



Health Care Coverage and Access for Children in Low-Income Families: Stakeholder Perspectives from California

Research Brief 1

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State Statistics

- With a population of 38.8 million, California is the most populous state in the country; 24 percent of Californians are under age 18.
- The population of California is 61 percent white, 6 percent black, 14 percent Asian, 1 percent American Indian or Alaska Native, and 18 percent other; 39 percent of Californians are Latino or Hispanic.
- The governor and most state representatives and senators are Democrats.

Sources: California Department of Finance (2011); Henry J. Kaiser Family Foundation (2015); U.S. Census Bureau (2014a).



Map of California, with Monterey County (upper left) and Los Angeles County (lower left) shaded red.

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Policy Research

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Executive Summary

An important question to ask about any health care system is how well it serves children in low-income families. In California, the question raises much optimism, though there are continuing areas of concern. On one hand, 88 percent of eligible children were enrolled in Medi-Cal as of 2013, the state's Medicaid program, up 7 percent since 2007 (The Urban Institute 2015). Moreover, the state is now gearing to expand Medi-Cal eligibility to all children in low-income families. The increase is thanks to California's comprehensive implementation of the Affordable Care Act (ACA) and additional state-based initiatives that will soon expand. On the other hand, stakeholders are concerned that access to high quality health care services for children in low-income families is not keeping pace with rapid expansion in access to insurance.

Purpose. This issue brief was prepared as part of a small-scale qualitative study funded by the David and Lucile Packard Foundation to convey recent positive developments, remaining unmet needs, and emerging issues in children's health care coverage and delivery, from the perspective of knowledgeable stakeholders. Issue briefs on children's health in Colorado and Texas and a cross-state analysis will be available in early 2016.

Methods. The brief draws information from telephone interviews with 32 respondents in summer 2015. Respondents represented the California Department of Health Care Services, Medi-Cal managed care plans, primary care facilities, county indigent care programs, community clinics, community-based organizations, advocacy organizations, and a health foundation. To capture some of the variation in insurance access and care delivery across the state, the interviews focused on three areas: (1) the state as a whole; (2) Los Angeles (LA) County, the county with the greatest number of children enrolled in Medicaid or the Children's Health Insurance Program (CHIP); and (3) Monterey County, a largely agricultural county home to a large proportion of undocumented workers and their families.

Key findings. When asked about health insurance coverage, interview respondents identified positive developments in insurance eligibility expansion, outreach, and enrollment, stemming from both ACA mandates and state-based initiatives. With coverage for low-income children approaching a universal level, respondents are now more concerned with coverage retention and health care access and utilization. When asked about access to care, respondents described barriers that prevent children from accessing needed services—primarily an inadequate supply of primary and specialty providers, including dentists, who accept Medi-Cal patients, and that these issues were more severe in rural areas. Looking ahead, respondents will pay attention to the need for more and better quality monitoring of Medi-Cal managed care health plans, new California legislation that provides coverage for undocumented children, the redesign of the state's Medi-Cal carve-out program for children with complex health care needs, and the provision of long-term financing for Medi-Cal.

Implications for advocates, decision makers, and funders. Respondents identified a number of strategies for making the health care system in California work better for

low-income children in the years ahead that may be of interest to stakeholders working to improve children's health insurance coverage and access to care. These include (1) enhancing data collection and analysis to provide information to help identify coverage and access areas in need of improvement, (2) conducting outreach to enroll hard-to-reach populations and undocumented children who will become newly eligible for coverage in late spring 2016, (3) educating beneficiaries about the importance of obtaining health insurance coverage and using it appropriately, and (4) advancing workforce development to ensure that there are sufficient providers to serve covered children.

I. Access to Health Insurance Coverage

In what ways has it become easier for low-income families in California to obtain health insurance for their children in the past few years?

All children in low-income families in California will soon be eligible for publicly funded health insurance coverage, including those who are undocumented. Since 2013, California has covered low- to moderate-income children who are U.S. citizens or permanent residents through Medi-Cal with very broad eligibility requirements. Although some counties, such as LA, have historically offered local coverage options for undocumented children as well as for citizens and permanent residents, undocumented children statewide will become eligible for Medi-Cal as early as May 2016.

