

**Department of Health Care Services
Proposed Trailer Bill Language**

**Healthy Families Program Managed Care Plan Capitation Rates and
Transition of Children from the Healthy Families Program to Medi-Cal**

FACT SHEET

Summary

Under this proposed Trailer Bill Language (TBL) the Managed Risk Medical Insurance Board (MRMIB) would be required to negotiate managed care health plan capitation rates for children receiving health care services in the Healthy Families Program (HFP) at a statewide weighted average capitation rate that is less than or equal to the statewide average capitation rate established by the Department of Health Care Services (DHCS) for health benefits for children up to age 19 in the Medi-Cal program. MRMIB would be able to adjust the rate to add costs determined reasonable by the Department of Finance to reflect the cost of any services provided by HFP plans that, while available under Medi-Cal, may be carved out of Medi-Cal managed care plans.

Additionally, this proposal would require all HFP enrollees with family incomes up to 250 percent of federal poverty level (FPL) to transition to Medi-Cal as targeted low-income Medicaid children, as allowed under federal law, over a nine-month period beginning 90 days after enactment or October 1, 2012, whichever is later. Approximately 875,000 eligible beneficiaries will move from HFP to Medi-Cal in three separate phases. The transition would occur in a manner that minimizes disruption in services, maintains adequate provider networks, and ensures access to care. All new children with family incomes up to 250 percent of FPL seeking enrollment into HFP, based upon the implementation date of the first phase of this proposal will enroll in Medi-Cal.

Transition of HFP Children to Medi-Cal

The transition process would occur in three phases over a nine-month period as follows:

- Phase one, which would commence 90 days after enactment or October 1, 2012, whichever is later, transitions children enrolled in HFP plans that are also Medi-Cal managed care plans. Those children would, unless they choose a different Medi-Cal managed care plan, remain in the same plan after transitioning to Medi-Cal. The Medi-Cal managed care plans into which the children would transition must meet specified performance standards and comply with all existing performance standards and measurements set forth in the law prior to the transition of any children such as network adequacy, access to care, and linguistic services.

- Phase two transitions the remaining HFP enrollees that live in a county with a Medi-Cal managed care plan and were not included in Phase 1. It also allows them, to the extent possible and unless they choose a different Medi-Cal managed care plan, to enroll in a Medi-Cal managed care plan that includes their current primary care provider. The transition of the individuals in phase two would begin no earlier than January 1, 2013.
- Phase three transitions HFP enrollees in counties without Medi-Cal managed care. These individuals would receive services through managed care once DHCS expands managed care to those counties in June 2013. The transition of individuals in phase three would begin no earlier than January 1, 2013.

Under this proposal, once the enrollees transition into Medi-Cal for medical care, they will concurrently transition into Medi-Cal for dental coverage. Individuals enrolled in an HFP dental plan would transition to the same dental plan to the extent that the plan is a Medi-Cal dental managed care plan. If the enrollee's HFP dental plan is not a Medi-Cal dental managed care plan, DHCS would be authorized to contract with the dental plan to allow the individuals to enroll in the same plan. Individuals who are enrolled in the HFP Exclusive Provider Organization would enroll in the Medi-Cal dental FFS system.

MRMIB would be required to provide DHCS with specified information regarding their plan networks, including primary care and specialty care providers assigned to the children in their respective HFP health plan, along with cost, utilization, financial, and other data pertinent to a smooth transition. DHCS will use the information to analyze the existing HFP delivery system network and compare it to the Medi-Cal managed care provider networks and Medi-Cal FFS provider networks in counties that do not have Medi-Cal managed care. DHCS will determine overlaps of the provider networks, and if there are gaps, DHCS will work with the HFP provider community to encourage participation in the Medi-Cal program and develop streamlined provider enrollment processes.

The transition process would be complete by June 30, 2013, and HFP would cease to operate after all HFP enrollees up to 250 percent FPL are transitioned into Medi-Cal. DHCS will claim federal reimbursement for this population under Title XXI at the 65 percent federal and 35 percent state ratio that is currently applied to HFP.

