiological services** (Section 2110(a)(8))
- 6.2.9. **Prenatal care and pre-pregnancy family services and supplies** (Section 2110(a)(9))
- 6.2.10. **Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services** (Section 2110(a)(10))
- 6.2.11. **Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services** (Section 2110(a)(11))
- 6.2.12. **Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)** (Section 2110(a)(12))
- 6.2.13. **Disposable medical supplies** (Section 2110(a)(13))
- 6.2.14. **Home and community-based health care services (See instructions)** (Section 2110(a)(14))

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- 6.2.15. **Nursing care services (See instructions) (Section 2110(a)(15))**
- 6.2.16. **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))**
- 6.2.17. **Dental services (Section 2110(a)(17))**
- 6.2.18. **Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))**
- 6.2.19. **Outpatient substance abuse treatment services (Section 2110(a)(19))**
- 6.2.20. **Case management services (Section 2110(a)(20))**
- 6.2.21. **Care coordination services (Section 2110(a)(21))**
- 6.2.22. **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))**
- 6.2.23. **Hospice care (Section 2110(a)(23))**
- 6.2.24. **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))**
- 6.2.25. **Premiums for private health care insurance coverage (Section 2110(a)(25))**
- 6.2.26. **Medical transportation (Section 2110(a)(26))**
- 6.2.27. **Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))**
- 6.2.28. **Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))**

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

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- 6.3.1. **The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR**
- 6.3.2. **The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6***

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

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

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

- 6.4.1.2. **The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

- 6.4.1.3. **The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such**

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as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

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

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

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

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

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Section 7. Quality and Appropriateness of Care

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

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

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

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

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

Quality Management Processes: The contractor must assure the State that its Quality Management processes have been reviewed and found to be satisfactory by either the

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National Committee on Quality Assurance, the Joint Commission on the Accreditation of Healthcare Organizations, or the State of California's Medi-Cal Managed Care Program. The contractor must also maintain a system of accountability for quality improvement activities which includes the participation of the contractor's governing body, the designation of a Quality Improvement Committee, supervision of the activities of the Medical Director, and the inclusion of contracted physicians and other providers in the process of quality improvement development and performance.

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

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

AIM Quality Assurance Measures

The AIM program relies on the quality assurance requirements of the Knox-Keene Act which regulates health plans. These requirements are detailed on pg. 20 of the state plan and include requirements governing accessibility of health services, consumer protection and quality assurance. Quality assurance requirements specifically require that plans have quality assurance programs, and that providers establish a program to review the quality of care being provided and identify, evaluate and remedy problems related to access, continuity of care, utilization and monitoring of plan providers.

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Quality Assurance Measures for Programs Not Under MRMIB's Purview

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

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

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

Quality Management Plan: At the local level, the quality management program coordinates performance monitoring activities including client and system outcomes, utilization management, credentialing and monitoring of providers, assessment of beneficiary and provider satisfaction, clinical records review and resolution of beneficiary grievance and fair hearing and provider appeals. The methodology for these functions is detailed in the county's local Quality Management Plan.

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

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

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

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

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

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

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

7.1.1. Quality standards

Insurance Programs. MRMIB will monitor quality standards in the purchasing

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pool and voucher programs through:

- Analysis and trending of reports from health, dental and vision plans. MRMIB staff will collect and analyze a variety of reports generated by participating plans, regulatory entities, and external review organizations to monitor the quality of care received and to focus plan efforts on areas needing improvement. These reports include:
 - Benefit Grievances: Benefit grievances filed by Healthy Families subscribers with participating plans. Participating plans will be contractually required to report benefit grievances once a year. These reports will be shared with subscribers who request the information. In addition, MRMIB will track any publicly available information on the number and type of benefit grievances filed by all subscribers enrolled in a participating plan (Department of Corporations reports all benefit grievances filed with plans annually). Grievance information will be used by MRMIB to identify plan performance needing improvement and to form the basis of future performance standards.
 - Regulatory Entity Reports: MRMIB will work with the state's two health insurance industry regulatory entities (the Departments of Insurance and Corporations) to assure that all publicly available data on health plan performance is known to MRMIB.
 - Enrollment and Disenrollment Reports: These reports will be generated by the program's administrative contractor and used by MRMIB as an early warning system of problems with a particular plan or medical group.
- Implementation of a risk assessment/risk adjustment process to minimize any financial incentives health plans may have to attempt to enroll healthier than average enrollees. While some observers view risk adjustment mechanisms in solely financial terms, MRMIB believes that inclusion of risk adjusted premium payments to plans is the single most important activity that MRMIB can undertake to assure the quality of care. MRMIB has been a pioneer in the risk adjustment field. In the HIPC, MRMIB currently oversees one of the nation's few operational risk adjustment processes. MRMIB believes that risk adjustment provides the necessary balance to the aggressive price negotiations

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undertaken in collective purchasing arrangements such as a purchasing pool. Through use of risk adjusted premiums, plans that provide quality services in an efficient manner would accrue the greatest financial benefit. MRMIB intends to seek philanthropic funding for development of a child focused risk assessment methodology. MRMIB intends to implement such a methodology in the third year of program operation. Implementation of risk assessment/adjustment in the third year of program operations will permit MRMIB to develop an understanding of the health risk based issues in children's health care and provide time to assure that all stakeholders are able to participate in development of the methodology.

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

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

- The specific indicators to be tracked will focus on child or adolescent specific outcome measures, such as the immunization status of two year olds. To the extent feasible, MRMIB intends to utilize the audited HEDIS measures generated by the California Cooperative HEDIS Reporting Initiative (CCHRI). CCHRI is a collaborative effort of purchasers, providers and plans who are committed to produce audited performance data on health plans which can be compared across plans and tracked over time. The health plans participating in CCHRI represent 95% of the commercially enrolled California health maintenance organization population. At present, the only audited child-specific HEDIS measure being collected by CCHRI is the immunization status of two year olds. Until audited measures are available, MRMIB will collect unaudited health plan reported information on other HEDIS child and adolescent based measures. MRMIB anticipates that the number of indicators collected during each contract period will expand as the field of outcome based quality measurement matures and as health plan's ability to produce data increases in response to purchasers demands.
- Each of the contacts between MRMIB and participating health, dental

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

CHDP. The Healthy Families gateway program, CHDP, reimburses for periodic health assessments and immunizations for children and adolescents under 21 years of age eligible for Medi-Cal and for those 19 years of age and under whose family's income is 200 percent of the federal poverty level or below. Through its administration of the CHDP and CCS programs, the Department of Health Services will use a variety of approaches to monitor quality standards. The state CHDP program is responsible for developing standards for the care delivered in a complete health assessment, including those components required by the EPSDT program (dental, nutrition, vision and hearing screening). In general, the standards of the American Academy of Pediatrics serve as the basis for preventive services standards. The program distributes Health Assessment Guidelines to enrolled CHDP providers (physicians, medical clinics, medical groups, and certified pediatric or family nurse practitioners) to provide a framework for the quality of care to be delivered during an assessment, including appropriate screening methodologies and specific tools. The local CHDP program is responsible for enrolling providers, both those who wish to provide health assessments and those who wish to deliver complete health care, if they meet the criteria outlined in Section 6860 of Title XXI. It also identifies providers who may be providing substandard services and can require corrective action in order to continue program participation.

Specialized Services. The CCS program develops standards for provider participation under the authority of Section 123925 of the Health and Safety

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Code. Providers, from individual pediatric specialists and sub-specialists to hospital inpatient facilities, wishing to participate in the program apply to have their qualifications reviewed and assessed. CCS state program staff perform on-site review of hospital facilities and special care centers that includes the determination of the appropriateness of the professional staff delivering care to CCS-eligible children and the quality of the health care provided (generally through the review of medical records).

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

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

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

- Analysis and trending of reports from health, dental and vision plans. MRMIB staff will collect and analyze a variety of reports generated by participating plans, regulatory entities, and external review organizations to monitor the quality of care received and to focus plan efforts on areas needing improvement. These reports include:
 - Benefit Grievances: Benefit grievances filed by Healthy Families subscribers with participating plans. Participating plans will be contractually required to report benefit grievances once a year. These reports will be shared with subscribers who request the information.

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In addition, MRMIB will track any publicly available information on the number and type of benefit grievances filed by all subscribers enrolled in a participating plan (Department of Corporations reports all benefit grievances filed with plans annually). Grievance information will be used by MRMIB to identify plan performance needing improvement and to form the basis of future performance standards.

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

- Monitoring the accreditation status of participating plans by entities such as the National Committee for Quality Assurance (NCQA).
- The specific indicators to be tracked will focus on child or adolescent specific outcome measures, such as the immunization status of two year olds. To the extent feasible, MRMIB intends to utilize the audited HEDIS measures generated by the California Cooperative HEDIS Reporting Initiative (CCHRI). CCHRI is a collaborative effort of purchasers, providers and plans who are committed to produce audited performance data on health plans which can be compared across plans and tracked over time. The health plans participating in CCHRI represent 95% of the commercially enrolled California health maintenance organization population. At present, the only audited child-specific HEDIS measure being collected by CCHRI is the immunization status of two year olds. Until audited measures are available, MRMIB will collect unaudited health plan reported information on other HEDIS child and adolescent based measures. MRMIB anticipates that the number of indicators collected during each contract period will expand as the field of outcome based quality measurement matures and as health plan's ability to produce data increases in response to purchasers demands.

7.1.2. ☒ Performance measurement

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

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- Collaboration on performance measures with other large purchasers such as CalPERS and the Pacific Business Group on Health (PBGH). MRMIB is a member organization of PBGH. Using the purchasing power of the Healthy Families subscriber base, MRMIB intends to collaborate actively with other large purchasers to encourage the health plan and provider communities to move more quickly to identify and expanded set of clinical quality indicators.
- Requiring all participating health plans to submit yearly results of the latest version of the Health Employer Data Information Set (HEDIS). As mentioned above, audited HEDIS results will be used when available.
- Establishing contractual agreements with participating plans obligating them to submit the results of standardized subscriber satisfaction surveys. While the exact survey instrument has not been determined, the instrument used by the NCQA will be evaluated for its applicability to the issues of importance to children and adolescents.

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

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

7.1.3. ☒ Information strategies

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

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- The Healthy Families Program brochure/application will include an easy to read chart summarizing the program benefits. Participating plans will be required to distribute to all subscribers a detailed description of covered benefits and exclusions in their Evidence of Coverage Document (EOC), a list of physicians and hospitals available in their network (Directories) and an identification card for subscribers to use to access services. Through its contractual relationships with plans, MRMIB will require the provision of these documents to families no later than the effective date of coverage. In addition, all plans participating in the Healthy Families program will be required to make EOCs available on a pre-enrollment basis to those families wishing to review the coverage documents in detail prior to selecting a health plan.
- The Healthy Families Program brochure/application will include a section where all participating plans will have the opportunity to respond to a standardized set of topics of interest to families when selecting a plan, such as a description of the plan's provider network, how language support services are accessed, the plan's view of why a family should want to select the plan, and how approval for specialty care is handled in the plan. The exact list of issues will be developed by MRMIB using input received at MRMIB public meetings, available market research, and in consultation with the Healthy Families Advisory Panel.
- The Healthy Families Program brochure/application will include a chart comparing responses to commonly asked questions. These questions will be generated using input received at the MRMIB public meetings, available market research, and in consultation with the Healthy Families Advisory Panel. These may include answers to questions such as:
 - How many times can a child change their primary care physician in one benefit year?
 - Does the plan require physicians to prescribe pharmacy products from a list of drugs (a formulary) approved by the plan?
 - What is the total number of primary care physicians in

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the plan?

- MRMIB's experience in purchasing health benefits for small employers and their employees' families through HIPC shows that most families want to know the plans that include the child's physician when selecting a plan. To respond to this consumer need the Healthy Families Program will create a Provider Information Service. The Provider Information Service will be modeled on the Physician Super Directory developed by MRMIB for its small employer purchasing pool. It will include a listing of the pediatricians, family practice and general practice doctors, clinics/medical groups and hospitals that will be available through Healthy Families participating health plans. Additional information will include languages spoken in the physician's office, the gender of the physician, and if the physician is accepting new patients. The Provider Information Service will be available to families as they make their initial health plan choices and again at each annual open enrollment.
- MRMIB will require all plans providing services to Healthy Families program subscribers to prominently display in their Evidence of Coverage documents the grievance procedures of the plan and the plan's regulatory entity's toll free phone number.
- Application/enrollment materials will be available in English, Spanish, and other threshold languages designated by the Department of Health Services. Staff answering the toll-free number used by the administrator of the program will speak English and Spanish and have access to translator services for other languages.