Parents have more opportunities to learn about health insurance coverage options. Respondents noted that outreach and enrollment efforts increased significantly in the past few years and that parents were more likely than ever before to see or hear messages on billboards, television, and radio, or to attend health fairs and community events promoting health insurance availability and enrollment. Respondents from LA and Monterey counties reported strong grassroots outreach efforts, especially by community clinics, and said that the provision of bilingual, bicultural outreach was vitally important in reaching families who are eligible for coverage.

Parents seeking coverage for their children can apply through many pathways, with or without assistance. Respondents identified a variety of enrollment pathways available to parents, including applying independently online or receiving assistance via certified enrollment entities, community-based organizations, school-based health centers, enrollment navigators or promotoras, community clinics, and county offices. Parents can also receive help with their applications or find organizations to help them via telephone hotlines through counties and Covered California, the state health insurance exchange.

"Political leadership has, by far and away, been the most important [driver of children's access to health care coverage in California]. The state has been on the front, or in the front, [of] just about every step of the implementation and didn't wait to pass implementation regulations or laws."

– State-level respondent

With more family members eligible for the same type of insurance, acquiring family coverage may be less complicated and confusing. Prior to the ACA, many California children were enrolled in Medi-Cal while their parents had other health insurance or were uninsured. Respondents explained that ACA expansion may have made coverage more convenient and less confusing for families because more parents and children may now enroll in Medi-Cal or the same Covered California plan. As a result, fewer families have to apply for, renew, or understand different coverage options for different family members. Stakeholders cautioned, however, that the existence of two insurance programs—Medi-Cal and Covered California—may also confuse parents because the

programs are not well-coordinated and families may receive multiple notices from each program.

What key factors are driving these changes?

California continues to be at the forefront of coverage expansion, especially for children. Nearly all respondents remarked that children in California have historically fared better than children in other states with regard to access to affordable health insurance coverage. They attributed this situation to the progressiveness of the state's elected officials, the hard work of advocacy organizations, and the existence of forward-thinking foundations, First 5 California county commissions, and health plans operating in the state. California-specific policies and programs that support access to health insurance for children in low-income families include:

- **Broad Medi-Cal coverage.** The income eligibility requirements for children to access Medi-Cal were expanded in 2013, when the state transitioned children from Healthy Families (its separate Children's Health Insurance Program) to Medi-Cal, and are more generous than those of the federal government and many other states. The implementation of CA Senate Bills 75 and 4 will further broaden Medi-Cal to undocumented children, as early as May 2016 (National Immigration Law Center 2015). California is the largest state to cover undocumented children in low income families. It joins Illinois, Massachusetts, New York, Washington, and Washington DC.
- **Gap programs.** Multiple local programs have historically existed in California to cover health care costs for children who do not qualify for Medi-Cal and do not have access to other health insurance options. Examples include Kaiser Permanente's Child Health Plan for children in the plan's service areas and Healthy Kids programs in some counties. LA County in particular has provided a number of coverage options for children from low-income families, meaning that most such children have been covered or have had the option for some time already. For example, the First 5 LA Healthy Kids program has provided health insurance coverage to children from birth to age 5 who are not otherwise eligible for state-sponsored insurance, irrespective of documentation status, since 2003. According to respondents, Healthy Kids will remain available until CA Senate Bills 75 and 4 are implemented and will act as a bridge to Medi-Cal for newly eligible children. In Monterey and other counties that lack similar coverage options for children who are not eligible for Medi-Cal, the implementation of CA Senate Bills 75 and 4 is expected to extend coverage to a large population of children for the first time.

