CHIP Reauthorization: Analysis of Policy Changes for Healthy Families

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About the Author

This report was prepared by Harbage Consulting, a Washington, D.C.-based health policy consultancy. President Peter Harbage has more than 17 years of experience in federal and state health care policy. He has served as special assistant to the administrator of the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services) and as an assistant secretary at the California Health and Human Services Agency, where he oversaw Medi-Cal and the Healthy Families Program.

About the Foundation

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I. Introduction

The reauthorization of the Children's Health Insurance Program (CHIP) in February 2009 included several policy changes that will affect California's CHIP program, Healthy Families. This paper provides an overview of key mandatory and optional program changes provided for under the reauthorization law.

Background

On Feb. 4, 2009, President Barack Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA 2009) into law, reauthorizing CHIP for four and a half years and increasing federal funding for the program over that time period by $32.8 billion. The midrange estimate for California's share of that funding is approximately 12 percent, or $1.4 billion in 2009 increasing to $2.2 billion in 2013.[1] CHIPRA 2009 made several changes to CHIP policy and financing, most of which took effect April 1, 2009. States are given more time to implement certain provisions, particularly if they require a change in state law. Based on the available funding, the Congressional Budget Office estimates that the legislation could extend coverage to 4.1 million children nationally who would otherwise be uninsured.

Although CHIPRA 2009 provides additional federal funding for CHIP programs, the law also requires a significant increase in state program activities, including expanding benefit packages and quality of care reporting. These activities will in turn increase operational costs. The total increased spending need cannot be determined until there is more guidance from the federal government and additional work to estimate costs.

Recent developments at the state and federal level suggest that there will be further changes to CHIP. While CHIPRA 2009 offers significant new federal funding for California and its Healthy Families program, drawing down those funds will require the state to continue to invest in Healthy Families. Enrollment had been temporarily halted due to budget concerns, but Healthy Families funding has since been secured and people on the waitlist are being enrolled. However, given ongoing budget concerns in California, the governor's budget proposal calls for a series of reductions to the Healthy Families program.

Federal health reform also presents an uncertain future for the CHIP program. At a minimum, CHIP will remain in effect in its current form during what will probably be a multiyear implementation period. However, there is significant discussion around possibly shifting CHIP children into a new insurance exchange, with CHIP then providing secondary coverage.

Despite the uncertainty, CHIPRA 2009 requires changes to the Healthy Families program. While it is still too early to know the ultimate impact of the state budget and federal reform on the program, this paper attempts to bring light to the federal changes needed as they stand in law today.

II. Issue Areas

This review focuses on the CHIPRA 2009 provisions that are most likely to require significant operational changes for Healthy Families, which is operated by the Managed Risk Medical Insurance Board (MRMIB). This analysis identifies changes that may affect administration of Healthy Families, as well as the enrollment process, benefit packages, and potentially cost sharing for certain services. In many instances, federal clarification is necessary to understand the exact nature of the changes. In addition, several of the federal changes will increase program spending, requiring the state to pay more to just maintain the Healthy Families program. A full explanation of the issues, and their impact on California, is summarized in Table 1.

Table 1: Issue Summary

Key Elements of CHIPRA 2009	**Federal Clarification Needed**	**State Law Change Needed**	**Implementation Deadline**
1. Citizenship Documentation Requirements Apply to CHIP Applicants	Federal rules for developing the Social Security number matching system will be required, as well as clarification of penalties for exceeding allowable error rates in the system.	Probably none if state uses Medi-Cal birth record matching system for Healthy Families citizenship identification rather than Social Security number matching.	Provision in effect.
2. Dental Coverage Required in CHIP Benefits	CHIPRA requires Healthy Families dental coverage to be "equivalent" to benchmark plans, but needs to clarify if Healthy Families' current dental benefits qualify.	If current Healthy Families dental benefits are not equivalent, state law must be changed to achieve compliance.	Jan. 1, 2011, if change to state law required.
3. Dental Benefits May Be Offered as Supplemental Coverage	The federal government will need to specify the process for creating a supplemental program and clarify prerequisites for offering one.	State law probably would have to be changed to offer the supplemental benefits.	No deadline.
4. Public Program	None.	California has submitted the necessary paperwork to	Provision in

Eligibility Extended to Legal Immigrant Children and Pregnant Women		earn additional federal dollars; approval is expected.	effect.
5. Matching Rate Reduced for Children with Gross Family Incomes Above 300% Federal Poverty Level	None, although clarification is needed on how to report children no longer eligible for CHIP enhanced matching rate.	None likely.	Provision in effect.
6. Medicaid Managed Care Standards for CHIP Plans	None, as Medicaid managed care standards are well documented.	If California cannot negotiate the reporting into contracts with Healthy Families plans, state law may need to be changed to require compliance.	July 1, 2009, if no state law change required; otherwise, Jan. 1, 2011.
7. Mental Health and Substance Abuse Parity in CHIP Benefits	Absent specific federal rules, it is unclear if California's current benefits meet the new parity requirement.	If Healthy Families mental health and substance abuse benefits do not meet new parity requirements, changes to state law will be required to bring the program into compliance.	Jan. 1, 2011, if change to state law required.
8. Performance Bonus Payments for Meeting Medicaid Enrollment Targets	It is unclear whether California meets the minimum five of eight metrics to qualify for bonus payments; federal clarification is required.	None required.	Provision in effect.
9. Prospective	Healthy Families does not	State law would need to be	Jan. 1, 2011,

