THE HENRY J. KAISER FAMILY FOUNDATION

S-CHIP IMPLEMENTATION IN CALIFORNIA

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EXECUTIVE SUMMARY

This issue brief examines the design and implementation of the California State Children's Health Insurance Program (S-CHIP) in its first year of operation. California's program, known as Healthy Families, provides eligible children a private health insurance benefit package. To learn how the program operated, we conducted an extensive site visit and also conducted a detailed analysis of all relevant S-CHIP documents and available enrollment, capitation, and quality data.

This California case study was part of a larger five-state analysis of S-CHIP implementation. Two of the other study states -- Connecticut and Utah -- also opted to enroll S-CHIP eligible children into private health insurance arrangements and two -- Maryland and Missouri -- chose to insure them through Medicaid. (See the Appendix for a description of the five S-CHIP programs.)

Our major study findings suggest that Healthy Families' unique administrative arrangement made implementation and administration easier for the state and the participating plans but that adolescents and children with special health care needs nonetheless faced difficulties accessing care.

- **Managed Care Contracting**. Healthy Families had fewer contracting requirements governing provider availability, access to care, and quality performance than Medi-Cal, California's Medicaid program. Plans, not surprisingly, appreciated that Healthy Families was structured in a manner similar to commercial insurance, as there were fewer contract requirements with which to comply.

- **Program Design**. The state's decision to impose cost-sharing requirements in the form of monthly premiums and copayments did not appear to be a barrier to care for families because the charges were nominal.

- **Adolescents' Access to Care**. Adolescents' access to certain covered services through Healthy Families was reportedly limited because of the lack of primary care providers able to provide multidisciplinary care, shortages of psychiatrists and psychologists, and the limited participation of dentists willing to accept new Healthy Families patients. While plans had sufficient family planning providers, and Healthy Families covered comprehensive family planning services, many adolescents reportedly obtained family planning services from other publicly funded providers to protect their privacy.

- **Wraparound Programs**. Benefits for certain children with special health care needs were available through two wrap-around programs, one for children with serious physical conditions and another for children with serious emotional conditions. The programs provided all physical health and almost all mental health services related to the child's eligible condition. However, provider shortages hampered children's access to care, and plan and provider confusion about the programs contributed to lower-than-expected participation.

- **Children with Special Health Care Needs' Access to Care.** For children with special needs who did not qualify for the wrap-around programs, accessing mental health and ancillary therapy services was reportedly difficult. Psychiatrists frequently limited the number of Healthy Families and Medi-Cal clients they would see, creating long waits for medication management and therapy services. Access to home health care and durable medical equipment was not mentioned as a problem. Providers reported, however, that plans' pediatric ancillary therapist networks were not adequate and that children with developmental delays and disabilities were seldom receiving ancillary therapy services through Healthy Families plans, but were instead being referred to regional centers and schools.

INTRODUCTION AND METHODS

This report, prepared for the Henry J. Kaiser Family Foundation, is a part of a larger study focusing on the implementation issues and challenges during the first year of S-CHIP operation in five states. Our goal was to understand how program arrangements and plan requirements influence program implementation for states and plans and the delivery of care for S-CHIP participants.

Healthy Families began offering coverage to children in families with incomes above Medicaid eligibility levels[1] and below 200 percent of the federal poverty level on July 1, 1998.[2] It also provided S-CHIP eligibility under Medi-Cal to uninsured adolescents ages 15 to 19 in families with incomes up to 100 percent of the federal poverty level. The program was unique among our study states in that it was administered by a quasi-governmental entity, the Managed Risk Medical Insurance Board (MRMIB). Healthy Families participants, all of whom were charged monthly premiums and copayments, were enrolled in managed care plans and received a benefit package modeled after the insurance program for state employees. Children with intensive physical or mental health needs were eligible for supplemental benefits which, along with their other specialty services, were furnished through wrap-around programs operated by the state's Title V program, known as California Children's Services (CCS), and the county mental health departments at no cost to families. The state had projected that 200,000 children would enroll in Healthy Families in the first year; at the end of its first year of operation, the program was serving 138,869 children. Approximately 2,000 of these children were being served by CCS and 425 by the county mental health departments.

At the outset of the project, we developed a detailed set of core research questions. These questions primarily addressed the intent and effect of various state and plan policies, such as state contract requirements regarding benefits, provider networks, and quality assurance, and plan payment and authorization policies for important covered services. From these core questions, we developed a model survey instrument for each of the groups to be interviewed. Based on our analysis of the state's S-CHIP plan and contract documents, we modified each instrument to reflect state-specific program arrangements. Each interview took approximately two hours to conduct and was later

[1] Prior to S-CHIP, California's Medicaid eligibility levels were set at 200 percent of poverty for infants, 133 percent of poverty for children ages 1 to 6, and 100 percent of poverty for children ages 6 to 15.

[2] Beginning July 1, 1999, S-CHIP coverage was extended to children in families with incomes between 200 and 250 percent of the federal poverty level.

followed up by additional telephone interviews and data requests to verify or clarify the information provided.

We conducted our California site visit in February 2000, meeting with the Healthy Families program director and senior staff, the medical director and other key staff from the two managed care plans with the largest Healthy Families enrollment, a variety of physical and mental health care providers, and families whose children have special needs. Interviews with program officials took place in MRMIB's office in Sacramento, and other interviews were conducted in Los Angeles County where the state's two largest Healthy Families plans were based.

The study is essentially a qualitative study that attempts to glean from the various perspectives of the state, the plans, providers, and families what the first year's experience of the S-CHIP program has been -- what aspects of the program appear to be working well and what aspects are causing difficulties or confusion. Our findings are based primarily on the opinions and insights of key decision makers as well as providers and families affected by state and plan policies. Often the responses of different groups were at odds, and understanding the complete picture was difficult. In these instances, we attempted to piece together what were the facts and underlying issues. Our findings are current only as of the date of our site visit. Healthy Families is now in its third year of operation, and, as enrollment has grown, and plans and providers become more experienced with the program, substantial changes have likely occurred.

This issue brief is divided into three sections. The first on administration and accountability addresses how the state made its basic program design and administrative decisions. The second section covers managed care contracting and examines the plan selection process, the managed care contract provisions pertaining to provider networks, quality reporting requirements, and capitation rates. The third section reviews access to care by selected population groups, including access to care by adolescents with regard to primary care, dental care, family planning, mental health care, and prescription drugs, and access to care by children requiring intensive physical or mental health services

delivered through managed care plans and in the wrap-around programs. The appendix briefly describes the other study states' S-CHIP programs and also includes five tables. Appendix Table I provides a summary of the five states' S-CHIP programs. Table II describes their benefits in detail and Table III describes their mental health benefits. Table IV summarizes their quality performance measures. Table V describes their cost-sharing requirements.

PROGRAM DESIGN AND ADMINISTRATIVE DECISIONS

APPROACH. California selected a non-Medicaid program for S-CHIP children, largely as a result of its governor's strong preference for a private health insurance option. Concerned that the stigma of Medi-Cal's association with welfare would discourage enrollment, former Governor Wilson insisted that the S-CHIP program not be affiliated with Medi-Cal, either in terms of benefits or administration. Another reason cited for using a non-Medicaid approach was the possible lower cost of a private sector option rather than expanding Medi-Cal.[3]

California, like the two other non-Medicaid programs in our study, also chose to require that participants not have insurance for a specified period of time prior to applying for Healthy Families. However, its required three-month period of uninsurance was half as long as that in the other two states. Criticism of the uninsurance requirement was much more muted in California than in the other study states, where providers thought long waiting periods were unfair for families who have children with serious physical or behavioral conditions and could not risk being uninsured for such a long period of time.

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[3] Unlike the other states in our study, California conducted a financial analysis prior to implementing an S-CHIP program to determine whether expanding Medi-Cal or developing a new program would be less costly. In fact, two analyses were conducted, which yielded different results. A state-financed study concluded that a non-Medicaid option would be less expensive, costing $74.75 per month per child, compared with $76.60 per month per child under a Medi-Cal expansion. A privately funded study, sponsored by the Henry J. Kaiser Family Foundation, concluded the opposite, primarily because of lower utilization assumptions.

BENEFITS. California modeled its Healthy Families benefit package after that of the state employees' health benefit plan as did the other two non-Medicaid programs in our study. However, it added vision and comprehensive dental services, which would not otherwise have been included. The package included unlimited coverage for hospital and physician services and prescription drugs. It also provided limited coverage for ancillary therapy services, outpatient mental health services, inpatient mental health services, outpatient substance abuse services, inpatient detoxification, durable medical equipment, home health care, and skilled nursing care. (See Appendix Table II.)