ACA provisions drove many of the enhancements to California's coverage accessibility mentioned by respondents. Although adults were the focus of Medicaid expansion under the ACA, many respondents noted that California's expansion of Medi-Cal had several positive side effects for children:

- **No wrong door.** Many respondents reported that California embraced the ACA's "no-wrong-door" approach to coverage—the idea that wherever and however people try to get coverage, they will experience a seamless system that will help them find the most appropriate program—and that this increased the number of pathways through which parents and their children could enroll. Regardless of where parents tried to enroll themselves or their children, all family members were assessed for eligibility for Medi-Cal and Covered California plans. Other pathways to coverage in California include Emergency Medi-Cal (Presumptive Eligibility), which provides temporary coverage for children who need emergency medical care, and the one-time Express Lane enrollment via CalFresh, California's Supplemental Nutrition Assistance Program. In addition, the Child Health and Disability Prevention Program Gateway is an automated pre-enrollment process for low-income uninsured children and serves as an additional doorway for children to enroll in ongoing health care coverage through Medi-Cal.

Children's Well-Being

- 23 percent of children in California live in poverty.
- 43 percent of children in California (4.2 million) were enrolled in Medi-Cal in 2015.
- Medi-Cal/CHIP participation among eligible California children increased from 81 percent in 2008 to 88 percent in 2013.
- California's Medicaid program, Medi-Cal, covers children up to 261 percent of the federal poverty level (FPL). California does not have a separate CHIP program.

Sources: CMS (2015); Henry J. Kaiser Family Foundation (2015); Kenney et al. (2012); Urban Institute (2015); U.S. Census Bureau (2014b).

Health Care

- 5 percent of children and 17 percent of working-age adults in California lacked health insurance in 2014.
- California expanded its Medicaid program as envisioned by the ACA. It operates a state-based insurance Marketplace called Covered California.
- Most Medicaid services in California are delivered through managed care, at the county level.

Sources: DHCS (2015b); Henry J. Kaiser Family Foundation (2015); U.S. Census Bureau (2014c).

- **Welcome mat effect.** The “welcome mat” effect refers to insurance enrollment that results from eligible but unenrolled individuals’ exposure to heightened outreach and enrollment activities under the ACA. Although state-level respondents did not cite the welcome mat effect as a cause for significant increases in coverage state-wide, Monterey County respondents said the effect is noticeable in their county. They suggested that as more adults in the county became aware of their potential eligibility for Medi-Cal and applied for coverage, those who were parents applied for their children as well. Thus, the no wrong door policy and the welcome mat effect worked together to increase children’s coverage.

Funding from foundations, the state, and counties allowed for extensive outreach and enrollment efforts, particularly around the time of the ACA Medicaid expansion. Examples of the effects of these types of funding include:

- **Foundation funding.** The California Endowment provided more than \$20 million to the California Department of Health Care Services, which was then disbursed to counties, to increase Medi-Cal outreach and renewal efforts (DHCS 2014). Blue Shield of California also provided grants to counties to support outreach and enrollment efforts. A number of respondents said these grants supported strong outreach activities by community clinics and other community-based organizations, as they tried to target eligible but unenrolled children.
- **State funding.** Covered California gave grants to community-based organizations to identify people who might be eligible for coverage through the state’s health insurance exchange. Although this funding was not slated for outreach that targeted potential Medi-Cal enrollees, respondents explained that the no wrong door policy meant that many people who were screened for Covered California eligibility by these funded organizations were found eligible for and then enrolled in Medi-Cal.
- **County funding.** LA County respondents explained that First 5 LA established a more than 10-year contract with the LA Department of Public Health in 2003, which in turn subcontracted with community entities to support comprehensive outreach, enrollment, retention, and utilization efforts directed to low-income families with young children.

In what ways has it remained difficult for low-income families to obtain coverage for their children? What factors are at work?

Even though there is “no wrong door,” respondents explained that some doors may be “more open” than others. Because of inconsistent staffing and training, families may receive different levels of support and different information depending on how they try to enroll. For example, one respondent explained that, if a mother applies for coverage for her child online, the child is granted temporary eligibility while her application is being verified, but if the mother applies in person at a county office, the child is not covered temporarily. Similarly, staff at certified enrollment entities may have been better prepared than county staff to handle new income eligibility requirements such as criteria for foster care youth. A few respondents offered anecdotal evidence that many families who enrolled in Medi-Cal through Covered California brokers received less follow-up support than if they had enrolled through a Medi-Cal-specific enrollment entity. Respondents cautioned that for many parents, especially those with limited English proficiency or limited literacy, receiving high quality support in their primary language when enrolling for Medi-Cal coverage is critical because the application itself remains complicated and confusing.