Payment System Must Be Used for Federally Qualified Health Centers (FQHCs)	currently contract with FQHCs directly, and clarity is needed regarding whether the state would need to do so moving forward.	changed to allow Healthy Families to contract directly with FQHCs.	given that a change to state law is required.
10. Quality of Care Measuring and Reporting Requirements	Further information is needed on the exact reporting requirements, particularly as related to the quality of care delivered through CHIP plans.	No changes likely.	The first annual report is due in February 2011.
11. Translation and Interpretation to Receive Enhanced FMAP	None likely needed.	Unlikely, although Healthy Families will need to find a way to track translation and interpretation costs separately, which could be complicated given that costs are wrapped into capitation rates.	Provision in effect.

1. Citizenship Documentation Requirements

New law. Section 211 of CHIPRA 2009 requires CHIP programs to follow Medicaid rules requiring applicants to provide proof of citizenship and identity, as outlined in the Deficit Reduction Act of 2005, and includes support to help states meet this new requirement. CHIP and Medicaid programs may choose to meet the requirement by electronically matching CHIP applicant names and Social Security Numbers (SSNs). States that decide to develop this system can earn an enhanced Federal Medical Assistance Percentage (FMAP)[2] of 90 percent for implementation. This matching system would streamline the citizenship documentation requirement, but states would still need to collect proof of identity. States also have the option to conduct vital statistics matches in which applications are electronically compared to birth records. The bill specifically allows CHIP programs to cover children while determining their citizenship and identity (this is not presumptive eligibility, which allows doctors to treat patients under Medi-Cal while their full eligibility, including income, is verified).

Federal follow-up. Specific federal rules will be needed to help states develop SSN matching systems, if they choose to do so. In addition, specific federal rules are needed to set the penalties

which may be imposed if CHIP programs cannot meet the federal requirement of a 3 percent error rate on SSN matches, and to clarify whether the same error rare requirement will apply to states that use a vital statistics match. The federal government should offer technical assistance to the states.

California impact and next steps. This provision probably will affect Healthy Families more than Medi-Cal:

- *New citizenship requirement for Healthy Families.* Healthy Families has always required applicants to prove citizenship by providing their birth certificates and does not require applicants to provide SSNs. Healthy Families could choose to use the Medi-Cal citizenship verification system, which matches an applicant's information to vital statistics databases to find birth certificates, rather than developing a new SSN system. This probably will be effective given that most Healthy Families applicants were born in California and are in the state's birth record database. If Healthy Families were to pursue SSN match, a change in state law would be required.

- *New identification requirement in Healthy Families.* A more significant change for Healthy Families will be the new identity documentation requirements, which will disproportionately affect 17- and 18-year-olds. Only children 16 or younger are eligible to have their parents attest to their identification, so older children will need documentation of their identity.

- *Minimal impact on Medi-Cal.* Medi-Cal has already developed a birth record matching system; implementing a system for matching SSNs has a high level of technical difficulty.

California will need to determine how best to move forward in extending citizenship and identity documentation rules to Healthy Families, including how to maintain such records. The federal government issued guidance on December 28, 2009. While the new rules are now in effect, the state will need time to interpret and implement the specific changes.

2. Dental Benefits: Required Coverage

New law. Under Section 501 of CHIPRA 2009, CHIP programs are required to include dental coverage as a benefit. The dental services to be covered are defined broadly and include preventive, restorative, and emergency services. States must provide dental coverage "equivalent" to one of several benchmark plans; options include the most commonly selected state employee dental benefit packages and the most commonly selected federal employee dental plan. CHIPRA 2009 also requires states to implement a dental education program for new parents, as well as systems such as online provider lists and a telephone hotline to improve access.

Federal follow-up. The federal government should clarify what constitutes dental coverage equivalent to the benchmark plans, and whether it means providing the exact same benefit package or an actuarially equivalent plan would suffice. An actuarially equivalent plan would ensure children receive the same dollar value of dental services but not the exact same benefits, giving California flexibility in varying specific benefits. Requiring states to provide actuarially equivalent health plans has precedence in Title XXI. Without further federal guidance or regulations, California will not be able to determine compliance.

