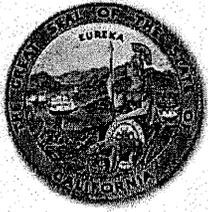


Responses to the Administration's Proposal to Eliminate the Board and the Transition of  
It's Programs to the Department of Health Care Services

# State of California HEALTH AND HUMAN SERVICES AGENCY



DIANA S. DOOLEY  
SECRETARY

## **BENEFITS OF SHIFTING HEALTHY FAMILIES CHILDREN TO MEDI-CAL**

The Governor proposes to shift all Healthy Families Program members into Medi-Cal over a six-month period beginning in January 2012. Approximately 892,000 eligible beneficiaries will move to Medi-Cal in phases between January and June of 2012. This transition will create benefits for our children and families, health plans and providers, and the state.

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Development

This proposal will simplify eligibility and coverage for children and families while providing additional benefits and lowering costs for children at certain income levels. The state will gain administrative efficiencies, achieve general funds savings, and provide a more consistent health plan contracting process while increasing plan accountability for providing high quality services to children.

Now is the time to take this important step to improve coverage for children in advance of federal health care reform. The state must implement many changes before 2014 including a new online enrollment process, new eligibility rules, and expansion of coverage to newly eligible adults. If the state delays taking this important step, we may jeopardize the success of implementing other major reforms.

Many details will need to be worked out once this proposal is enacted including all the steps necessary to ensure a streamlined enrollment and reenrollment process and ensuring continuity of providers. The Administration looks forward to collaborating with stakeholder partners over the coming months to ensure a successful transition of children from Healthy Families to Medi-Cal.

## **BENEFITS TO CHILDREN AND FAMILIES**

**Simplified coverage programs and unified family coverage.** Enrollment for children will be simplified with a unified program of coverage for all eligibles up to 250% FPL. This will facilitate continuity of coverage when a family's income fluctuates as the children will no longer have to transition between the two programs. Approximately 42% of children eligible for Healthy Families in 2009-10 were eligible for Medi-Cal at some time over the previous three years. This proposal will also allow children to remain in the same coverage program as their parents.

**No wrong door to eligibility.** Families will be able to apply for coverage at a county, by mail, or on-line and will not have their application bounced between programs facilitating a consumer friendly enrollment process.

**Reduced cost sharing.** Children at or below 150% of the federal poverty level (FPL) will no longer pay premiums. Families with income between 134% and 150% FPL currently pay a \$7 monthly premium for one child or a \$14 premium for two or more children enrolled in Healthy Families.

**Expanded Benefits.** Children will receive retroactive coverage for three months prior to their application. Children will also be eligible for free Vaccines for Children, a federal program that provides free vaccines to doctors who serve eligible children 0 through 18 years of age. This will improve access to vaccines since providers will not have to purchase and distribute.

**Significant provider continuity.** It is expected that children will be able to remain with their existing provider during this transition as plans contract with providers for both Medi-Cal and Healthy Families whenever possible or appropriate. Updated data show that 73% of members match to a health plan that currently participates in both Medi-Cal and Healthy Families. Prior data did not account for additional overlap with health plans that subcontract with Medi-Cal. For the remaining 27% of children who do not match to a plan or must move into fee for service (50,000 children), the Department of Health Care Services (DHCS) and the plans will attempt to link these children to their existing provider.

**More stable plan choices.** There has been a significant decline in commercial health plans participation in Healthy Families in many counties. For example, Santa Clara County has seen a reduction in Healthy Families participation from 5 plans to 3 plans over the past three years. By consolidating Healthy Families and Medi-Cal, members will have more stable plan choices.

### **BENEFITS TO PLANS AND PROVIDERS**

**Simplified contracting.** Plans and providers currently manage two different contracts (one with DHCS and one with MRMIB) that have different requirements, quality measures and deliverables. Plans must also respond to different regulations, audits and compliance documents creating additional administrative burden for them.

**Simplified benefit administration.** Plan's relationship with behavioral health, dental and vision services which are managed differently in Healthy Families and Medi-Cal will be simplified and will benefit members who can get caught up in the confusion about Healthy Families and Medi-Cal benefits.

### **ADMINISTRATION EFFICIENCIES AND GENERAL FUND SAVINGS**

**Consolidates health care entitlement programs.** The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Affordable Care Act (ACA) applied federal Medicaid rules and maintenance of eligibility requirements to the Healthy Families Program. The Healthy Families can no longer take certain steps to contain program costs such as implementing waiting lists. The new entitlement nature of the

Healthy Families program calls into the question the value of running two separate programs that must follow virtually the same federal rules. This proposal will consolidate both programs under one department so that duplicate systems and processes can be eliminated to gain administrative efficiencies

**Simplifies administration of two major public coverage programs.** Medi-Cal and Healthy Families serve very similar populations with similar benefits and contract with many of the same plans. Consolidation of the membership into one program will simplify program administration.

**Increases Plan Accountability and Monitoring.** DHCS already requires plans to provide encounter and payment data that Healthy Families current is unable to receive. DHCS will be able to use this data to ensure the state is receiving the best value for the dollars it invests in children's coverage.

**Addresses reduction in Healthy Families purchasing power.** The move of Healthy Families members to Medi-Cal anticipates the required move of children up to 133% FPL in 2014 as required by ACA. Remaining members could be left in a smaller and shrinking Healthy Families Program with implications for their access to care and costs to the state. A smaller Healthy Families Program would likely see a continued exodus of health plans and providers.

**Achieves General Fund savings.** The state would save approximately \$100 million annually because children's coverage costs less in Medi-Cal than in Healthy Families.

#### **FURTHERS THE GOALS OF HEALTH CARE REFORM**

**Aligns with a more consumer friendly and seamless coverage system of 2014.** By consolidating Healthy Families into Medi-Cal, it will reduce consumer confusion since there will be two programs (Medi-Cal and the Exchange) instead of three.

**Serves as early building block for successful implementation of Health Care Reform.** The state must implement many changes before 2014 including a new online enrollment process, new eligibility rules, an expansion of coverage, and the development of the Health Benefit Exchange. Waiting to implement the transfer of Healthy Families to Medi-Cal until 2014 will impede the success of implementing these other major reforms.



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	Program	Budget Issue	LAO Finding Or Recommendation	Last Updated
<a href="#">Go Back</a>	Department of Health Care Services	Transfer Healthy Families Program to Department of Health Care Services	Recommend that the administration's proposal to transfer Healthy Families Program be referred to policy committees. Recommend that the Legislature reject the administration's proposed BBL that would provide DOF with authority to transfer both staff and expenditure authority between appropriations for MRMIB and DHCS just ten days after giving the Legislature notification.	5-22-11

### Detailed Narrative

## Governor Proposes to Transfer Healthy Families Program to the Department of Health Care Services

The Governor's May Revision budget plan includes a proposal to shift children in the Healthy Families Program (HFP) that is administered by the Managed Risk Medical Insurance Board (MRMIB) to the Medi-Cal Program that is administered by the Department of Health Care Services (DHCS).

### Background

Here we provide background information on HFP and Medi-Cal that serves to illustrate some of the similarities and differences between the two programs.

**Medi-Cal.** In California, the federal Medicaid program is administered by DHCS as the California Medical Assistance Program (Medi-Cal). The Medi-Cal Program provides health care services to qualified low-income persons, primarily consisting of families with children, seniors, and persons with disabilities. Federal law establishes some minimum requirements for state Medicaid programs regarding the types of services offered and who is eligible to receive them. Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government.

Medi-Cal provides health care coverage through two basic types of arrangements—fee-for-service and managed care. In a fee-for-service system, a health care provider receives an individual payment from DHCS for each medical service delivered to a Medi-Cal beneficiary. Beneficiaries generally may obtain services from any provider who has agreed to accept Medi-Cal payments. Under managed care, DHCS contracts with health care plans to provide health care coverage for Medi-Cal beneficiaries residing in certain counties. The health care plans undergo quality reviews conducted by DHCS and the Department of Managed Health Care publishes information regarding the plans' quality in an annual *Quality of Care Report Card* that is available to the public on the Internet. In contrast to managed care arrangements, the network of FFS providers is not regularly monitored and measured for quality of care.

Most eligibility determinations and redeterminations for Medi-Cal are performed by counties and generally no premiums are collected from Medi-Cal enrollees.

**Healthy Families Program (HFP).** The HFP is California's federal Children's Health Insurance Program (CHIP) and it provides health insurance for about 892,000 children up to age 19 in families with incomes above the thresholds needed to qualify for Medi-Cal and up to 250 percent of the Federal Poverty Level (FPL). (The FPL is about \$22,000 in annual income for a family of four.) The Managed Risk Medical Insurance Board (MRMIB) administers HFP and provides coverage through a managed care arrangement by contracting with health plans that provide health, dental and vision benefits. Generally, families pay a monthly premium for each child enrolled in HFP and the state and federal government pay the remaining costs. For every dollar the state spends, the federal government provides roughly a two dollar match. The HFP has a tiered premium structure that specifies lower premiums for families under 150 of FPL, and higher premiums for higher-income families.