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

7.1.4. ☒ Quality improvement strategies

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

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strategic approaches. These are:

- Keeping up to date on developments in quality improvement, including any indicators that may be developed regarding the high quality medical home;
- Feeding back information to plans to help them understand their own performance over time and how they compare to other plans providing services to Healthy Families Program subscribers;
- Enforcing of contractual provisions which link quality based measures to plan performance;
- Increasing plan performance targets over time; and
- Providing quality based information to families. This final approach empowers the consumer to punish or reward plans with enrollment based on the value each family places on the quality standards.

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

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

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

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

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

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

- MRMIB will monitor the ongoing status of health plans with their regulators to assure quality services are available to subscribers.
- MRMIB will use plan enrollment and disenrollment reports as a early warning signal of access problems with a health plan. All families choosing to switch their child from one health plan to another will be surveyed to find out why they are requesting a plan change. This survey will alert MRMIB staff to family concerns regarding access to specialty care, wait time for appointments, provider network instability or other access related barriers.
- CHDP and CCS services are monitored through authorization of services and claims review by county CHDP and CCS programs. County staff can serve an important role in training, and review of service provision.

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

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

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

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

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babies, young children and adolescents.

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

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

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

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

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

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

The State also conducts an annual consumer satisfaction survey of families

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which address their experience with their health plan. The survey instrument used (CAHPS) requests information on access to care and the ability of members to get the care they needed quickly.

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

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

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

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

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

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

The state will include in its C-CHIP contracts a requirement to report the number of active C-CHIP/CCS cases and the number of children referred to the CCS program. Of those children enrolled in C-CHIP, some will qualify for CCS services based on CCS eligibility requirements whereby services for the qualifying CCS eligible condition will be provided by CCS. In those cases where a family does not qualify based on CCS eligibility requirements, the medically necessary services will be provided by the C-CHIP health plan. California's State Department of Managed Healthcare licensure requirements includes adequacy of network including specialists covered services not

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available in network must be covered out of network.

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

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

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

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

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

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

8.1.1. **YES**

8.1.2. **NO, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.

(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

Purchasing Pool Premiums

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

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

	Family Value Package
Above 100-150% FPL	
One child	\$ 7
Two or more children	14
Above 150-200% FPL	
One child	9
Two children	18
Three or more children	27

Families who prepay three months of premiums will not have to pay a

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premium for the fourth month.

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

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

Community Provider Plan	
Above 100-150% FPL	
One child	\$ 4
Two or more children	8
Above 150-200% FPL	
One child	6
Two children	12
Three or more children	18

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

Again, families that pay 3 months of premiums in advance will receive the fourth month free.

Disenrollment for Non-Payment of Premium

MRMIB will disenroll families that fail to make their family contribution. Where a family has failed to make payment for 60 days and MRMIB has provided a 30 day notice to the family, in writing, of the fact that payment is

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late, the subscriber will be disenrolled effective the last period for which full payment was made. Children disenrolled pursuant to this section will not be eligible for reenrollment for six months. The authorizing statute permits MRMIB to waive the six month enrollment exclusion period if it finds that a family had “good cause” for nonpayment.

Purchasing Credit

The amounts charged for coverage under the purchasing credit will be no greater than the amounts charged under the purchasing pool for the Family Value Package.

Family Contribution Sponsors

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

1. a person that is a health care, dental care or vision care provider that participates in the Healthy Families Program or an organization composed primarily of or controlled by such persons,
2. an entity, including governmental, school, non-profit and charitable organizations, that is, or that operates, an institution or facility that is a health care, dental care or vision care provider that participates in the Healthy Families Program,
3. a participating plan,
4. any person or entity acting on behalf of or representing a person or entity identified in (1) through (3) above.

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

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or encourage an applicant to violate program rules.

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Subscribers enrolled in the AIM Program prior to July 1, 2004 pay premiums equal to 2% of the families annual income for coverage of the pregnant woman and the infant through age one. An additional \$100 is charged for the second year of the infant's life. Subscribers enrolled in the AIM Program on or after July 1, 2004 will pay premiums equal to 1.5% of the families' annual income for coverage of the pregnant woman and upon birth, the infant will be enrolled in the Healthy Families Program. Once enrolled in the Healthy Families Program, infants will be subject to the standard cost sharing requirements of the program. [Note: The state seeks FFP ~~only~~ for infants up to age one who were born to mothers enrolled in the AIM Program prior to July 1, 2004 with family income between 200-25% FPL and for infants up to age two with family income between 200-~~250%~~300% FPL.]

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Premiums range from \$4 - \$12 per month with two of the C-CHIP projects charging premiums monthly while the other two charge premiums on a quarterly basis. As is true in the Healthy Families Program, three of the four C-CHIP projects provide for discounts when payments are made in advance: if three quarters are paid in advance, the fourth quarter is free; if three months are paid in advance, the fourth month is free. Santa Clara County C-CHIP project has established a monthly premium maximum cap of \$18. In addition the FVP in the Healthy Families Program does not apply to C-CHIP. See Attachment 7d for details of premiums for each of the C-CHIP projects.

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

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8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments:

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

Health Coverage

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

Dental and Vision Coverage

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

ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM

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

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

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description of the benefits provided and the related copay.

8.2.4. Other: N/A

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

The public will be notified of Healthy Families' cost-sharing requirements, including differences based on income, in the Program's application, enrollment materials and program regulations. Copays will also be listed in plan disclosure documents such as Evidence of Coverage (EOC) documents provided to each family. Agencies and individuals who help families with their application will also be familiar with the program's cost-sharing requirements and be able to communicate them to families when discussing the program. Because the total cost sharing possible based on the Healthy Families Program and C-CHIP family contribution (premium) levels and copayments, at all income levels, does not exceed 5% (see 8.5), no separate notification of the cumulative maximum is necessary or appropriate. As staff communicated to CMS in a conference call on September 9, 2002, the Healthy Families Program benefits and premiums are structured in such a way that families cannot exceed the five percent cost sharing maximum (see 8.5). As a result of the September 2002 conference call California submitted a revised Compliance SPA to CMS on September 11, 2002 that withdrew language committing California to do additional analysis on this issue. In CMS' approval letter dated September 19, 2002, CMS based its approval on the September 11, 2002 clarifications.

While it is true that dental and vision benefits are not subject to a dollar cap, the nature of the covered services, including limitations on services, is such that the copayments for those services, in combination with premiums and health copayments, will not bring a family's cost sharing above the limit. The cost sharing maximum is also described in the Healthy Families Member Handbook which describes premiums, copayments, and benefits of the program. Therefore, it is not necessary to calculate a separate cost sharing maximum for each individual.

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

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- 8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan:** (Section 2103(e))
- 8.4.1. Cost-sharing does not favor children from higher income families over lower income families.** (Section 2103(e)(1)(B)) (42CFR 457.530)
 - 8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations.** (Section 2103(e)(2)) (42CFR 457.520)
 - 8.4.3. No additional cost-sharing applies to the costs of emergency medical services delivered outside the network.** (Section 2103(e)(1)(A)) (42CFR 457.515(f))
- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee:** (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

Healthy Families Insurance Program

Families with incomes over 150% of poverty:

California ensures that the annual aggregate cost-sharing for a family does not exceed 5% of a family's income as is required by Section 2103(3)(B) of Title XXI. Healthy Families' premiums are established in statute, along with a limit of \$250 on the total copayments which would be required of a family annually. Table 1 below demonstrates that the maximum cost sharing for a family at 150% of poverty (Column V) falls well within the 5% annual cap (Column III).

Table 1: Aggregate Cost Sharing for Families Above 150% for HFP

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I	II	III	IV	V	VI
Family Size	Annual Income of a Single Parent Family @ 150% FPL	5% Ceiling	Annual Premium Contribution*	Annual Premium + \$250 Family Cap on Health Copays	Number of Dental and Vision Visits for Non-Preventive Services Needed to Exceed Ceiling
1 child	\$ 15,915	\$ 795.75	\$ 108	\$ 358	87
2 children	\$ 19,995	\$ 999.75	\$ 216	\$ 466	106
3+children	\$ 24,075	\$1,203.75	\$ 324	\$ 574	125

* Does not include premium discount for prepayment. If included, would reduced figures in this column by 25%.

Families with incomes under 150% of poverty:

Premiums. California will ensure that the annual aggregate cost-sharing for a family with incomes less than 150% FPL is less than that required by Section 1916(b)(1) and Section 1916(2)(3) as is required under Title XXI. The maximum monthly premium charge for Healthy Families insurance programs is consistent with the standards established under Section 447.52 of Title 42 CFR. As noted earlier, Healthy Families' premiums for families below 150% FPL are \$7 per child per month (with a maximum family contribution of \$14 per family per month). Table 2 below demonstrates that the maximum premium payments for a family at 100% FPL under Healthy Families (Column II) falls within the maximum monthly charges established under Section 447.42 of Title 42 of the Code of Federal Regulations. Note that the maximum monthly charges identified below were established in 1978 and are unadjusted for inflation.

Table 2: HFP Premium Contributions for Families below 150% FPL

I.	II.	III.	IV.
Family Size	Income of a Single Parent Family at	Premium Contribution*	Medicaid Maximum Monthly Charge

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	100% FPL		(Unadjusted for Inflation)
1 child	\$884 mo./ \$10,610 yr.	\$7 mo./ \$84 yr.	\$16 mo./ \$192 yr.
2 children	\$1,111 mo./ \$13,330 yr.	\$14 mo./ \$168 yr.	\$15-\$16 mo./ \$180-\$192 yr.

* Does not include premium discount for families who prepay 3 months in advance.

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

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

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California’s approved State Plan demonstrates that the cost sharing requirements do not exceed those allowable under Title XXI. Even though the cost sharing requirements are slightly higher in the C-CHIP projects compared to the Healthy Families Program, the higher income level is commensurate with the difference. Using 250% FPL as the baseline income, Table 3 below provides an analysis of the five percent cost sharing limit compared to the highest premium that would be charged by any given county. Therefore California provides assurances that the cost sharing requirements continue to be within the allowable limits established under Title XXI.

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Included in the cost sharing limit California assures that the \$250 copayment cap also applies to the C-CHIP projects. This is also reflected in Attachment 6 and 7.

Table 3: Aggregate Cost Sharing for Families Above 250% for C-CHIP

I	II	III	IV	V	VI
Family Size	Annual Income of a Single Parent Family @ 251% FPL	5% Ceiling	Annual Premium Contribution*	Annual Premium + \$250 Family Cap on Health Copays	Number of Dental and Vision Visits for Non-Preventive Services Needed to Exceed Ceiling
1 child	\$ 31,236	\$1,561.80	\$ 144	\$ 394	233
2 children	\$ 39,180	\$1,959.00	\$ 288	\$ 538	284
3 children	\$ 47,136	\$2,356.80	\$ 432	\$ 682	334

* Does not include premium discount for prepayment. If included, would reduced figures in this column. Based on April 1, 2004 FPL levels.**ACCESS TO INFANTS AND MOTHERS (AIM) PROGRAM**

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

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

The provision of child health assistance to low income children who are American Indians (as defined in section 49(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c), (Section 2102)(b)(3)(D)) or who are Alaskan Natives (as defined in

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the Alaska Native Claims Settlement Act, 43 U.S.C. 1601), will be assured through the following procedures:

- Technical assistance by the state American Indian Health Program, Federal Indian Health Services, and tribes in tracking of services to American Indians.
- Inclusion of American Indian ethnicity using the federal definition on the application form for tracking purposes.
- Training to local American Indian clinic staff for outreach and referral to the Healthy Families Program.
- Use of the 30 American Indian primary care clinics (which are CHDP providers) to screen low income youth, provide initial treatment and referral either to Medi-Cal or Healthy families.
- Implementation of a provision to exempt American Indian and Alaska Native (AI/AN) families that meet the cost sharing waiver requirements, from monthly premiums and benefit copayments. This exemption is implemented the same in C-CHIP as it is in the Healthy Families Program. The exemption from premiums will be made at the time of application submission when a family declares AI/AN status consistent with the documentation requirements listed below. The family will have two months to submit the required documentation to continue the premium waiver. If documentation is not submitted within two months from enrollment, premiums will be charged prospectively. When acceptable documentation is submitted, the copayment waiver will also be applied. Acceptable documentation for the applicant or the child includes:
 1. An American Indian or Alaskan Native enrollment document from a federally recognized tribe; or
 2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs; or
 3. A Certificate of Indian Heritage from an Indian Health Service facility operating in the State of California.
- Education to Certified Application Assistants about the cost sharing exemption for AI/AN families that meet the cost sharing waiver requirements.