California impact and next steps. California currently provides dental coverage under Healthy Families based on the state employee dental benefit package. Healthy Families does not cover orthodontia benefits in the same way as the benchmark state employees' health plan, on which it is otherwise modeled. The private benchmark plan used by California requires high cost sharing for orthodontia services, exceeding the level generally preferred by the federal government for CHIP programs. Simply offering the private level of orthodontia benefits but with the lower CHIP cost-sharing requirements would create significant costs for the state. Due in part to the high costs of offering orthodontia benefits at Healthy Families cost-sharing levels, the state only offers this coverage through California Children's Services Program (CCS) to children who meet the CCS criteria. Orthodontia coverage for children is further constrained, although unintentionally, by the limited number of orthodontia providers participating in CCS.

The first step for the state is to determine if Healthy Families is in compliance with CHIPRA 2009. If the current package meets the new benchmark requirements, the impact on California may be small. If the state is determined to not be in compliance, then California must change state law to come into compliance with the requirement by Jan. 1, 2011.[3] As noted, offering orthodontia benefits to the entire Healthy Families population at low CHIP cost-sharing levels could result in a significant increase in costs to the state.

3. Dental Benefits: Optional Supplemental Coverage

New law. Also under Section 501, states are authorized to offer dental-only wrap-around benefits to children who qualify for CHIP coverage but have private health coverage that does not include dental benefits. This coverage must be as generous as the dental coverage offered through CHIP, and with the same cost sharing. While the state must require children to remain uninsured for a three-month waiting period prior to becoming eligible for enrollment in Healthy Families, the state can waive this waiting period for supplemental dental coverage if it wishes.

Federal follow-up. The federal government will need to specify the process for creating a supplemental program. In addition, the federal government will need to clarify what is meant by the requirement that states meet the "highest income eligibility standard" condition to create a supplemental dental program. This language is subject to interpretation because there is no one such standard for the CHIP program, as states are allowed to set their own eligibility standards.

CHIPRA 2009 clarified that only children with family incomes up to 300 percent of the federal poverty level (FPL) will be eligible for the enhanced CHIP match, but that does not limit states from increasing eligibility above that level and drawing down the reduced Medicaid match.

California impact and next steps. Children without dental insurance are less likely to receive dental care than those with coverage,[4] and public programs have reported spikes in dental utilization among children newly enrolled in public dental insurance.[5] Given ongoing state budget constraints, this expansion may not be financially viable for the state without obtaining outside funds, especially if the enrollment waiting period is waived. The only means of accurately determining the costs would be to conduct a full actuarial study of the benefit.

To be able to exercise this option, the state must certify that it meets criteria including:

- The income eligibility level for the overall CHIP plan is at the "highest income eligibility standard permitted" under Title XXI. California's program eligibility level is at 250 percent of the FPL, and clarification is needed to determine whether the state meets this ambiguous condition.

- Healthy Families "does not limit the acceptance of applications for children or impose numerical limitations, waiting lists, or similar limitation on the eligibility of such children." While there is currently no such limitation, Healthy Families regulations allow for one to be imposed. The federal government will need to clarify this issue through regulation.

- Healthy Families benefits are granted to all children who apply and higher-income children are treated no better than lower-income children in terms of dental benefits offered and cost-sharing.

4. Immigrant Children's Health Improvement Act

New law. Section 214 of CHIPRA 2009 allows states to extend Medicaid and CHIP coverage to immigrant children and pregnant women who are otherwise eligible for those programs and who have legally resided in the United States for five years or less. This population had previously been excluded from public health coverage programs by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Women and children must present documentation allowing the state to verify their legal immigration status.

Federal follow-up. None.

California impact and next steps. The state had already extended Medicaid and CHIP coverage to new legal immigrant children and pregnant women using 100 percent state dollars. Under this provision, the state has submitted the needed state plan amendment to begin drawing down on the enhanced match. This request is already pending with the federal government, and it is

expected to be approved. Once approved, the state will earn a 65 percent federal match for enrolled women and children, resulting in new federal dollars for the state.

By covering both Medi-Cal and Healthy Families legal immigrant children, the state will earn approximately $20 million a year, depending on the assumptions used.[6] By dropping the state-only program from Medi-Cal for legal immigrant children, the state would have reduced state fiscal year 07-08 spending by $7.9 million.[7] The benefit to the state is even greater with the enhanced Medicaid match that is currently available under the American Recovery and Reinvestment Act of 2009.

5. Matching Rate Reduced for Children with Family Incomes Above 300 Percent of Poverty Level

New law. Under Section 114 of CHIPRA 2009, any children enrolled in CHIP whose families' net income is above 300 percent of the federal poverty level will receive the regular Medicaid match rate of 50 percent. The enhanced match rate (currently 65 percent for California) continues to apply to children with family incomes below 300 percent of the FPL. States are not allowed to use "block of income" to make families with gross income above the limit eligible for the enhanced federal match. Previously, all covered children were funded at the enhanced rate.

The upper income eligibility limit in Healthy Families is a net family income of 250 percent of the FPL. States have some options to cover children with higher family incomes, including waivers to expand eligibility and income disregards. Income disregards allow certain types of income or expenses, such as child support or child care, to be deducted from a family's total gross income when calculating net income to determine eligibility.