The MRMIB contracts with a private vendor to do eligibility determinations and perform certain other administrative functions.

**Federal Health Care Reform.** The federal Affordable Care Act (ACA), also referred to as federal health care reform, implements broad changes to the nation's health care system. Among these changes, it requires states to expand Medicaid eligibility for children to 133 percent of the FPL in 2014.

## Proposal Has Merit, But Details Are Lacking

The Governor's proposal would implement the Medicaid expansion for children to 133 percent of FPL required under federal health care reform and take the additional step of transitioning all the remaining HFP enrollees between 133 percent and 250 percent of FPL into Medi-Cal. The federal matching rate for HFP enrollees would continue. In addition, children in families with income less than 150 percent FPL would no longer make premium payments. The administration estimates that state savings would be generated primarily through the state's ability to leverage Medi-Cal's purchasing power by paying lower rates to health plans to provide health coverage.

According to the administration, the net partial-year statewide impact of this proposal is a General Fund savings of \$31.2 million in 2011-12 with ongoing full-year savings of \$75 million in the following years. This budget year net General Fund savings is the result of a reduction of \$108.8 million in the HFP and an increase of \$77.6 million in Medi-Cal expenditures.

**Proposal Has Merit.** We believe certain aspects of the administration's proposal have merit. Some of the potential benefits include the leveraging of the state's purchasing power by consolidating its purchases of health care services, lower premiums and more affordable health coverage for some children, greater continuity of coverage for children when family income changes, and early implementation of changes required by the ACA.

**Details Are Lacking.** The administration has not provided a detailed plan for how the resources for administering HFP would be transferred from MRMIB to DHCS. However the administration has requested Budget Bill Language (BBL) to provide DHCS with the flexibility to implement the reorganization proposal. The proposed BBL would give the Department of Finance (DOF) authority to transfer both staff and expenditure authority between appropriations for MRMIB and DHCS. Prior to authorizing such a transfer DOF would give the Legislature 10 days notification. The notification would include the reasons for the transfer, the fiscal assumptions used in calculating the transfer amount, and any potential fiscal effects on the program from which funds are being transferred.

## Legislature Should Seek More Information

In our view, before going forward with the Governor's proposal, the Legislature needs to receive additional information. Specifically, the Legislature should require the administration to provide a transition plan before it authorizes the administration to move forward. At a minimum, the plan should answer the following questions:

- **What Would the Timeline for the Transition Be?** The DOF should provide a timeline that shows when transfers of positions, expenditure authority and administrative functions between departments would occur.
- **How Would DHCS Be Reorganized?** The DOF should provide a proposal for departmental reorganization that includes: (1) positions that would be eliminated at MRMIB; (2) positions that would be created at DHCS; (3) a revised organization chart for DHCS, and (4) workload description and justification for new DHCS positions.
- **What Efficiencies Would Be Achieved?** The DOF should provide flow charts that show how key work processes transferred from MRMIB would be performed by DHCS. These flow charts should demonstrate any efficiencies that are achieved through the transfer by eliminating redundant steps.
- **What Would the Fiscal Impact Be on MRMIB and DHCS?** The DOF should provide an estimate of the fiscal effect on state operations for MRMIB and DHCS.

## Policy Issues for Legislative Consideration

Here we highlight some policy issues the Legislature may wish to consider in its deliberations.

- **Fee-for-Service May Not Offer Equivalent Care.** The administration estimates that about 49,600 children reside in Medi-Cal fee-for-service counties and these children would receive fee-for-service instead of managed care. Because quality and access to fee-for-service care is not systematically measured, it is difficult to determine whether these children would receive equivalent care after they are shifted into Medi-Cal.
- **Potential Disruption of Service for Some HFP Beneficiaries.** The administration assumes that about 73 percent of the children that transfer into Medi-Cal managed care counties will be able to remain in the same plan in Medi-Cal as in HFP. Accordingly, about 27 percent of the children would switch to a new health plan or fee-for-service and may have to switch to a new primary care physician.
- **Eligibility and Case Management Issues.** The administration has not provided details on how eligibility determinations and other administrative functions would be transitioned from the private vendor that HFP contracts with to the counties. Therefore, it is difficult to assess how such a transition may affect HFP beneficiaries or administrative costs.
- **Interaction With Other ACA Provisions.** As implementation of ACA moves forward, including the development of the California Health Benefits Exchange, the Legislature should consider the merits of a system that would allow for low-income children enrolled in state health programs and their parents to obtain coverage from the same provider.

### Analyst's Recommendation

We recommend that the administration's proposal to transfer HFP beneficiaries into Medi-Cal in 2011-12 be referred to the appropriate policy committees for further consideration. We further recommend that the Legislature reject the administration's proposed BBL that would provide DOF with authority to transfer both staff and expenditure authority between appropriations for MRMIB and DHCS ten days after giving the Legislature notification. However, if the Legislature does provide transfer authority through BBL, we recommend it modify the proposed BBL to require a comprehensive transition plan and at least a 45-day notification period to give the Legislature sufficient time to consider the proposal.

# American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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May 23, 2011

To: Chair Senator Mark DeSaulnier  
Senate Budget Subcommittee On Health and Human Services  
From: American Academy of Pediatrics, California  
Re: Proposed Move of Children from Healthy Families Program to Medi-Cal

Position: (1) Concerns about Rapidity of Significant Child Health Policy Decision occurring in the Budget and (2) Support for Partial Implementation of the Proposal: Moving "Bright-Line" Kids in 2011-2012

The American Academy of Pediatrics, California representing 5,000 California pediatricians (over 80% of board-certified pediatricians statewide) appreciates the opportunity to comment on Governor Brown's 2011-2012 Budget May Revision proposal to transition all children from the Healthy Families Program (HF) to the Medi-Cal program in 2011-2012.

Part of that proposal includes implementing the federal Medicaid expansion for children to 133 percent of the federal poverty level required under federal law now, prior to the federal deadline. These are the so-called "bright line children" that will move out of Healthy Families into Medi-Cal per ACA in 2014, separate from whatever else California may decide to do relative to the structure of children's health care coverage in our state.

**RECOMMENDATION 1: AAP-CA SUPPORTS TRANSITIONING THE "BRIGHT-LINE" POPULATION OF CHILDREN (TO 133% OF FPL) FROM HEALTHY FAMILIES TO MEDI-CAL IN 2011-2012 (AHEAD OF THE FEDERAL DEADLINE) SO THAT CA MAY LEARN FROM THAT EXPERIENCE HOW BEST TO ENSURE ACCESS AND QUALITY OF CARE FOR A LARGER MEDI-CAL POPULATION OF CHILDREN. THIS WOULD PERMIT THE STATE TO REALIZE SOME SAVINGS IN THE 2011-2012 FROM THE EARLY TRANSITION OF WHAT WE UNDERSTAND ARE APPROXIMATELY 200,000 CHILDREN.**

As to the larger proposal to move all Healthy Families kids this coming budget year into Medi-Cal, we applaud the Governor's commitment to streamline government and better serve consumers through a simplified and improved system of care. However, more data and time are needed to be able to determine whether the movement of all these children, as conceived in the May revise, would accomplish either one.

In particular, the Healthy Families Program has been immensely successful, well-received by families and pediatricians in the 11 years it has been in existence. In contrast, the Medi-Cal program, burdened with the much larger and more complex charge of serving adults and children, has struggled to provide access to a medical home for its existing caseload of children. Many private health care providers do not participate in Medi-Cal. Barriers to an expanded physician network and better access in Medi-Cal have included poor reimbursement and an unwieldy bureaucracy/red tape.

We have begun to collect data from our members on the full shift as proposed in the May revise. Responses include identification of significant pluses that would result from the proposal, including (1) that Medi-Cal is an entitlement and Healthy Families is not; and (2) Medi-Cal kids get vaccines fully paid through the federal Vaccines for Children program and Healthy Families do not.

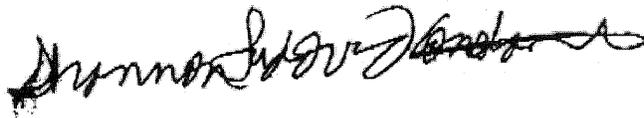
However, potential negatives include that some doctors currently accepting children in Healthy Families state that they are not Medi-Cal providers and will not seek that status if this proposal is enacted. Further, the temporary increase in reimbursement for primary care codes is not stable. This time-limited increase does not seem to be sufficient inducement for many doctors to accept what they perceive to be the other problems with the Medi-Cal program. As such, access has the potential to suffer under the shift, and children may end up in the emergency room for routine care, diminishing any hoped-for savings. There are also significant concerns about dental access under Medi-cal.

