Using Title XXI Funds for Initiatives to Address the Health Care Needs of Vulnerable Children in California

A Report to the California Legislature
Pursuant to Insurance Code Section 12693.925

September 2004
Managed Risk Medical Insurance Board

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Acknowledgements

MRMIB wishes to thank members of the Healthy Families Program Advisory Panel, Dena Bullard, California Primary Care Association, Marty Martinez, California Pan Ethnic Health Network, Randy Boyle, National Health Law Program and Celinda Vasquez, staff member to Senator Martha Escutia, for their assistance in preparing this report.

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Introduction

Senate Bill 59, authored by Senator Escutia and enacted as Insurance Code Section 12693.925, requires the Managed Risk Medical Insurance Board (MRMIB) to report to the Legislature a list of categories of vulnerable children who should be targets of public health initiatives under the State Children's Health Insurance Program (SCHIP). The law also requires MRMIB to recommend innovative methods available under SCHIP for addressing the health care needs of vulnerable children. The law directs MRMIB to seek input at regularly scheduled meetings of the Board, from the Healthy Families Program (HFP) Advisory Panel and from stakeholder organizations.

This report has been prepared in fulfillment of Insurance Code Section 12693.925. The sources of information presented in this report include recently released reports on uninsured children in the State and other children with unmet health care needs, information obtained during the discussions with the HFP Advisory Panel and the MRMIB at their public meetings where the public was invited to comment, and information presented to MRMIB by stakeholders.

Background

Sections 2105 (a)(2)(B) and 2105(c) of Title XXI of the Social Security Act authorize the funding of public health initiatives under the 10 percent "administrative cap," a limit on certain costs (such as outreach, or other administrative costs).[1] Based on information from the Centers for Medicare and Medicaid Services' (CMS) website, three states have received approval to implement public health initiatives under this authority. On July 31, 2000, CMS issued a letter outlining CMS' guidelines for SCHIP Section 1115 waivers. In that letter, CMS discussed the possibility of submitting waivers for public health initiatives. According to CMS, no state has been approved for public health initiatives under the 1115 waiver.

At the present time, California has sufficient federal funds under the 10 percent cap to cover costs associated with public health initiatives. In past years, there was no room under the cap for additional expenditures. This was because outreach funding was counted against the cap.[2] The State eliminated funding for outreach due to the State's fiscal crisis and room under the administrative cap is now available. Unfortunately, the State's fiscal crisis has not improved since the elimination of outreach funds.

[1] Title XXI allows states to use up to 10 percent of their total SCHIP program costs for certain services.

[2] In the early years of the program, the program costs (net administrative expenditures) ranged from $94 million in federal fiscal year (FFY) 1999 to $254 million in FFY 2000, providing for a 10% administrative cap of $10 million in FFY 1999 and $28 million in FFY 2000. The outreach budget in FY 1998/99 was $21 million and in FY 1999/2000 was $31 million which, when added to other administrative costs, resulted in the program costs exceeding the 10% administrative cap. However, in FFY 2004, the program expenditures (net administrative costs) are projected to grow to $940 million, creating a 10% administrative cap of $104 million. MRMIB currently projects administrative expenditures of $65 million for FFY 2004, leaving California with $39 million available for additional administrative expenditures within the 10% cap.

Vulnerable Children To Be Served By Public Health Initiatives Under Title XXI

Senate Bill 59 (Escutia) cites several sources of information regarding vulnerable children needing access to health care services. The facts contained in Section 12693.925 illustrate the high risk of poor access to medical care associated with certain categories of children. Uninsured children and children of immigrant and homeless families are listed as children likely to: (a) not have a usual source of medical care; and (b) be less likely than insured children to receive treatment for childhood conditions or injuries. Children of immigrant and homeless families are less likely to be enrolled in the Healthy Families Program (or Medi-Cal).

In addition to the sources cited in Insurance Code Section 12693.925, the 2001 California Health Interview Survey (CHIS)[3] reports disparities in access to a usual source of medical care and insurance coverage among age, ethnic, language and immigrant groups. Categories of children experiencing disparities in health care access include adolescents, Latino and American Indian/Alaska Native children, non-citizen children with non-citizen parents, citizen children with non-citizen parents, and children in limited-English proficient families.