At one point, California had been considering expanding eligibility limits for Healthy Families, which might have put the state at risk of losing the enhanced CHIP match for some newly enrollees. However, the state budget crisis has prompted policymakers to instead consider significant reductions. At the end of the legislative session in September 2009, eligibility remained unchanged.

Federal follow-up. The provision is clear and should not require additional guidance, other than how the state should report which children—if any—are no longer eligible for the enhanced match.

California impact and next steps. Today, California uses income disregards to maximize income eligibility. It will be necessary to determine whether the state's income disregards are allowed under CHIPRA 2009, and to determine if any children above 300 percent of the program can remain enrolled in Healthy Families. By law, the provision was effective in federal fiscal year (FFY) 2009.

6. Medicaid Managed Care Standards for CHIP Patients

New law. Under Section 403 of CHIPRA 2009, Medicaid managed care standards are extended to CHIP managed care plans. More specifically, all the provisions of Section 1932 of the Social Security Act apply to health plans providing services related to Title XXI. The provisions are a broad set of beneficiary protections, or "quality safeguards," that have been used in Medicaid over time. Some of the more critical standards include:

1. *Specification of benefits.* Every managed care contract must outline the benefits for which the managed care organization (MCO) is responsible.
2. *Emergency services coverage.* Out-of-network emergency services must be covered without prior authorization.
3. *Protection of patient-provider communications*. MCOs cannot interfere in providers' ability to provide professional advice to their patients.
4. *Grievance procedures.* MCOs must create internal grievance procedures for patients to challenge coverage or payment denials.
5. *Demonstration of adequate capacity and services.* MCOs must provide access to preventive and primary care services for the enrolled population.
6. *Protecting patients against liability for payment.* If the MCO or state fails to make payments for services provided to patients, those patients must not be held liable.
7. *Antidiscrimination.* MCOs cannot discriminate against providers acting within their scope of practice.
8. *External review.* Every MCO must provide for an annual review of quality outcomes and access to services.
9. *Restrictions on marketing.* All marketing materials used by MCOs must have the state's prior approval and cannot contain false or misleading information.
10. *State conflict-of-interest safeguards.* States must have conflict-of-interest safeguards for their employees with respect to any MCO.
11. *Sanctions for noncompliance.* The state may use various sanctions to force MCOs to comply with the requirements.

Federal follow-up. Medicaid managed care standards are well-documented by the federal government, and no immediate federal follow-up appears necessary as those standards can simply be applied to Healthy Families plans.

California impact and next steps. MRMIB operates Healthy Families managed care plans through contractual agreements it negotiates with the plans. Those agreements include provisions regarding eligibility appeals and other issues. In addition, California's extensive Knox-Keene managed care standards apply to Healthy Families plans, which means they are primarily regulated by the California Department of Managed Care. To the extent that Knox-Keene standards and the contractual obligations are inconsistent with the Medicaid standards, Healthy Families will need to bring the plans into compliance.

The next important step is for California to compare the Medicaid standards to both Knox-Keene and contractual standards to determine what changes are necessary for compliance. Given that many Healthy Families plans also participate in Medi-Cal, the rules should be well understood. If state law does not need to be changed, which is probably the case, California was due to bring Healthy Families plans into compliance by July 1, 2009. If the state determines a change to state law is required, the compliance deadline would be Jan. 1, 2011.

7. Mental Health and Substance Abuse Services Parity in CHIP Benefits

New law. Section 502 of CHIPRA 2009 is the latest in a series of federal mental health parity expansions,[8] including efforts in 2008 to extend mental health parity in Medicare and to some commercial insurance plans through the Emergency Economic Stabilization Act of 2008. Under CHIPRA 2009, if a CHIP program provides coverage for mental health and substance abuse services, that coverage must be provided with at least the same level of "financial requirements" and "treatment limitations" as medical and surgical benefits. The financial requirements provision means that mental health benefits must be subject to the same cost sharing as other medical benefits; for example, office visit copayments must be equal. The treatment limitations provision means that the actual mental health benefits must be the same as medical benefits; for example, mental health inpatient days cannot be limited if there are no limits to medical hospital inpatient days.

Many CHIP plans that stand separate from the state's Medicaid program, as in California, are based on state employee health coverage plans and offer more limited mental health coverage, consistent with private market coverage. Relative to the separate CHIP benefit package, new benefits under the new law are more extensive than those generally offered. Some CHIP programs, including all those offered through Medicaid, provide the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) health benefit—a comprehensive benefit package included in Medicaid offering any treatment a child needs for overall mental health well-being. EPSDT essentially covers screening for any mental health issue, and then any treatment prescribed for

that issue. CHIP programs that offer expansive benefits equivalent to the Medicaid EPSDT benefit may be deemed in compliance with this requirement.