The bottom line for AAP-CA is that we require a reasonable period of time in which to learn from our members and to educate them about the various options in order to address the above concerns and questions. Further, we feel this is an opportunity to have a robust discussion regarding children's coverage in California, as we approach health care reform implementation in California, rather than limiting it to an "either/or" Healthy Families versus Medi-Cal. We want to join the state in looking at how to build the best system of care for children that considers integration of existing structures and the possibility of creating new ones. This is not possible in the few months time that we have to meet budget process deadlines.

RECOMMENDATION 2: AAP-CA SUPPORTS CONSIDERATION OF MULTIPLE OPTIONS TO STREAMLINE AND IMPROVE HEALTH CARE FOR CHILDREN IN CALIFORNIA OVER A TIMELINE THAT IS REASONABLE TO COLLECT, ANALYZE AND UTILIZE NEEDED DATA. WE HAVE CONCERNS ABOUT THIS BEING POSSIBLE IN THE BUDGET PROCESS.

We recognize that there is a savings of \$31.2 million attached to this proposal. Part of that will still be realized if the proposal is amended to apply only to "bright-line kids" this first year. However, we also believe that in the foreseeable future the savings achieved by getting this right will also be measurable. AAP-CA is committed to working with the Administration and the Legislature with an open mind to support the best system we can for children under the fiscal realities the state faces.

Sincerely,



Shannon Udovic-Constant  
State Government Affairs Co-Chair, AAP-CA

Wilbert Mason MD MPH

Wilbert Mason, MD  
State Government Affairs Co-Chair, AAP-CA

cc: AAP-CA Executive Board and State Government Affairs Committee



CWDA

May 20, 2011

To: The Honorable Holly Mitchell, Chair  
Assembly Budget Subcommittee No. 1

Honorable Members  
Assembly Budget Subcommittee No. 1

From: Frank J. Mecca, Executive Director *FM*

Re: **Healthy Families to Medi-Cal Shift (Item 4260) – SUPPORT**

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EXECUTIVE DIRECTOR  
Frank Mecca, CWDA

The County Welfare Directors Association of California (CWDA) supports the Brown Administration's proposal to move about 890,000 children currently enrolled in the Healthy Families program into Medi-Cal. This proposal makes sense, particularly as counties and the state prepare to implement health care reform and streamline health care coverage for all Californians.

County human services departments manage eligibility for health and human services programs for 8 million Californians, including Medi-Cal, CalWORKs and CalFresh. Counties enrolled several hundred thousand new clients into Medi-Cal during the two-year recession period, and added millions to CalFresh and CalWORKs. Statewide, we receive about 400,000 applications for the various programs each month. This proposal would add about 20,000 monthly applications to that number, based on April 2011 data showing 19,522 applications forwarded from the Single Point of Entry to Healthy Families.

Counties' modern eligibility automation systems, which include online application capacity, can accommodate the cases that would be added under this proposal. We will be working with the Administration and our automation system staff in the coming days to identify the automation changes that will be required to implement the transition, such as updates to the systems' rules engines and new electronic linkages.

It is our understanding that the cases that are to be transitioned will be evaluated under simple eligibility rules, as just one example, without requiring asset tests for these children. Based on this, we are committed to working with the Administration and Legislature to develop a cost estimate for the eligibility work associated with these cases that we are confident will be in line with costs under Healthy Families today. The current cost per case on Medi-Cal is, on average, higher than the cost for Healthy Families cases because Medi-Cal is significantly more complex. The Medi-Cal "program" is actually a collection of dozens of programs under the Medi-Cal umbrella, with more than 120 aid codes, compared to the single program that Healthy Families runs. Many Medi-Cal recipients are subject to mid-year status reporting that these children would not be required to meet, and must provide in-depth detail about their assets, including retirement accounts, life insurance policies, jewelry and burial plots.

From an enrollment perspective, the technical questions that need to be worked through include the actual work flow of transferring applications from MRMIB's

CWDA Budget Memo  
May 20, 2011  
Page Two

Single Point of Entry to the counties, what role Maximus might play in the collection of premiums for enrollees in the 150% to 250% income range, and how ongoing case maintenance duties for these cases might be split between counties and Maximus.

While the 2014 implementation date for health care reform seems a long way off, it will be here very quickly. California can get a head start on this process by transitioning Healthy Families children into the Medi-Cal program early. For these reasons, we support the Administration's proposal. We look forward to working with the Administration, Legislature, and stakeholders to develop the necessary policies and procedures to ensure a successful transition for all affected children.

cc: Andrea Margolis, Consultant, Assembly Budget Committee  
Eric Swanson, Consultant, Assembly Republican Fiscal Office  
Agnes Lee, Speakers Office of Policy  
Gareth Elliott, Office of Governor Jerry Brown  
Mike Wilkening, Health and Human Services Agency  
Lisa Mangat, Department of Finance  
Toby Douglas, Director, Department of Health Care Services  
Patricia Huston, Department of Social Services  
Shawn Martin, Legislative Analyst's Office  
Ross Brown, Legislative Analyst's Office  
County Caucus

**CWDA Response to the MRMIB Open Letter dated May 16, 2011**

The County Welfare Directors Association of California represents the 58 county human services agencies that determine initial and ongoing eligibility for the Medi-Cal program. Counties have been determining eligibility for Medi-Cal since the program's inception in 1966.

The state and Legislature chose in 1998 to create a separate program to implement the federal Children's Health Insurance Program, Healthy Families, which is overseen by the Managed Risk Medical Insurance Board (MRMIB). As a result of that decision, a series of "bridges" were created between Medi-Cal and Healthy Families, which is administered by a private, for-profit company (Maximus) under a contract with MRMIB. These bridges are necessary because as families' incomes change, and as children age, they move back and forth between Medi-Cal and Healthy Families, which offer different benefit packages and contract with different provider networks, and have separate eligibility determination systems.

Governor Brown's May Revise proposes to integrate Healthy Families into Medi-Cal, bringing together these two programs under the county eligibility structure along with CalFresh (formerly Food Stamps) and CalWORKs, the state's welfare-to-work program. These programs serve many of the same families. In fact, a child on Healthy Families often has one or more siblings or parents receiving Medi-Cal, and the entire family may also be receiving CalFresh and CalWORKs. This proposal hastens a discussion that we have expected to occur as the state moves toward the implementation of the federal Affordable Care Act in January 2014. We support the proposed integration of Healthy Families into Medi-Cal and stand ready to work with the Brown Administration and all interested stakeholders to develop a detailed plan that will ease enrollment and minimize disruptive transitions between programs for these children.

Given the overlaps between Healthy Families and Medi-Cal, we have valued the partnership developed between counties, DHCS, and MRMIB. However, we take issue with a number of characterizations in the "Open Letter" released on May 16, 2011 by MRMIB that paint such an inaccurate picture of county eligibility operations that we must respond.

**Administrative Costs: It's the Rules, Not Who Administers the Program**

The MRMIB letter states: "County administrative costs are a significant multiple higher than those of the Healthy Families administrative vendor costs. How are the additional information technology costs or county administrative costs calculated and how do they compare to the Healthy Families administrative vendor costs?"

CWDA response: We have for years consistently noted that any comparison of today's Medi-Cal administrative costs to the costs for administering Healthy Families is apples to oranges. Medi-Cal is a collection of dozens of programs, of varying degrees of complexity, under a single umbrella. The programs encompass 150-plus aid codes; many require significant amounts of information and verification at the time of application. Most parents have a mid-year status report requirement in addition to the annual redetermination required by federal law. The Healthy Families program, in contrast, is one program with one set of simple rules, no asset test, applies only to children, and uses an income calculation that is identical to that used in Medi-Cal. This means that for all applications that start at the county human services department, *zero* additional work is required on the part of the contractor to determine the family's income – *the county has already done the work for Maximus.*

Conclusion: The costs for these two vastly different programs are simply incomparable, as we have noted many times in the past in numerous public settings. Simplification of the rules for Medi-Cal, and the simplification contained in the ACA (and already used for Healthy Families to a great degree), will result in much simpler eligibility determinations and, accordingly, a lower average cost per case.

#### **To Have No Wrong Door, One Needs Multiple Doors**

The MRMIB letter states: "Eligibility and enrollment functions are complex and attempting to join the centralized, automated Healthy Families enrollment system to a decentralized and diverse Medi-Cal system is an undertaking that requires careful planning and implementation – assuming this is even consistent with a "no wrong door" approach to a seamless, user-friendly enrollment system."

CWDA response: County human services departments currently offer a "no wrong door" approach that is consistent with federal ACA requirements, allowing for online, mail-in, in-person and phone-based applications. Unlike the Healthy Families online system, which only recently was made available to public users, counties designed our online applications to be used by individuals wherever a computer is available and to allow for a single click of the button to submit an application that can be used for Medi-Cal (and, by extension, Healthy Families), CalFresh and CalWORKs. The counties' online applications deliver information electronically and seamlessly into the automated eligibility system, unlike the Healthy Families system which requires applications to be printed out and retyped into the county eligibility system when a child is screened as being likely eligible for Medi-Cal, causing potential delays in eligibility determination. (See comments below regarding screening issues.)