Children in their teen years may be especially vulnerable because a significant portion of the morbidity and mortality among adolescents is attributed to substance abuse, including tobacco use, unsafe sexual activity, violence, inadequate physical activity, and poor nutrition. In general, barriers to health care for adolescents include transportation and inconvenient hours, confidentiality, and focus on treatment of physical problems rather than health promotion and mental health care.[4]

Some reports have shown that children without a home are in fair or poor health twice as often as other children, and have higher rates of asthma, ear infections, stomach problems, and speech problems.[5] They also experience more mental health problems, such as anxiety, depression, and withdrawal. They are twice as likely to experience hunger, and four times as likely to have delayed development.

Stakeholders who have expressed an interest in seeing MRMIB develop and implement public health initiatives under Title XXI have suggested that these initiatives target many of the children that CHIS and other reports have identified as lacking access to medical care. Specific suggestions borne from public discussions during the HFP Advisory Panel meetings included services for homeless, undocumented, and migrant children. Panel members also recommended services for two medical conditions: autism and asthma. An issue paper submitted to MRMIB by a group of stakeholders also

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[3] E.R. Brown, N. Ponce, T. Rice, SA Lavarreda. *The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey*. Los Angeles, CA: UCLA Center for Health Policy Research, November 2003.
[4] Brindis, Claire D,. Morreale, Madlyn C., English, Abigail. *The Unique Health Care Needs of Adolescents*. The Future of Children, vol. 13, Number 1. 2003.
[5] Better Homes Fund, 1999, as cited by National Coalition for the Homeless, NCH Fact Sheet #7: Homeless Families with Children, http://www.nationalhomeless.org/families.html (December 28, 2003).

suggested categories of vulnerable children that were identified by CHIS and during discussions with the HFP Advisory Panel.[6]

Innovative Services To Address The Additional Needs Of Vulnerable Children

The only guidance on what types of services the Federal government might approve for vulnerable children comes from previously approved state plan amendments from other states. At the time this report was prepared, CMS approved three public health initiatives in three states: Florida, Maine and Minnesota. Florida's public health initiative consists of school-based services that include direct health services, screenings, referrals, and clinical follow-up. A component of these services includes medical supervision of pregnant and parenting teens. Maine's public health initiative consists of grants to providers to establish school health programs, community-based pregnancy prevention programs and grants for media campaigns directed at discouraging children and adolescents from using tobacco products. Minnesota's public health initiative is a mental health screening of children in the court system, outreach and mental health screenings for homeless children, comprehensive services for children with special health care needs and family planning services for uninsured teens.

Some of the methods used by Florida, Maine, and Minnesota to provide health care services to children could be used for vulnerable children in California. For example, school-based services might be used to provide preventive health services to adolescents and immigrant children. Grants might be used to provide for community-based services for homeless children. Funds may also be used to improve access to services for limited-English proficient families.

Suggestions contained in the white paper submitted to MRMIB by stakeholders include: language assistance services for limited-English proficient families, enabling services, mobile services and increased coverage for mental health and substance abuse services.[7] These suggestions are applicable to vulnerable children residing in rural and urban areas of the state. The types of public health initiatives implemented by Florida, Maine, and Minnesota, could also be proposed as urban demonstration projects.

Because the HFP serves diverse communities, it is preferable to allow local health care providers in these communities to design services within guidelines established by MRMIB. MRMIB has used this approach successfully in implementing the Rural Health Demonstration Projects (RHDP). The authorizing statute for the HFP established the RHDP to increase access to services for geographically isolated children, and children living in migrant and seasonal worker families and other special populations. To implement the RHDP, MRMIB provided guidance on the types of projects that MRMIB would consider funding through the RHDP, but allowed participating plans to propose

[6] Ballard, Dena; Boyle, Randy; Finocchio, Len; Lessard; Gabrielle; Martinez, Marty. *Ensuring Equal Access to Health Care for All Children.* Submitted to MRMIB in 2003.
[7] Ibid.

innovative projects for increasing access to the target populations. This approach provided plans and their provider partners with the flexibility to design projects that met the specific needs of the targeted population.

To implement a public health initiative for vulnerable children under SCHIP, MRMIB could use the "demonstration project" model. Under this model, MRMIB would prepare a solicitation for proposals that would outline the goal of the demonstration project (in this case, to provide health care services to categories of vulnerable children). The solicitation would also outline the types of projects (as identified by MRMIB and stakeholders) that MRMIB would consider for funding. Stakeholders would have an opportunity to comment on the solicitation package before the package was distributed. Because MRMIB does not have a reimbursement mechanism to contract directly with providers, only those plans that are participating in the HFP would be eligible to respond. Plans would be encouraged to partner with providers who have experience serving vulnerable children.