Federal follow-up. California will need clarity on how states could fulfill the parity requirement and determine comparable financial and treatment limits, and whether the state's programs already meet those requirements. It is unclear whether the state's carve-out, described below, will meet the requirements of the law.

California impact and next steps. The key step will be determining how the new law overlays with California's current system and what changes are required. Today, Healthy Families provides inpatient and outpatient mental health services to all enrollees. Mental health and substance abuse services are provided through participating plans and are unlimited for individuals who meet the eligibility requirements established under state law for "serious mental illnesses."[9] Children with "serious emotional disturbances" (SED)[10]—a more serious categorization of mental health service need—also are eligible for unlimited mental health benefits, but those benefits are carved out of Healthy Families and generally are provided through county mental health departments. However, this raises a number of questions:

- *Is a mental health carve-out for services sufficient to fulfill the requirements?* CHIPRA could be read to require that the health plans must directly offer mental health parity. Children with mental health conditions that are not considered SED are not subject to state mental health parity laws and health plans may limit the services covered for those conditions. This lack of parity for some conditions makes it unclear if the SED carve-out approach will meet the CHIPRA requirement. If the current California system does not meet federal rules, then it could be necessary to significantly restructure how services are delivered, possibly requiring the plans themselves to offer services.

- *What is the availability of services?* While there is a process in place for delivering mental health services under Healthy Families, there are no evaluations of the process for referrals from a health plan to a county and then how, if any, services are delivered. The delivery of mental health services by the county is dependent on county funding, which could be inconsistent with the new law.

- *What is the interaction with existing law?* California already has a mental health parity law focused on certain mental health issues, known as AB 88. The goal was to increase parity in private insurance and lighten the burden of providing mental health services faced by public programs such as Medi-Cal and Healthy Families.[11] Further analysis is needed to understand if AB 88 is consentient with CHIPRA.

Moving forward with implementation will require federal clarification on whether Healthy Families' partnership with counties to serve SED children fulfills the parity requirement, or if California needs to adopt EPSDT benefits for all mental conditions. If California does not meet

the new parity requirements, then state law will need to be changed to bring the Healthy Families benefit package into compliance by Jan. 1, 2011.

8. Performance Bonus Payments for Reaching Medicaid Enrollment Targets

New law. Section 104 of CHIPRA 2009 establishes performance bonuses for states that improve enrollment in their Medicaid programs. To be eligible for the bonus, states must meet two requirements:

1. *Streamline Medicaid enrollment and retention practices.* States must implement five of the following eight enrollment and retention practices:
   - 12-month continuous eligibility;
   - Elimination of the asset test;
   - Elimination of in-person interview requirements;
   - A joint application and identification verification process for Medicaid and CHIP;
   - Automatic/administrative renewal processes;
   - Presumptive eligibility;
   - Premium assistance subsidies; and/or
   - "Express Lane" processes that allow other public agencies to determine Medicaid eligibility.

2. *Enroll target level of children in Medicaid.* Enrollment targets are based on the monthly average unduplicated number of qualified children enrolled in a state's Medicaid program in 2007. Qualified children are defined as being under 19 years of age and meeting certain immigration requirements.[12] Each year, states must increase the number of qualified children enrolled in their Medicaid program by a percentage of the 2007 baseline total enrollment (this is adjusted for a state's child population growth rate). The annual percentage increase shrinks over time. In 2008, the law sets the increase at 4 percent above the baseline, but by 2016 the increase is 2 percent. The required increases also are cumulative. For example, in 2013 enrollment is expected to be more than 20 percent more than the 2007 baseline to earn the full bonus (not including the population adjustment). If a state exceeds its baseline in a given year, the additional children enrolled above baseline will count toward enrollment targets the next year. If a state falls short, it must make up those enrollment numbers to achieve future targets.

   Performance bonuses will be awarded based on how well states meet or exceed their targets. For each child a state enrolls between 100 and 110 percent of its target, the state will receive a payment equivalent to 15 percent of the state's average per-capita Medicaid expenditures for qualifying children. This is essentially a one-time 15 percent subsidy for newly enrolled children. If a state enrolls more than 110 percent of its target, then the

federal government will provide an award of 62.5 percent of the state's average per-capita Medicaid.

Federal follow-up. Guidance from the Centers for Medicare & Medicaid Services (CMS) will be needed to:

- Verify that California meets five of the eight enrollment and retention processes;
- Calculate the change in child population. The Census Bureau can use different methodologies to calculate population rates. CMS should be specific as to the data needed for the calculation; and
- Confirm that states with negative child growth rates will be able to use that negative growth rate in the formula. It has been suggested that CMS would assume flat growth in the enrollment target formula for states experiencing a decrease in the number of children. This is because the law specifically refers to accounting for "increases" in enrollment due to population growth—not decreases.