To assure a comprehensive benefit package for children with special needs, California elected to offer two wrap-around programs to children who qualified as having a serious physical or mental health condition. Children with selected chronic physical conditions who require tertiary level, multidisciplinary, or multispecialty care[4] could receive supplemental ancillary therapy visits, durable medical equipment and medical supplies, home health care, and dental services. They could also receive certain services not available through the regular Healthy Families benefit package -- specialty care center services, medical nutrition therapy, nonemergency transportation, and case management. Children with severe emotional disturbances that cause substantial impairment or risk of harm[5] could receive supplemental outpatient mental health visits, inpatient hospitalization services, and residential treatment services in addition to

[4] These are children with serious illnesses in diagnostic categories that include: infectious diseases; neoplasms; endocrine, nutritional and metabolic diseases and immune disorders; diseases of blood and blood-forming organs; diseases of the nervous system; diseases of the eye and ear; diseases of the circulatory system; diseases of the respiratory system; diseases of the digestive system; diseases of the genitourinary system; diseases of the skin and subcutaneous tissues; diseases of the musculoskeletal system and connective tissues; congenital anomalies; perinatal morbidity; and accidents, poisonings, violence, and immunization reactions.

[5] These are children who have a mental disorder other than a primary substance abuse disorder or developmental disorder and who meet one or more of the following criteria: 1) the child has impairments in at least two functional areas (self care, school functioning, family relationships, or ability to function in the community) and either has been removed or is at risk for removal from home or has a condition and impairments that have persisted for six months and are expected to continue a year or longer without treatment, 2) the child shows psychotic features or risk of suicide or violence due to a mental disorder, or 3) the child meets the special education eligibility requirements.

services otherwise not covered, including day rehabilitation, crisis intervention, intensive outpatient therapy, and targeted case management.

COST SHARING. California, like one Medicaid and one other non-Medicaid state in our study, chose to require monthly premium payments. California's premiums were the lowest among the study states ($7 to $14 per child, depending on income level), as shown in Appendix Table V. Healthy Families staff and families considered premiums to be both affordable and a good value. Moreover, it was the only state in our study to institute a special administrative mechanism to facilitate premium collection, allowing families to pay their premiums for three months at a time and receive the fourth month of coverage at no cost. The policy reportedly has been quite popular among Healthy Families participants and has minimized administrative burdens for the state. Still, as in the two other states with premiums, nonpayment of premiums was the leading reason for a child to be disenrolled from Healthy Families, although the total number of disenrollees in the first year was very low.

The state also chose to make Healthy Families participants responsible for copayments at the time of service, as did three other study states. The copayments were nominal, $5 for most services, with the exception of vision services and eyeglasses, which carried higher copayments ($10 and $25, respectively). In addition, no charges were imposed for medical equipment, home health care, lab and x-ray services, inpatient and outpatient hospital services, and audiology services.

In California the maximum annual out-of-pocket liability for families was set at $250, which would assure that no family's cost-sharing obligation exceeded five percent of its income. Among our study states, California was the only one that required families to be responsible not only for tracking their own out-of-pocket expenses but also for notifying the plans when they met the out-of-pocket maximum. When the maximum was reached, plans were expected to inform providers when they called for verification of enrollment that the family could not be charged a copayment and to adjust their

reimbursement amount accordingly. California reported that only 11 families met the cost-sharing maximum in the program's first year, but the extent to which families understood their reporting obligations was unclear, even though these obligations were explained in the Healthy Families Program Handbook. Families we interviewed were generally unaware that there was an out-of-pocket maximum or that it was their responsibility to track it. Although families in the other states with copayment requirements may also have been unaware of the out-of-pocket maximum, tracking still occurred because the responsibility rested with either the state or the plans.

ADMINISTRATIVE INFRASTRUCTURE. To implement a private health insurance option, California selected an administrative entity independent of the Medi-Cal program. Instead of relying on the Medicaid infrastructure, as the other non-Medicaid states in our study did, the legislature chose to use a quasi-governmental entity -- the Managed Risk Medical Insurance Board (MRMIB) – to administer the S-CHIP program. The legislature and the governor made this decision because MRMIB already had demonstrated experience implementing and administering new health benefits programs.[6] Plans and representatives from the wrap-around programs spoke highly of the agency's efficiency and limited oversight and involvement, and, unlike in the other two non-Medicaid states, plans did not criticize the agency for failing to understand the differences between the Medicaid and S-CHIP programs.

The state chose to contract with managed care plans to deliver all Healthy Families benefits except dental and vision services, for which separate plans were chosen. Only specialty services for children with intensive physical health or mental health needs were furnished on a fee-for-service basis. To deliver these services -- including both the enriched package of specialty services and those that would otherwise be available from plans -- the state contracted directly with its Title V CCS program, which has a network

[6] One of these programs is for low-income mothers and infants, and the other is for persons considered to be high insurance risks. At the time of implementation, MRMIB also administered the purchasing pool for small businesses, a responsibility that was recently given over to the Pacific Business Group on Health.

of approved pediatric providers and specialty care centers, and with its county mental health departments, which have community-based provider networks. The CCS program and the county mental health departments were given responsibility for determining eligibility for the enriched package of specialty services.[7]

MANAGED CARE CONTRACTING

PLAN SELECTION. Among our five study states, California, because of its size, contracted with the largest number of managed care plans. In the program's first year of operation, the state contracted with four dental care plans and one vision care plan as well as 26 health maintenance organizations (HMOs) and exclusive provider organizations (EPOs). In the majority of the state's 58 counties, enrollees had a choice of at least two managed care plans; seven counties had only one EPO available.

California had solicited bids from all interested parties and based its selection of plans on whether the plan had an adequate provider network, was financially solvent, and had the capacity to perform the contract requirements.[8] Of the 26 plans that were selected, 20 were among the state's 24 Medi-Cal contractors and four were serving the Medi-Cal population as subcontractors.[9] State Healthy Families staff reported that obtaining contractors had not been difficult because Medi-Cal plans were eager to participate in Healthy Families. Staff thought that this was a positive outcome and that using Medi-Cal contractors to serve the Healthy Families population was better for

[7] The state has the same arrangement with the Title V program for Medi-Cal, but the arrangement with the county mental health departments is somewhat different: under Medi-Cal, all mental health services -- not just those for seriously emotionally disturbed children -- are carved out of the capitated contracts and provided by the counties.

[8] The California S-CHIP contract incorporates the regulatory requirements of the Department of Corporations. All participating plans were expected to meet these requirements and obtain what is referred to as a "Knox-Keene" license by July 1, 2000. Only one plan chose not to pursue a Knox-Keene license and did not continue participating in Healthy Families when the new contract period began July 1, 2000.

[9] Two Medicaid plans in the Two-Plan Model of Medicaid managed care -- one in Los Angeles County, and the other in Orange County -- contract with other plans to serve Medicaid enrollees.

families transitioning between the two programs, and was particularly important in California, where families might have children enrolled in both programs.

CONTRACT REQUIREMENTS. California took a very different path from the other four study states in developing its Healthy Families managed care contract. Rather than relying on the existing Medicaid contract, MRMIB chose to model the Healthy Families contract on one used for the state employees' benefit plan, and relied primarily on regulations for commercial HMOs issued by the Department of Corporations. As a result, California's contract included the fewest managed care requirements among our five study states. With respect to provider network requirements, the contract established a numerical ratio for primary care -- 2,000 children for every provider -- but included no requirements pertaining to specific types of pediatric specialists or subspecialists, as other states did, for pediatric medical subspecialists, surgical specialists, ancillary therapists, and mental health providers. Interestingly, though, the state did encourage subcontracting with traditional and safety net providers by enabling the plan that subcontracted with the largest number of these providers in each county to offer a discounted premium.[10]

With respect to access standards, the Healthy Families contract did not specify any distance, appointment, or other provisions related to the availability of care. In contrast, the other study states all had appointment standards – such as enrollees must be able to have an appointment within 30 days -- for emergent, urgent, and routine primary care, and three states specified appointment standards for specialty care. Three states also had distance standards – such as a provider must be available within 15 miles -- that addressed primary care and, in some cases, dental, pharmacy, and mental health services as well.

[10] These plans are known as community provider plans.