Families face administrative complexities and may lose coverage when their income fluctuates or they move to another county. Respondents described the confusion parents experience when their income level changes and family members transition from Medi-Cal to Covered California or vice versa. Children may cycle on and off coverage plans, increasing the potential for them to fall off coverage as they transition

between public and commercial plans. A respondent from LA Care Health Plan (one of the county's two Medi-Cal managed care plans) described steps the plan is taking to support these families. Because LA Care Health Plan offers coverage through both Medi-Cal and Covered California, it is proactively identifying families with incomes on the border of the public and commercial plans and trying to link them to primary care providers that participate in both plans so that care remains as continuous as possible even as coverage changes.

Because Medi-Cal is operated at the county level, residents have to re-establish coverage if they move to a new county. This is a common (and longstanding) challenge for children in counties like Monterey, where many parents are migrant agricultural workers. Children in these families risk losing coverage if their parents are not proactive about obtaining new coverage after they move to follow the work. A respondent from the Central California Alliance for Health (Monterey County's Medi-Cal managed care plan) explained that the plan is taking steps to support these families by educating parents about how to re-connect to coverage in neighboring counties.

Renewal and redetermination processes pose challenges to families. These processes require parents to actively demonstrate their child's continued eligibility by responding to notices and affirming that there have been no household size or income changes and that they want to continue coverage. Although respondents said the switch to annual rather than quarterly Medi-Cal redetermination was an improvement, most argued that it was not enough to prevent children from cycling off coverage. For example, some claimed that it was common for parents to enroll their child in Medi-Cal when the child was sick or injured, and then to neglect to submit required paperwork to maintain or renew eligibility when the child was healthy; the parents would then have to re-enroll the child during the next illness or emergency experience.

The enactment of an ex-parte process for renewals means that the state can use electronic information available through the federal hub to make redetermination decisions and that counties can send prepopulated applications to individuals who are up for renewal. According to respondents, this process may make coverage renewal easier for individuals who enrolled recently because information necessary for redetermination is available through the federal hub. However, they also said it may complicate coverage renewal for individuals who enrolled prior to the ACA because required redetermination data on their household size and income are not yet available through the federal hub.

II. Access to Health Care Services

In what ways has it become easier for low-income families in California to get health care services for their children in the past few years?

Parents can turn to a variety of places to seek health care for their children. Many public and private health care organizations, including public hospitals, local health departments, community clinics, federally qualified health centers, rural health centers, and school-based clinics provide care to low-income and uninsured people, including those who are undocumented, regardless of their ability to pay. According to respondents, many low-income families continue to use these community-based "safety net" organizations even after they acquire health insurance coverage.

Although there is still a long way to go, children living in rural areas may more easily access health care services today than a few years ago. Respondents reported that the expansion of Medi-Cal managed care in 2012 to all 58 counties has likely improved access to primary and specialty care for children living in rural and remote areas. They explained that this is because managed care plans are held accountable to timely access standards and "have to find a way to make needed care available," whereas before the expansion of managed care, parents had to locate providers for their children on their

own – which could be especially hard when children needed specialty services. Respondents said that some health plans operating in rural areas have been experimenting with innovative ways to increase access, including the use of technology to deliver health services virtually (using telehealth strategies) when they are not available locally. In particular, they noted the use of electronic consultation, which enables primary care providers to consult specialists about a child’s treatment without having the child visit the specialist in person. Although improved since 2012, access to primary, and especially specialty care, remains challenging in some rural and remote areas.

The list of covered benefits is expanding for children with Medi-Cal. Respondents reported recent improvements to behavioral health service benefits under Medi-Cal. They explained that children with mild-to-moderate mental, emotional, or behavioral issues now have access to expanded benefits, and that children diagnosed with autism spectrum disorders will soon experience improvements to services covered through Medi-Cal. Additionally, many respondents noted that children who transitioned from Healthy Families to Medi-Cal now have access to more comprehensive screening, diagnosis, and treatment services than they did under Healthy Families.