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

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

Currently, if a program participant fails to make a payment, the next month's invoice he receives includes a 30 day past due warning. The second month's invoice includes the amount due for the previous month and the current month, the date by which payment must be remitted, and the date the coverage will end if payment is not made. All invoices with past due warnings include a statement that if the subscriber is disenrolled for non-payment, they may be financially responsible for health care services they received during the two month period of non-payment.

If the premium is 45 days past due, a warning letter is sent to the applicant, which includes information on payment options, the disenrollment date, and an instructions on how to complete the request form for continued enrollment. If the premium has not been received on the 20th of the second month, a courtesy call is placed to the applicant. The applicant is reminded that a premium payment is due and that his or her child will be disenrolled as of the end of the month. He or she is also questioned regarding whether he or she received the notification. A last billing statement is also mailed to the applicant on the 20th day of the month, and if HFP has not received payment by the last day of the second month, a disenrollment with appeal information letter is sent to the applicant.

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

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program during the time an appeal disputing the decision to disenroll from the program is being reviewed.

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

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

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

- 8.8.1. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)**
- 8.8.2. No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)**
- 8.8.3. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**
- 8.8.4. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))**
- 8.8.5. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105(c)(7)(B)) (42CFR 457.475)**

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

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

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

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

1. Increase the awareness of low income uninsured families about the availability of comprehensive low or no cost health coverage for children as well as the importance of timely and ongoing care for children. Motivate such families to obtain coverage for their children.
2. Provide a choice of health plans for families to choose from in obtaining coverage for their children.
3. Provide an application and enrollment process which is easy for targeted low-income families to understand and use.
4. Assure that financial barriers do not keep families from enrolling their children in the program.
5. Assure that health services purchased by the program are accessible to enrolled children.
6. Assure the participation of community-based organizations in outreach and education activities.
7. Encourage the inclusion of traditional and safety net providers in health plan networks.
8. Strengthen and encourage employer-sponsored coverage to the maximum extent possible.
9. Assure that enrolled children with significant health needs receive access to appropriate care.

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

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

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

Performance goals:

- 1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.
- 1.2 Reduce the percentage of uninsured children in target income families that have family incomes above no cost Medi-Cal levels.
- 1.3 Reduce the percentage of children using the emergency room as their usual source of primary care.

Proposed measures:

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

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

Performance goals:

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

Proposed measures:

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

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

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Performance goals:

- 3.1 Assure that Medi-Cal and the insurance program's enrollment contractor provide written and telephone services in the languages spoken by the target population.
- 3.2 Develop an application process that can be completed without an in-person meeting.

Proposed measures:

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

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

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

Performance goals:

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

Proposed measures:

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

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

Performance goals:

- 5.1 Achieve year to year improvements in the percentage of targeted low income

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children that have had a visit with a primary care provider during the year.

- 5.2 Achieve year to year improvements in the percentage of targeted low income children that have had well-child examinations at the appropriate intervals for their age.
- 5.3 Achieve year to year improvements in the percentage of targeted low income children who receive required immunizations by age 2 and by age 13.

Proposed measures:

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

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

Performance goals:

- 6.1 Insure that a variety of entities experienced in working with targeted low income populations are eligible to receive the application assistance fee for assisting families with enrollment.
- 6.2 Insure that a variety of entities experience in working with targeted low income populations receive subcontracts with the outreach/education contractor have input in the development of culturally and linguistically appropriate outreach and enrollment materials.

Proposed measures:

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

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

Performance goals:

- 7.1 Achieve increases in the number of children enrolled in the insurance pool

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who have access to a provider located within their zip code.

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

Proposed measures:

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

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

Performance goals:

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

Proposed measures:

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

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

Performance goals:

- 9.1 Achieve year to year maintenance and/or improvements in the percentage of children with special health care needs with a source of insurance for primary care and specialty care.
- 9.2 Ensure that children with special health care needs experience no break in coverage/services as they access specialized services.

Proposed measures:

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

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health plans' compliance with referral requirements.

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

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

Measures are outlined in Section 9.2 above.

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

- 9.3.1. **The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**
- 9.3.2. **The reduction in the percentage of uninsured children.**
- 9.3.3. **The increase in the percentage of children with a usual source of care.**
- 9.3.4. **The extent to which outcome measures show progress on one or more of the health problems identified by the state.**
- 9.3.5. **HEDIS Measurement Set relevant to children and adolescents younger than 19.**
- 9.3.6. **Other child appropriate measurement set. List or describe the set used.**
- 9.3.7. **If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**
 - 9.3.7.1. **Immunizations**
 - 9.3.7.2. **Well child care**
 - 9.3.7.3. **Adolescent well visits**
 - 9.3.7.4. **Satisfaction with care**
 - 9.3.7.5. **Mental health**

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9.3.7.6. Dental care

9.3.7.7. Other, please list:

9.3.8. Performance measures for special targeted populations.

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

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

The state will perform the annual assessments and evaluations required in Section 2108(a) to assess its progress in meeting the performance goals and measures identified in Section 9. Data necessary to prepare these reports will be drawn from administrative files maintained by the Healthy Families and Medi-Cal programs, the Current Population Survey, disenrollment surveys of Healthy Families Program participants, and HEDIS reports. In addition, the state intends to secure philanthropic funding for an independent third party evaluation of the Healthy Families program.

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

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

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

- Demographics of children assisted under the state plan.
- Quality of health coverage provided under the plan. As Section 7.1 demonstrates, California will use HEDIS and subscriber disenrollment data to

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- evaluate the effectiveness of care offered through Healthy Families.
- Subsidies and cost-sharing. The state will report the amount of subsidies paid out of state and federal funds and the amount of cost-sharing paid by enrolled families.
- Service area.
- Time limits. Healthy Families offers enrolled children 12 months of continued eligibility. The state will evaluate how many children receive a full year of coverage, and if not, why coverage was dropped.
- Benefits covered and other methods used to provide health assistance.
- Sources of non-federal funding.

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

- 9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)**
- 9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))**
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)**
- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)**
 - 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**
 - 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)**
 - 9.8.4. Section 1132 (relating to periods within which claims must be filed)**

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

From the beginning, California has sought to gather public input in the design of the Healthy Families program. In anticipation of developing a Title XXI children's health program, in late July and early August of 1997, the Secretary of the Health and Welfare Agency and the Director of DHS held round table discussions with interested parties and solicited written feedback from constituency groups. Governor Wilson introduced his children's health proposal on August 27, 1997. After introduction of the plan, the Secretary of the Health and Welfare Agency held meetings with numerous stakeholder groups to obtain their feedback on the proposal. Using the Governor's proposal as a framework, the Healthy Families state legislative package (AB 1126, SB 903, AB 217, and AB 1572) was developed through a joint "Health Access" conference committee. The conference committee held several open committee meetings, during which time the public was invited to offer feedback on the Healthy Families proposal.

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

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

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

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

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

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

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

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

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

- Participation in American Indian sponsored conferences, meetings and workgroups.
- Coordinated distribution of targeted outreach materials to the American

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Indian population via conferences, clinics, and meetings.

- Meetings with various tribal affiliated organizations and boards to identify acceptable documentation to demonstrate tribal affiliation for families to qualify for the Healthy Families cost sharing waiver.

C-CHIP

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

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

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

- **Planned use of funds, including --**
 - **Projected amount to be spent on health services;**
 - **Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and**
 - **Assumptions on which the budget is based, including cost per child and expected enrollment.**
- **Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.**

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

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

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- County mental health which will be matched by local funds;
- California Children’s Services (CCS) which will be matched by General Fund and local funds;
- Child Health and Disability Prevention program (CHDP) which will be matched by General Fund and local funds.
- C-CHIP implementation. The source of funds vary by county and are detailed below:
 1. Santa Clara: Proposition 10 (County Tobacco Settlement) Funds, and City of San Jose will provide their Tobacco Settlement funds that are directly allocated to them.
 2. Alameda: Proposition 10 (County Tobacco Settlement) Funds.
 3. San Francisco: Proposition 10 (County Tobacco Settlement) Funds, and City/County General Funds. The specific sources of City/County General Funds include: property taxes, business taxes, and other local taxes.
 4. San Mateo: Proposition 10 Funds, and County General Funds. The specific sources of County General Funds include: the Solid Waste fund, and the Peninsula and Sequoia Healthcare Districts. The Districts are formed and operated pursuant to the Local Health Care District Law (California Health and Safety code Sections 32000et seq.). The Districts are financed by a property tax this is assessed on property owners within their catchments areas and the Districts will use these tax receipts only (rather than any rental or investment income).

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

MRMIB will implement a uniform system for determining costs in accordance with Office of Management and Budget (OMB) circular A-87, “Cost Principles for State, Local, and Indian Tribal Governments.” To ensure proper determination of allowable costs, all costs charged to Title XXI will be reviewed to ensure that they are

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necessary, reasonable, adequately documented, and properly reconciled. Additionally, MRMIB will establish periodic review of our cost structure to ensure that operating costs are properly allocated among the appropriate federal and state programs.

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

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

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

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

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

CASELOAD ESTIMATE ASSUMPTIONS

HFP Monthly Enrollment – Base Program

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

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

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

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income deductions would not be applied for the HFP5.

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

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

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

DMH FOR SED SERVICES

- Assumes 3% of the average annual HFP enrollment.

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

HFP EXPANSION ENROLLMENT ASSUMPTIONS

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

- Caseload estimates assume enrollment will begin 7/99.
- Assumes 132,000 potentially eligible children with net family income under 250 percent of FPL, in addition to above estimated 328,000 base eligible children.
- Of the 328,000 identified as potentially eligible, assumes 129,370 children will be enrolling in the HFP. This estimate is based on the January 1999 UCLA estimate of 132,000 children between 0-19 years old that would be eligible if income deductions and income disregards were used to determine income eligibility

5 Steve P. Wallace et al. "Technical Notes for *New Estimates find 400,000 Children Eligible for Healthy Families Program, Policy Brief 98-4.*" UCLA Center for Health Policy Research. October 1998.

6 Helen Halpon Schauffler et al. "The State of Health Insurance in California, 1998." UC Berkeley Center for Health and Public Policy Studies and the UCLA Center for Health Policy Research. January 1999. Page 24.

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reduced by MRMIB's estimate of 2,630 children between 0-1 years old. The exclusion of the 0-1 age band was made because the 0-1 years children whose net family incomes (when using Medi-Cal income deductions) are below 200% fpl are eligible for free Medi-Cal and therefore are ineligible for HFP. Estimated monthly enrollment is projected as follows:

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

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

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

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

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

LEGAL IMMIGRANTS POST 8/22/96

(Cost for legal immigrants are funded from 100 percent State Funds and are excluded in the budget display)

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

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

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

DMH FOR SED SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

Child Health & Disability Prevention (CHDP) (Without EDS processing costs). The CHDP estimate reflects payment to CHDP providers for screening exams and initial

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follow-up treatment for new HFP enrollees during a period up to 90 days during which their application to the Program is pending. It is anticipated the CHDP providers would be a significant source of referral for the Program.

- a) Average cost of a CHDP screening for age 1 through 18, per eligible per month is \$64.38.
- b) Average cost of a 30-day follow-up treatment is \$18.50.
- c) Estimated average one time cost per case is \$82.88 for screening and treatment combined.

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

The MRMIB's \$6 million (\$2.038 million GF and \$3.962 million FFP) augmentation is to develop and enhance existing health care delivery networks through contract amendments with participating HFP health dental and vision plans. This augmentation addresses geographic access barriers and access barriers for special population subscribers enrolled in the HFP (seasonal and migrant farm workers, and American Indians).

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

The estimated average cost per child per month is \$229.00. The estimated monthly

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enrollment of children with SED in HFP for 1999, 2000 and 2001 is 2,965, 7,510 and 11,840 respectively.

Accelerate Coverage of Children Under 100 Percent of Federal Poverty Level (FPL).

The DHS 100 percent program previously provided coverage to children whose families have income in excess of the maintenance need but less than 100 percent of poverty if they were born after September 30, 1983. In March 1998, the program was expanded to cover children under the age of 19.

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

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

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

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

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

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the families' first month premium payments.

Statewide Outreach Campaign. The State has implemented various activities to provide information to families regarding both Medi-Cal and HFP, and to encourage and increase enrollment of children in both programs. Full year outreach activities are estimated at \$12 million annually.