With respect to quality reporting requirements, the state specified only a limited number of clinical effectiveness, utilization, and access and availability of care measures and required no encounter data submissions, as shown in Appendix Table IV. The clinical effectiveness measures required were childhood and adolescent immunizations and ambulatory follow-up after hospitalization for mental health disorders. The one utilization measure required was for well-child visits, and the two access measures were for annual primary care and dental visits. California was the only one of the study states not to require plans to conduct an annual member satisfaction survey, although it was intending to conduct a survey in the coming year. While plans in the other study states with non-Medicaid programs were required to submit semiannual reports on complaints and grievances and their resolution to the state S-CHIP agency, those in California were required only to submit annual reports on grievances. California, though, was one of two states in our study to include information about the complaints and grievance process in materials given to families.

CAPITATION RATES. The state established its S-CHIP capitation rates on the basis of competitive bidding and subsequent negotiation, as did another of our study states. Healthy Families, however, established an acceptable upper limit for each geographic area by averaging the two lowest bids and adding ten percent. The capitation rates varied according to geography, but not enrollees' age, gender, or health status. In the program's first year, the average statewide composite rate for the general managed care plans, dental plans, and vision plan was $70.23.[11] This rate was slightly higher than the rate paid in one of our two non-Medicaid states (Utah), but only about 60 percent of the rate paid in the other (Connecticut).

Managed care plan officials found the Healthy Families capitation rate to be generally reasonable, given their limited responsibilities for specialty services. The largest dental plan had a different perspective on the adequacy of the rates, however.

[11] The state would not release separate rates for basic health, vision, and dental services.

This dental plan had based its original capitation bid on its experiences with the Medi-Cal program, but Healthy Families enrollment and utilization exceeded its expectations. As a result of its difficulties, the plan chose not to re-bid to participate in four counties that accounted for more than 50 percent of Healthy Families enrollment for the new contract period that began July 1, 2000.[12]

ACCESS TO CARE BY SELECTED POPULATION GROUPS

ACCESS TO CARE BY ADOLESCENTS

Adolescents constituted a large proportion of S-CHIP enrollees in California. In the first year of the Healthy Families program, 32,949 or 23.7 percent of all enrollees were adolescents ages 13 to 18.[13] Attending to the health care needs of adolescents is critical because of their behavioral risk status[14] and their low health service utilization rates,[15] which are substantially different from those of younger children. Adolescents commonly require comprehensive preventive and primary care, including risk assessment, anticipatory guidance, and counseling; dental care, including preventive, diagnostic, restorative, and emergency treatment; reproductive health services, including pregnancy and sexually transmitted disease services; and mental health services, including evaluation, outpatient counseling, medications, and case management.

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[12] Dentists raised concerns for the future of dental care in Healthy Families as a result of the largest plan curtailing its involvement. The other three dental plans are dental HMOs, which capitate the participating dentists and reportedly have onerous authorization policies and, as a result, have difficulty attracting a sufficient number of providers.

[13] According to the U.S. Census Bureau, adolescents age 13 to 19 constitute 28.7 percent of the child population in California with family incomes between 100 and 200 percent of poverty.

[14] Clayton SL, Brindis CD, Hamor JA, Raiden-Wright H, and Fong C. *Investing in Adolescent Health: A Social Imperative for California's Future.* San Francisco, CA: University of California, San Francisco, National Adolescent Health Information Center, 2000.

[15] Ozer EM, Brindis CD, Millstein SG, Knopf DK, Irwin CE. *America's Adolescents: Are They Healthy?* San Francisco, CA: University of California, San Francisco, National Adolescent Health Information Center, 1998.

PRIMARY CARE. The Healthy Families benefit package covered primary and preventive care services, including immunizations, well-child care, and physician office visits, and staff from the largest managed care plans reported having a sufficient supply of primary care providers to serve the adolescent population, as was the case in the other four study states. The two California plans we interviewed -- those serving the largest number of Healthy Families participants -- based this assessment on providers' identification of the age groups they were interested in serving; they did not use specific criteria to designate primary care providers with experience and training in the care of adolescents. Although a large proportion of primary care providers self-designated an ability to serve adolescents, we heard from adolescent providers that many community-based primary care providers did not have the requisite skills, experience, and confidence to address adolescents' unique health care needs effectively.

Access to multidisciplinary primary care was difficult because few hospital-based adolescent clinics were participating in plans' provider networks. In addition, comprehensive school-based clinics did not participate as primary care providers in either of the two plans we interviewed because they lacked the capacity to deliver year-round primary care.

Reimbursement concerns contributed to access difficulties. Although plans reimbursed adolescent primary care providers for an initial adolescent preventive visit at rates that were equal to or higher than commercial rates,[16] primary care providers reported that without enhanced payments, they could not be expected to provide all components of a comprehensive preventive visit for the adolescent age group.[17] Moreover, if high-risk behaviors were identified during a preventive visit that required follow-up monitoring and counseling, the plans had no mechanism to pay for these as

[16] The largest plan paid $64 for an S-CHIP adolescent preventive visit and $40.52 for a commercially insured adolescent. The other plan paid $80.85 for both populations. In the other study states, the S-CHIP reimbursement rates for preventive care ranged from $23 to $120 and the commercial rates from $40 to $120.

[17] The *Bright Futures* recommendations, developed by the federal Maternal and Child Health Bureau, and the *Guidelines for Adolescent Preventive Services* (GAPS), developed by the American Medical Association, both direct primary care providers to conduct a detailed assessment of adolescents' social, emotional, and physical development and provide anticipatory guidance.

interperiodic preventive health services. In addition, hospital-based adolescent clinics could not bill in either of the two plans under a clinic category that would encompass multidisciplinary care.

DENTAL CARE. Healthy Families included a generous dental benefit, with preventive, diagnostic, and restorative services. Only orthodontia was excluded, as it was in one other non-Medicaid state. Although California's largest dental plan listed 5,500 dentists, we heard that dental networks were not adequate to serve Healthy Families enrollees effectively because dentists limited the number of publicly insured clients they served. Dental network shortages were pervasive, reportedly involving both general and specialty dentists. One of the major reasons for dentists limiting their participation in Healthy Families was low reimbursement rates, which were comparable to the rates paid for the Medic-Cal population.[18] In fact, the largest dental plan reported that it could not maintain its Healthy Families business in four counties, which together accounted for the majority of Healthy Families enrollment, because of higher-than-expected utilization that compounded the effect of low reimbursement. Importantly, the only S-CHIP program in our study without a shortage of dentists was one that contracted with its state employees' dental plan and paid commercial rates.

FAMILY PLANNING SERVICES. Benefits for family planning and reproductive services were generous in Healthy Families. As in all but one of our study states, benefits included gynecological exams, family planning counseling services, testing for sexually transmitted diseases, prescription contraception, and prenatal and maternity care. Abortion other than to save the life of the mother or in cases of rape or incest was

[18] On average, based on four dental codes, these rates were 48 percent of commercial reimbursement rates. In the other study states, the S-CHIP dental reimbursement rates ranged from 49 percent to 108 percent of commercial reimbursement rates.

excluded.[19] Adolescents in California could apparently access family planning services fairly easily. As in the other study states, both of the largest California plans appeared to have sufficient networks of private family planning providers, and one also contracted with Planned Parenthood clinics. However, plan policies related to confidentiality often deterred adolescents from seeking family planning services from available in-network providers because they routinely mailed an explanation of benefits statement[20] to parents. Adolescents reportedly chose instead to obtain confidential, free care at clinics supported by grant funding.

MENTAL HEALTH TREATMENT. California covered 20 outpatient mental health visits. [21] Among the five states we studied, California's outpatient mental health benefits were the most restrictive because of the limited number of visits covered in the absence of any authorization for benefit conversion and because of the requirement that coverage be available only for conditions that would significantly improve with short-term therapy. Access to outpatient services in the plans we interviewed did not require a primary care provider referral but did require authorization by the plans' behavioral health subcontractor. If the behavioral health subcontractor -- the same one was used by both plans -- determined that the adolescent required mental health services, it authorized six initial visits.[22] However, as in the other study states, additional visits required the provider to submit a detailed treatment plan with an acceptable diagnosis, and not all mental health diagnoses were considered acceptable. Treatment was denied for adolescents with symptoms not yet diagnosed as a mental health disorder (V-codes),

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[19] Healthy Families pays for abortions only in the cases of rape or incest or to save the life of the mother. Medi-Cal pays for abortions under the same circumstances but also uses state-only money to pay for abortions in additional circumstances.