Stakeholder engagement, legislative reporting, and beneficiary notification

The transition of HFP children into Medi-Cal will necessitate consultation between DHCS and stakeholders to ensure a smooth transition. Under this proposal, transition phases two and three would be conducted in accordance with implementation plans and developed in consultation with stakeholders, which ensures continuity of care and continued access for coverage. The proposal would prohibit DHCS from transitioning any enrollees in phases two or

three until 90 days after it submits the implementation plans to the Legislature. All individuals transitioning from HFP to Medi-Cal would receive in advance written notification that provides information about the transition including how the individual's system of care may change, and who they can contact for assistance with choosing a managed care plan or with other questions or problems. DHCS will develop these materials in consultation with stakeholders.

Eligibility

Under this proposal, HFP enrollees with incomes up to 250 percent FPL would be determined presumptively eligible for Medi-Cal, based on the most recent information contained in the enrollee's HFP file. The presumptive eligibility would continue until a Medi-Cal eligibility determination is made which would occur within one year of the individual's HFP application date.

County eligibility workers will make eligibility determinations for individuals who apply to HFP but have not yet been determined HFP eligible, transitioned cases, and all new applicants seeking services as of the effective date of the first transition phase. Individuals will continue to be able to apply for program services via the county welfare offices (in person, mail-in or online) or via the Single Point of Entry (SPE)/Public Access (PA) (mail-in or online).

Counties will make eligibility determinations as they do today for children applying at the local county welfare offices. Children with incomes up to 150 percent FPL will enroll into no-cost Medi-Cal, receive services through the appropriate Medi-Cal delivery system (managed care or FFS) and receive ongoing case management through the county. Children with incomes between 150 percent and 250¹ percent FPL will enroll in Medi-Cal and be subject to premiums. DHCS will use the same premium amounts as HFP. The existing contractor that handles HFP eligibility determinations will handle the ongoing case management of the cases for individuals with incomes between 150 percent and 250 percent FPL. DHCS will contract with a select number of counties (rather than all counties) to make the annual redetermination for these children.

The SPE vendor will continue to do the initial screening of applications it receives and will grant presumptive eligibility² for those who appear to meet established income guidelines. The SPE will forward the case to the county for a final eligibility determination. Once the county establishes eligibility, the income level of the child will determine how the case will be managed as described above.

This proposal would establish new county eligibility reporting and performance standards. Counties would be required to report to DHCS the number of

¹ As noted in the accompanying TBL, income eligibility for targeted low-income children is technically 200 percent of the FPL pursuant to federal Medicaid law. Thus for individuals with incomes above 200 percent and up to 250 percent the FPL, an income deduction pursuant to 42 U.S.C. Sec 1396(r)(2) is provided in an amount that will result in an effective income of 200 percent of the FPL

² DHCS is working out the details for how presumptive eligibility will be handled since elimination of this would be considered an ACA eligibility maintenance of effort violation.

applications and annual redetermination forms processed on a monthly basis, a breakout of applications and annual redetermination forms based on poverty level, final disposition of applications and annual redetermination forms, and average number of days to process applications and annual redetermination forms received directly into the county and from the SPE. DHCS would determine the manner and time period for county submission of reports and would provide enrollment information regarding the transition enrollees to the Legislature within one year of enactment.

Additionally, this proposal would establish a new 10 working day standard for counties for processing applications and redetermination forms received from the SPE and for acting on information received from the SPE that may impact eligibility for individuals with incomes between 150 percent and 250 percent FPL. Existing performances standards pursuant to current state law will still apply for those cases received directly by the county.

DHCS is in the process of consulting with the counties to develop a new budgeting methodology for eligibility processing. Currently application processing and case management for HFP enrollees is handled through a contract with an administrative vendor, using a per member per month (PMPM) rate. To the extent the new budgeting methodology currently under development is not complete, DHCS will use the budgeting methodology contained in the November 2011 Medi-Cal Local Assistance Estimate to determine county administrative costs for eligibility operations for children with incomes up to 150 percent FPL. For those children with incomes between 150 percent and 250 percent FPL, DHCS will develop an estimate of county eligibility operations based on the projected number of final determinations and projected county costs. Given the simplified application processing for these cases, the new budgeting methodology is necessary to demonstrate current and out year savings and to create the means to separately identify the county administrative costs for this population. This will also help to inform fiscal policy when adding new coverage groups under Medi-Cal as required in 2014 when national health care reform becomes operational.