Note: The Outreach budget includes the one-time application assistance fees and annual eligibility review fees.

Mental Health County Administration. This is the administrative cost portion of the Healthy Families Program county mental health funding.

Medi-Cal Conforming Costs - County Administration. This represents the total estimated cost for counties to determine eligibility for a) accelerated Coverage of Children Under 100 percent FPL; b) asset waiver for children.

EDS Costs - Fiscal Intermediary (FI). Provider reimbursement for all fee-for-service elements of expanded access is processed by EDS, the Medi-Cal Fiscal Intermediary (FI) through an automated payment system integrated with the California-Medi-Cal Management Information System (CA-MMIS). It is assumed that all providers would utilize the HCFA 1500 and UB92 standardized Medi-Cal claim forms as well as the CHDP PM 160. The current CA-MMIS models for expanded access for HFP. The CHDP system will allow assessments and the CA-MMIS will accommodate any treatment claims. Both systems require enhancements to comply with Title XXI requirements.

One Month Bridge. This is the county administration cost associated with implementation of the One Month Bridge Program described in Section I.B.5.

State Administration - MRMIB. MRMIB administers the HFP estimates health care for approximately 497,000 children of moderate income working individuals through subsidized private health insurance plans. The current state fiscal year 1999/00 budget includes authority for 28.0 positions and \$3.314 million total funds (\$1.342 million General Fund).

State Administration - DHS. The Department of Health Services has, in the current state fiscal year 99/00, budget authority for 12 positions and \$1.268 million (\$.387 million General Fund). These resources are necessary to meet requirements of the HFP legislation, conduct the activities necessary to expand Medi-Cal health coverage

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for low-income uninsured children, and provide education and outreach activities.

Attached are a series of exhibits which explain how the amounts for benefits and other cost components were calculated.

Exhibit 1- Estimated enrollment and related costs for Healthy Family program benefits, premium payments, contractor payments and assistance fees.

Exhibit 2- Enrollment assumptions

Exhibit 3- Benefit cost assumptions

Exhibit 4- Average premium calculation

Exhibit 5- Basis for Title XXI-eligible Access for Infants and Mothers program costs (the AIM estimate has since been reduced by 4 percent in response to HCFA's concern that AIM covers infants with access to insurance coverage)

Exhibit 6- Basis for Title XXI-eligible California Children's Services program costs

Exhibit 7- Basis for Title XXI-eligible Child Health and Disability Prevention program costs

Exhibit 8- Basis for Title XXI- Mental Health Services benefit and associated administrative costs

Exhibit 9- Assumptions and calculations for conforming Medi-Cal program costs for accelerated coverage, asset waiver, extended eligibility and outreach program costs (First year outreach costs revised to match chaptered legislation. First year estimate for extended eligibility has been reduced because California will have to pass state clean-up legislation before it can implement extended eligibility in accordance with HCFA's parameters. Original extended eligibility estimate assumed a May 1, 1998 implementation date, while amended estimate assumes a July 1, 1998 implementation date.)

Exhibit 10- Basis for cost estimate for the Fiscal Intermediary requirements (Revised cost estimate. California will claim Fiscal Intermediary costs under Title XIX rather than seek the enhanced FFP under Title XXI)

Exhibit 11- The state budget proposal for DHS administrative staff costs (Revised cost estimate includes amount for overhead costs consistent with the HCFA-approved indirect cost rate plan and additional application printing costs)

Exhibit 12- The state budget proposal for MRMIB administrative staff costs (Revised cost estimate includes additional financial accounting and processing staff in response to HCFA draft guidelines)

Exhibit 13- Revised State Plan budget table with revised administrative cost amounts and percentage calculations

Payment to Health, Dental and Vision Plans. Current Population Survey data estimates that, for children ages 1 to 18 between 100 percent and 200 percent of the

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federal poverty level, as many as 580,000 may be uninsured, and thus could potentially be served by the Healthy Families Program. These health services costs are the estimated insurance premium costs as the served population grows over time.

Estimated payment for health, dental, vision per month is \$70.25; estimated monthly enrollment by the end of Federal Fiscal Year (FFY) 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Offsetting Premium Payments. The total health services costs will be offset by a monthly premium payment per child paid by the family. These premiums will be collected by the health plan.

Estimated offset of premium payments per child per month is \$6.00; estimated monthly enrollment by the end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

Payments to Enrollment Contractor. The Managed Risk Medical Insurance Board (MRMIB) will contract with a private company to conduct the eligibility and enrollment process. This is the same process that it uses for its three existing programs.

Estimated payment to enrollment contractor per child per month is \$3.50; estimated monthly enrollment by end of FFY 1, 2, and 3 is 57,000, 261,000, and 501,000 respectively.

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

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

Payments to AIM Health Plans. AIM is administered by the MRMIB, which contracts with the private sector to provide subsidized coverage for beneficiaries. To cover the full cost of care, California uses Proposition 99 tobacco tax monies to subsidize subscriber copayments and contributions, while the subscriber pays two percent of

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their average annual income.

Estimated payments to AIM health plans average \$4,888,190 per year.

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

Average cost per eligible per month is \$180.50; estimated monthly enrollment by end of FFY 1, 2, and 3 is 2,048, 9,377, and 18,000 respectively. It is also assumed that the county and state will participate equally in the match requirement.

Child Health Disability Prevention (CHDP) (Without EDS Costs). The CHDP estimate reflects payment to CHDP providers for screening exams and initial follow-up treatment for new Healthy Families Program enrollees during a period up to 30 days during which their application to the Program is pending. It is anticipated the CHDP providers will be a major source of referral for the Program.

Average cost of CHDP screen for age 1-18 is \$65.96 and average cost of 30-day follow up treatment is \$18.50. It is estimated that 12,500 enrolled first month and 8,000 each additional month through June 1998; thereafter, 10,000 enrolled each month through June 1999.

Mental Health. The mental health component of the Healthy Kids program represents the total estimated costs of providing mental health services to children who are under 200% of poverty with serious emotional disturbance (SED) consistent with the Bronzan/McCorkadale Act. These services are provided through a single, local, public entity because the expertise and resources for serving this special needs population is currently in the county mental health programs.

Average cost per child per month is \$220.00; estimated monthly enrollment for FFY 1, 2, and 3 is 1,710, 7,830, and 15,030 respectively.

Accelerate Coverage of Children Under 100% of FPL. The 100% program currently

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provides coverage to children who have income in excess of the maintenance need but less than 100% of poverty if they were born after September 30, 1983. The program is being expanded to cover children under the age of 19.

Average cost per child is \$89 per month; estimated number of children is 15,818 per month.

Asset Waiver for Children. Resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits.

Average cost per child under 15 years is \$48, and 15-18 years is \$89; estimated number of 67 children eligible is 33,935 per month.

One Month Extended Eligibility When Income Increases. All Medi-Cal Only children discontinued from Medi-Cal or given a share of cost will be given an additional month of zero share of cost Medi-Cal in order to give them time to apply for the Healthy Families Program.

Average cost per child is \$43 per month; estimated number of children eligible is 52,391 per month.

Statewide Outreach Campaign. The Department will implement various activities to provide information to families regarding Medi-Cal and the Healthy Families Program.

Full year outreach activities are estimated at \$12 million annually.

DMH County Administration. This is the total estimated administrative cost of providing mental health services to the eligible children.

Medi-Cal Conforming Costs - County Administration. This represents the total estimated share of cost for counties providing a) Accelerate Coverage of Children Under 100% FPL, and b) Asset Waiver for Children services.

EDS Costs - Fiscal Intermediary (FI). Provider reimbursement for all fee for service elements of expanded access would be processed by the Medi-Cal FI through an automated payment system integrated with CA-MMIS. It is assumed that all providers would utilize the HCFA 1500 and UB92 standardized Medi-Cal claim forms as well as the CHDP PM 160. Initial analysis of the CHDP providers system could be used as cost effective model for expanded access for the Healthy Families Program. While this

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system will require some level of enhancement and will be contingent upon the final parameters identified for implementation, it is anticipated that these modifications can be accommodated on a timely basis.

Ongoing operational costs are estimated to be \$1,444,160 annually.

State Administration - MRMIB. MRMIB will administer the Healthy Families Program, and will provide health care for approximately 580,000 children of moderate income working individuals through subsidized private health insurance plans. MRMIB is requesting 18 positions and \$1.600 million (\$560 thousand General Fund) in the current state fiscal year; and 21 positions and \$2.156 million (\$755 thousand General Fund) for the state fiscal year 1998- 99.

State Administration - DHS. The Department of Health Services is requesting 19 positions and \$2.679 million (\$937 thousand General Fund) in the current state fiscal year; and 19 positions and \$2.836 million (\$993 thousand General Fund) for the state fiscal year 1998-99.

This request is necessary to meet the requirement of the Healthy Families legislation, conduct 68 the activities necessary to expand Medi-Cal health coverage for low-income uninsured children, and provide education and outreach activities.

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Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

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Section 11. Program Integrity (Section 2101(a))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1 The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

11.2.1. 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. Section 1124 (relating to disclosure of ownership and related information)

11.2.3. Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. Section 1128A (relating to civil monetary penalties)

11.2.5. Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. Section 1128E (relating to the National health care fraud and abuse data collection program)

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Section 12. Applicant and enrollee protections (Sections 2101(a))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

Described below is a description of California's review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. These processes reflect those in the Healthy Families Program and C-CHIP.

- a.) As required in 42 CFR 457.1130(a), California provides applicants and enrollees the opportunity to review eligibility and enrollment issues such as denial of eligibility; failure to make a timely determination of eligibility; and suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. These eligibility and enrollment issues are specifically included in the Healthy Families regulations, program handbook, and notification letters to applicants and enrollees. All decisions are provided in writing and all decisions which have a negative impact on an applicant or enrollee include instructions on how to appeal the decision if the applicant or enrollee believes the decision is incorrect.
- b.) For purposes of implementing 42 CFR 457.1170 California has determined that the first level appeal review conducted by the Appeals Unit within the administrative vendor meets the core requirements as defined in 42 CFR 457.1150(a) as an impartial review. The Appeals Unit is a distinct and separate unit from the Eligibility Unit that makes the initial eligibility determination and is not directly involved in the matter under review.
- c.) Included in the program's administrative vendor contract is a section on reviewing appeals. In addressing the need for expedited review when there is an immediate need for health services, a contractual provision requires the administrative vendor to forward all appeals in need of immediate review to the Managed Risk Medical Insurance Board within five (5) business days.
- d.) As required in 42 CFR 457.1170, California provides enrollees the

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opportunity for continuation of enrollment pending the completion of review of a termination of enrollment, including a decision to disenroll for failure to pay cost sharing. Prior to disenrollment, enrollees are notified of the impending termination, the reason for such termination, and a pre-printed form in which to request continued enrollment and to provide the necessary information or explanation as to why termination should not occur. This provision of the Healthy Families Program was implemented in February 2003. California already provides written notification to applicants and enrollees on all decisions made. In addition, as explained in a. and d. above, all decisions which have a negative impact on an applicant or enrollee include instructions on how to appeal the decision and request continued enrollment if the applicant or enrollee believes the decision is incorrect.

- f.) California provides all review decisions in writing.
- g.) California affirms that each applicant or enrollee has the right to represent him or herself or choose a representative, the right to review his or her file and other relevant information and the right to participate fully in the review process. In reviewing the specific requirements of 42 CFR 457.1140(d)(1)-(3) California will modify its current appeal language to include an affirmative statement regarding an applicant's or enrollee's right to representation and opportunity to review his or her records. This modification is in process with California's new administrative vendor and should be complete by March 2004. California complies with the requirement to allow an applicant or enrollee to participate fully in the review process. Any notification of an appeal able determination includes full notification of appeal rights and instructs the applicant or enrollee that he or she can submit additional information for review.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

Participating plans are required by state law to establish and maintain a grievance system approved by the Department of Managed Health Care (DMHC). The DMHC is responsible for licensing and regulating pre-paid plans (health, dental, and vision) in California.

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The plan's grievance process must provide reasonable procedures in accordance with DMHC regulations to ensure adequate consideration of grievances and provide for recertification when appropriate. Subscribers who are not satisfied with the plan's final determination or who have not received a response to their grievance within 30 calendar days, have the option of appealing to the DMHC.

DMHC will review the appeals as a standard review or as an Independent Medical Review (IMR). (The IMR allows subscribers to obtain an impartial review of any health care service eligible for coverage and payment under a health plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the services are not medically necessary). The standard review and Independent Medical Review process include a final resolution by DMHC staff or DMHC contractor that is binding on the health plan.