California impact and next steps. California clearly uses four of the eight enrollment and retention practices required to receive the performance bonus: no asset tests, no in-person interviews, presumptive eligibility, and 12-month continuous eligibility (though only enacted this year, CHIPRA 2009 would seem to permit this as a qualification). The fifth potential practice is less clear. For example, "a joint application and verification" process for Medi-Cal and Healthy Families may qualify. While California has a joint application, it will be up to CMS to determine whether California qualifies for "joint verification," as counties are responsible for Medi-Cal verification while a private contractor is used to verify Healthy Families eligibility. If California does not meet the joint verification standard, then the state may want to implement another practice to ensure the state qualifies for the performance bonus. For example, California has pioneered the use of Express Lane eligibility, though not on a widespread basis.

Assuming California has five qualifying practices, then the second test must be met: the enrollment increase. The specific formula for determining the target enrollment can be complex, and Table 2 displays the calculations explained below. The needed steps can be summarized as follows:

1) Determine the baseline enrollment of qualified children in FFY 2007. Based on California Department of Health Care Services (DHCS) data, this is approximately 3.4 million children.[13]
2) For 2008, this amount is adjusted by the change in the state's population of children (-1.5 percent,[14] assuming negative growth is allowed by CMS) and then increased by 4 percent

as the target enrollment growth level. No bonus is possible for 2008, and this step is simply needed for the calculation. The resulting 2008 enrollment target is 3.48 million.

3) For 2009, the calculation process is the same is for 2008, with an adjustment of -1.6 percent for population,[15] and 4 percent as the target enrollment growth level. The estimated 2009 enrollment target is 3.56 million.

4) For future years, this process is repeated, although with a falling growth rate applied each year as provided by the bill and displayed in Table 2. The population growth rate is estimated to be 0.7 percent.[16]

5) If actual enrollment is between 100 percent and 110 percent of the target level,[17] then the state will be awarded a bonus of $109 per child. As provided for in the bill, this is calculated by taking 15 percent of the state share of Medicaid child spending as based on the most recent available Medi-Cal spending level for children ($1,228[18] in FFY 2006), grown forward at the National Health Expenditure rate to $1,458[19]). The use of the National Health Expenditure rate is based on statute because there is a data lag in determining actual state spending.

Table 2: Estimated Medi-Cal Enrollment Targets for Performance Award, 2009 to 2013

	2008	**2009**	**2010**	**2011**	**2012**	**2013**
Minimum Enrollment Level for Award	3,480,000	3,560,000	3,710,000	3,870,000	4,030,000	4,180,000
Minimum Needed Increase in Medi-Cal Child Enrollment (from 2007)		160,000	310,000	470,000	630,000	780,000
Adjusted Total Growth Rate	2.4%	2.3%	4.2%	4.2%	4.2%	3.7%
Adjustment - California Child Population Growth Rate	-1.5%	-1.6%	0.7%	0.7%	0.7%	0.7%
Statutory Growth Rate	4.0%	4.0%	3.5%	3.5%	3.5%	3.0%

Notes: According to the formula, the percentage adjustments are not added together but are calculated as separate steps, as reflected in the Adjusted Total Growth Rate. Chart assumes CMS will use the negative growth rates for population.

With the calculation completed, the next step is to project whether California is likely to earn a bonus. While FFY 2009 has come to a close, DHCS has not made available the needed enrollment data to determine if a bonus has been earned. Under Medi-Cal data systems, the most recent month available is January 2009,[20] which shows a total enrollment of 3.41 million—roughly the same average as FFY 2007.[21] However, data through September 2009 is needed to determine total enrollment for FFY 2009. Notwithstanding the seemingly flat growth, DHCS estimates that the number of qualified children will average 3.58 million children in FFY 2009.[22] Assuming that is achieved, California could earn a bonus of $2.18 million.[23,24] This analysis shows the importance of California accounting for negative growth. If CMS instead treats negative growth as flat, then the 2009 target level would be 3.68 million children[25] and California probably would not receive a 2009 bonus. Indeed, California would find it very difficult to achieve a bonus in future years if CMS fails to account for negative population growth.

9. Prospective Payment System for FQHCs

New law. Section 503 of CHIPRA 2009 requires CHIP programs to convert to the Medicaid prospective payment system for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics for all services provided to CHIP enrollees. While states have implementation options, the provision means that clinics will be paid for 100 percent of their average reasonable costs for a service, increased every year at a set inflation rate and adjusted for changes in volume and services offered. This is a change from the previous cost-based reimbursement payment system, which offers more restrictive payment levels. A total of $5 million will be available to all states to assist with this transition.

Federal follow-up. California needs to determine if Healthy Families would be required to contract directly with FQHCs under this provision. It is probably up to the state to decide how to implement this provision.