Healthy Families children that are eligible for California Children's Services (CCS) will continue to receive CCS under the Medi-Cal program as they do today. Counties will continue to administer CCS for these children and be required to fund the same share of the non-federal share of the CCS costs as they do today for these children with a CCS-eligible condition.

Managed care plan standards

This proposal would require Medi-Cal managed care plans into which the HFP enrollees would transition, to meet specified performance standards and comply with all existing performance standards and measurements set forth in the law *prior* to the transition of any children. Additionally, the plans would be required to

allow the enrollees to remain with their current primary care provider, or report to DHCS how they will provide continuity of care.

The proposal would establish performance measures for dental managed care contracts. These measures will ensure continuity of care and improve access and accountability for dental plan performance for all dental managed care beneficiaries, including transitioned HFP enrollees. The proposal would also require the plans to report to DHCS specified information pertaining to transition implementation, enrollees and providers, including grievances related to access to care, continuity of care requests, and changes to provider networks.

Finally, this TBL would provide that infants born to mothers in the Access for Infants and Mothers (AIM) program, with incomes between 250 and 300 percent FPL, would be able to enroll into the HFP for their health care coverage until June 30, 2013 after which the HFP would cease to operate. As of July 1, 2013, these infants would be covered under the AIM program administered by MRMIB, or by DHCS if the Legislature approves the Administration's separate proposal to eliminate MRMIB and transfer AIM and its remaining programs to DHCS.

Background and History: Established in 1998, the HFP is California's version of the national Children's Health Insurance Program (CHIP) and provides comprehensive health, dental, and vision benefits through participating health plans for children who are not eligible for Medi-Cal. MRMIB administers the HFP and currently serves approximately 875,000 children up to age 19, in families with incomes up to 250 percent FPL. Families pay a monthly premium and the program subsidizes the remaining cost of coverage. Premiums account for 8.4 percent of total program expenditures. The General Fund funds 35 percent of the cost of program services, and federal CHIP funds under Title XXI of the federal Social Security Act (SSA) reimburses 65 percent of total program costs. Due to recent federal changes, the HFP operates under rules similar to Medi-Cal including the availability of an alternate choice for enrollees wishing to disenroll from a managed care plan, the inability to establish wait lists for program enrollment and the requirement to assure that federally qualified health care centers (FQHCs) receive reimbursement under the prospective payment system.

Currently, MRMIB's Chief Deputy Director and Lead Negotiator negotiates HFP rates with contracting plans during the months of January through April for Board approval in May. These negotiated rates are effectuated annually with an October 1 start date.

Under this proposal, MRMIB would be required to negotiate its managed care health plan capitation rates for HFP enrollees at a statewide weighted average capitation rate that is less than or equal to the statewide weighted average capitation rate established by DHCS for health benefits for children in the Medi-Cal program.

DHCS is the single state agency that administers Medi-Cal, California's version of Medicaid. Medi-Cal is a public health insurance program providing no or low-cost comprehensive health care services to approximately 7.7 million low-income individuals including families with dependent children, seniors, persons with disabilities, foster care children, and pregnant women. Of the population served, approximately 4.8 million are children up to the age of 21. Medi-Cal includes a comprehensive set of services including the federally required Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children. Medi-Cal provides services through FFS or managed care delivery systems, and a combination of state and federal Medicaid funds (under the federal SSA, Title XIX) pay for program services (50 percent federal funds and 50 percent General Fund).

AIM-linked infants

The AIM Program, established in 1992, provides medically necessary services to pregnant women with incomes between 200 and 300 percent of poverty through participating health plans. Eligibility for the AIM Program requires the pregnant woman to have no maternity insurance, or have health insurance with a high (over \$500) maternity-only deductible, and to have a family income too high to qualify for no-cost Medi-Cal. Babies born to AIM Program subscribers, referred to as "AIM-linked infants", are automatically eligible for enrollment in HFP for one year without review of the family's income. Family income at the first HFP annual review for the baby must be within the AIM program guidelines for continued HFP eligibility for the second year of coverage. AIM-linked infants enrolled in HFP are subject to the premiums imposed under HFP.