Conclusion: The Governor's proposal would build on the current "no wrong door" approach to application submittal, by ensuring that an application sent in via any means is fully vetted and giving families an opportunity to apply for multiple programs seamlessly.

#### **Why Assume Delay if County Processes Application?**

The MRMIB letter states: "Instead, the applications would be sent in some form to the county welfare offices for eligibility determination. This will delay enrollment and complicate access to services."

CWDA response: The letter states that Healthy Families is "automated," implying that the Medi-Cal program is not. We are confused by this implication and the assumption that a delay would be automatic if counties process these application. Counties' Medi-Cal automation systems are fully functional and integrated with CalFresh and CalWORKs, along with other programs like the County Medical Services Program (CMSP), and offer numerous modern tools. Counties today process hundreds of thousands of applications for various programs every month, while the Single Point of Entry receives less than 30,000 (thousands of which are already forwarded to the counties after screening). Further, it is our understanding that the Governor's proposal would create an electronic interface to pass application information quickly from the Single Point of Entry to the county systems. If the Single Point of Entry is maintained, this concept is consistent with how counties receive applications through our own online application systems today, without delays.

Conclusion: County automation systems already receive applications electronically today. We look forward to discussing the future of the Single Point of Entry in an integrated environment and how to best expedite the receipt of applications by the counties so as not to delay services to children.

### **Performance and Accuracy: Different Definitions?**

The MRMIB letter states: “For example, MRMIB’s contracted administrative vendor (Maximus) must screen 98% of the applications for program eligibility within 4 days at a 98% accuracy level and 99% of applications for completeness within 3 days.”

CWDA response: It may be the case that applications are screened for program eligibility within 4 days, but the accuracy of the screening is in question. A legal challenge to the screening tool utilized by Maximus, which had long been questioned by client advocates, has resulted in a court judgment against the state in December 2010. The court found that the screening tool Maximus uses violates federal law because it is not robust enough – specifically, it does not screen for the largest Medi-Cal program, 1931(b), resulting in children being sent to Healthy Families who actually could be found eligible for Medi-Cal if the counties were given the opportunity to work with them to collect the necessary information.

Further, “screening” does not equal “eligibility determination.” Counties operate under legislatively mandated performance standards, including federal standards as well as state-instituted standards that are in statute. These standards are related to the full determination of eligibility (not just screening) as well as timely performance of annual redeterminations. The state, counties and the Legislature jointly developed these standards several years ago in conjunction with the development of a new budgeting methodology to accurately reimburse counties for the cost of administering the program. The budgeting portion of the agreement was later suspended due to the budget crisis, but counties continue to operate under the performance standard structure, which includes reviews and corrective action plans for underperformance. (Penalties associated with the performance standards have been held in abeyance while the budgeting portion of the methodology is suspended.)

Counties also are subject to regular Medi-Cal Eligibility Quality Control (MEQC) reviews of case samples; targeted reviews on new tasks or rules that have been identified as important for particular attention by the state; and corrective action plans when needed. MEQC reviews of more than 3,000 cases in 2009 found a county accuracy rate of over 98%.

Conclusion: Like MRMIB, counties take performance very seriously and strive to complete eligibility determinations and annual renewals accurately and within required time frames. As the court case shows, however, “accuracy” is not always easily defined. Eligibility determinations also differ from screenings. Medi-Cal performance measures have been carefully developed in order to avoid negative consequences. Integrating Healthy Families with Medi-Cal offers an opportunity for counties to ensure that children are found eligible for the correct program, in a timely and accurate manner.

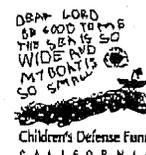
### **Conclusion: Counties Can Provide Integrated, Comprehensive and Cost-Effective Eligibility**

Certainly, many details need to be worked out in order to seamlessly transition children into the Medi-Cal program from Healthy Families. We note that our memo addresses only the eligibility and enrollment issues raised by MRMIB in its open letter. We look forward to working with the Administration and the Legislature, as well as client advocates, to ensure that Healthy Families is integrated seamlessly into the Medi-Cal eligibility structure already in place today – including automation as well as on-the-ground eligibility support – in a manner that is cost-effective for the state and responsive to families’ needs.

CHILDREN NOW



PICO California

The Children's  
Partnership

May 23, 2011

The Honorable Mark DeSaulnier  
Chair, Senate Budget Subcommittee on  
Health & Human Services  
State Capitol, Room 5019  
Sacramento, CA 95814

The Honorable Holly Mitchell  
Chair, Assembly Budget Subcommittee on  
Health & Human Services  
State Capitol, Room 6026  
Sacramento, CA 95814

**Re: Healthy Families to Medi-Cal Shift (Item 4260)**

Dear Senator DeSaulnier & Assemblymember Mitchell:

Our California children's health coverage coalition – comprised of the 100% Campaign, a collaborative effort of The Children's Partnership, Children Now, and Children's Defense Fund-California, along with PICO California and United Ways of California – is writing in regard to the Governor's May Revise budget proposal to shift children from the Healthy Families Program (HFP) into Medi-Cal.

We believe this proposal has merit and stand ready to work closely with state officials on a thoughtful solution that prioritizes the needs of children. Medi-Cal offers several important advantages for children. For example, Medicaid's entitlement policy will protect children's access to coverage during budget deficits, and the Early and Periodic Screening, Diagnosis and Treatment benefits in Medicaid allow children to get critical medically necessary services. Also, the lowest income children are protected from cost sharing including premiums. These benefits can not be understated in their importance to children's health and development. Moreover, Medi-Cal is already intended to be a core pillar of the new coverage system starting in 2014, with many new low-income adults and almost one quarter of all HFP children scheduled to transfer to Medi-Cal by that date. This proposal offers the state not only the opportunity to assess and prepare Medi-Cal's capacity now for the important task ahead, but also to accept the daunting responsibility of ensuring that the nearly 4.5 million children currently enrolled in Medi-Cal and HFP are assured as good if not better coverage and care as what they receive now.

**As further discussed below, we support the transfer of children up to 150% of the federal poverty level (FPL) from HFP into Medi-Cal in the timeframe proposed by the Governor's May Revise Budget. For HFP children 150-250% FPL, several issues must be addressed before these children are transferred, which will likely require a longer timeframe than proposed before any transfers could begin. For Medi-Cal to successfully cover both currently eligible children and children who are currently HFP-eligible, a variety of important considerations will need to be addressed and solutions in place before the HFP children are transferred:**

1. **Access Issues.** It is critical that children in Medi-Cal (both current and potential future enrollees) have meaningful and timely access to the health care providers and services they need to thrive. The state must ensure that the current health plans will continue to participate in the Medi-Cal program and be able to maintain a provider network of primary and specialty care providers (including dental, mental health, and vision providers) capable of ensuring children get prompt access to needed care. It is especially important that there is a concrete plan to ensure timely access to care for children in rural counties and in Medi-Cal fee-for-service areas. In addition, Medi-Cal will need to develop a mechanism to assist families locate a participating provider for their children in fee-for-service areas.
2. **Reinvestment of Savings.** This proposal saves the General Fund an estimated \$31.2 million in FY 2011-12 and roughly \$75 to \$100 million in out-years. A large portion of these savings should remain invested in

**Healthy Families to Medi-Cal Shift (Item 4250) – page 2**

children's health programs to help ensure they work effectively for children, especially in light of the challenges presented by the Medi-Cal expansion. For example, savings could be used to:

- Boost provider reimbursement rates for pediatric services, especially in fee-for-service and rural areas.
- Develop a statewide system to assist families in identifying participating providers who can serve children on a timely basis, especially in fee-for-service and rural areas.
- Fund outreach and assistance for children transitioning between programs, especially those who are having trouble enrolling in a health plan; this could include training for staff at community-based organizations who serve the target populations in other programs.
- Fund a public education and communications effort to ensure that families are aware of impending changes and the continuing availability of children's coverage programs.