What key factors are driving these changes?

California’s safety net continues to play a key role in the health care delivery system for children in low-income families. Respondents agreed that the safety net has been historically strong statewide, and is especially robust in LA County. The Community Clinic Association of Los Angeles County operates about 300 sites countywide and reportedly serves as a medical home for many county residents. In addition, the LA County Department of Health Services administers the My Health LA program. Complementing the insurance coverage provided to young children in the county through the Healthy Kids program, My Health LA offers no-cost primary care services to low-income county residents ages 6 and older who cannot get insurance. My Health LA also will serve as bridge to Medi-Cal for children newly eligible for coverage under CA Senate Bills 75 and 4.

Improvements in children’s access to care in remote areas were attributed to the expansion of Medi-Cal managed care. Many respondents cited the implementation of CA Assembly Bill 1467, which authorized the expansion of Medi-Cal managed care to Medi-Cal beneficiaries residing in 28 rural California counties, as instrumental in improving access. They hypothesized that residents in these areas experience better access under managed care because plans are required to provide timely access to specialty and preventive care. They referred to the example of Monterey County, where the introduction of Medi-Cal managed care improved access for children in rural agricultural areas of the county. Respondents attributed improvements in access to and quality of care in the county to the Central California Alliance for Health’s commitment to medical home transformation and the plan’s use of a case management model that links all beneficiaries to a primary care provider. The alignment of state Medi-Cal coverage and reimbursement policies for telehealth with state and federal regulations also supported improvements in access to care in California’s rural and underserved areas.

Improved behavioral health services reflect mandated Medi-Cal benefit expansions. Effective January 2014, managed care plans were required to deliver services to children with mild-to-moderate mental, emotional, or behavioral health issues. In September 2014, the state required plans to adhere to federal regulations by including behavioral health treatment for children as a covered service, including services for children with pervasive developmental disorder or autism spectrum disorder. Although implementation is delayed, the responsibility for the provision of behavioral health treatment services will transition from the state’s regional centers to Medi-Cal managed care plans in February 2016.

The transition of Healthy Families to Medi-Cal has improved preventive health care service benefits available for children. In accordance with federal Medicaid law, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit gives children access to comprehensive and preventive health care services and requires states to provide care considered “medically necessary” to treat or improve conditions discovered through screening. These services often include physical, speech/language, and occupational therapies; substance abuse and mental health treatment; home health services; and medical equipment.

In what ways has it remained difficult for low-income families to get health care services for their children? What factors are at work?

Children may not find access to primary care providers with sufficient capacity to provide high quality care. Although there was some debate among respondents as to whether there was an outright shortage of primary care providers who serve children or simply too few such providers who participate in Medi-Cal, the result is the same—some children in low-income families face challenges finding primary care providers.

“We are poised to be a county and a state where there is coverage universally available and I think the conversation is increasingly going to pivot from coverage to issues around enrollment and retention and, importantly, utilization.”

– Monterey County respondent

A number of respondents cited the state’s decision not to maintain Medicare-Medicaid payment parity after the ACA provision expired as one of the causes of the workforce shortages. A common concern was that low Medi-Cal reimbursement rates for outpatient care, coupled with burdensome administrative requirements for participation, mean that many providers simply choose not to provide care for children covered by Medi-Cal. Additionally, respondents noted that, while the transition of Healthy Families to Medi-Cal granted children access to a broader list of covered benefits, it may also have made it harder for children to find a provider who accepted their health insurance. Healthy Families paid higher rates to providers than Medi-Cal; respondents said that when those rates decreased, many of these providers either stopped accepting additional Medi-Cal-covered children, or curtailed services to children they were already seeing. A complicating factor is the high cost of living in California, which many respondents felt made it difficult for many providers to earn a living and keep their doors open when a large portion of their panel was covered by Medi-Cal. To overcome some of these provider supply concerns, some health plans such as the Central California Alliance for Health are providing incentives to member practices or clinics that want to recruit additional providers, including co-sponsoring recruitment costs and first-year salaries.