Under this proposal, children in income levels above 250 percent and up to 300 percent FPL are not considered to be targeted low-income children for purposes of Medicaid programs per federal requirements. However, this TBL does not change the current policy of the assuring health coverage for AIM-linked infants with family incomes that meet the income eligibility standard that was in effect in the AIM program at the time the infant's mother became eligible. AIM-linked infants with family incomes up to 250 percent FPL will enroll in Medi-Cal as targeted low-income children for the first 12 months of the infant's life. At the end of the 12 months, program eligibility is redetermined. The AIM-linked infant will be disenrolled from Medi-Cal if the family income exceeds 250 percent FPL. However, if their income does not exceed 300 percent FPL, they will remain eligible for a second year of coverage, which will be provided by HFP during 2012-13 and AIM beginning July 1, 2013. At the end of their second year, these infants will be screened for eligibility for the Medi-Cal program.

HFP will continue to cover all AIM-linked infants at income levels above 250 percent FPL up to 300 percent FPL throughout FY 2012-13, whether they are born in that fiscal year or are in their second year of AIM eligibility. However, since this proposal will end HFP on June 30, 2013, it will not be available to provide coverage to these AIM-linked infants after that date. As of July 1, 2013,

either MRMIB must cover these infants under AIM, or if the Legislature approves the Administration's proposal to eliminate MRMIB and transfer its remaining programs to DHCS, the AIM program and these babies would transfer to DHCS.

Why Changes are Necessary: This approach will create a more consumer friendly approach to coverage for children with a more streamlined enrollment and reenrollment process and expanded benefits including retroactive coverage, more comprehensive mental health services, better access to immunizations, and lower cost sharing.

The State is experiencing unprecedented fiscal challenges necessitating creative solutions across all state agencies and departments. Reducing the capitated rates paid on behalf of the HFP population to the level of rates paid in Medi-Cal while HFP enrollees transition to Medi-Cal will enable the State to save substantial funds.

Additionally, moving the HFP population to Medi-Cal would create state level operational efficiencies with program consolidation. HFP and Medi-Cal largely contract with the same plans creating inefficiencies at the state and plan level.

On an annual basis, the estimated cost for shifting HFP to Medi-Cal will result in approximately \$90 million in General Fund savings.

Additionally, recent federal legislation (i.e. the Children's Health Insurance Program Reauthorization Act of 2009 [CHIPRA]) imposed requirements on state CHIP that are similar to Medicaid requirements. MRMIB needs to contract with DHCS for cost efficient implementation of the requirements. For example, CHIPRA required CHIP plans to reimburse FQHC's in a similar manner as Medicaid using the prospective payment system. CHIPRA also required the CHIP program to offer a choice of health plans. In some areas HFP only had one plan and MRMIB was working with DHCS to use the Medi-Cal FFS system as a second option. Rather than having MRMIB contract with DHCS to meet those requirements, it is more efficient for DHCS to administer the HFP and capitalize on the existing Medi-Cal program infrastructure.

Finally, under federal health care reform, much of the HFP population will become Medi-Cal beneficiaries on January 1, 2014. If DHCS begins implementation of health care reform now, by providing services to this population now rather than waiting until 2014, it can focus later activities on other populations that will be coming into Medi-Cal by 2014 such as low income, childless adults.

Summary of Arguments in Support:

This proposal will simplify eligibility and coverage for children and families while providing additional benefits and lowering costs for children and certain income

levels. It will also provide for administrative efficiencies, achieve General Fund savings, and provide a more consistent health plan contracting process while increasing plan accountability for providing high quality services to children.

Specifically, the proposal:

- Begins an early implementation of health care reform and goes further by covering all children currently eligible for the HFP. Children ages 6-18 with incomes up to 133 percent of poverty become a mandatory coverage group under Medicaid programs in 2014.
- Makes available to low-income children comprehensive Medi-Cal services including EPDST.
- Provides more low-income children with no cost comprehensive health care services.
- Simplifies coverage options for low-income families and children, unifies family coverage, and provides “no wrong door” approach to eligibility.
- Facilitates implementation of federally mandated “Medicaid like” requirements under CHIPRA.
- Streamlines administration of California’s health care programs for its low-income populations, and simplifies contracting and benefit administration.
- Results in General Fund savings.
- Facilitates continuity of coverage when a family’s income fluctuates as the children will no longer have to transition between Medi-Cal and the HFP.
- Increases dental plan accountability and monitoring for all beneficiaries.

Is there a BCP associated with this language? – No

Legislative History:

Not applicable.