3. **Transitional Issues.** For this proposal to best serve current HFP children, it is critical that parents of these HFP children should be fully notified and offered as seamless as possible a transition from HFP to Medi-Cal. This would optimally include ensuring that children can still access their current providers and stay in the same plan. The phase-in schedule should take into account these transitional elements for families. If this proposal goes forward, the phase-in should mitigate any additional disruption for families who are subject to HFP plan changes set to take effect before 2012. Effective notifications, trainings and public education efforts, will be needed to inform the parents of HFP-enrolled children, application assistants, community-based organizations, and the public about the changes before they happen. The state must also have a plan to provide direct assistance to help families navigate through the transition successfully and without any disruption in coverage or care.
4. **Triggers and Monitoring Systems.** The state must work closely with stakeholders to identify markers that demonstrate readiness to implement the proposal in an effective fashion. Before any children are transitioned to Medi-Cal, fulfillment of these trigger conditions must be documented. The state must also work with stakeholders to develop a monitoring and reporting system, as well as a regular mechanism through which the Department of Health Care Services (DHCS) can communicate important information about transitions to the Legislature as well as to children's health advocates, application assistants, and other stakeholders. This monitoring system should include the ability to track:
  - The progress of transitions, for example, number of children successfully transitioned to Medi-Cal within the month, and number of children who experienced difficulty in transitioning (and the type of barrier that was encountered).
  - Wait times for children to access services, including primary care and specialty services (including dental, mental health, and vision services).
  - Percent of transitioned children utilizing services, such as a primary care visit and well-child visits.
5. **Streamlining of Administration and Eligibility Systems.** This proposal provides an enormous opportunity to truly simplify the enrollment for children. Unfortunately, the proposal's aggressive timeframe does not afford the time to make improvements to the enrollment process. This proposal does not seize the opportunity to build a path toward the coordinated, efficient, and seamless enrollment system required under ACA. As a result the proposed enrollment process must explicitly be an interim step prior to the development and implementation of the ACA-required enrollment system. During that time, the Accelerated Enrollment (AE) must continue and state officials should begin work with stakeholders immediately in the implementation of the larger enrollment system. The proposal also does not appear to account for the necessary systems changes needed to complete the shift from HFP to Medi-Cal. These costs and timeframes must also be taken into consideration.
6. **Special Focus on Children's Issues at DHCS.** DHCS should consider building on the existing Children's Medical Services branch by designating a staff person or unit to act as a liaison with stakeholders and the public on the transition of HFP children into Medi-Cal, as well as other children's enrollment, coverage and access issues moving forward. There are critical, specific issues related to children that are currently being addressed at the Managed Risk Medical Insurance Board (MRMIB) – such as compliance with the CHIP

**Healthy Families to Medi-Cal Shift (Item 4260) -- page 3**

Reauthorization Act and quality improvement efforts to increase dental service utilization for young children. If MRMIB is eliminated, it will be crucial not to sacrifice the focus MRMIB has placed on these critical children's issues. We would recommend that DHCS adopt the key transparency and data reporting standards provided under HFP, whereby DHCS would provide regular public reports on utilization, outcomes, and satisfaction.

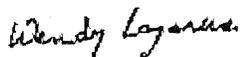
As noted above, we support the transfer of children up to 150% FPL from HFP into Medi-Cal in the timeframe proposed by the Governor's May Revise Budget. The HFP children below 133% FPL are already scheduled to transfer to Medicaid as part of ACA. It makes sense to transfer children up to 150% FPL together with this population in 2012 because children are protected from premiums in Medi-Cal up to 150% FPL. State officials must work closely with stakeholders to ensure that this transition proceeds smoothly and as seamlessly as possible for children and their families. As a result, the transition and monitoring issues mentioned above will be critical.

With regard to the remaining HFP children (those with incomes between 150-250% FPL), the expectations laid out above should be met and demonstrated before these children are transferred, which will likely require a longer timeframe than proposed before any transfers could begin. The Legislature should require a report from DHCS three months after children up to 150% FPL begin transitioning to Medi-Cal, documenting the progress of the transition and showing data relevant to the trigger conditions identified. This means that children 150-250% FPL will stay in HFP unless and until the report shows that Medi-Cal is prepared to enroll the additional children.

This measured approach can offer some assurance that Medi-Cal will not be overwhelmed by a large influx of new children into its system and provider network. A thoughtful and smooth transition will not only serve the interest of children's health, but also demonstrate the ability of Medi-Cal to assume its new duties in our reformed coverage system.

We look forward to working with the Administration, DHCS, and MRMIB staff to learn more about this proposal and its implications for children's health. For more information, please contact Kelly Hardy at [khardy@childrennow.org](mailto:khardy@childrennow.org) or 510-763-2444 x 126.

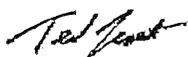
Sincerely,



Wendy Lazarus  
Founder and Co-President  
The Children's Partnership



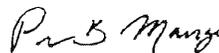
Corey Timpson  
Director  
PICO California



Ted Lempert  
President  
Children Now



Deena Lahn  
Policy Director  
Children's Defense Fund California



Peter Manzo  
President & CEO  
United Ways of California

cc:

The Honorable Bob Blumenfield, Chair, Assembly Budget Committee  
The Honorable Mark Leno, Chair, Senate Budget Committee  
Members, Assembly Budget Subcommittee on Health & Human Services  
Members, Senate Budget Subcommittee on Health & Human Services  
Diana Dooley, Secretary, California Health and Human Services Agency  
Toby Douglas, Director, California Department of Health Care Services  
Janette Casillas, Executive Director, Managed Risk Medical Insurance Board  
Gareth Elliot, Legislative Affairs Secretary, Governor's Office

Diane Van Maren, Consultant, Senate Budget Committee  
Kirk Feely, Consultant, Senate Republican Fiscal Office  
Andrea Margolis, Consultant, Assembly Budget Committee  
Eric Swanson, Consultant, Assembly Republican Fiscal Office  
Michelle Baca, Consultant, Assembly Republican Fiscal Office  
Agnes Lee, Office of Speaker of the Assembly John Pérez  
David Panush, Office of Senate Speaker Pro Tempore Darrell Steinberg  
Ana Matosantos, Director, Department of Finance  
Lisa Mangat, Program Budget Manager, Department of Finance



May 24, 2011

**TO:** Honorable Members, Senate Committee on Budget & Fiscal Review  
Honorable Members, Assembly Budget Committee

**FROM:** Patricia Ryan, Executive Director  
Kirsten Barlow, Associate Director, Legislation and Public Policy  
California Mental Health Directors Association

**SUBJECT: Governor's FY 2011-12 May Revise: Transition Healthy Families Program to Medi-Cal**

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, I am writing to communicate our thoughts and questions thus far regarding the Governor's 2011-12 May Revise proposal to transition all Healthy Families beneficiaries to the Medi-Cal program.

Healthy Families is a non-entitlement children's insurance program in California that includes expanded coverage to children with serious emotional disturbances (SED), under the provisions of 1991 mental health realignment. Today, county Mental Health Plans (MHPs) provide mental health services "to the extent resources are available" to Healthy Families beneficiaries who meet the criteria specified under realignment. If a county is unable to provide the services, the contracted health plans are responsible.

The Governor's 2011-12 May Revise proposes to shift all Healthy Families beneficiaries to the Medi-Cal program, which could have significant impacts on the caseload and costs of the Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. CMHDA is working on estimating the potential fiscal implications in FY 2011-12.

CMHDA has identified the following additional issues that we believe are important to consider in evaluating this proposal:

- The covered mental health services provided by counties under the Healthy Families-SED benefit are different than those specified for EPSDT in our Medi-Cal state plans which are approved by the federal government. Under Healthy Families, the health plans are responsible for the first 30 days of psychiatric hospitalization in each plan year, and the Healthy Families-SED services available are much more limited than those that are available to EPSDT beneficiaries.
- The Healthy Families-SED administrative and claiming requirements on counties are minimal, in comparison to those required in the Medi-Cal program.

- Due to decreased mental health realignment resources available to counties, counties' ability to provide Healthy Families-SED services has resulted in a very low penetration rate of approximately 1% to 2%. In contrast, the statewide average EPSDT penetration rate for specialty mental health services is approximately 5% to 6%. Therefore, transitioning Healthy Families beneficiaries to EPSDT will certainly increase demand in the EPSDT program.
- This proposal is scheduled to occur in the same fiscal year in which AB 100 (Committee on Budget, Statutes of 2011) redirected Mental Health Services Act (Prop. 63) dollars to fund the state's EPSDT State General Fund obligations. The amount of funding that AB 100 will provide to counties for EPSDT did not account for this proposal's impact on the EPSDT caseload. If the \$579 million is inadequate, many counties will need to fund remaining obligations for federally required Medi-Cal services using other local funds. If counties are unable to identify sufficient local funds for FY 2011-12, the state may be out of federal compliance with the obligations specified in California's state Medicaid plan and waivers.
- A critical element of this proposal is the availability of the enhanced FMAP, which could help to mitigate the impact on counties. Access to these federal funds would be further enhanced by implementing the proposals that CMHDA has advanced under Assembly Bill 1297 by Assemblyman Chesbro, which would enhance the efficiency and timeliness of full federal reimbursement to the counties.
- The proposed transition from a non-entitlement insurance program to the Medi-Cal EPSDT entitlement will impact the mental health service and Medicaid Certified Public Expenditure (CPE) obligations of the counties. Therefore, it is critical to involve county representatives in all aspects of the planning and implementation of this proposal, if approved.

Thank you for your consideration of our preliminary analysis of the Governor's May Revise to transition Healthy Families beneficiaries to the Medi-Cal program. Please do not hesitate to contact Patricia Ryan at [pryan@cmhda.org](mailto:pryan@cmhda.org) or Kirsten Barlow at [kbarlow@cmhda.org](mailto:kbarlow@cmhda.org), or by phone at (916) 556-3477 with any questions you may have.