[20] While physicians may modify the reason for visits to protect confidentiality, explanation of benefits statements always accurately report laboratory tests.

[21] California also covered 30 inpatient mental health days and permitted plans, at their discretion, to convert one inpatient mental health day for four outpatient visits.

[22] The Maryland plan allowed 12 initial visits, and one Missouri plan authorized anywhere from two to eight visits, depending on the particular circumstances. The other plans authorized one to three initial visits.

including sexual abuse, relational problems, and identity problems, as well as for adolescents engaging in high-risk behaviors.

With an acceptable diagnosis, authorization did not appear to be a substantial barrier to outpatient care. However, the shortage of psychiatrists did constitute a very serious problem, as it did in the other study states. The behavioral health subcontractor, which operated to serve commercially insured populations, relied primarily on its existing panel of independent mental health practitioners to serve Healthy Families enrollees and reimbursed providers according to its commercial fee schedule.[23] As in the other study states, however, licensed clinical social workers and other therapists formed the bulk of the network. While the behavioral health subcontractor may have appeared to have an adequate supply of psychiatrists identifying themselves as able to serve the child and adolescent population, we heard repeatedly from several sources that network listings failed to account for the fact that psychiatrists severely restricted the number of Healthy Families participants they accept in their practices and may, in fact, see only one or two each year in order to remain on network lists. We heard, for example, that participating university-affiliated psychiatrists were refusing to accept S-CHIP patients, as they were in two other study states. In addition, providers cited a lack of psychiatrists to serve Spanish-speaking adolescents and those in rural areas. Providers complained about long waits for psychiatric referrals, typically ranging from three to six months, and difficulties obtaining medication management services. Because of these shortages, primary care providers were often relied upon to prescribe and manage psychotropic medications, which many felt were beyond the scope of their practice.[24]

PRESCRIPTION DRUGS. The Healthy Families benefit package included prescription drugs, and both California plans we interviewed used a formulary and pharmacy benefit

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[23] Among the four CPT codes we looked at for mental health services, the California plans had the highest S-CHIP reimbursement rates for two of the four codes—for 20-30 minute individual therapy and 45-50 minute individual therapy.

[24] A national survey of more than 12,000 physicians, conducted in 1996-1997, found that about a quarter of primary care physicians felt that the scope of care that they were expected to provide was greater than it should be. St. Peter RE, Reed MC, Kemper P, and Blumenthal D. Changes in the Scope of Care Provided by Primary Care Physicians. *The New England Journal of Medicine*. Vol 341, No. 26, December 1999.

manager to limit available medications, as did all but two of the other plans in our study. The plans required automatic generic substitution for all brand name drugs at pharmacies whenever available, permitting physicians to override the policy without prior authorization but monitoring the frequency with which they did so. In addition, the plans required step therapy for certain categories of drugs, stipulating that less expensive drugs be tried unsuccessfully before newer, more expensive ones would be approved.

Adolescent providers often voiced concerns about their inability to prescribe four types of drugs commonly needed by adolescents: antibiotics for sinus and upper respiratory infections, non-sedating allergy medications, contraceptives, and psychotropic medications for mild and moderate mental health diagnoses. With respect to allergy medications and antibiotics, providers complained, as they did in one other state, that plans required them first to prescribe a sedating antihistamine before a nonsedating medication could be prescribed. Similarly, they complained that brand name antibiotics could not be prescribed until they first used a generic substitute, which they said sometimes were ineffective or caused allergic reactions. Although in specific cases providers could seek prior authorization to avoid step therapy, this process was typically time consuming and forced adolescents to leave providers' offices without a prescription in hand. To avoid this, providers reportedly gave out free samples or encouraged enrollees to pay out-of-pocket for a brand name medication. With respect to contraceptives, provider complaints were due primarily to the omission of specific medications on plans' formularies. In particular, adolescent providers in California complained about their inability to provide Depo-Provera (a long-lasting, injectable contraceptive). Complaints were voiced by providers about their inability to prescribe psychotropic medications, but there were fewer complaints than for other types of medications.

Our analysis of the formularies used by both plans generally corroborated provider concerns. For each of the four types of prescription drugs we examined, we obtained advice from members of national professional associations to identify specific

medications considered important for inclusion on a formulary. Overall, the two plans were among the most restrictive formularies of the ten plans we interviewed.

- *Non-sedating allergy medications*. The California plans were particularly restrictive with regard to the allergy medications. The three nonsedating medications[25] were available, but only after two failed trials or unacceptable side effects with first-line medications.

- *Antibiotics for sinusitis and upper respiratory infections*.[26] Both plans also had restrictive policies for antibiotics, requiring that before five recommended brand name antibiotics[27] could be approved, a generically available antibiotic had to be used first unsuccessfully.

- *Contraceptives*.[28] The plans' formularies were fairly generous with respect to oral contraceptives, covering more low dose, monophasic birth control pills[29] than any other plan in our study (although most were available in generic form only) and all six of the available high dose, monophasic pills.[30] However, they covered only one of the six available triphasic low dose oral contraceptives, and their formularies did not include Depo-Provera or Norplant (a long-lasting, implantable contraceptive).

- *Psychotropic medications for mild and moderate mental health diagnoses*.[31] Both plans were the most restrictive in our study. They covered the three important stimulant medications[32] for the treatment of attention deficit hyperactivity disorder (ADHD) but did not cover the

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[25] These antihistamines are Allegra, Claritin, and Zyrtec.

[26] Members of the American Academy of Pediatrics recommended that for sinusitis or upper respiratory infections an acceptable formulary would have to include: Augmentin, either Cefzil or Ceftin; and either Biaxin or Zithromax. This would assure adequate coverage for penicillins, cephalosporins, and macrolides.

[27] These antibiotics are Augmentin, Biaxin, Cefzil, Ceftin, and Zithromax.

[28] Members of the American College of Obstetricians and Gynecologists recommended that an acceptable formulary would have to include coverage for at least one drug in the high-dosage monophasic category and at least one in the low-dosage triphasic category. In the category of low-dosage monophasics, which are used most frequently for adolescents, an acceptable formulary would have to include at least one drug with 20 mcgs estrogen, one with 30 mcgs estrogen, and one with 35 mcgs estrogen.

[29] Low dose is defined as having 35 mcgs or less of estrogen. Monophasic means that the dose of estrogen is constant throughout the cycle.

[30] High dose is defined as having more than 35 mcgs of estrogen.

[31] Members of the American Academy of Child and Adolescent Psychiatry recommended specific psychotropic medications that are most important to have on plans' formularies. Most stressed, however, that the broadest possible range of psychotropic medications should be available.

[32] The three recommended drugs are Adderall, Ritalin, and Dexedrine.

sustained-release forms available for two of the three recommended drugs.[33] They covered three of the four important serotonin reputake inhibitors (SSRIs) for the treatment of depression,[34] but required prior authorization for certain doses for two of the three. They only covered one of the two important atypical antidepressants and did not cover the sustained release forms.[35] Both plans, however, covered the three important drugs for the treatment of anxiety.[36]

ACCESS TO CARE BY CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Children with special health care needs also represent an important S-CHIP population. Although California, like most other states, had no estimates of the number of special needs children enrolled in S-CHIP, national estimates suggest that 17 percent of children with chronic physical, developmental, behavioral, or emotional conditions who require an elevated level of health care services would be potentially eligible for S-CHIP.[37] The types of services that these children might require include comprehensive preventive and primary care, pediatric specialty care, mental health treatment, case management, and family support.

WRAPAROUND PROGRAM FEATURES. Unlike the four other states in our study, California included no specific provider, access, or quality provisions in its managed care contracts to address the unique needs of children with chronic conditions. It relied exclusively on the wrap-around strategy: one specialty services program for children with

[33] The two drugs available in sustained-release forms, which last up to seven or eight hours, are Ritalin SR and Dexedrine Spansule.

[34] The four recommended SSRI drugs are Celexa, Paxil, Prozac, and Zoloft.

[35] These two drugs are Effexor and Wellbutrin. The sustained-release forms of these drugs are Effexor XR and Wellbutrin SR.

[36] These three drugs are Ativan, BuSpar, and Klonopin.

[37] Newacheck PW, Marchi K, McManus MA, and Fox HB. *New Estimates of Children with Special Health Care Needs and Implications for the State Children's Health Insurance Program.* Washington, DC: Maternal and Child Health Policy Research Center, March 1998.

severe physical health conditions and another specialty program for children with serious mental health conditions. Another non-Medicaid S-CHIP program in our study, Connecticut, also adopted two separate wrap-around programs for children with intensive physical[38] or mental health[39] conditions, but it used the programs only to furnish services in addition to those available as plan benefits.