The patient protection provision in state law that was established for managed care enrollees in California also apply to HFP and C-CHIP subscribers since they are enrolled in licensed managed care plans. Thus, members are instructed to use their health plan's grievance process-including the DMHC's IMR process, if the subscriber has a grievance. When subscribers call MRMIB directly, MRMIB staff serves as an ombudsman assisting subscribers with the grievance process.

MRMIB requires all HFP participating plans to report benefits-related grievances once a year. In addition, MRMIB tracks all complaints directly received from subscribers, and any publicly available information on the number and type of benefit grievances filed by subscribers enrolled in a participating plan. Grievance information is used by MRMIB to identify problem areas and to take appropriate steps towards improvements.

MRMIB complies with 42 CFR 457.1120(a)(2)(b) using the statewide review system which is required of all health care service plans operating in California, including HFP and C-CHIP participating plans. This system is enforced by the California Department of Managed Care (DMHC). The statewide review system provides an impartial review of any health care service eligible for coverage and payment under a health plan contract. The issues that are handled through this process include:

- Accessibility
- Coverage/Benefits Disputes
- Appeals of Denials of Care/Payment
- Quality of Care

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- Billing and Financial
- Attitude and Service

These issues handled through the statewide review system are consistent with the issues that would otherwise be addressed by 42 CFR 457.1130(b).

Premium Assistance Programs

- 12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.**

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Healthy Families Benefit Package and Co payments

Overview of the Comprehensive Healthy Families Benefit Package

California plans to have a comprehensive, coordinated benefit package for its Healthy Families enrollees. The central component is the health plan benefits under the benchmark coverage, CalPERS, the state employee benefit package. The benchmark plan will be augmented with comprehensive dental and vision benefits. Furthermore, the coordinated benefit package includes screening and initial treatment services provided through the CHDP program. Services needed by “special needs” children, but not provided by health plans, will be provided through a specialized delivery system under the CCS program. Mental health services provided severely emotionally disabled children will be provided through the county mental health departments with referral and coordination with the health plans. This component is similar to the provisions of the Federal Balanced Budget Act which excluded severely ill children from mandatory enrollment in Medi-Cal managed care. California will also provide comprehensive benefits to targeted low-income children who are eligible for Medi-Cal or the Access for Infants and Mothers (AIM) program. AIM’s health benefit package resembles the CalPERS benchmark plan while Medi-Cal’s benefit package is consistent with coverage currently provided under the state’s Title XIX plan.

Healthy Families Insurance Component

Purchasing pool health benefits.

California will use the state employees’ health benefit package – CalPERS – as the benchmark plan under Title XXI. The basic scope of benefits offered by participating health plans will include all of the benefits and services listed in this section, subject to the identified exclusions. No other benefits will be permitted to be offered by a participating health plan as part of the program. There will be no annual or lifetime financial benefit maximums for any health benefits covered. The basic scope of benefits includes:

- Health Facilities
 - Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. Includes all medically necessary ancillary services such as: use of operating room and related facilities, intensive care unit and services; drugs, medications, and biological; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy (subject to visit

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limitations under the Physical/Occupational/Speech Therapy benefit), respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Includes inpatient hospital services in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Excludes services of dental or oral surgeon.

Excludes: Personal or comfort items or a private room in a hospital unless medically necessary.

- **Outpatient Services:** Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes: physical, occupational, and speech therapy as appropriate; and those hospital services which can reasonably be provided on an ambulatory basis. Includes related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber's stay at the facility.

Includes outpatient services in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Excludes services of the dentist or oral surgeon.

- **Professional Services:** Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Includes surgery assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary.
- Hearing tests and eye examinations, including eye refractions to determine the need for corrective lenses, and dilated retinal eye exams for the treatment of diabetes.
- **Immunizations:** Immunizations consistent with the most current Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics, and the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians. Immunizations required for travel as recommended by the US Public Health Services. Other immunizations

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for adults as recommended by the US Public Health Services. Immunizations, such as Hepatitis B, for subscribers at occupational risk as recommended by the Immunization Practice Committee, US Public Health Services.

- Periodic health examinations; including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices and the American Academy of Family Physicians.

The frequency of such examinations shall not be increased for reasons which are not related to the medical needs including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

- Well baby care: Care up to the age of 24 months, including newborn hospital visits, health examinations and other office visits.
- Diagnostic X-ray and Laboratory Services: Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, and mammography for screening or diagnostic purposes.

Including laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL, and Hemoglobin A-1C (Glycohemoglobin).

- Prescription Drugs: Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication (including insulin), needles and syringes necessary for the administration of the covered injectable medication, blood glucose testing strips in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes, ketone urine testing strips for type I diabetes, and lancets. Also includes prenatal vitamins and vitamins with fluoride which require a physician's prescription.

Includes laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).

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Medically necessary drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when provided through a participating pharmacy.

Health plan may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The Program encourages formulary, maximum allowable cost (MAC), and mail order programs.

Coverage must be provided for one cycle or course of treatment of smoking cessation drugs per benefit year. The health plan must also require the member to attend smoking cessation classes or programs in conjunction with the use of smoking cessation drugs.

Contraceptive Drugs and Devices: Oral and injectable contraceptive drugs are covered including internally implemented time release contraceptives such as Norplant. Contraceptive devices such as diaphragms are covered.

Excludes: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc.; or medicines not requiring a written prescription order (except insulin); and dietary supplements, appetite suppressants or any other diet drugs or medications.

- Durable Medical Equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. Rental or purchase as determined by the plan for standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Includes oxygen and oxygen equipment, blood glucose monitors, and apnea monitors, insulin pumps and all related necessary supplies, ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines.

Excludes coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment, or more than one piece of equipment that serves the same function.

Orthotics and prosthetics are covered, including medically necessary replacement prosthetic devices as prescribed by a physician and medically necessary replacement orthotic devices when prescribed by a physician or ordered by a licensed health care provider acting within the scope of his or her license. Includes coverage for the initial and subsequent prosthetic devices and

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installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetes consistent with Medicare coverage guidelines.

Excludes: Corrective shoes and arch supports, except for therapeutic footwear for diabetics consistent with Medicare coverage guidelines, non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts, dental appliances; electronic voice producing machines; or more than one device for the same part of the body.

Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens. The benefit shall be consistent with Medicare coverage guidelines.

- Maternity Care: Medically necessary professional and hospital services relating to maternity care including: pre-natal and post-natal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized.
- Family Planning: Voluntary family planning services including counseling, surgical procedures for sterilization, and the provision of diaphragms and other contraceptive devices. Contraceptive drugs are covered under the prescription drug benefit.
- Medical Transportation Services: Emergency ambulance transportation in connection with life threatening emergency services to the first hospital or urgent care center which actually accepts the subscriber for emergency care.

Non-emergency ambulance transportation for the transfer of a subscriber from a hospital to another hospital or facility to home when:

- Medically necessary, and
- Requested by a plan provider, and
- Authorized in advance by the participating health plan.

Excludes: Coverage for transportation by airplane, passenger care, taxi or other form of public conveyance.

- Emergency Health Care Services: Twenty-four hour emergency care for alleviation of sudden, serious and unexpected illness, injury or condition requiring immediate diagnosis and treatment both in and out of health plan service area.
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- **Inpatient:** Mental health care when ordered and performed by a participating mental health professional for the treatment of an acute phase of a mental health condition during a certified confinement in a participating hospital. Limit of 30 days per benefit year. Participating health plans may substitute two days of day care for one day of hospitalization, or three or four outpatient visits for one day of hospitalization at their discretion. Plans may provide a mechanism for inpatient hospital care provided under the Mental Health benefit through which applicants may agree to a treatment plan in which each inpatient day may be substituted by two residential treatment days or three day treatment program days.
- **Outpatient:** Mental health care when ordered and performed by a participating mental health professional. Mental health services are limited to evaluation, crisis intervention, and treatment for conditions which are subject to significant improvement through relatively short term therapy. Up to 20 visits per benefit year. Participating health plans may elect to provide additional visits at their option.

Excludes: Services for conditions not subject to significant improvement through relatively short-term therapy including chronic psychosis, chronic brain syndrome, intractable personality disorder and mental retardation.

- **Alcohol and Drug Abuse:**

- **Inpatient:** Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.
- **Outpatient:** Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. Up to 20 visits per benefit year. Participating health plans may elect to provide additional visits at their option.

- **Home Health Services:** Health services provided at the home by health care personnel. Includes visits by RNs, LVNs, home health aides and short term physical, occupational and speech therapy (subject to visit limitations under the Physical/Occupational/Speech Therapy benefit); and respiratory therapy when prescribed by a plan physician.

Home health services are limited to those services that are prescribed or directed by the responsible physician or other authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan to choose the setting for providing the care. Plans should exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice

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among several medically appropriate alternative services or settings.

Excludes: Custodial care and long term physical therapy and rehabilitation.

- **Skilled Nursing Care:** Services prescribed by a plan physician and provided in a licensed skilled nursing facility when medically necessary. Includes: skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy (subject to visit limitations under the Physical/Occupational/Speech Therapy benefit); medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. Limited to a maximum of 100 days per benefit year.

Excludes: Custodial care.

- **Physical, Occupational, and Speech Therapy:** May be provided in medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Limited to short-term therapy for a period not exceeding 60 consecutive calendar days per condition following the date of the first therapy session. Plans must provide additional therapy beyond the 60 days if medically necessary and if the condition will improve significantly.
- **Acupuncture and Chiropractic:** Optional benefits which plans may offer. If offered, the plan must provide a self referral benefit, and cannot require referral from a primary care or other physician or health professional. Limited to a maximum of 20 visits each per benefit year for acupuncture and chiropractic.
- **Biofeedback:** Optional benefit which plans may offer.
- **Hearing Aids and Services:** Audio logical evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for one year period following the provision of a covered hearing aid.

Excludes: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Excludes replacement parts for hearing aids, repair of a hearing aid after the covered one year warranty period, and replacement of a hearing aid more than once in any period of thirty-six months. Also excludes surgically implanted hearing devices.

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- Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood.
- Health Education: Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.
- Hospice: The hospice benefits shall include: nursing care, medical social services, home health aid services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit shall also include: physical therapy, occupational therapy, speech therapy, and short-term inpatient care for pain control and symptom management.

The benefit may include, at the option of the health plan: homemaker services, services of volunteers, and short-term inpatient respite care. The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of six months or less and who elect hospice care for such illness instead of the restorative services covered by the plan.

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

- Transplants: Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants are covered. Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank are covered.

- Any other or enhanced benefits required in Section 1300.67 of Title 10 of the California Code of Regulations.

Excluded Health Benefits: Health benefit plans offered under this program exclude all of the following:

- Any services or items specified as excluded in the basic scope of benefits.
- Any benefits in excess of limits specified in the basic scope of benefits.

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- Services, supplies, items, procedures or equipment, which are not medically necessary unless otherwise specified in the basic scope of benefits.
- Any services which are received prior to the subscriber's effective date of coverage except those covered through the presumptive eligibility process conducted at CHDP provider offices.
- Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:
 - Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or
 - Outmoded or not efficacious.
- Emergency facility services for non-emergency conditions.
- Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery.
- Treatment for infertility. Infertility is defined as a diminished or absent ability to conceive, and subsequently produce, offspring after unprotected sexual relations on a regular basis in excess of a period of twelve months. This section does not exclude treatments of medical conditions of the reproductive system.
- Long-term care benefits including long-term skilled nursing care in a license facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided in the basic scope of benefits.
- Conditions resulting from acts of war (declared or not).
- Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker's Compensation benefit plan.
- Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided in the basic scope of benefits.
- Services which are eligible for reimbursement by insurance or reimbursable under any other

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group or health service plans. The participating health plan shall provide the services at the time of need, but the subscriber or applicant shall execute such documents as necessary to assure that the participating health plan is reimbursed for such benefits.

Enrollee Share of Cost for Health Benefits.