Cc: Diane Van Maren, Consultant, Senate Committee on Budget & Fiscal Review  
 Andrea Margolis, Consultant, Assembly Budget Committee  
 Kirk Feely, Consultant, Senate Republican Fiscal  
 Michelle Baca, Consultant, Assembly Republican Fiscal  
 Diane Cummins, John Doyle, Department of Finance  
 Diana Dooley, Michael Wilkening, Health and Human Services Agency  
 Cliff Allenby, Kathy Gaither, Department of Mental Health  
 Toby Douglas, Department of Health Care Services  
 Janette Casillas, Executive Director, MRMIB  
 Shawn Martin, Lishaun Francis, Legislative Analyst Office



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May 19, 2011

The Honorable Mark DeSaulnier  
Chair, Senate Budget & Fiscal Review Subcommittee No. 3  
State Capitol, Room 5035  
Sacramento, California 95814

**Re: Governor's May Revision Proposal: Shift Healthy Families Children to Medi-Cal –  
SUPPORT IN CONCEPT**

Dear Senator DeSaulnier:

The California State Association of Counties (CSAC) is writing in support of Governor Brown's May Revision proposal to move children currently served by the Healthy Families Program into the Medi-Cal program. Counties are supportive of the policy to move more children into Medi-Cal and consolidate state health programs. The May Revision proposal is the first step in the discussions that need to occur in California about how individual health programs may change or merge prior to implementation of federal health care reform. Counties applaud Governor Brown for beginning this dialogue. Counties know there will be numerous technical issues to work through regarding this proposal and look forward to participating in these discussions.

Counties will be impacted by the shift in a number of ways – as the entities conducting Medi-Cal eligibility determinations, as the county mental health plans providing Early Periodic Screening Diagnosis and Treatment (EPSDT) services, as the entities administering the California Children's Services (CCS) program, and as health care providers.

The Affordable Care Act (ACA) expands Medicaid eligibility for children up to 133 percent of the federal poverty level (FPL) starting in 2014. The Governor's proposal would implement this provision of federal health reform early in California and takes the additional step of transitioning all Healthy Families children to Medi-Cal. Under the proposal, children with family incomes below 150 percent of FPL would be exempt from cost sharing (no premiums or co-pays). Under the Administration's proposal, the March 2011 co-pay and premium increases will still be applicable to children with family incomes between 150-250 percent of FPL. By providing Medi-Cal instead of Healthy Families, children will be entitled to a more comprehensive benefit package that includes services such as Early Periodic Screening Diagnosis and Treatment (EPSDT).

**Eligibility.** Counties will be critical partners in providing Medi-Cal eligibility determinations and enrolling this group of children in the Medi-Cal program. The Governor's proposal would maintain a Single Point of Entry (run by Maximus) where applications would be transmitted electronically to county human services departments for eligibility determinations. County human services departments also would accept applications directly, as under current rules. As proposed, Maximus would be responsible for premium collection for the 150 to 250 percent FPL cases, with county human services departments conducting eligibility determinations and annual redeterminations for those cases. To the extent that current processes will change, it will be important for counties to provide input, along with other key stakeholders, on issues such as premium deductions, case management, automation needs, and the role of the Single Point of Entry. There may be streamlining and more effective use of technology that can be achieved.

**Early Periodic Screening Diagnosis and Treatment (EPSDT).** The Governor's proposal will provide EPSDT services to children up to 250 percent of the FPL. These services are more

comprehensive than the behavioral health benefits under the Healthy Families Program which are specified under 1991 Realignment and thus provided by counties subject to available resources. Counties have identified a technical issue with the Administration's proposal. The Administration's 2011-12 appropriation to counties for EPSDT services in AB 100 (Statutes of 2011) does not include funding for the increased caseload related to the shift. Additionally, the Administration's 2011 Realignment proposal does not take into account increased EPSDT caseload due to the shift. Counties will need to work with the Legislature and Administration to be sure funding is providing for this entitlement. Providing an accurate estimate for EPSDT caseload will be especially critical to make the Realignment proposal workable in the long-term. Counties also want to ensure that county mental plans are able to access Title XXI federal matching funds at the enhanced FMAP for services for this group of children.

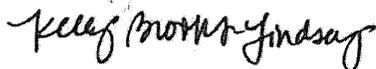
**California Children's Services (CCS).** Counties currently share in costs for the California Children's Services. Since trailer bill language is not available, it is not clear what the Administration is proposing. Implementing statute will need to specify that county financial obligations for CCS are not increased beyond the current requirements in Health and Safety Code 123940.

**Substance Use Disorder Treatment.** There is a limited benefit under Healthy Families for adolescents in need of alcohol or other drug treatment services. Unfortunately, access to these services has been problematic, and out of the thousands of eligible adolescents in California who are in need of substance use disorder treatment, less than 100 annually have been able to access services. Moving these children into the Medi-Cal program should enable them to receive treatment services that are more accessible and comprehensive than the benefits under the Healthy Families Program.

**Access.** Counties are aware that some children may either lose their current provider or their current health plan with the transition from Healthy Families to Medi-Cal. Some providers accept Healthy Families but not Medi-Cal. Some plans that are offered in Healthy Families may not be offered in Medi-Cal. As a result, there may be continuity of care and access issues, particularly in rural areas. Further discussion and deliberation will be required to mitigate access issues.

In closing, counties are supportive of the policy of moving children from the Healthy Families Program into Medi-Cal. It is imperative that counties be included in the planning and implementation process for transitioning children into Medi-Cal. Please do not hesitate to contact me at 916-327-7500, ext. 531 or [kbrooks@counties.org](mailto:kbrooks@counties.org) if you have additional questions about our support in concept position. Thank you.

Sincerely,



Kelly Brooks-Lindsey  
Legislative Representative

cc: Members, Senate Budget & Fiscal Review Subcommittee No. 3  
Diane Van Maren, Consultant, Senate Budget & Fiscal Review  
Kirk Feely, Consultant, Senate Republican Fiscal  
Diana Dooley, Secretary, California Health & Human Services Agency  
Toby Douglas, Director, Department of Health Care Services  
Ana Matosantos, Director, Department of Finance  
Lisa Mangat, PBM, Department of Finance  
Garreth Elliot, Legislative Affairs, Governor's Office



May 24, 2011

The Honorable Mark DeSaulnier  
Chair, Senate Budget Subcommittee on  
Health & Human Services  
State Capitol, Room 5019  
Sacramento, CA 95814

The Honorable Holly Mitchell  
Chair, Assembly Budget Subcommittee on  
Health & Human Services  
State Capitol, Room 6026  
Sacramento, CA 95814

**Re: Healthy Families to Medi-Cal Shift (Item 4260)**

Dear Senator DeSaulnier and Assemblymember Mitchell:

California Coverage & Health Initiatives (CCHI), the association of 28 Children's Health Initiatives across our state, writes in regard to the Governor's May Revise budget proposal to shift children from the Healthy Families Program (HFP) into Medi-Cal. The health of our state's children and their access to quality health care provided by a strong and adequately-funded provider network are the chief concerns of CCHI. Any shift as dramatic as that proposed in the May Revise should be taken after very careful consideration of the impacts on the wellbeing of children and the success of the Affordable Care Act in improving the health care system in California.

We believe that there are very positive aspects to the Governor's proposal, namely the opportunity to create an entitlement for children up to 250% of the federal poverty line and to provide the substantial protections implicit in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit in Medicaid. However, we also believe that this proposal requires thorough and careful consideration of the short and long term implications with respect to several critical issues. Among the many issues the state must address in order to ensure that the proposal will benefit California's children and not jeopardize their health coverage are:

- **Ensure access to robust provider networks.** It is critical that children in Medi-Cal have meaningful and timely access to the health and dental care providers and services needed to ensure their healthy development. Under this proposal, it will be essential to make sure that health plans are committed to continuing to participate in the Medi-Cal program and will be able and are committed to maintaining vigorous networks of primary and specialty care providers. The extremely low provider reimbursement rates under the Medi-Cal Program discourage providers and tie the hands of plans. Currently, access to providers is especially problematic in the Denti-Cal program, where access is extremely limited in many parts of the state. Our CHIs report that most of their client families experience difficulty in finding a provider willing to take Denti-Cal, and many children are unable to access dental care on a regular basis. In addition, we are concerned about children residing in rural counties who will be transitioned to a Medi-Cal fee-for-service plan and will likely find it difficult to access providers of any services. These issues must be addressed at the outset, and meaningful commitments must be made by the State to ameliorate access issues in Medi-Cal and Denti-Cal prior to transitioning nearly a million additional children into the program.