Respondents explained that, because so many primary care providers choose not to participate in Medi-Cal, many newly insured adults and children turn to safety net providers. They also said that many individuals who sought care through the safety net when they were uninsured continue to seek care from these providers once they have insurance because they have histories and trusted relationships with those providers. Respondents reported that safety net health clinics have become “completely overwhelmed” and that many are at capacity. There is concern that high-volume clinics have less time to provide patient-centered and comprehensive care. Respondents reported stories of families having to wait a long time to obtain appointments—even for newborn well-child visits.

Parents also have difficulty locating primary care providers because plan and network directories are often inaccurate and out of date. Respondents pointed to numerous

Los Angeles County Context

- Los Angeles County is the most populous county in the United States. It has 10.1 million residents, and 48 percent of its population is Latino or Hispanic.
- 27 percent of children in LA County live in poverty.
- 6 percent of children in LA County lacked health insurance in 2014.

Sources: U.S. Census Bureau (2014a, 2014b, 2014c).

Monterey County Context

- *Monterey County has approximately 430 thousand residents; 57 percent of its population is Latino or Hispanic, a higher percentage than in the populations of the state and LA County.*
- *27 percent of children in Monterey County live in poverty.*
- *9 percent of children lacked health insurance in 2014, higher than in both the state and LA County.*

Sources: U.S. Census Bureau (2014a, 2014b, 2014c).

examples of directories listing providers that no longer accept patients with Medi-Cal coverage. CA Senate Bill 137, passed in October 2015 and slated for implementation in July 2016, is designed to remedy this challenge by requiring health plans to keep their directories up to date.

Many low-income children, especially those who have special health care needs or do not live in cities, may have difficulty accessing specialty care. Most respondents agreed that children with complex health issues that qualify them for the California Children's Services (CCS) program have access to high quality specialty services through a certified provider network, but that children with less severe concerns have a much harder time. They remarked that some health plan networks do not include sufficient numbers or types of specialists and some plans do not adhere to timely access requirements. Shortages of psychiatrists, clinical therapists, developmental pediatricians, dermatologists, neurologists, endocrinologists, and gastroenterologists were most commonly reported. Respondents also remarked that some parents may be challenged with knowing how to navigate complex health care systems or how to advocate for their child's access to specialty care.

Reasons for the perceived deficiencies in access to specialists (outside the CCS program) are similar to those in primary care, and are exacerbated in rural and remote areas even though somewhat improved since before Medi-Cal expansion. Respondents in LA suggested that, although there may be an adequate number of pediatric specialists in the city, many do not participate in Medi-Cal. For example, although a respondent from Health Net (a for-profit company contracted to offer Medi-Cal managed care in LA County) remarked that the "network is pretty good," a respondent from LA Care (a publicly operated health plan that offers Medi-Cal managed care in LA County) reported concern that low reimbursement rates may affect the plan's ability to keep pediatric specialists in the network. Additionally, although there may be an adequate supply of providers in LA city, other areas, like Antelope Valley on the other side of the San Gabriel Mountains in northern LA County, remained underserved and residents often have to travel long distances to receive specialty care.

"I know that in some cases the hospitals and emergency departments end up being that point of contact, and in some cases transportation is a big issue. We have a very rural southern part of Monterey County where transportation can be a huge barrier, so there are community health clinics in existence, but I honestly don't know if there's enough to serve the need."

– Monterey County respondent

Accessing specialty services in counties like Monterey that have diverse geographic and socioeconomic regions and no large urban centers is more challenging for children in low-income families than for those in more populous counties - even after the expansion of managed care. Respondents reported an outright shortage of specialists, and described difficulty recruiting pediatricians and pediatric specialists to Monterey County, especially those willing to serve the Medi-Cal population. Recruitment challenges cited include the high cost of living and low Medi-Cal reimbursement rates. The county's Medi-Cal managed care plan, CCS program, and hospital system use creative strategies to increase patients' access to specialty care, such as telehealth and bringing in specialists from the San Francisco Bay Area a few days per month. It is not uncommon for children with complex and chronic health issues to receive care outside their county of residence.

Respondents uniformly agreed that children in low-income families throughout California have inadequate access to dental services. Again, low Medi-Cal (called Denti-Cal) reimbursement rates and an insufficient supply of dentists were cited as root causes.