- In any benefit year that the applicant has paid \$250 in health benefit copayments for services received by subscribers for whom the applicant applied to the program on behalf of, the children shall be deemed to have met the copayment maximum.
- No deductibles shall be charged to subscribers for health benefits.
- The following specific copayments shall apply:
 - Inpatient facility services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.
 - Inpatient professional services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility. No copayment.
 - Facility services on an outpatient basis: No copayment, except for a \$5 copayment per visit for Emergency Health Care Services.
 - Outpatient professional services: \$5 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.
 - Outpatient mental health: \$5 copayment per visit. Participating health plans may provide mental health group therapy visits performed at a reduced copayment.
 - Home health care: No copayment except for \$5 per visit for physical, occupational, and speech therapy visits performed in the home.
 - Alcohol and drug abuse: No copayment for inpatient services. \$5 per visit for outpatient services.
 - Hospice: No copayment for any services provided under this benefit.
 - Transplants: No copayment for any services provided under this benefit.
 - Physical, occupational, and speech therapy: No copayment for therapy performed on an

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inpatient basis. \$5 copayment per visit for therapy performed on an outpatient basis.

- Biofeedback, acupuncture, and chiropractic visits, when offered at the participating health plan's option: \$5 copayment per visit.
- Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services: durable medical equipment, prosthetics and orthotics; blood and blood products; medical transportation services. No copayment.
- Hearing Aids: No copayments.
- Prescription Drugs: No copayment for prescription drugs provided in an inpatient setting or for drugs administered in the doctor's office in an outpatient facility setting during the subscriber's stay at the facility. \$5 per prescription for up to a 30-34 day supply for brand name or generic drugs, including smoking cessation drugs.

Maintenance drugs, including oral and injectable contraceptives: \$5 per 90-100 day supply either through a participating health plans participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

Norplant - \$100 copayment. No refund if medication is removed.

Contraceptive devices - \$5 copayment per device.

- Preventive services, including services for the detection of asymptomatic diseases, as defined by Title 10, Section 1300.67(f) of the California Code of Regulations, shall be provided with no copayment. These include:
 - Periodic health exams;
 - A variety of voluntary family planning services;
 - Prenatal care;
 - Vision and hearing testing;
 - Immunizations;

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- Venereal disease tests;
- Cytology examinations on a reasonable periodic basis, and
- Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the participating health plan or health care organizations affiliated with the participating health plan.
- No copayment shall be charged to subscribers under 24 months of age for well baby care, health examinations and other office visits.

Purchasing Credit Coverage.

Have benefits provided under the insurance purchasing credit will have at least 95% actuarial equivalence to the benefits available to subscribers through the purchasing pool (exclusive of dental and vision) and the coverage can cost the family no more than coverage through the pool. The determination of actuarial equivalence will be made by an actuary under contract to the MRMIB who is certified by the American Academy of Actuaries. Health plan's actuaries will be consulted during the actuarial equivalence evaluation. Where the dependent coverage available to an employee has less than 95% actuarial equivalence, the program will provide the employee with supplemental coverage to adjust the coverage to at least the 95% level. The supplemental coverage will adjust cost-sharing levels if an adjustment is necessary to assure the cost-sharing levels are equivalent to those charged through the purchasing pool. Dental and vision coverage will be provided through the purchasing pool.

Dental Benefit Package

The basic scope of benefits offered by a participating dental plan shall include all of the benefits and services listed in this section, subject to the identified exclusions. The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefit. Participating dental plans may not subject enrollees to waiting periods for receipt of specified benefits.

No other dental benefits shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

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- Diagnostic and Preventive Benefits
 - Initial and periodic oral examinations.
 - Consultations, including specialist consultations.
 - Roentgenology, limited as follows:
 - Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
 - Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
 - Panoramic film x-rays are limited to once every 24 consecutive months.
 - Prophylaxis services, limited as follows:
 - Not to exceed two in a twelve month period.
 - Topical fluoride treatment.
 - Dental sealant treatments, limited as follows:
 - Permanent first and second molars only.
 - Space maintainers, including removable acrylic and fixed band type.
 - Preventive dental education and oral hygiene instruction.
- Restorative Dentistry
 - Restorations, limited as follows:
 - Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.
 - Composite resin or acrylic restorations in posterior teeth are optional.

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- Micro filled resin restorations which are non-cosmetic.
 - Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.
 - Use of pins and pin build-up in conjunction with a restoration.
 - Sedative base and sedative fillings.
- Oral Surgery
 - Extractions, including surgical extractions
 - Removal of impacted teeth, limited as follows:
 - Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
 - Biopsy of oral tissues
 - Alveolectomies
 - Excision of cysts and neoplasm's
 - Treatment of palatal torus
 - Treatment of mandibular torus
 - Frenectomy
 - Incision and drainage of abscesses
 - Post-operative services including exams, suture removal and treatment of complications.
 - Root recovery (separate procedure).
 - Endodontics
 - Direct pulp capping

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- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal, limited as follows:
 - Re-treatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or re-treatment of silver points overfills, under-fills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
- Apicoectomy
- Vitality tests
- Periodontics
 - Emergency treatment, including treatment for periodontal abscess and acute periodontitis.
 - Periodontal scaling and root planning, and subgingival curettage, limited as follows:
 - Five quadrant treatments in any 12 consecutive months.
 - Gingivectomy
 - Osseous or muco-gingival surgery
- Crowns and Fixed Bridges
 - Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:
 - Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan.
 - Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of

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age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:
 - Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
 - A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a subscriber under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
 - Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
 - Fixed bridges are optional when provided in connection with a partial denture on the same arch.
 - Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
- The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is optional treatment.
- Recementation of crowns, bridges, inlay and onlays.
- Cast post and core, including cast retention under crowns.

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- Repair or replacement of crowns, abutments or pontics.
- Removable Prosthetics
 - Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps, and stress breakers, limited as follows:
 - Partial dentures are not to be replaced within 36 consecutive months, unless:
 - o It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
 - o The denture is unsatisfactory and cannot be made satisfactory.
 - The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
 - A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
 - Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by relines or repair.
 - The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.
 - Office or laboratory relines or rebases, limited as follows:
 - One per arch in any 12 consecutive months.
 - Denture repair
 - Denture adjustment
 - Tissue conditioning, limited to two per denture

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- Denture duplication
- Implants are considered an optional benefit.
- Stayplates, limited as follows:
 - Stayplates are a benefit only when used as anterior space maintainers for children and to replace extracted anterior teeth for adults during a healing period.
- Orthodontic Treatment, limited as follows:
 - Orthodontic treatment shall only be a benefit when it is determined to be medically necessary according to Medi-Cal guidelines. The orthodontic benefit shall include all benefits required under Medi-Cal.
- Other Dental Benefits
 - Local anesthetics
 - Emergency treatment, palliative treatment

Excluded Dental Benefits. The following benefits will be excluded from coverage:

- Services which, in the opinion of the attending dentist, are not necessary to the subscriber's or purchasing credit member's dental health.
- Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the scope of benefits.
- Cosmetic dental care.
- General anesthesia or intravenous/conscious sedation and the services of a special anesthesiologist.
- Experimental procedures.
- Dental conditions arising out of and due to a subscribers employment or for which Worker's Compensation is payable.

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- Services which are provided without cost to the subscriber by State government or an agency thereof, or any municipality, county or other subdivisions.
- Treatment required by reason of war.
- Hospital charges of any kind.
- Major surgery for fractures and dislocations.
- Loss of theft of dentures or bridgework.
- Dental expense incurred in connection with any dental procedures started after termination of coverage.
- Any service that is not specifically listed as a covered benefit.
- Malignancies.
- Dispensing of drugs not normally supplies in a dental office.
- Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the subscriber.
- The cost of precious metals used in any form of dental benefits.
- The removal of implants.
- Services of a pedodontist for children under six years of age unless they are unable to be treated by their panel provider or unless their panel provider is a pedodontist.
- Services which are eligible for reimbursement by insurance or reimbursable under any other group or health service plans. The participating dental plan shall provide the services at the time of need, but the subscriber or applicant shall execute such documents as necessary to assure that the participating dental plan is reimbursed for such benefits.

Enrollee Share of Cost for Dental Benefits. Every participating dental health plan will change copayments for the dental benefits listed in the scope of benefits, as follows:

- No copayments shall be charged for benefits listed under Diagnostic and Preventive Benefits.

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- No copayment shall be charged for benefits listed under Restorative Dentistry, with the following exceptions:
 - Micro filled resin restorations (non-cosmetic, acid etched, bonded, light cured):
 - One surface-\$40
 - Two or more surfaces -- \$65
- No copayments shall be charged for benefits listed under Oral Surgery, with the following exceptions:
 - Removal of impacted teeth is subject to a copayment per tooth as follows:
 - Soft tissue impaction – No copayment.
 - Partially bony impaction -- \$15 copayment per tooth.
 - Completely bony impaction -- \$15 copayment per tooth.
 - Root recovery as a separate procedure -- \$5 per root.
- No copayments shall be charged for benefits listed under Endodontics, with the following exceptions:
 - Root canal therapy is subject to copayments as follows:
 - Single root canal -- \$20
 - Bi-root canal -- \$40
 - Tri-root canal -- \$60
 - Quad-root canal - \$80
 - An Apicoectomy performed in conjunction with root canal therapy is subject to a copayment of \$60 per canal. When performed as a separate procedure, an Apicoectomy is subject to a copayment of \$50 per canal.
- No copayments shall be charged for benefits listed under Periodontics, with the following

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exceptions:

- Osseous or muco-gingival surgery is subject to a copayment of \$150 per quadrant.
- Gingivectomy is not subject to a copayment by quadrant or by tooth.
- No copayments shall be charged for benefits listed under Crowns and Fixed Bridges, with the following exceptions:
 - Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or $\frac{3}{4}$ crowns; are each subject to a copayment of \$50.
 - Pontics: Tru-pontic type; cast (sanitary); and porcelain baked with metal; are each subject to a copayment of \$50. No copayment shall be charged for pontics made of plastic processed to gold.
- No copayments shall be charged for benefits listed under Removable Prosthetics, with the following exceptions:
 - Dentures are subject to copayments as follows:
 - Complete maxillary denture -- \$65
 - Complete mandibular dentures -- \$65
 - Partial upper or lower dentures with clasps -- \$65
 - Partial upper or lower denture with chrome cobalt allow lingual or palatal bar, clasps and acrylic saddles -- \$65
 - Removable unilateral partial denture -- \$50
 - Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:
 - Office reline – No copayment
 - Laboratory reline -- \$15
 - Denture duplication -- \$20

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- No copayments shall be charged for benefits listed under Orthodontia.
- No copayments shall be charged for benefits listed under Other.
- The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.
- Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist, the copayment is equal to 50% of the pedodontist's fee.
- A fee of \$5 shall be charged for failure to cancel an appointment with 24 hours prior notification.

Vision Benefit Package

The basic scope of benefits offered by a participating vision plan as a vision benefit plan shall include all of the benefits and services listed in this section, subject to the identified exclusions. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:

- Examinations: Each subscriber or purchasing credit member shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:
 - Case history: Review of subscriber's or purchasing credit member's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.
 - Evaluation of the health status of the visual system; including:
 - External and internal examination, including direct and/or indirect ophthalmoscopy;
 - Assessment of neurological integrity, including that of papillary reflexes and extraocular muscles;
 - Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;
 - Screening of gross visual fields, and

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- Pressure testing through tonometry.
- Evaluation of refractive status, including:
 - Evaluation for visual acuity;
 - Evaluation of subjective, refractive, and accommodative function, and
 - Objective testing of a patient's prescription through retinoscopy.
- Binocular function test.
- Diagnosis and treatment plan, if needed.
- Examinations are limited to once each twelve month period, which begins with the date of the last exam.
- When the vision examination indicates that corrective lenses are necessary, each subscriber or purchasing credit member is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular lenses as appropriate.

Frames and lenses are limited to once each twelve month period, which begins with the date of the last exam.

- Contact lenses shall be covered as follows:
 - Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for the following conditions:
 - Following cataract surgery;
 - To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
 - Certain conditions of Anisometropia, and
 - Keratoconus
 - Elective contact lenses may be chosen instead of corrective lenses and a frame at an alternative copayment level.

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- Contact lenses are limited to once each twelve month period, which begins with the date of the last exam.
- A low vision benefit shall be provided to subscribers or purchasing credit members who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

The maximum benefit available to a subscriber or purchasing credit member for low vision benefits is \$1,000 (excluding any copayment) in each two year period.

Excluded Vision Benefits: A vision benefits plan offered under this program shall exclude:

- Benefits which are neither necessary nor appropriate.
- Benefits which are not obtained in compliance with the rules and policies of the subscriber's or purchasing credit member's vision plan.
- Vision training.
- Aniseikonic lenses.
- Plano lenses.
- Two pair of glasses in lieu of bifocals, unless medically necessary and with the prior authorization of the vision plan.
- Replacement or repair of lost or broken lenses or frames.
- Medical or surgical treatment of the eyes.
- Services or materials for which the subscriber or purchasing credit member is covered under a Worker's Compensation policy.
- Eye examination required as a condition of employment.
- Services or materials provided by any other group benefit providing for vision care.