- **Create a special focus on children's health within Medi-Cal administration.** We need to protect and prioritize the youngest members of our state. HFP is a program designed for children, and MRMIB has been thoughtful in addressing issues specific to children and their particular needs in various forums with stakeholders. In any transition, it will be important to make sure the leadership and learnings from MRMIB are not lost, and that some entity with sufficient authority and resources oversees the process from the viewpoint of children's wellbeing. DHCS should consider enhancing the Children's Medical Service branch or otherwise identifying a staff person or unit to act as a liaison with stakeholders and the public on the transition of HFP children into Medi-Cal, as well as other children's issues into the future.
- **Smooth transitions.** Various estimates indicate that hundreds of thousands of children will be required under the May Revise proposal to change health plans starting January 1, 2012. Systems will need to be developed to educate parents and the public about the transition from HFP to Medi-Cal much in advance of the transition. Families will need direct assistance in navigating through the transition successfully without any disruption of coverage or care for their child. To ensure that the transition is a smooth and transparent process, a tracking, monitoring, and reporting system for the transition would need to be developed prior to initiating any transition.
- **Streamline administration, eligibility and enrollment systems.** We applaud the administration's focus on simplification of children's coverage. CCHI welcomes the opportunity the proposal carries to simplify and streamline the administration, eligibility and enrollment systems for children's health programs. The complexity and duplication in the current system create substantive barriers that unnecessarily keep children out of the programs. However, we are concerned that the proposal builds on existing administrative structures without a clear path to simplifying the processes and creating efficiencies, or identifying resources to implement the necessary systems changes needed to complete the shift from HFP into Medi-Cal. We look forward to working with the administration to fully understand how these systems can be streamlined and to help create a system that gets children into coverage easily and keeps them there.
- **Position California for successful implementation of the ACA.** It is essential that California craft decisions about health care programs with a view to the efficient implementation of the Affordable Care Act, while also meeting the specific needs of children. As noteworthy and laudable as California's leadership has been with the ACA, the State so far has not taken a sharp focus on children's health concerns in its implementation. We encourage the State to make decisions about the structure of the Healthy Families and Medi-Cal Programs both in terms of what is best for children and what puts California in the best position to implement the Affordable Care Act.

Our sole objective is that California's children have access to quality health care. Our member Children's Health Initiatives have extensive experience working with the Healthy Families and Medi-Cal Programs and their members, and can provide insight and information that would be very useful for any restructuring of the programs. We look forward to being part of the ongoing discussion and working with the Administration, DHCS, and MRMIB to address the many issues involved.

For more information, please contact Suzie Shupe at [sshupe@cchi4families.org](mailto:sshupe@cchi4families.org), (707) 527-9213 or Alison Lobb at [alobb@cchi4families.org](mailto:alobb@cchi4families.org), (707) 225-5298.

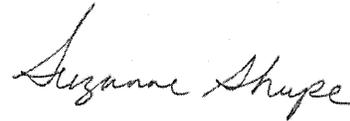
Sincerely,



Leslie Connor  
Co-Chair  
Executive Board



Jennifer Kwan  
Co-Chair  
Executive Board



Suzie Shupe  
Executive Director

cc: The Honorable Bob Blumenfield, Chair, Assembly Budget Committee  
The Honorable Mark Leno, Chair, Senate Budget Committee  
Honorable Members of the Assembly Budget Subcommittee on Health & Human Services  
Honorable Members of the Senate Budget Subcommittee on Health & Human Services  
Diana Dooley, Secretary, California Health and Human Services Agency  
Toby Douglas, Director, California Department of Health Care Services  
Janette Casillas, Executive Director, Managed Risk Medical Insurance Board



May 25, 2011

The Honorable Mark DeSaulnier  
Chair, Senate Budget Subcommittee on  
Health & Human Services  
State Capitol, Room 5019  
Sacramento, CA 95814

The Honorable Holly Mitchell  
Chair, Assembly Budget Subcommittee on  
Health & Human Services  
State Capitol, Room 6026  
Sacramento, CA 95814

**Re: Healthy Families to Medi-Cal Shift (Item 4260)**

Dear Senator DeSaulnier & Assemblymember Mitchell:

Consumers Union, nonprofit publisher of *Consumer Reports*, writes regarding the Governor's May Revise budget proposal to shift children from the Healthy Families Program (HFP) into Medi-Cal.

We appreciate that there are significant advantages to moving HFP children into the Medi-Cal program and support the current proposal as it pertains to moving HFP beneficiaries into Medi-Cal for children at the lower end of the income spectrum. The Medi-Cal program's entitlement status carries an assurance of coverage under difficult state budgets; its more comprehensive benefit package and more limited cost-sharing for low- and moderate- income families make it a beneficial option. Federal law requires that HFP children up to 133% of the Federal Poverty Level be moved to Medi-Cal in 2014 under the Affordable Care Act (ACA). Thus moving the lower-income HFP children into Medi-Cal in the proposed time frame makes sense.

Consumers Union encourages a slower approach for children at the higher end of the income scale, up to 250% FPL. A phased approach would allow the Legislature to assess the many and complex policy issues involved in such a transition, including the overall impact on California families. We do not recommend moving all HFP children up to 250% to Medi-Cal at once.

In any transition timetable, the state will need to ensure that those children have sufficient access to providers; are given assistance in resolving inevitable glitches to smooth the path into Medi-Cal, and that systems are put in place to manage the

transition between agencies and ensure reliable communication to families undergoing a shift in coverage. Timely and adequate reporting systems will be needed to monitor and identify enrollment demographics, evaluate wait times, and avoid gaps in health care.

A thoughtful, well planned approach to moving HFP children into Medi-Cal can ensure that Medi-Cal is able to integrate a large number of children into the system and the provider network without overwhelming families and those responsible at the county level for enrollment and retention. A seamless transition will protect children and ensure that the state is able to undertake its responsibilities under the ACA by 2014.

Sincerely,



Elizabeth M. Imholz  
Special Projects Director

cc: The Honorable Bob Blumenfield, Chair, Assembly Budget Committee  
The Honorable Mark Leno, Chair, Senate Budget Committee  
Members, Assembly Budget Subcommittee on Health & Human Services  
Members, Senate Budget Subcommittee on Health & Human Services  
Diana Dooley, Secretary, California Health and Human Services Agency  
Toby Douglas, Director, California Department of Health Care Services  
Janette Casillas, Executive Director, Managed Risk Medical Insurance Board  
Gareth Elliot, Legislative Affairs Secretary, Governor's Office  
Diane Van Maren, Consultant, Senate Budget Committee  
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Andrea Margolis, Consultant, Assembly Budget Committee  
Eric Swanson, Consultant, Assembly Republican Fiscal Office  
Michelle Baca, Consultant, Assembly Republican Fiscal Office  
Agnes Lee, Office of Speaker of the Assembly John Pérez  
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May 25, 2011

The Honorable Mark DeSaulnier  
State Capitol, Room 5035  
Sacramento, CA 95814

Dear Senator DeSaulnier:

The California Association of Health Plans represents public, non-profit, and commercial Knox-Keene licensed health plans arranging high quality, coordinated care for approximately 4 million beneficiaries in Medi-Cal managed care and nearly 900,000 children in the Healthy Families Program.

California's health plans have serious concerns about the May Revise proposal to shift the entire Healthy Families population into Medi-Cal within a year. A population move of this magnitude requires careful consideration of the impact on access to services, continuity of care, program funding and other important issues. Our members understand that federal law expands Medicaid eligibility to children up to 133 percent of the federal poverty level in 2014. This May Revise proposal, however, is a significant departure from that provision of law in terms of timing and scope.

Our members believe that accelerating and expanding the transfer of this population has both budget and policy implications and must be vetted accordingly. By way of comparison, the move of up to 360,000 seniors and persons with disabilities from Medi-Cal fee-for-service into managed care was thoroughly debated before the policy was eventually adopted last year. The adoption of this policy came within the context of a robust stakeholder process hosted by the Department of Health Care Services (DHCS) as well as extensive legislative review in both the policy and budget processes. Moving a much larger population consisting entirely of low-income children certainly deserves thoughtful consideration.

Moreover, the proposal, when fully implemented, is estimated to reduce state general fund expenditures by \$100 million. When matching federal funds are factored in, this proposed savings means total health care expenditures for these children will be reduced by \$300 million. This level of assumed savings will represent a significant loss to the health care system not simply a decrease in administrative workload. The reduction is also completely unrelated to the cost or value of the services being provided to these children but instead represents an arbitrary reduction to below-cost levels.

The ability of our members' to continue to deliver access to quality care for this population is directly impacted by the May Revise proposal. Therefore, in order to better understand its implications, we have sent a series of questions to DHCS. These questions, attached for your review, revolve around reimbursement, access, funding, and other issues. Unfortunately, we have

not yet received a response from DHCS. Without more information, our Association remains concerned and cannot support this budget proposal at this time.

### **Impact on Access and Continuity of Care**

The delivery of appropriate and accessible care, through adequate provider networks, for any managed care enrollee rests upon the adequacy of resources available to the health plan. The limited information our members have on the proposed child-only Medi-Cal rate for these Healthy Families children has raised significant concern. We have been provided only a composite rate that includes medical, dental and vision benefits. Based on initial estimates, this proposed rate may be between 25-30 percent lower than the current Healthy Families health plan rates. In practically, this rate reduction will mean health plans will be forced to pay providers 25-30 percent less for seeing the same patient. We fear this lower level of reimbursement will be inadequate and seriously diminish access for these children.