Respondents also said the state's decision to exclude dental services from adult Medi-Cal coverage has negatively affected children's access to these services, stating that many dental provider networks that previously served low-income populations have collapsed. Although the state did invest in increasing Denti-Cal reimbursement rates in July 2014, none of the respondents could cite evidence that this increase had yet improved children's access to dental care. Respondents also mentioned that parents' lack of knowledge about the value of preventive dental care contributes to low utilization rates.

III. Emerging Issues and Opportunities

What issues will children's health stakeholders in California keep their eyes on during the next year or two, and why?

The need for data to assess and drive children's coverage and access to quality health services, the upcoming implementation of CA Senate Bills 75 and 4, the outcome of the CCS redesign effort, and prospects for funding Medi-Cal in the long term were high priority topics for many respondents.

- **Quality monitoring and improvement.** Respondents noted a need for improved monitoring of Medi-Cal managed care, especially for children, and increased efforts to publicly report and use these data to drive quality improvement efforts. Although California law requires health plans to separately monitor timely access to care for their Medi-Cal and commercial members, respondents reported that monitoring is rarely enforced. Because few data are currently available, respondents were unable to answer questions about access and utilization with confidence, and were even more hesitant to talk about the quality of care provided to California's low-income children. As one respondent explained, there is concern that many policy conversations are taking place "in a vacuum because no one really knows for sure what's going on. All you ever hear about are the anecdotes." Respondents suggested pushing the California Department of Health Care Services to invest in more robust data collection and to more carefully enforce its managed care contracts. Some also argued for the use of value-based purchasing (VBP), which would tie payments to outcomes. Although the state's 1115 waiver renewal, called Medi-Cal 2020, proposes using VBP with health plans, respondents said the focus was not on children's health care (DHCS 2015a).
- **CA Senate Bills 75 and 4.** Respondents are proud of recent legislation that will expand Medi-Cal coverage to the state's undocumented children and make access to coverage for children in California universal as early as May 2016. Yet they are concerned about the state's and counties' abilities to enroll these children and provide them with health care services. They warn that significant and tailored outreach will be required to convince parents, who may be too fearful of the legal repercussions of identifying themselves to enrollment entities, to even consider enrolling their legally residing or undocumented children. Respondents also fear that the provider networks may already be too stretched to serve this additional influx of patients. Respondents are eager to advocate for further Medi-Cal expansion to undocumented adults, positing that this would likely support the enrollment of undocumented children as well. They are anxious that the state and counties be able to reach and enroll these children because the stakes are high. As one respondent said, "if the State doesn't get close to its target [for enrolling children], it will have a chilling effect in terms of any further expansions to cover the remaining uninsured."
- **CCS redesign.** Respondents expressed uncertainty about how children with complex special health care needs who currently receive specialty care and supportive services (such as transportation assistance) through CCS will be affected by the rollout of a redesigned program in January 2016. Some are in favor of the redesign

because they think that accessing all care through the child's Medi-Cal managed care plan will be easier for families to navigate than the current CCS model in which children obtain services through multiple systems. Others fear that, following the redesign, children who were previously covered by CCS will lose continuity of care with the certified providers they have seen for many years and they may not have equal access to needed services through Medi-Cal. Respondents are awaiting lessons from demonstrations taking place as part of the redesign planning process, one of which is in Monterey County. The demonstrations are experimenting with regionalized delivery systems that integrate the special needs population into managed care, but results are not yet available.

"We're really good at expanding eligibility. You can put that on paper, you can pass a law. That costs us money, yes, that's true, but the federal government is picking up a large portion of that, at least for now. It's on the 'how much do we pay for services' and 'what benefits do we provide' where we've had a little bit more trouble, in part because they have become the center of budget debates as we've come out of some very tough times, and then have been making decisions about how to prioritize funding as we're moving into better times."