Share of Cost for Vision Benefits: A participating vision plan shall require copayments for benefits

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provided to subscribers or purchasing credit members utilizing the services of the vision plan's panel of approved providers subject to the following:

- Examinations: \$10 copayment per examination.
- Frames and lenses: \$25 copayment, for frames with lenses, frames or lenses.

A wholesale frame allowance of \$30 will be provided by the vision plan. If a subscriber or purchasing credit member chooses a frame with a wholesale value above \$30, the provider will bill the subscriber or purchasing credit member the difference between the standard retail value of \$75 for a \$30 wholesale frame and the retail cost of the frame the subscriber or purchasing credit member has selected.

The following options are considered cosmetic and any costs associated with the selection of these options will be financial responsibility of the applicant.

- Blended lenses (bifocals which do not have a visible dividing line);
- Contact lenses except as specified in the scope of benefits;
- Oversized lenses (larger than standard lens blank to accommodate prescriptions);
- Progressive multifocal issues;
- Coated or laminated lenses;
- UV protected lenses.
- Other optional cosmetic processes.
- Necessary contact lenses, as defined in the scope of benefits: no copayment.
- Elective contact lenses: an allowance of \$110 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all benefits including examination and material costs. The subscriber is responsible for any costs exceeding this allowance.
- Low vision benefits:
 - Supplementary testing: No copayment; and

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- Supplemental care: Copayment is 25% of the cost.

- Services from providers not included in the vision plan's panel of approved providers:

When a subscriber or purchasing credit member obtains services from a provider not included in the vision plan's panel for approved providers, the applicant will be responsible for paying the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen days after receipt of the paid itemized bill or statement, when accompanied by the benefit form, according to the schedule of allowances as follows:

- Professional fees:

- Vision exams, up to \$35.00

- Materials:

- Each single vision lens, up to \$12.50
- Each bifocal lens, up to \$20.00
- Each trifocal lens, up to \$25.00
- Each lenticular lens, up to \$50.00
- Frame, up to \$40.00
- Tint allowance, up to \$5.00
- Each pair necessary contact lenses, up to \$250.00
- Each pair elective contact lenses, up to \$110.00

- Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.

Child Health and Disability Prevention

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CHDP Coverage: The Child Health and Disability Prevention Program (CHDP) provide preventive health screens and immunizations to children. At the time a child seeks services with a CHDP provider, the family is required to complete a CHDP application which also serves as an application for presumptive eligibility. The presumptive eligibility period is for the month of application and the following month. All children granted presumptive eligibility receives their services via the Medi-Cal fee-for-service delivery system. Families granted presumptive eligibility are also mailed the joint Medi-Cal/Healthy Families application to complete and return to the state's Single Point of Entry. Applications submitted before the end of the second month of presumptive eligibility are granted on going eligibility until a final eligibility determination is made. These services will not be subject to copayment. CHDP program scope of services includes all of the following:

- History and Physical Examination by Comprehensive Care Provider
 - New Patient – child who has not previously received a health assessment from the examiner, and there is no health assessment record for the child established with the provider.
 - Extended Visit – a visit in which the patient requires as much or more time to be given a health assessment as does a new patient.
 - Routine Visit – a visit in which the patient requires less time than ordinarily needed with a new patient or an extended visit.
- Health and developmental history
- Assessment of nutritional status
- Unclothed physical examination including assessment of physical growth
- Pelvic Exam
- Vision Screening:
Snellen eye test or equivalent visual acuity test.
- Hearing Screening:
Pure Tone Audiometry
- Tuberculin Testing

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- Laboratory Tests:
 - Hematocrit or Hemoglobin
 - Sickle Cell Status (Electrophoresis)
 - Blood Lead Screening
 - Urinalysis, routine, complete or Urine “Dipstick”
 - Culture for Neisseria Gonorrhoea
 - Papanicolaou (Pap) Smear
 - Ova and Parasites, direct smears, concentration and identification
 - Venereal disease research laboratories (VDRL), rapid plasma regain (RPR) and Automated regain test (ART)
 - Chlamydia Test
- Immunizations:
 - DTP (diphtheria and tetanus toxoid with pertussis vaccine)
 - DT (combined tetanus and diphtheria toxoid, pediatric type)
 - Td (combined tetanus and diphtheria toxoid, adult type)
 - Hib (Haemophilus Influenza Type b) vaccine
 - Polio: IPV (inactivated trivalent poliovirus vaccine)
TOPV (trivalent oral poliovirus vaccine)
 - Measles vaccine
 - Rubella vaccine
 - MMR (measles, mumps, rubella) vaccine
 - HBIG (hepatitis B immune globulin) for post-exposure
 - Hepatitis B vaccine
 - Varicella vaccine
 - Hepatitis B/Haemophilus Influenza Type b vaccine
 - DTaP (diphtheria and tetanus toxoid with acellular pertussis vaccine)
 - DTaP/Haemophilus Influenza Type b vaccine
 - DTP/Haemophilus Influenza Type b vaccine
 - Pneumococcal vaccine
 - Influenza vaccine

Specialized Services

Mental Health Coverage for Emotionally Disturbed Youth

Health plans will develop memoranda of understanding with county mental health departments for

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treatment of serious emotional disturbances. “Seriously emotionally disturbed children or adolescents” are minors who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child’s age according to expected developmental norms. Members of this target population meet one or more of the following criteria:

- As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - The child is at risk of removal from home or has already been removed from the home.
 - The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
- The child meets special education eligibility requirements under California law.

Seriously emotionally disturbed children or adolescents will have access to the following scope of benefits:

- *Acute Psychiatric Inpatient Hospital Services.* Services are provided by a hospital to beneficiaries who need facilities, services and equipment for diagnosis or treatment of a mental disorder. The determination of the need for acute care shall be made in accordance with existing law. An acute patient shall be considered stable when no deterioration of the patient’s condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the hospital.
- *Administrative Day Service.* Psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary’s stay at the hospital must be continued beyond the beneficiary’s need for acute psychiatric inpatient hospital services due to a lack of residential placement options at appropriate, non-acute treatment facilities.
- *Adult Residential Treatment Service.* Rehabilitative services, provided in a non-institutional residential setting, which provide a therapeutic community including a range of activities and services for beneficiaries who would be at risk of hospitalization or other institutional placement

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if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation and collateral.

- *Crisis Residential Treatment Service.* Therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program for beneficiaries as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.
- *Crisis Intervention.* A service, lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis intervention is distinguished from crisis stabilization by being delivered by providers who are not eligible to deliver crisis stabilization or who are eligible, but deliver the service at a site other than a provider site that has been certified by the Department or a Mental Health Plan to provide crisis stabilization.
- *Crisis Stabilization.* A service lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis stabilization must be provided on site at a 24 hour health facility or hospital-based outpatient program or at other provider sites which have been certified by the Department or a Mental Health Plan to provide crisis stabilization services.
- *Day Rehabilitation.* A structured program of rehabilitation and therapy to improve, maintain or restore personal independence and functioning consistent with requirements for learning and development which provides services to a distinct group of beneficiaries and is available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.
- *Day Treatment Intensive.* A structured, multi-disciplinary program of therapy which may be an alternative to hospitalization, avoid placement in a more restrictive setting, or maintain the beneficiary in a community setting, with services available at least three hours and less than twenty-four hours each day the program is open. Service activities may include, but are not limited to, assessment, plan development, therapy, rehabilitation and collateral.

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- *Medication Support Services.* Those services which include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals which are necessary to alleviate the symptoms of mental illness. The services may include evaluation of the need for medication, evaluation of clinical effectiveness and side effects, the obtaining of informed consent, medication education and plan development related to the delivery of the service and/or assessment of the beneficiary.
- *Mental Health Services.* Those individual or group therapies and interventions that are designed to provide reduction of mental disability and improvement or maintenance of functioning consistent with the requirements for learning, development, independent living and enhanced self-sufficiency and that are not provided as a component of adult residential services, crisis residential treatment services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Service activities may include but are not limited to assessment, plan development, therapy, rehabilitation and collateral.
- *Psychiatric Health Facility Services.* Therapeutic and/or rehabilitative services provided in a non-hospital psychiatric health facility on an inpatient basis to beneficiaries who need acute care and whose physical health needs can be met in an affiliated hospital or in outpatient settings. The determination of the need for acute care shall be made in accordance with Section 1820.205. An acute patient shall be considered stable when no deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the psychiatric health facility.
- *Targeted Case Management.* Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure a beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; and plan development.

California Children's Services

The CCS benefit package provides those services that are medically necessary for the diagnosis or treatment of a CCS-eligible illness, injury or medical condition. Medically necessary services also include those services, in accord with accepted medical standards of practice, which promote optimum health and improve, maintain or prevent deterioration of function. The program does not provide long-term institutional care (e.g., nursing home facility, pediatric subacute facility) or long-term hourly nursing services in the home.

It requires children with long-term conditions to receive ongoing medical care at special care centers

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and reimburses those centers for the additional case coordination and staffing management required by CCS. CCS also pays for assisting a family in accessing medical care (transportation costs, meals and lodging). Scope of services includes all medically necessary diagnostic assessments, treatment, rehabilitation, and follow up care in addition to those case management and other services that are necessary for the treatment of the CCS eligible condition. The California Children Services Program provides the following services for children enrolled in the program:

- *Physician services.*
- *Inpatient/Outpatient hospital services.* Inpatient and outpatient hospital services are covered for the treatment of the condition including medical and surgical procedures and rehabilitative services.
- *Home health agency service provided by a licensed and certified Health Agency.* At a minimum, the following home and community services shall be provided.
 - *Licensed nursing care in the home.* Licensed nursing services provided at the child's place of residence shall be a benefit if there is a need, in the provisions of services to the child, for a licensed nurse to:
 - Perform medical/nursing interventions which require the ability to interpret, evaluate, assess and monitor the child's response to interventions.
 - Identify and evaluate clinical changes which would result in significant ramifications for the child's medical condition, and initiate appropriate medical and/or nursing interventions.
 - Analyze and respond to physiological changes found through monitoring various physiological parameters.
 - Assess parent or other caregiver's ability to manage the child's medical needs in the home and develop a training plan for the caregivers.

These services are authorized on an intermittent basis, with visits lasting two hours or less when prescribed by the CCS authorized providers.

- *Certified home health aide visits.* Services by a home health aide, provided through a home health agency under the supervision of a RN are a benefit when such services are clinically indicated to assist children enrolled in the Pilot Project with the following activities: personal hygiene, such as skin, mouth, hair care and bathing; ambulation; prescribed exercises; the use

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of the bathroom, commodes or bedpans, preparation of meals and the performance of household services which will facilitate the care in the home; and/or performance of other activities as outlined in the plan of care and taught by a health professional for a specific child or adolescent. Such services are required when they can not reasonably be expected to be performed by the child's caretaker because of the caretaker's illness, medical condition and/or recovery from injury.

- *Physical and occupational therapy.* Physical and occupational therapy services are a benefit in the home when clinically indicated and the instability of the child's medical condition prohibits the child from accessing those services through an outpatient medical facility, private practitioner's office or a CCS medical therapy unit.
- *Other licensed and non-licensed services.* Other licensed and nonlicensed services provided by a home health agency, including medical social services and home infusion therapy, are a benefit when the requested service(s) is to treat a child's medical condition, is requested by the CCS approved physician authorized to provide care, and can be provided safely in the child's place of residence.
- *Medical transportation.* The CCS Program provides emergency transportation by ground ambulance when it is needed to access medically necessary care in an emergency situation. CCS also provides emergency transportation by air ambulance when the enrolled child's condition requires rapid transport, when it is a reasonable alternative to ground transport (due to distance and/or time required) or when air transport is less costly.

CCS will provide non-emergency transport by ambulance or wheelchair van and litter van when there is documentation that the child's medical condition warrants the use of one of these types of transport rather than private car or public transportation. CCS will also provide this method of transportation when an enrolled child is to be transferred from a tertiary care facility for inpatient care in a lower level facility in his/her own community or nearer to his/her community.

- *Second opinions.* CCS provides access to second opinions from CCS paneled specialty or sub-specialty providers.
- *Pediatric specialist services:* CCS provides pediatric specialist and sub-specialist services as required for the appropriate diagnosis and/or treatment of medical conditions.
- *Special care center (SCC) services.* CCS provides SCC services for those children whose medical condition and/or complicating conditions require referral to and treatment by a CCS approved SCC.