California impact and next steps. Unlike Medi-Cal, Healthy Families currently contracts only with health plans, and not directly with providers such as FQHCs. However, Healthy Families could implement a wrap-around payment approach to ensure FQHCs receive the reimbursement as required by law, as is done with Medi-Cal managed care. In order to do this, Healthy Families would create a supplemental payment schedule for clinics that also are paid by the managed care entity. Healthy Families could also decide to contract directly with FQHCs, but managing those contracts probably would increase state costs and staff workload. The change to the prospective payment system reimbursement under Medi-Cal—and the higher payment rates—has helped drive the 28 percent increase in utilization of California's FQHCs between 2003 and 2006.[26] It is reasonable to assume that clinic use in Healthy Families would increase as well due to this provision.

If California is required to change state law in how it chooses to comply with this provision, the deadline for implementation is Jan. 1, 2011. If no state law change is required, the deadline is Oct. 1, 2009.

10. Quality Care Measurement and Reporting Requirements

New law. Under Section 401 of CHIPRA 2009, the federal Department of Health and Human Services (HHS) was to develop a set of core child health quality measures and a Pediatric Quality Measures Program by January 2010. A standard format for reporting information must be completed by the federal government within two years of enactment of CHIPRA 2009. States are required to report on quality of care in their programs, and federal technical support and funding for collecting and reporting child health measures will be available for states to encourage voluntary use of the new measures.

Under Section 401(c) the states must provide annual reports to the secretary of HHS on "state-specific child health measures" including those listed in Section 401(a)(6)(A):

> "(i) quality related to the duration and stability of health insurance coverage for children under titles XIX and XXI;
>
> "(ii) the quality of children's health care under such titles, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and
>
> "(iii) the quality of children's health care under such titles across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care."[27]

Annual state reports shall also include "state-specific information on the quality of health care furnished to children under such plans, including information collected through":

- External quality reviews of managed care organizations under Section 1932 of the Social Security Act; and
- Benchmark plans defined under sections 1937 and 2103 of the Social Security Act, which include plans equivalent to the standard plans offered to federal[28] or state employees or the most common commercial HMO plan in the state. Alternatively, the state may use a different plan as long as it has been approved by the secretary of HHS.

Federal follow-up. Further guidance on the exact reporting requirements as they are developed by HHS will be necessary. While reporting on findings from external quality reviews is a defined process, the reporting on benchmark plans is not specifically defined in statue.

California impact and next steps. California will need to begin annual reports to the secretary of HHS by February 2011, but more clarification on what should be included in those reports is necessary. The full impact on California will ultimately depend on the extent to which Healthy Families must collect and report additional data to the federal government. There are two complicating factors here that the state will need to consider in developing data reporting systems.

- *Privacy laws.* Federal and state rules on privacy could complicate data collection. In general, privacy rules are designed to allow aggregate, non-personally identifiable data to be disclosed. However, ensuring compliance with the rules will be an administrative burden.

- *Data collection tools.* The intent of the bill seems to be to gather personal-level encounter data. There is currently no system available for doing that in California. The development of such a system would bring with it administrative barriers and significant additional administrative costs.

11. Translation and Interpretation to Receive Enhanced FMAP

New law. Under Section 201 of CHIPRA 2009, states will begin receiving an enhanced CHIP matching rate for translation and interpretation services provided to patients and their families for whom English is not their first language. This new rate is the higher of two options: 75 percent or the sum of a state's CHIP FMAP plus 5 percentage points.

Federal follow-up. Beyond technical guidance and changes to federal forms, no federal follow-up is likely needed.

California impact and next steps. California already provides the Healthy Families application and program information in 12 languages, and now could receive a 75 percent match for providing those services. However, this provision seems geared to helping states that make direct (and therefore easily identifiable) expenditures on translation activities. California purchases health care through managed care plans at a given per-member-per-month rate, and the state purchases enrollment services for a set monthly rate through an outside contractor, Maximus. As such, there is not an easily identifiable expenditure for translation services. It is possible that all Healthy Families contractors could make an effort to document the portion of their per-member-per-month rate dedicated to translation services, and then the state could seek a higher match rate for that cost. However, this could be administratively cumbersome and costly. California can begin claiming the enhanced translation and interpretation match immediately.

III. Conclusion

CHIPRA 2009 has made a number of substantive policy changes to the CHIP program. It is likely that these policy changes will affect those enrolled in Healthy Families, as well as the community-based organizations and local government workers who help administer the program. Given the significant amount of federal clarification required for California to implement many of these policy changes, there is an equal amount of uncertainty for what those changes will mean for enrollment processes, benefits, and cost sharing. As California receives greater clarity from the federal government regarding how the CHIPRA provisions will affect the Healthy Families program, the state should work with foundations, community-based organizations, and local agencies to bring every stakeholder in the system up to speed–including families.

Endnotes

[1] Author calculations. This is similar to other projections, including the $1.5 billion project allotment estimated by the 100% Campaign. Given the unanticipated enrollment waitlist in 2009, federal funds earned probably will be at the lower end of the estimate.

[2] CHIP programs, such as Medicaid, are funded by both the state and federal governments. The federal government matches a percentage of state spending on the programs based on a formula that includes state per capita income.