At the end of its first year of operation, Healthy Families had not enrolled a significant number of children with special needs in its wrap-around programs. The number of participants in the physical health wrap-around program equaled 1.4 percent of California's total S-CHIP enrollment, 1,944 children, and in the mental health wrap-around program, only 0.31 percent, 425 children. The participation rate in the physical health program was probably only about a quarter of the rate that might have been expected,[40] and in the mental health program, it was probably less than 10 percent of the rate that might have been expected.[41] Connecticut also experienced low participation

[38] These are children with serious illnesses in diagnostic categories that include: infectious diseases; neoplasms; endocrine, nutritional and metabolic diseases and immune disorders; diseases of blood and blood-forming organs; diseases of the nervous system; diseases of the eye and ear; diseases of the circulatory system; diseases of the respiratory system; diseases of the digestive system; diseases of the genitourinary system; diseases of the skin and subcutaneous tissues; diseases of the musculoskeletal system and connective tissues; congenital anomalies; perinatal morbidity; and accidents, poisonings, violence, and immunization reactions.

[39] These are children who have a mental disorder other than a primary substance abuse disorder or developmental disorder and who meet one or more of the following criteria: 1) the child has impairments in at least two functional areas (self care, school functioning, family relationships, or ability to function in the community) and either has been removed or is at risk for removal from home or has a condition and impairments that have persisted for six months and are expected to continue a year or longer without treatment, 2) the child shows psychotic features or risk of suicide or violence due to a mental disorder, or 3) the child meets the special education eligibility requirements.

[40] Based on the opinions of four national experts in the epidemiology of chronic childhood illness, we estimate that between five to seven percent of children in California's S-CHIP program might have been eligible for wrap-around services. (The approximately 2,000 children participating in California comprise 21 to 29 percent of the estimated eligible participation.)

[41] According to prevalence estimates developed by a group of technical experts for the Florida Mental Health Institute, among children ages 9 to 17, an estimated 9 to 13 percent have a serious emotional disturbance causing significant impairment, and an estimated 5 to 9 percent have a serious emotional disturbance causing extreme impairment. In Manderscheid RW and Henderson MJ (eds.) Center for Mental Health Services. *Mental Health, United States, 1998*. Washington, DC: Government Printing Office, 1998. Assuming 3 to 5 percent of children of all ages could meet SED criteria with functional impairment, the 425 S-CHIP children participating in California's mental health wrap-around program comprise only 6 to 10 percent of the estimated eligible population.

rates in its wrap-around programs.[42] We heard several possible explanations for why the benefit programs were not serving more children.[43] One explanation was that the medically needy program was enabling these children to participate in Medi-Cal. Another was that families whose children had extensive service requirements were more likely than other families to purchase group health insurance coverage, despite the cost. In addition, children with severe behavioral health problems may have been receiving services through the juvenile justice system, child welfare, or special education. A lack of awareness among families and providers also appeared to contribute to low participation. Plans referred children to these programs only when they identified the children on the basis of high-cost claims. Connecticut officials expressed a similar opinion.

MEDICAL NECESSITY. The Healthy Families program did not provide participating plans with an established definition of medical necessity. Like one other non-Medicaid program in our study, it left full discretion in medical necessity determinations to plans, allowing them to rely on their commercial standards. Both plans we interviewed in the state used medical necessity definitions that covered interventions to treat medical conditions, illnesses, and injuries but did not specify coverage for preventive purposes. Their definitions also required conformance with standards of accepted medical practice and scientific evidence of effectiveness.

PEDIATRIC SPECIALTY CARE. Specialty physician services for Healthy Families children were covered without visit limits. In one of the two California plans we interviewed a primary care referral was required to access these services, whereas in the other plan, unlike any others in our study, prior authorization was required. Also, for

[42] In Connecticut the number of participants in the physical health wrap-around -- 37 -- was only 1 percent of Connecticut's total S-CHIP enrollment and only about 21 to 35 percent of the estimated eligible population. The number of participants in the behavioral health wrap-around program was even lower -- 6 -- or .17 percent of Connecticut's S-CHIP participants and comprising only 3 to 6 percent of the estimated eligible population.

[43] California's CCS program director was not concerned about the participation rate. She believed that the program was serving the expected population of S-CHIP children.

children with serious chronic conditions, specialty physician services were available through the wrap-around program, described earlier.

Officials in the two California plans reported having a generally sufficient supply of pediatric subspecialists to serve the S-CHIP population, although they mentioned provider shortages in rural areas. In plans' specialty provider directories, board certification was indicated, but there were no distinctions between those certified in an adult specialty area, an adult specialty area plus pediatrics, or a pediatric subspecialty area. Pediatricians reported fairly extensive shortages in the California Healthy Families plans' subspecialty networks, as they did in two other of our study states. Community-based pediatric subspecialists were usually not participating in Healthy Families, and families apparently faced long waits for particular types of subspecialists, most commonly pediatric neurologists and orthopedists.

Several factors contributed to these network shortages. One was the very limited supply of certain types of board-certified pediatric subspecialists practicing in any setting. For example, according to the American Academy of Pediatrics, there were only 26 practicing board-certified pediatric pulmonologists in California.[44] Another factor was reimbursement rates, which were characterized as inadequate to attract the community-based pediatric subspecialty providers who could have served the Healthy Families special-needs populations. Even more important than the California program's low physician reimbursement rates were the low fees it paid to outpatient hospital-based specialty care centers, where most pediatric subspecialists practiced. As a result, the ability of hospitals to support special care centers and provide staffing and faculty support reportedly was deteriorating. A third factor, contributing directly to the waiting list problem, was the tendency of primary care providers treating children with complex physical conditions to make referrals to the same few participating subspecialists with board certification in pediatrics.

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[44] Cull WP. *Physician Workforce: Ratio for Child Health, 1998*. Elk Grove Village, IL: American Academy of Pediatrics, June 2000.

Healthy Families provided limited physical therapy, occupational therapy, and speech therapy benefits -- 60 consecutive days, although the contract specified that additional visits could be provided if the child's condition would improve significantly -- but more coverage than the other two non-Medicaid states in our study. The two California plans required prior authorization for ancillary therapies, as did most other plans we interviewed. Both plans reported that children with serious medical conditions -- such as spina bifida, cerebral palsy, or cleft lip and palate -- would receive ancillary therapies, although they would also refer these children to the CCS program. Children with developmental disabilities, including pervasive developmental disorder and autism would typically be referred to schools or regional service centers. Children with developmental delay, motor planning dysfunction, oral motor dysfunction, or sensory integration disorder would receive services up to age three.

Plan officials reported having a sufficient number of physical therapists, occupational therapists, and speech and language therapists to meet the needs of Healthy Families children; however, one plan's provider directory listed no office-based occupational therapists while the other listed 119 privately operated centers, which typically offered only a single type of therapy, namely physical therapy or sports rehabilitation. Providers commented that there were either too few therapists or too few with pediatric training and experience in the networks. Families in California, like those in the other study states, tended to rely on hospital-based therapists.

Coverage of home health services was available in the Healthy Families benefit package. The state covered skilled nursing care and home health aide services without visit limits, and it was the only non-Medicaid state in our study to cover ancillary therapies under the home health benefit.[45] The California plans, like the others in our study, had prior authorization criteria regarding the need for skilled nursing care, but they also stipulated that home health services could only be authorized as a post-hospital service or as a substitute for hospitalization. Neither providers nor families reported any

[45] However, custodial care and long-term therapies were excluded.

difficulties accessing these services. Information about home health agencies was provided in plans' directories, and, although they did not identify those with pediatric expertise, plan officials reported having an adequate supply of home health agencies in their networks.

California covered durable medical equipment, including hearing aids, eyeglasses, prosthetics, and orthotics, but not motorized wheelchairs and assistive technologies. Plans in California and the other study states required prior authorization for durable medical equipment. Like those in the other non-Medicaid programs, the California plans generally limited coverage for durable medical equipment to rehabilitative or restorative purposes. Plans reported that children were referred to the CCS program for most medical equipment.

Specialty Program Access. For Healthy Families children with serious chronic physical conditions, the CCS wrap-around program provided all specialty care services needed for the treatment of the child's eligible condition. Potentially eligible children were referred to the program by their plans. Eligibility determinations were made by county-level CCS staff on the basis of information obtained from medical records, including the results of physical examinations and laboratory and other tests.