Special Considerations

To implement any new initiative under Title XXI, there are a few considerations.

Federal Approval — There is no way to know for sure which proposals would be rejected or approved. There is some precedent based on the three public health initiatives already approved by CMS. This is not to say that any new, innovative proposal would not be accepted. The only way to know for sure would be to submit a formal state plan amendment (SPA) or a request for approval of a waiver as appropriate to the specific proposal. Note, that a waiver is not needed if proposals are within the requirements of Title XXI.

State Budget Crisis — If MRMIB were to implement a new public health initiative using an insurance model, State funds would be required for a federal match. Recent actions taken by the Legislature and the Administration to address the State's unprecedented budget deficit make it difficult to obtain general funds for public health initiatives. The budget for the HFP has been affected by the budget crisis which has lasted through two fiscal years. The first effect on the HFP budget was the elimination of General Fund money for the Rural Health Demonstration Project. (Funding was later restored at a lower amount using Proposition 99 funds.) This past budget placed a freeze on HFP health, dental, and vision plan rates for two years. For 2003/04 and 2004/05, the Administration has proposed a cap on enrollment, and has proposed other changes to achieve cost savings for the program.

One alternative to implementing public health initiatives for vulnerable children or urban demonstration projects with State funds may be county sponsored initiatives. In response to the solicitation MRMIB conducted of counties for projects pursuant to

AB 495 (Diaz)[8], a few counties submitted concepts for public health initiatives. Although only a few of these initiatives are similar to the projects proposed, it does serve as a potential model for exploration. Note, however, that the federal government has yet to approve the state plan amendment that authorizes the use of county funds for AB 495.

Current Draw on the 10% Administrative Cap — MRMIB recently submitted two state plan amendments to use funds under the 10% administrative cap for demonstration projects. MRMIB, in collaboration with the California First 5 Children and Families Commission (First 5 Commission), has developed a three-year initiative to increase the utilization of preventive dental care services to children ages five years and younger. These projects will be implemented through contracts between MRMIB and health and dental plans participating in the HFP. The interest in having these projects coordinated with the school readiness sites established by the First 5 Commission necessitated the preparation of the state plan amendment as a public health initiative. Many of the services that participating plans will provide will target children living in school readiness areas, making it difficult to isolate children who are enrolled in the HFP from those who are uninsured. Of the $39 million in federal funds available under the 10% administrative cap, MRMIB expects this oral health initiative to draw $2 million per year for three years. CMA approved this state plan amendment on January 16, 2004.

The second state plan amendment is for the Rural Health Demonstration Projects. An amendment was required due to a change in the source of state funding (from General Fund to Prop. 99 funds). The Rural Health Demonstration Projects are being proposed to be funded under the 10% cap to allow greater flexibility in the administration of the projects by participating health, dental, and vision plans. Of the $39 million available in federal funds under the 10% cap, MRMIB expects the Rural Health Demonstration Projects to draw $1.2 million per year.

Another potential draw on the 10% administrative cap is the proposed AB 495 public health initiatives. MRMIB received several proposals from counties interested in implementing public health initiatives under Title XXI. These proposals consist of programs to address asthma, dental, vision and specialty care services, immunizations, targeted case management for mental health services for probationary and high risk young children, dental and oral health treatment education and prevention, and the expansion of mental health services. The proposals are in the form of general concepts and require additional development. Collectively, the county proposals identify approximately $2.3 million in county funds, which would draw $4.6 million Title XXI funds if approved by CMS.

Staffing — Recent reductions in personnel would make it very difficult for MRMIB to absorb any new activities. At a minimum, MRMIB would need an additional two

[8] AB 495 (Diaz) authorized the Children's Health Initiative Matching Fund (CHIM). The CHIM increases the State's ability to use Title XXI funds available to California by allowing the use of local funds to expand access for uninsured persons.

positions for the oversight of this project as well as a full time staff person to support activities associated with the implementation of a new public health initiative.

Conclusion

There are several options available to the State for implementing public health initiatives to address the health needs of vulnerable children in California. Any of these may be implemented by MRMIB using the "demonstration project" model that has been successful in expanding access to care for children living in rural areas or in migrant and seasonal worker families. Because the demonstration project model gives plans and their provider partners the flexibility to develop projects that will meet the specific needs of a community, these projects can been implemented anywhere in the state to address unique community needs, including needs of children in urban areas.

The current economic climate dampens the optimism of initiating any new initiatives under the SCHIP program.

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