[3] If changes to state law are required for the other dental health provisions of CHIPRA 2009, including creating an encounter claims-based system for dental coverage to comply with the access and outreach provisions, the same implementation deadline of January 2011 would apply.

[4] Hughes, Dana. "Access, Use, and Costs of Dental Services in the Healthy Kids Program." The Urban Institute, August 2007 (www.urban.org/UploadedPDF/411528_dental_service_kids.pdf).

[5] Almeida, Ruth A.; Ian Hill; and Genevieve M. Kenney. "Does SCHIP Spell Better Dental Care Access for Children?: An Early Look at New Initiatives." The Urban Institute, July 2001 (www.urban.org/publications/310224.html).

[6] Harbage Consulting. "Funding California's CHIP Coverage: What Will It Cost: 2009." California HealthCare Foundation, 2009.

[7] Author conversation with California Department of Health Care Services staff.

[8] Mental health parity laws require insurance plans to provide the same level of coverage for mental and physical health care.

[9] Serious mental illness is defined in the California Welfare and Institutions Code 1347.72 as being one of nine specific mental conditions.

[10] Serious emotional disturbance is defined in California Welfare and Institutions Code 5600.3. It is a more serious level of status, and it considers the behavior of the child, not just the disease condition.

[11] Timothy Lake, et al. "A Snapshot of the Implementation of California's Mental Health Parity Law." Mathematica Policy Research Inc. for CHCF, March 2002 (www.chcf.org/documents/policy/SnapshotMentalHealthParityLaw.pdf).

[12] Children are excluded from this tally if they are covered under a new section of law created by CHIPRA, §1093(v)(4), which permits states to cover legal immigrant children within the five-year delay created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

[13] Author analysis of Department of Health Care Services enrollment data (www.dhcs.ca.gov/dataandstats/statistics/Pages/BeneficiaryDataFiles.aspx).

[14] The Census Bureau does not make enrollment growth rates available based on the federal fiscal year. This calculation is based on the weighted average of the enrollment change in 2006 (weighted at one-third) and 2007 (weighted at two-thirds) to reflect the 2007 federal fiscal year.

[15] The Census Bureau does not make enrollment growth rates available based on the federal fiscal year. This calculation is based on the weighted average of the enrollment change in 2007 (weighted at one-third) and 2008 (weighted at two-thirds) to reflect the 2008 federal fiscal year.

[16] Author calculation based on data from the California Department of Finance (www.dof.ca.gov/research/demographic/). While this may be an optimistic assumption given the recent population growth pattern and the state's weakened economy, it is the most recent information available.

[17] Given this analysis, there is little reason to assume that California will exceed 110 percent of the enrollment target, and therefore this analysis does not calculate the higher bonus level available under that scenario.

[18] "Medicaid Payments per Enrollee, 2006." Statehealthfacts.org (statehealthfacts.org/comparetable.jsp?ind=183&cat=4). The bill seems to imply that per-child spending should be calculated based on calendar year, not FFY. Calendar-year spending is not readily available.

[19] Based on National Health Expenditures (NHE) growth in total health expenditures of 6.1 percent in 2007, 6.1 percent in 2008, and 5.5 percent in 2009 (www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf). The secretary of Health and Human Services has discretion regarding the use of NHE and could opt to select the NHE Medicaid growth projections of 6.4 percent in 2007, 6.9 percent in 2008, and 9.6 percent in 2009. It is worth noting that NHE is based on calendar year, and Medicaid spending is based on the federal fiscal year. CMS will need to provide guidance on how it intends to keep the data consistent.

[20] It is common in all states for there to be a lag as long as 12 months in program enrollment numbers.

[21] Given the economy, it may surprise some that that the number of children enrolled in Medi-Cal in January 2009 is roughly the same as the FFY 2007 average. This could be related to the estimated drop in the number of children in California, according to Census Bureau estimates.

[22] "An Estimate of California's CHIPRA Enrollment Performance Bonus." DHCS Medical Care Statistics Section, undated.

[23] Federal funds available for the bonus are capped under the law. This assumes that there is no need to reduce California's funding under the cap.

[24] If the estimate is accurate, California would exceed the target by 20,000 children at a bonus of $109 per child. Numbers here are rounded to avoid giving a false sense of accuracy under the data limitations; the bonus payment would be based on actual enrollment.

[25] Based on author calculations.

[26] Capital Link. "California Community Clinics: A Financial Profile." CHCF, March 2009 (www.caplink.org/resources/California%20Community%20Clinics%20-%20A%20Financial%20Profile%20March%202009a.pdf).

[27] There appears to be a drafting error in that the law also requires states to report on Section 401(a)(6)(B): "the status of voluntary reporting by States under titles XIX and XXI, utilizing the initial core quality measurement set."

[28] The benchmark plan at the federal level is the standard Blue Cross/Blue Shield plan available through the Federal Employee Health Benefit Plan.