Eligibility for the CCS wrap-around program appeared to cause confusion for plans, providers, and families, who did not fully understand which conditions met the eligibility criteria and what the division of responsibility was between plans and the CCS agency. State officials reported that eligibility determinations could take only five days, but sometimes took as long as six months. Delays were due to several factors. Plans often failed to provide sufficient medical documentation with their referrals, and overall they referred far too many children in an effort to avoid financial risk.[46] Also, the CCS program had staffing shortages and lacked an automated management information system

[46] Often multiple referrals were submitted to the CCS program for the same child. Plans typically devoted substantial administrative resources reviewing their claims data daily to identify potentially eligible children. In the two plans we interviewed, a total of 12 staff were conducting these reviews.

for processing applications. Another problem that affected families, plans, and providers was the frequency with which certain children gained and lost their CCS eligibility depending on whether their condition improved or deteriorated.[47]

Once in the wrap-around program, however, children in California received their services as defined in a plan of care. Services were consistently viewed as being of high quality, although problems were identified regarding the coordination of services furnished by plans and the wrap-around program. Interestingly, plans reported that they would have preferred to assume full responsibility for the child's care or to have all of the child's services carved out of the managed care contract to make care coordination easier.

MENTAL HEALTH TREATMENT. As discussed earlier in the adolescent section of this report, coverage of outpatient mental health services in California was limited to 20 visits for conditions that will significantly improve with short-term therapy. Inpatient hospitalization, also with a short-term improvement requirement, was limited to 30 days, which, at a plan's option, could be converted to 120 outpatient visits. Although coverage was not available in the basic benefit package for crisis intervention, in-home services, or intensive outpatient visits, it was available for residential care at the option of a plan.

Plans required prior authorization for outpatient mental health services; if services were deemed necessary, the plan authorized six initial visits. Obtaining visits beyond the initial six required the provider to submit a detailed treatment plan with an acceptable diagnosis. Treatment was denied for children with pervasive developmental disorders and autism, personality disorders, and identity problems, as it was by the majority of the plans in the other states. Treatment was also denied for children with emotional problems associated with a complex physical condition, referring them instead to community resources. As previously discussed, access to mental health services was hampered for

[47] Severity was a factor used in determining CCS eligibility for children with diseases of the blood, benign neoplasms, asthma, burns, diabetes, hearing loss, scoliosis, seizure disorder, strabismus, fractures of the skull, spine, pelvis, or femur, primary hypertension, and cardiac dysrhythmias.

all children by the shortage of participating psychiatrists, despite the fact that plans appeared to have an adequate supply of psychiatrists in their network listings.

Access to inpatient mental health services in the California Healthy Families plans was conditioned on prior plan authorization, as it was in the other study states. Authorization criteria were generally similar in all the study states: the child was expected to demonstrate imminent suicidal or homicidal risk, presence of acute psychotic symptoms, pervasive functional deterioration, or potentially lethal self-abusive or risk-taking behavior. Providers expressed concern in all the study states that the authorized length of stay for children was too short, generally only three to four days. Because hospitalization required that the child's condition be in an acute and potentially dangerous phase, once it stabilized, the child was released.

Plans reportedly seldom authorized residential treatment services for Healthy Families enrollees, which is not surprising given the stringent authorization criteria used by the two plans we interviewed and the availability of wrap-around services. Both plans required that a child either be discharged from a hospital but still require intensive treatment or have qualified for partial hospitalization but have no access to a program providing this service. In addition, they required that treatment goals be met within seven to 28 days.

Specialty Program Access. Healthy Families children with intensive mental health service needs were referred by behavioral health plans, schools, and a variety of public agencies to county mental health departments. County mental health staff determined if the child met the wrap-around program's diagnostic and functional criteria for a severe emotional disturbance. Although providers commented on the variable interpretations of severe emotional disturbances across counties, the determination process overall was fairly lenient. Gaining access to the mental health wrap-around program did not appear to be a problem. However, providers and plans referred very few children. Providers were not well-informed about the program, and plans relied on high-cost service utilization, primarily hospitalization, to identify children for referral. Wrap-around

services in California were primarily being provided to children previously in the county mental health system; new referrals came largely from schools and other agencies.

Once in the program, children could receive any covered service indicated in their treatment plans, and no concerns were reported regarding the quality of services. The wrap-around program furnished residential treatment for children with severe emotional disturbances, and authorization apparently was not a problem. Still, this publicly supported system apparently had shortages of residential treatment facilities that caused delays in admissions. The program also covered intensive outpatient therapy and crisis intervention but not intensive in-home therapy. No authorization problems were reported for these services either, although we heard that specialty mental health services were not available statewide because services could not be established and sustained by reimbursement revenue alone. County mental health staff told us that the inability to hire and maintain a sufficient number of competent therapists sometimes delayed treatment. In addition, according to providers, bureaucratic delays slowed access to services as well. A general problem noted by everyone was that service coordination for children who required inpatient hospitalization, which was covered as a basic Healthy Families plan benefit, was sometimes a problem.

OTHER COMPONENTS OF HEALTH CARE ACCESS

PLAN SELECTION. The ability of a Healthy Families participant to select the most appropriate managed care plan depended in large part on the amount of information available to the family, particularly regarding provider networks. As in the other study states, prospective Healthy Families participants had access to enrollment specialists who provided information about plans' primary care, hospital, specialty physician, and mental health provider networks in addition to helping them complete the Healthy Families application. In California, these enrollment specialists were community-based individuals who were paid a per-application fee for each successful application and met in person with applicants; in the other states, they were either state workers or employees of

contracted companies who furnished telephone assistance. Healthy Families applicants who chose not to meet with an enrollment specialist could complete the application on their own and mail it in, in which case they would have access only to summary information about plans available in their counties, not to provider network information. Families typically reported that they relied on their primary care and specialty care providers to tell them their plan affiliations or else they called the plans directly. Families were required to select a plan at the time they applied for Healthy Families coverage; if none was selected, the child would not receive services as the state did not auto-assign eligible children to a plan.

HEALTH RISK ASSESSMENTS. Identifying children with special health care needs and adolescents with significant health risks can assist plans in anticipating their service needs. Yet, California had no health risk assessment requirements for its Healthy Families program. In three of our four other study states, health risk assessments were required to identify children with diagnosed health problems. None of these states, however, designed their health risk assessments to identify high-risk or underserved adolescents. The lack of a health risk assessment requirement in California may have contributed to lower-than-expected rates of participation among children with special health care needs in the physical and mental health wrap-around programs and possibly also to low primary and preventive care utilization among adolescents. Questions related to children with special needs that could be helpful as part of the application process might include the presence of serious medical or emotional conditions or specific qualifying conditions, functional impairments, or the need for certain specialty physical or mental health services. Questions for adolescents that could be useful might ask about the absence of a regular primary care doctor or the receipt of a physician or dental service in the last year.

CASE MANAGEMENT. Families whose children require services from multiple sources -- including plan and out-of-network providers, behavioral health plan providers,

and early intervention, special education, and other community programs -- may benefit from having a case manager to help them advocate for appropriate services and coordinate their multiple sources of care. California's Healthy Families program, unlike the S-CHIP programs in three of our four other study states, had no specific requirements for furnishing case management to children with special needs. Plans in California were required only to develop memoranda of understanding with each of the county health departments administering the CCS program and each of the county mental health departments regarding procedures for assuring continuity of care between plan and wrap-around services.[48] Case management services were available from both wrap-around programs. The ratio of case managers to families in the CCS program was exceptionally high, however, and, as a result, primary care providers voiced concerns that they were not usually informed about the specialty services furnished to their patients unless they happened to have an established relationship with the responsible CCS provider.

MULTIDISCIPLINARY CARE. Children with complex chronic conditions often need a plan of care and coordinated interventions from a multidisciplinary team of health professionals. Multidisciplinary care in California was not a required component of care from plans, as it was in two of the other four states in our study. These states included multidisciplinary care requirements in their managed care contracts and three out of the four plans in these states reported having a mechanism for reimbursing individual providers who participate in team conferences. California did, however, require multidisciplinary care under the physical health wrap-around program. Specialty clinics could bill for this service under designated codes. Nonetheless, providers complained that payment rates were inadequate to maintain a comprehensive team of professionals at clinic sites. In fact, across all our study states, most plans and providers commented that multidisciplinary care was difficult to support because payment for physical and mental health services was separately financed.

[48] Plans complained that this requirement was somewhat challenging since there are 58 counties in the state.