It is also important to note that the federal government is considering the state's request to cut Medi-Cal reimbursement rates by 10 percent and employ copayments and service caps in the program. Each one of these proposals will further reduce Medi-Cal managed care rates. Our understanding at this point in time is that the child-only Medi-Cal rate contemplated for the May Revise proposal does not incorporate the 10 percent rate cut or the other Medi-Cal program cuts. The proposed rate for the Healthy Families children will be driven down further and our ability to maintain adequate provider access will be diminished. Health plans need more detail on how the managed care rate for the child-only population was developed.

The impact of this proposed shift on access and continuity of care is undeniable. Consider the following:

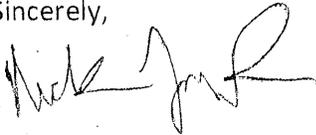
- Medi-Cal managed care is not available in every county in which Healthy Families operates a managed care network. According to Department estimates, about 50,000 children will go from a managed care network of providers into the Medi-Cal fee-for-service program with one of the worst levels of provider reimbursement--and thus access--in the country.
- Conversely, not every plan that participates in Healthy Families is a part of Medi-Cal managed care. In that case, children will need to switch plans. Switching plans in some cases could leave families with the task of having to find new doctors, including specialists and other providers; creating gaps in continuity of care.
- Not every provider that participates in Healthy Families may be willing to participate in Medi-Cal. Some of our plans report that not all Healthy Families providers are willing to participate in Medi-Cal. Even if there is an overlap of provider networks between programs, not all providers will agree to take on additional Medi-Cal beneficiaries if the rate is inadequate. Some families may need to find new providers for their children even if they can stay in the same plan—and the universe of providers will be smaller and in greater demand.

### Funding the Coverage

Our industry worked hard to enact AB 1422 (Bass) of 2010. This measure applied a tax on our Medi-Cal managed care plans to help fund the Healthy Families Program at a time when Healthy Families was on the verge of disenrolling hundreds of thousands of children due to a lack of funding. This funding mechanism brings approximately \$100 million dollars of support for specific coverage programs. Health plans championed that tax to help save a specific program – Healthy Families - that our members fully supported. We are proud of that effort. At this point, however, we do not know how that funding mechanism will be impacted by shifting lives to a new entitlement arrangement nor do we know how those dollars will be used to ensure health care coverage for California's children.

There are too many unanswered questions about this proposal for the Legislature to make a quick decision on the transition of nearly 900,000 lives. A proposal of this magnitude must be fully evaluated and the impacts considered thoughtfully in order to protect the lives of these children. Our members have serious questions and concerns about the feasibility of this proposal and cannot support it moving forward at this time.

Sincerely,

A handwritten signature in black ink, appearing to read "Nick Louizos", written in a cursive style.

NICHOLAS LOUIZOS  
Director of Legislative Affairs

## Health Plan Questions

### RATES

- We assume that DHCS will develop a new child-only rate for the children transitioning to Medi-Cal from the Healthy Families Program (HFP). The May Revise attributes savings to this proposal and therefore DHCS must know what this rate will be. What is the child only rate and how was it developed?
- What is the difference in the PMPM rate between the HFP rate and the new child-only Medi-Cal reimbursement cost for covering these kids?
- What will the new PMPM rate include/exclude – for instance does it include benefits like dental, vision, etc... Does it factor in the 10% provider rate cut?
- Will the new child only rate be for all Medi-Cal children or will it only apply to the children transitioning from HFP?

### ACCESS

- The pending 10 % cut in rates will strain capacity in Medi-Cal. Has DHCS done an analysis to determine the impact of the additional HFP lives in the Medi-Cal program on physician and hospital access in FFS and managed care?

### MCO TAX

- How would this impact the MCO tax; a portion of which currently funds HFP? How is this tax generated funding affected and where would the funding go?

### ENROLLMENT and TRANSITION

- Will children have to participate in a re-enrollment process in their respective counties or will they be block transferred?
  - If children are block transferred, will the family have the option to discontinue coverage?
  - If children are not block transferred, will HFP coverage continue until Medi-Cal eligibility is established?
- What is the member notification process? Example, will HFP members receive a 60 or 90 day notification of termination?
- What is the impact on the Health-E-App process?

### COST SHARE

- If the pending Medi-Cal co-payments are enacted, will the \$250 family co-pay max currently in place with HFP still apply to this population? Also, will Medi-Cal co-payments be tiered based on FPL?
- Our understanding is that members with a family FPL 151% and above will continue to pay premiums, is the State still considering increasing premiums?
- How will the cost-share be applied to the plan rate calculation?

### RECONCILIATION OF EXISTING HFP REQUIREMENTS POST-TRANSITION

- How is benefit delivery going to work? Specifically what will happen to mental health services which are currently carved out of Medi-Cal?

- Will the MLR requirements that are currently part of the HFP contracts be continued or would they be irrelevant?
- Will HFP rates continue to include appropriate rate escalation based on age? Currently 0 - 2 months of age gets a lump sum when baby is born to mother from AIM, another higher rate for 0 to 1 year of age, then another rate for age 1-18.
- What happens to the Family Value Package rate development process at MRMIB or will rates now be set?
- Are HFP child rates subject to risk adjustment?
- How does this impact the AB97 related changes to HFP?
- How does this impact the CPP process in HFP?
- Would the Vaccine for Children's Program be in effect for the transferred population?

#### OTHER ISSUES

- Clarification on Maximus role. What will their overall role be and please comment specifically on their role in eligibility determination?
- Now that the HFP children are placed in Medi-Cal, is it now considered an entitlement? If so, what happens if California exceeds its S-CHIP allotment or if not funded by the federal government in the future?



# California Medical Association

*Physicians dedicated to the health of Californians*

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May 26, 2011

The Honorable Mark DeSaulnier  
Chair, Senate Budget Subcommittee #3  
State Capitol  
Sacramento, CA 95814

## **Re: Healthy Families to Medi-Cal Transfer Proposal**

Dear Senator DeSaulnier:

The California Medical Association (CMA), representing 35,000 physicians throughout California in all specialties and modes of practice, appreciates the opportunity to comment on Governor Brown's 2011-12 May Revise proposal to shift all children currently enrolled in the Healthy Families Program (HFP) into the Medi-Cal program during this budget year.

CMA understands the basis of this proposal, which is the implementation of a provision of the federal Patient Protection and Affordable Care Act (PPACA) that expands states' Medicaid program eligibility to include children from families with incomes up to 133% of federal poverty level (FPL) by January 1, 2014. While there are many benefits inherent in the Medi-Cal program, including entitlement status and protection as well as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, we have serious concerns about the Administration's desire to enact such a substantive policy change outside of the policy committee process. With the deadline for budget passage being just three weeks away, we do not believe there is sufficient time to allow for the analysis, discussion and stakeholder input required to make such a substantive change in service delivery for California's low-income children.

First and foremost among CMA's concerns about this proposal is that the Medi-Cal provider network will not be able to accommodate this large influx of children. Years of chronic underfunding have driven many physicians out of the Medi-Cal program, and the recently passed 10% across-the-board rate reduction will only make matters worse.

The Healthy Families program has been far more successful in ensuring timely access to care and sufficient payment to participating providers. As a result, that program is far better-received by both enrollees and physicians. Although we have experienced problems in the past even in Healthy Families in ensuring a sufficient provider network exists (especially in rural and underserved areas), these struggles pale in comparison to those we deal with daily in the Medi-Cal program.

The Honorable Mark DeSaulnier

May 26, 2011

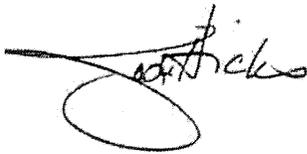
Page Two

Many physicians in Healthy Families refuse to participate in Medi-Cal as a result of ongoing reimbursement reductions as well as cumbersome bureaucratic procedures and excessive authorization requirements. CMA has little confidence that attempting a wholesale shift of Healthy Families enrollees into the Medi-Cal program—especially on the tight timeframe proposed by the Administration—can avoid serious continuity of care issues, service disruptions and breakdowns of physician/patient relationships as a result of insufficient provider network overlap between the Healthy Families and Medi-Cal programs.

California's physicians are sympathetic to the state's need to address the ongoing budget crisis, and stand ready to help in any way possible. However, we feel that the Administration's proposal to eliminate Healthy Families—a successful and longstanding program—and expand our broken Medi-Cal system absent sufficient stakeholder discussion and analysis will merely serve to score budgetary savings at the expense of access to critical medical care for California's low-income children. This is not a 'solution' the Legislature should support.

Should you have any questions or concerns, please do not hesitate to contact me. Thank you in advance for your time and consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Hicks", with a large, stylized flourish underneath.

Jodi Hicks, Vice President  
CMA Center for Government Relations

CC: Members, Senate Committee on Budget & Fiscal Review  
Diane VanMaren, Consultant, Senate Committee on Budget & Fiscal Review  
Seren Taylor, Senate Republican Caucus

