Lucile Packard Foundation for Children's Health

Issue Brief

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Children with Special Health Care Needs and California's Healthy Families Transition to Medi-Cal

Abstract

As California's state health officials start transferring children from Healthy Families to Medi-Cal, this report outlines some of the promises and pitfalls that lie ahead for families of children with special health care needs, and offers recommendations for a smoother transition.

Background

On January 1, 2013, The California State Department of Health Services began transferring nearly 860,000 children from the rolls of the Healthy Families program into Medi-Cal managed care. This is the largest transition between publicly funded health programs undertaken by any state. State policymakers decided to end the Healthy Families program and shift eligible children to Medi-Cal.

The state's Medicaid (Medi-Cal) program carries distinct benefits for children. Chief among these is the federally mandated Early Periodic, Screening, Diagnosis and Treatment (EPSDT) program. This gold standard for child health care benefits was designed specifically to assure comprehensive care, and is generally considered a good model to meet the medical care needs of children with special health care needs (CSHCN).

Unfortunately, the promise of California's Medicaid EPSDT program is compromised by the low rate of provider reimbursement that is paid – the lowest in the U.S. – which can cause providers to decline serving these patients.

The federal Children's Health Insurance Program (CHIP), which in California is called Healthy Families, offers states the opportunity to expand health coverage to families who earn more than the income limits that define Medicaid eligibility. The program allows states flexibility in designing the benefit plan and requires that families share some of the costs of care by paying part of the insurance policy premiums and copayments. Federal regulations require that the state's CHIP benefits be based on the largest HMO in the state or the federal/state employees benefit package.

Generally more restrictive than Medicaid, CHIP programs often result in fewer services being available, especially for CSHCN. This is particularly true for mental health and developmental services, as well as speech, respiratory, and occupational therapies for which states frequently limit the amount, duration, and scope. However, as a private insurance product CHIP generally offers higher provider reimbursement than Medicaid, which facilitates access to care. This higher rate is partly enabled by the higher federal match available to CHIP programs, compared to the match available to state Medicaid programs.

Rationale for Transition

By transferring patients covered by CHIP/Healthy Families to Medicaid/Medi-Cal, the State of California expects to lower costs by $73 million per year. This would be achieved by lowering administrative overhead through the concentration of administration in one program, simplifying eligibility determination, and paying providers the lower Medi-Cal managed care reimbursement rate. These cost savings may still be realized when the more comprehensive EPSDT services are extended to the additional 860,000 children.

During 2013 and 2014, the Affordable Care Act provides federal funds to increase the Medicaid reimbursement rate up to the 2009 Medicare rate for pediatricians, including most, but not all, pediatric subspecialists participating in the Medicaid program.

This rate is approximately double the current Medicaid reimbursement rate, roughly increasing reimbursement

payments to 80% of commercial insurance reimbursement. It is anticipated that this will encourage health care providers currently caring for children in the Healthy Families program to continue to offer care to their patients under Medi-Cal.

Critical Issues for CSHCN

Access and Continuity of Care: Whenever there are changes in insurance coverage, some patients experience lapses in continuity of care either through confusion about benefits, or changes in the panel of participating providers. The state should carefully address the following questions for families of CSHCN transitioning to Medi-Cal:

- How will continuity of care, especially pediatric specialty care, be monitored and assured?
- What is being done to assure that health plans have adequate numbers of pediatric specialists in their provider panels, especially for those operating in more rural areas that traditionally have limited access to pediatric specialty care?
- In some areas, Kaiser Permanente currently covers Healthy Families children. What Medi-Cal options will be available for children in these areas?
- How will children requiring mental and behavioral health services fare during the transition? How will children covered by Regional Centers, previously funded by Healthy Families, access care in Medi-Cal if they no longer meet the acuity criteria? (A recently passed law, SB 946, requires insurance coverage of these services in the Healthy Families program. Medi-Cal is exempt).

Costs: Pediatricians and subspecialists were spared the 10 percent cut in reimbursement experienced by adult care physicians under the Affordable Care Act. They will benefit from the new Medicare equivalency rate for Medi-Cal until the end of 2014. However, if Congress does not act to extend this federal provision, these funds will no longer be available for 2015. What are the state's plans to maintain these rates beyond 2014?

Monitoring of transition: Transitioning children from CHIP/Healthy Families to Medi-Cal will be an enormously complex administrative task. The state plans to implement the plan in four phases. It will take a year to complete.

What monitoring will the state conduct during the transition? What evaluation will be done after the initial phases to identify issues that will need to be dealt with to assure the rest of the transition goes well? Does the state have plans to report back on the transition in each of the planned phases? What access and quality criteria will the state use to assess success? Will gaps in coverage, adequacy of primary and specialty care networks, and pediatric health outcomes be evaluated during each phase of the transition? Will the monitoring reports be made public?

Recommendations

1) The state should have plans to address the most likely potential problems of the transition, and should be prepared to promptly implement those plans should it be necessary, such as slowing the phases of the transition, and implementing a process to ensure continuity of care for children whose health depends on established relationships with health care providers.

2) The state should plan for the transition of CSHCN and monitor system problems in real time. There will be an increased need for out-of-plan subspecialty care, transportation, and an expansion of the available health information technology to facilitate access and continuity during the transition.

3) The state should contract for a publicly reported evaluation of the transition after the first six and 12 months of the process. The evaluation should analyze changes in costs to the state, interruptions in continuity of care, access to primary and specialty care and patient satisfaction, particularly assessing the experience of families of CSHCN.