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A CCS approved SCC provides a coordinated multi-disciplinary, multi-specialty team approach to the assessment and management of children with chronic, complex medical conditions. A center's core team includes a medical director (a specialist in treatment of medical conditions seen at the center), a nurse specialist, and a social worker. A team also frequently involved the consultation of a dietitian, as well as other appropriate pediatric medical and surgical specialists and sub-specialists.

The services provided by the centers include:

- Initial and periodic comprehensive outpatient evaluations by health care professionals on the center team.
- Diagnostic services when there is a need to establish the presence of a CCS eligible condition or the status of the eligible condition.
- Treatment services provided or requested by CCS-paneled physician team members to manage a child's CCS eligible condition. These can include pharmaceuticals, durable medical equipment, and medical supplies.
- Initial and periodic team conferences to coordinate decision making and health care services identified by team members as needed by the child.
- Outpatient laboratory and/or radiology services as ordered by the CCS-paneled physician team members.
- *Organ transplantation services.*
 - Heart, Lung, Heart/Lung, Liver, Small Bowel or Bone Marrow Transplants. CCS refers children thought to require heart, lung, heart/lung, liver, small bowel, or bone marrow transplants to a Medi-Cal approved organ transplant center for the comprehensive evaluation of the need for the transplant. CCS will be responsible for the costs of this evaluation.
 - DHS (CMS Branch) reviews and determine the medical eligibility for the transplant;
 - Coordinate pre and post transplant services; and
 - Assists the family with necessary support services during the entire process.
 - Renal and Corneal Transplants

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- Children requiring renal transplants will be referred to a CCS approved renal center for care and evaluation of the need for a transplant.
- Children requiring corneal transplants will have that care provided under the direction of a CCS paneled ophthalmologist.

- *Pharmacy services.*

- Licensed pharmaceuticals

CCS provides all drugs licensed by the Federal Food and Drug Administrations that are necessary as part of the child's plan of treatment.

- Investigational Drugs

CCS provides for providing for investigational new drugs on an inpatient/outpatient basis when there is documentation that the drug has the approval of the Federal Food and Drug Administration as a treatment investigational new drug.

- Unlabeled Use of Drugs

CCS will authorize the un-labeled use of drugs when the requested unlabeled use represents reasonable and current prescribing practice, as determined by reference to current medical literature and consultation with provider organizations, academic and professional specialists and sub-specialists.

- Over-the-counter medications

CCS provides over-the-counter medications when the dosage required to treat the CCS eligible condition exceeds normal dosages and/or length of use for the over-the-counter medication.

- Enteral/parenteral nutrition

CCS provides parenteral solutions, replacement formulas, calorie dense formulas and additives when they are required in the medical management of a CCS eligible condition or would otherwise be a Medi-Cal benefit, e.g., a child of normal height and weight with no increased caloric needs who is nourished by the tube feeds only.

- Medical foods

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CCS provides medical foods which are specifically formulated to be consumed or administered internally, purchasable only through a pharmacy, intended for the specific dietary management of a CCS eligible condition for which specific nutritional requirements exist, and where medical/health problems can occur by consuming regular foods available in the grocery store.

- *Dialysis.* CCS provides either hemodialysis or peritoneal dialysis, when it is medically necessary.
- *Durable medical equipment (Rehabilitative).* CCS provides standard and custom durable medical equipment required for mobility, community access and independence in the home environment. This equipment may include, but will not be limited to, tilt wheelchairs, power chairs, walkers, commodes, positioning equipment, custom wheelchairs, custom wheel chair seating, custom motorized wheelchair bases and batteries. All repairs, replacements due to growth and/or new technology, maintenance, family training and follow up on the use of the equipment are also covered by CCS.
- *Durable medical equipment (Medical).* CCS provides medical, including respiratory, equipment required for the treatment of the child's medical conditions in the home. Such equipment may include, but is not limited to, apnea monitors, glucometers, infusion pumps, kangaroo pumps, ventilators, suction machines, gaseous and/or liquid oxygen, specialty beds and mattresses. CCS provides emergency back up equipment, maintenance of the equipment and family training in the use of the equipment.
- *Medical supplies:* CCS will provide those supplies that are necessary for treatment of medical conditions within the home, including those supplies that are necessary for the administration of prescribed pharmaceuticals. The supplies shall include, but are not limited to, gauze pads, syringes, infusion sets, and catheters.
- *Incontinence supplies.* CCS will provide diapers when a child is under five years of age and the use of diapers is medically necessary and exceeds the normal use by a child of the same age, or, a child is five years of age and older and the diapers are medically necessary.
- *Prosthetics and orthotics.* CCS provides prosthetics and orthotics. Orthotics are those devices required to correct or prevent deformity, to replace a body function and/or for positioning. Prosthetics are those devices utilized to replace or enhance a body part of function. These items shall include, but are not limited to, dynamic splints, shoes, braces, artificial arms and legs.

CCS arranges for orthotics repairs, adjustments and/or replacements necessary for growth or new technology; usage training, as well as routine clinical check ups by appropriate clinicians.

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- *Augmentative and alternative communication devices.* CCS is responsible for providing electronic or non-electronic aids, devices, or systems (in a form most appropriate for the child) that correct an expressive communication disability that precludes effective communication and precludes meaningful participation in daily activities. CCS provides an assessment by a CCS-paneled speech/language pathologist, in conjunction with either an occupational or physical therapist, to determine the necessity and appropriateness of a device. In addition, speech therapy is provided after delivery of the device.

CCS provides the necessary components, including computer software programs, symbol sets, overlays, mounting devices, switches, cables connectors and output devices, supplies, training in the use of the device and device repair, and modification.

- *Vision services.* CCS provides eye examinations when required for a CCS-eligible, medical condition including refraction, eyeglasses, contact lenses, low vision aids, prosthetic eyes and other eye appliances. Shatter resistant eyewear will be provided when there is absence of vision in one eye or one eye is absent.

- *Therapies*

- *Speech and language*

CCS provides speech therapy services for those children in whom a difficulty in speech accompanies and/or complicates the treatment of a CCS eligible condition. Such conditions include, but are not limited to orofacial anomalies, including cleft palate, speech defects, significant dysarthria or communication disorders associated with hearing impairment; loss of acquired voice speech or language due to head trauma; or loss of acquired voice, speech or language due to physiologically based disease process.

CCS provides speech and language therapy services for school-aged children when the medically necessary services are not available through the local special education agency or when the level if the intensity of services and/or the expertise required for the services is inappropriate for school therapists to administer.

- *Physical and Occupational Therapy*

CCS provides outpatient physical and occupational therapy when:

- Short-term physical and/or occupational therapy, with defined time-limited goals, is necessary to improve functional skills, eliminate the need for the extension of a patient

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stay and/or to prevent rehospitalization or

- Long-term physical and/or occupational therapy, with time-limited and frequently monitored goals, is necessary to maintain or prevent deterioration of functional skills.

- Oral motor feeding training

CCS provides oral motor feeding training when the oral motor feeding difficulty is related to the CCS eligible condition and the training is anticipated to result in adequate nutrition being provided only through oral feeding efforts.

- *Audiology*

- CCS is responsible for providing audiology services for enrolled children with hearing loss, including examination by a paneled otolaryngologist, audiological assessment by an approved hearing and speech center, and a speech/language evaluation by a paneled speech/language pathologist.

- If the child is a candidate for amplification, CCS provides:

- Hearing aids
- Hearing aids accessories, including cords, receivers, ear molds and batteries
- Assistive listening systems including FM systems
- Repairs and replacements of authorized equipment
- Aural rehabilitation services
- Periodic evaluation by approved hearing and speech center.

- *Cochlear implants.*

- Cochlear implants will be provided to children 18 months through 20 years of age (infants with acquired deafness secondary to meningitis are an exception to this age limit) with:
 - Diagnosis of bilateral sensorineural deafness with a loss of 90dB or greater in the speech range frequencies

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- An accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the CNS, as demonstrated by CT scan or other appropriate radiologic evaluation
 - No infection or other active disease of the middle ear
 - No contraindication to anesthesia and surgery
 - Cognitive ability to use auditory clues, as based on speech perception tests, communication skills assessment, language evaluation, reports from educational specialists, and educational/psychological assessments
 - Motivation of a candidate and/or commitment of family and/or caregivers, including a realistic expectation by the child and/family of the outcomes
 - A reasonable expectation by treating providers that the implant will confer awareness of speech at conversational levels
 - A recommendation from an approved cochlear implant facility.
- CCS provides:
 - The pre-cochlear implant evaluation, to include audiology testing, speech pathology assessments, psychological assessments, otolaryngological evaluation and team conferences.
 - Cochlear implant surgery for an enrolled child who meets the criteria above, that includes the physician services, the hospital stay, intraoperative nerve monitoring, electromyography and the cost of the device.
 - The post-cochlear implant services, that include implant orientation, implant mapping and processor programming, speech perception tests, audiological sound field tests, test assistant, speech and language evaluations at intervals following the implant and aural/oral rehabilitation services.
 - *Laboratory services.* CCS provides all laboratory services necessary for the diagnosis and ongoing monitoring of care and treatment
 - *Radiology services:* CCS provides all diagnostic, interventional and therapeutic radiological procedures necessary for the diagnosis, ongoing monitoring of care and treatment in x-ray,

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ultrasound and magnetic resonance imaging.

- *Medical nutrition therapy.* CCS provides medical nutrition therapy by a registered dietician that includes nutritional assessment and the development and implementation of a therapy plan.
- *Mental health.* CCS provides mental health services to include:
 - A psychological evaluation, which may include the parents and/or legal guardian, provided as part of a child's treatment services, when the possible psychological symptoms are considered by the CCS approved physician to be complicating the management of the CCS eligible condition and the psychological evaluation has been determined to be medically necessary.
 - Out-patient psychotherapy for a child when, after review of the medical records, it is found necessary to treat an intercurrent mental disorder complicating the treatment of an eligible medical condition, requested by the child or parents, and determined to be medically necessary by a CCS approved physician.
 - Referral to the county mental health plan for all other mental health services.
- *Other services and equipment.* Any other medically necessary services or equipment which promote optimum health and improve, maintain or prevent deterioration of function.
- *Out-of-state care.* CCS provides care out-of-state when medically-necessary care is not available within the State of California.
- *Investigational services.* CCS provides those drugs, equipment, procedures or services for which laboratory and animal studies have been completed and for which human studies are in progress when it is documented that the following conditions have been met:
 - Conventional therapy will not adequately treat the child's condition.
 - Conventional therapy will not prevent progressive disability or premature death
 - The provider of the proposed service has a record of safety and success with the service or procedure equal to that of other providers of the investigational services.
 - The investigational service is the lowest cost item that meets the client's medical needs and is less costly than all conventional alternatives.
 - There is reasonable expectation that the investigational service will significantly prolong the

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patient's life or will maintain or restore a range of physical and social function suited to activities of daily living.

- The service is not being performed as part of a research study protocol.
- *Dental services.* Dental care for those children whose CCS eligible condition makes dental care difficult, directly causes a dental problem and/or the nature or severity of the eligible condition makes the care of a necessary part of the management of the condition. These conditions include, but are not limited to:
 - Complex congenital heart disease;
 - Seizure disorders;
 - Immune deficiencies;
 - Cerebral palsy;
 - Hemophilia;
 - Malignant neoplasms, including leukemia;
 - Status post organ transplant.

AIM Benefit Package

AIM coverage. Health coverage under the AIM program is virtually identical to that available through the state employee's benchmark health plan. AIM does not cover dental or vision benefits. However, AIM has more restrictive mental health coverage (10 inpatient days), because the state views this benefit as not germane to a child of 0-1.

Medi-Cal Benefit Package

Medi-Cal coverage. Coverage under Medi-Cal will be consistent with that provided under California's Title XIX state plan.

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HFP/C-CHIP Premiums

Program	Premium Amount	Payments Due Monthly/Quarterly	Discounts
HFP	\$4 - \$9 per month per child (\$27 maximum per month)	Monthly	Pay 3 months get the 4 th free; 25% discount if paid by EFT
Alameda County	\$10 per month per child (no maximum per month)	Monthly	
San Francisco County	\$4 per month per child (no maximum per month)	Quarterly	Pay 3 quarters get the 4 th quarter free
San Mateo County	\$12 per month per child (no maximum per month)	Quarterly	Pay 3 quarters get the 4 th quarter free
Santa Clara County	\$6 per month per child (\$18 maximum per month)	Monthly	Pay 3 months get the 4 th month free

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