COST SHARING. Copayments and coinsurance can deter adolescents seeking care on their own as well as children with special needs from obtaining necessary health care services. Yet, the Healthy Families copayment requirement, which amounted to $5 for a physician, other ambulatory care, or therapy visit, did not appear to have a significant impact on access to care. In this regard, California compared favorably to two of the other three states with cost-sharing requirements, where relatively high charges for mental health services reportedly sometimes constituted a barrier to treatment. In California, providers and families perceived that the charges were nominal. Providers at hospital-based and other adolescent clinics, however, did not always collect copayments, similar to our other study states, opting instead to allow the clinic to bill parents for the copayment amounts after the visit or to forego the payment entirely. Importantly also, neither wrap-around program imposed any cost-sharing requirements.

CONFIDENTIALITY. Adolescents' ability to obtain confidential care for mental health, substance abuse, and obstetrical and gynecological services can affect their willingness to seek needed services. California was only one of two states in our study to allow minors to consent to their own care for outpatient mental health, substance abuse, family planning, and sexually transmitted disease services. However, the guarantee of confidential care for adolescents was weakened in the Healthy Families program by the plans' policy of sending enrollees an explanation of benefits statement after the delivery of services, as is common practice in commercial insurance.

CONCLUSIONS

California's first-year experience with its S-CHIP program appeared to be successful in terms of managed care contracting and administration. This success can likely be attributed to the efficiency of MRMIB and the fact that plans with Medi-Cal business were receptive to serving the Healthy Families population. There were problems, however, with provider participation, referrals into the two wrap-around programs for children with special health care needs, and coordination of care between plan and wrap-around services. As Healthy Families enrollment grows, the state and plans should carefully monitor the adequacy of provider network capacity and reimbursement levels. In addition, the state should consider additional financial support to enhance the wrap-around programs' service availability and administrative infrastructure and should further clarify the division of responsibility between plans and the wrap-around programs.

APPENDIX

OVERVIEW OF THE FIVE STUDY STATES' S-CHIP PROGRAMS

The five states in our study had been operating their S-CHIP programs for at least one year at the time of our site visits. In addition, we required that they set their upper income eligibility level no lower than 200 percent of the federal poverty level. We also sought to obtain geographic representation and some variation in covered services, cost-sharing requirements, and administrative structure. Three of the five study states -- California, Connecticut, and Utah -- chose to enroll S-CHIP eligible children into new private health insurance arrangements. The other two -- Maryland and Missouri -- chose to insure them through Medicaid. Connecticut and Missouri offered coverage to children in families with incomes up to 300 percent of the federal poverty level, while the other three states capped their eligibility at 200 percent. The non-Medicaid states all offered benchmark benefits modeled after those offered to the state employees, although the actual benefits varied significantly from state to state. Two of the three non-Medicaid states -- Connecticut and California -- included wrap-around programs to offer additional services to children with intensive physical and behavioral health problems. With regard to program administration, only California opted not to rely on its Medicaid agency to administer its S-CHIP program. All five states contracted predominately with managed care plans that were already enrolling Medicaid participants and only in Missouri was managed care not operating on a statewide basis. California and Utah contracted separately with dental plans. Three of the five study states imposed monthly premiums on S-CHIP participants; only Utah elected to require coinsurance, and Maryland was the only state not to require cost sharing of any kind.

Appendix Table I

Overview of S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
Program Name	Healthy Families	HUSKY B	Maryland Children's Health Insurance Program	MC+ for Kids	CHIP
Program Type	Non-Medicaid[1]	Non-Medicaid[2]	Medicaid	Medicaid	Non-Medicaid
Implementation Date	7/1/98	7/1/98	7/1/98	7/1/98	8/1/98
Income Eligibility Levels					
Infants	200-250%	185-300%	185-200%	185-300%	133-200%
Children Ages 1-6	133-200%	185-300%	133-200%	133-300%	133-200%
Older Children	100-200%	185-300%	100-200%	100-300%	100-200%
First Year Enrollment	138,869	3,787	57,000	42,251	10,729
Benefit Package	Benchmark Plan (state employees)	Benchmark Plan (state employees)	Medicaid	Medicaid	Benchmark Plan (state employees)
Populations Excluded from MCO Participation	None	None	Children with rare and expensive physical conditions	Children meeting SSI disability criteria and all children in some areas of the state	None
Services Excluded from MCO Contract	Dental, vision, specialty services for children with severe physical health conditions, and non-hospital specialty services for children with severe emotional disturbances	None	Personal care, early intervention, health-related special education, and all mental health	Early intervention, health-related special education, substance abuse, and crisis intervention for children with severe emotional disturbances	Dental

Continued on next page

Appendix Table I (continued)

	California	Connecticut	Maryland	Missouri	Utah
Wrap-around Program Services	All specialty services (supplemental and basic) for children with severe physical health conditions, and all non-hospital specialty services (supplemental and basic) for children with severe emotional disturbances	Supplemental specialty services for children with severe physical health conditions (HUSKY Plus Physical), and supplemental specialty services for children with severe emotional disturbances (HUSKY Plus Behavioral)	Not applicable	Not applicable	None
Cost-Sharing Requirements					
Monthly Premiums	Yes	Yes	No	Yes	No
Copayments	Yes	Yes	No	Yes	Yes
Coinsurance	No	No	No	No	Yes
Number of Managed Care Plans	26 MCOs 4 dental plans 1 vision plan	5 MCOs	8 MCOs	9 MCOs	5 MCOs 1 dental plan

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1] California had a small expansion of its Medicaid program to include adolescents ages 16 to 19 up to 100 percent of the federal poverty level.
[2] Connecticut had a small expansion of its Medicaid program to include adolescents ages 14 to 19 up to 185 percent of the federal poverty level.

Appendix Table II

Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Physician Services	Covered	Covered	Covered	Covered	Covered
Lab and X-ray Services	Covered	Covered	Covered	Covered	Covered
Preventive Care	Covered	Covered	Covered	Covered	Covered
Prescription Drugs	Covered	Covered	Covered	Covered	Covered
Family Planning Services	Covered except for abortion.	Covered except for abortion.	Covered	Covered except for abortion.	Covered except for routine HIV testing, Norplant, and abortion.
Outpatient Hospitalization	Covered	Covered	Covered	Covered	Covered
Inpatient Hospitalization	Covered	Covered	Covered	Covered	Covered
Outpatient Mental Health Services	Covered up to 20 visits/year for conditions that will significantly improve with short-term therapy, with additional visits available through conversion of inpatient mental health days (1:4).	Covered up to 30 visits/year, with additional visits available through conversion of inpatient mental health days (1:3).	Covered	Covered	Covered up to 30 visits/year (in combination with outpatient substance abuse), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities.
Inpatient Mental Health Services	Covered up to 30 days/year for conditions that will significantly improve with short term therapy.	Covered up to 60 days/year.	Covered	Covered	Covered up to 30 days/year (in combination with inpatient substance abuse), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities.
Residential Treatment Facilities	Covered by converting inpatient mental health days (1:2) for conditions that will significantly improve with short term therapy.	Covered by converting inpatient mental health days (1:1).	Covered	Covered, at plans' option.[2]	Covered by converting inpatient mental health days (1:1), but excluding conditions such as conduct disorder, oppositional defiant disorder, and learning disabilities.

Continued on next page

Appendix Table II (continued)

	California	Connecticut	Maryland	Missouri	Utah
Outpatient Substance Abuse Treatment Services	Covered up to 20 visits/year.	Covered up to 60 visits/year.	Covered	Covered	Covered up to 30 visits/year in combination with outpatient MH.
Inpatient Substance Abuse Treatment Services	Covered for detoxification.	Covered for drug abuse up to 60 days/year and for alcohol abuse up to 45 days/year.	Covered	Covered	Covered up to 30 days/year in combination with inpatient MH.
Physical, Occupational, and Speech Therapy	Each therapy covered up to 60 consecutive days/condition, additional visits available if condition will improve significantly.	Covered on a short-term basis.	Covered	Covered	Covered up to 16 visits/year, but excluding therapies for children with developmental delay, and excluding speech therapy not required to treat an injury, sickness, or surgically corrected congenital condition.
Optometry Services	Covered	Covered	Covered	Covered	Not covered
Eyeglasses	Covered	Covered	Covered	Covered	Not covered
Home Health Services	Covered for skilled nursing services and home health aide services, including PT, OT, and ST.	Covered for skilled nursing services and home health aide services.	Covered	Covered	Covered for skilled nursing services.
Durable Medical Equipment and Other Devices	Covered except for therapeutic footwear and motorized wheelchairs.	Covered except for hearing aids and motorized wheelchairs.	Covered	Covered	Covered except for eyeglasses and therapeutic footwear.
Dental Services	Covered except for orthodontia.	Covered	Covered	Covered	Covered except for replacement restorations for other than decay or fracture, orthodontia, sealants except when placed on permanent molars through age 17.