– State-level respondent

- **Long-term financing for Medi-Cal, especially if funding for CHIP is not reauthorized.** Many respondents are concerned that the state will be unable to pay for services if all recently enrolled beneficiaries and those who will be newly enrolled through CA Senate Bills 75 and 4 use their coverage. They are worried about the reappropriation of funding for CHIP in 2017 and the potential negative impacts of decreased federal funding on reimbursement rates and covered benefits.

What opportunities might advocates, decision makers, and funders choose to consider?

To further improve insurance coverage and access to high quality comprehensive services for low-income children, respondents recommended attention to and investments in the following areas:

- **Data collection and analysis.** Many respondents mentioned the need for information to answer key questions about which California children are currently enrolled in Medi-Cal or still uncovered, and how coverage translates to access and utilization of services. As one respondent said, "Until we can show there is a credible problem, we can't argue for money in the state budget to fix it." Respondents noted that it would be helpful to have support for more fully developing state and county health information technology systems to collect data that can (1) disaggregate children from adults; and (2) include key indicators of enrollment, retention, and utilization. Some applauded the California Department of Health Care Services' efforts to develop a pediatric dashboard, but thought it could be expanded to include more robust measures of access. Some suggested pushing for investments in targeted policy analyses and systematic reports that examine low-income children's access to care. Others suggested improved commitment by the state to track the Centers for Medicare & Medicaid Services Core Set of Children's Health Care Quality Measures.
- **Continued outreach.** Funding to organizations that provide outreach and enrollment support may be declining. Although the California Endowment grant funding will cover activities in many counties through June 2016, some long-term local funding such as that provided through First 5 LA will end in December 2015. Respondents caution that it may be too soon to de-emphasize outreach and

enrollment, especially as the state gears up to enroll undocumented children. They also described the continuing difficulty of reaching children in other traditionally hard-to-reach populations including those in very-low-income and homeless families, families in which parents do not speak English, and families living in rural areas. Respondents cited the importance of continuing to fund culturally and linguistically appropriate community-based outreach to disseminate information and build trust among these populations, and, in the case of undocumented parents, to assure them that their continued residence in the state is not at risk when they enroll their children.

- **Beneficiary education.** Many respondents expressed concern related to newly insured families' lack of familiarity with insurance and how to use it, especially in managed care environments. They worry that lower-than-anticipated utilization of services may be related to both provider-side (inadequate networks) and patient-side (health literacy) issues. Respondents suggested solutions such as investments in health systems' and providers' efforts to educate families about available covered benefits, the value of preventive care, and how to advocate for and receive the care they want. A few respondents suggested investments in broad communications campaigns to educate parents on these topics.

"Parents will deal with a broken bone. But really, for parents who are new to coverage, [to help] their kids access vision, dental, and behavioral health services ... education needs to be done for the whole family about the value in seeking that care, so that they actually access the benefit."

– Los Angeles County respondent

- **Workforce development.** Finding ways to increase the pool of primary and specialty care providers to serve children in low-income families continues to be a main priority for many respondents. Some suggested pushing for legislation to either increase Medi-Cal reimbursement rates or seek Medicare-Medicaid payment parity. Others suggested expanding the National Health Service Corps, providing loan repayment support, and offering other incentives for practices and health plans such as funding for medical home transformation efforts, information technology development, and training.

IV. Conclusion

Using data from interviews with children's health stakeholders, this issue brief has characterized the recent experiences of low-income families in California as they seek health care coverage and care for their children. Stakeholders are enthusiastic about the upcoming implementation of CA Senate Bills 75 and 4 legislation which will extend Medi-Cal to undocumented children, bringing eligibility for coverage among children in low income families to a universal level in the state. But their excitement is tempered with concern. They are apprehensive that the challenges with accessing care when needed – primarily an inadequate supply of primary and specialty providers who accept Medi-Cal payment – will only be exacerbated when newly eligible children enroll and use services. Stakeholders believe that continued outreach to newly eligible families to support enrollment; ongoing beneficiary education to inform newly insured families on how to effectively use their coverage; and workforce development to increase the pool of primary and specialty providers to serve covered children will further improve low income families' access to health care coverage and services. They also recommend investments in technology and measurement systems that support data collection and analyses specific to children and can thus pinpoint areas in coverage, access, and utilization that demand attention.

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