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs.

Notes: [1] The programs were implemented in either July or August of 1998.
[2] Plans in Missouri were only encouraged to provide residential treatment services to avoid inpatient hospitalization; no conversion ratio was provided.

Appendix Table III

Mental Health Benefits Offered by the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri	Utah
Outpatient Visits	Covered up to 20 visits/ year, with additional visits available through conversion of inpatient mental health days (1:4). Additional visits available fee-for-service to wrap-around participants.	Covered up to 30 visits/year, with additional visits available through conversion of inpatient mental health days (1:3). Additional visits available to wrap-around participants.	Covered	Covered	Covered up to 30 visits/year in combination with outpatient substance abuse visits.
Inpatient Hospitalizatio	Covered up to 30 days/ year. Additional days available fee-for-service to wrap-around participants.	Covered up to 60 days/year.	Covered	Covered	Covered up to 30 days/ year in combination with inpatient substance abuse services.
Crisis Intervention	Services only available fee-for-service to wrap-around participants.	Services available only to wrap-around participants.	Covered	Covered, at plans' option.[2] Also available fee-for-service to severely emotionally disturbed participants.	Not covered
Intensive Outpatient Visits	Services only available fee-for-service to wrap-around participants.	Covered through conversion of inpatient mental health days (1:2). Additional services available to wrap-around participants.	Covered	Covered	Not covered
Intensive In-Home Service	Not covered	Services available only to wrap-around participants.	Covered	Covered, at plans' option.[2]	Not covered
Residential Treatment	Covered at plans' option through conversion of inpatient mental health days (1:2). Additional services available fee-for-service to wrap-around participants.	Covered through conversion of inpatient mental health days (1:1).	Covered	Covered, at plans' option.[2]	Covered through conversion of inpatient mental health days (1:1).
Exclusions for Plan Benefits	Conditions that will not improve with short-term therapy.	None	None	None	Oppositional defiant disorder, conduct disorder, learning disabilities, and situational disturbances.

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1] The programs were implemented in either July or August of 1998.
[2] Plans in Missouri were only encouraged to provide crisis intervention, intensive in-home, and residential treatment services to avoid inpatient hospitalization; no conversion ratio was provided.

Appendix Table IV

S-CHIP Contract Requirements Pertaining to Quality Performance Measures in the Five Study States During the First Year of S-CHIP Implementation

	California	Connecticut	Maryland	Missouri	Utah
Effectiveness of Care Measures					
1. Health Promotion and Disease Prevention					
A. Immunizations					
- Childhood Immunizations	✓	✓	✓	✓	✓
- Adolescent Immunizations	✓		✓		✓
2. Early Detection and Screening					
A. Low Birthweight		✓		✓	
B. Cervical Cancer Screening			✓	✓	
C. Lead Screening				✓	
D. Alcohol, Substance Abuse, and Tobacco Screening				✓	
E. Sexually Transmitted Disease Screening				✓	
3. Acute Illness					
A. Otitis Media					
4. Chronic Physical Conditions					
A. Asthma			✓	✓	
B. Diabetes			✓	✓	
C. Sickle Cell Anemia			✓		
5. Chronic Mental Health or Substance Abuse Conditions					
A. Ambulatory Follow-up after Hospitalization for Mental Health Disorders	✓			✓	
Utilization of Care Measures					
1. Preventive Services					
A. Well Child Care	✓	✓	✓	✓	
2. Ambulatory Services					
A. Physician Services			✓		✓
B. Physician Specialty Services					✓
C. Outpatient Visits					✓
D. Emergency Room Visits					✓
E. Ambulatory Surgery/Procedures					
3. Pharmacy Services			✓		✓
4. Inpatient Hospital Services		✓	✓	✓	✓
5. Newborn Hospital Services			✓	✓	✓

Continued on next page

Appendix Table IV (continued)

	California	Connecticut	Maryland	Missouri	Utah
6. Mental Health Services					
A. Inpatient Hospital Services		✓	✓	✓	✓
B. Day/Night Services					✓
C. Ambulatory Services		✓		✓	✓
D. Hospital Readmissions		✓	✓		
7. Chemical Dependency Services					
A. Inpatient Hospital Services		✓	✓	✓	
B. Day/Night Services			✓		
C. Ambulatory Services		✓	✓	✓	
D. Hospital Readmissions		✓			
8. Other Services					
A. Physical Therapy Services					✓
B. Occupational Therapy Services					
C. Speech and Hearing Services					✓
D. Home Health Services				✓	✓
E. Hospice Services					✓
F. Medical Supplies					✓
G. Vision Services				✓	✓
H. Case Management Services				✓	
Access and Availability of Care Measures					
1. Primary Care Access					
A. Primary Care Visits	✓		✓	✓	✓
2. Specialized Care Access					
A. Low Birthweight Deliveries at Appropriate Facilities					
B. Coordination Between Primary Care Providers and Behavioral Health Providers			✓		
3. Dental Care Access					
A. Dental Care Visit	✓	✓			✓
Consumer Satisfaction Survey		✓	✓	✓	✓

Source: Information obtained by the MCH Policy Research Center through detailed on-site and follow-up telephone interviews and an analysis of the S-CHIP contracts in effect during the first year of S-CHIP implementation.

Appendix Table V

Cost-Sharing Requirements for S-CHIP Programs in the Five Study States During the First Year of S-CHIP Implementation[1]

	California	Connecticut	Maryland	Missouri		Utah	
Monthly Premiums							
101-150% FPL	$7 for 1 child[2] $14 for □2 children	Not applicable	None	None		None	
151-200% FPL	$9 for 1 child; $18 for 2 children; $27 for □3 children	None	None	None		None	
200-300% FPL	Not applicable	above 235% FPL: $30 for 1 child; $50 for □2 children	Not applicable	above 225% FPL: $65 per family		Not applicable	
>300% FPL	Not applicable	$113.87-$194.37, depending on plan selected	Not applicable	Not applicable		Not applicable	
Copayments/ Coinsurance	**101-200%**	**>185%**	None	**186-225%**	**226-300%**	**101-150%**	**151-200%**
Physician Visits	$5	$5			$10	$5	$10
Prescription Drugs	$5	$3 generic; $6 brand		$5	$5	$2	$4; 50%
Lab/X-ray	–	–		–	$10	–	nonformulary
Emergency Room Services	$5	$25		$5	–	$5-$10	10%
Inpatient Hospital Services	–	–		–	$10	–	$30
Outpatient Hospital Services	–	–		$5	$10	–	10%
Mental Health Services				$5			10%
Outpatient Visits	$5	11-20 visits $25; 21-30 visits $50 or 50%			$10	$5	
				$5			50%
Inpatient Hospital Services	–	–			$10	–	
Substance Abuse Services				$5			1-10 days, 10%;
Outpatient Visits	$5	–			–	$5	11-30 days, 50%
Inpatient Hospital Services	–	–		–	–	–	50%
				–			1-10 days, 10%;
PT, OT, ST Services	$5	–			$10	$5	11-30 days, 50%
Audiology Services	–	$5 hearing exams		$5	$10	–	$10
Optometry	$10	$5		$5	$10	–	–
				$5			–

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Appendix Table V (continued)

Monthly Premiums	California	Connecticut	Maryland	Missouri		Utah	
Copayments/ Coinsurance (Cont.)	**101-200%**	**>185%**	**None**	**186-225%**	**226-300%**	**101-150%**	**151-200%**
Home Health	–	–			$10	–	–
DME	–	–		$5	–	–	20%
Eyeglasses	$25	lenses covered and up to $50 for frames		–	–	–	–
Dental Services	varies	varies		– $5	$10	–	varies

Source: Information obtained by the Maternal and Child Health Policy Research Center through analysis of the states' S-CHIP applications and state S-CHIP documents constituting the standard insurance contracts or RFPs and through detailed on-site and follow-up telephone interviews.

Notes: [1] The programs were implemented in either July or August of 1998.
[2] California's Healthy Families participants who enroll in a community provider plan receive a discounted premium of $3 per child.

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