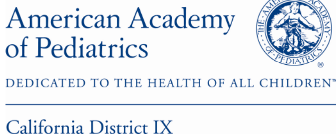
CH1LDREN NOW



June 8, 2012

California Health Benefit Exchange
2355 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

RE: Recommendations for Serving Children & Youth in the California Health Benefit Exchange

Dear California Health Benefit Exchange Board,

The undersigned organizations acknowledge and greatly appreciate your leadership in implementing a strong vision for the California Health Benefit Exchange (Exchange) that truly reflects a commitment to consumer-focused, consumer-friendly accessibility for all Californians. As some very important decisions about the structure and mechanics of the Exchange will soon be made, we would like to take this opportunity to highlight several issues that are critical to ensuring that the Exchange is a successful, effective, and equitable mechanism for meeting the significant and particular needs of California's children and youth.

The UC Berkeley Labor Center and the UCLA Center for Health Policy Research estimate that 560,000 Californians under 18 will be eligible to enroll in the Exchange, with another 675,000 children eligible for Medi-Cal or Healthy Families. The need to connect California children and youth with meaningful coverage is paramount, and the opportunities leading up to 2014 are tremendous.

Because issues affecting children and youth are interwoven throughout the complex workings of the Exchange apparatus, we respectfully request that an opportunity to comment on children's issues be integrated into an upcoming Exchange Board meeting or stakeholder input session. We believe that such

a public forum would be informative to the Exchange Board and staff and that it would engage a diverse group of stakeholders.

To highlight the unique health needs of children and youth and their implications for a child-/youth-friendly Exchange, we have developed six specific policy recommendations. These recommendations are described in more detail in the following pages, but, briefly, they are to:

- **Expand upon the federal definition of essential community providers to explicitly include specific child- and youth-serving providers;**

- **Include pediatric-specific access and quality measures in the selection and evaluation of Qualified Health Plans participating in the Exchange;**

- **Address and incorporate the requirements for child-only plans throughout the planning and development of Exchange-related contracts and systems;**

- **Maximize the role of schools, and school-based partners, in outreach and enrollment;**

- **Implement marketing, outreach and Navigator/Assister programs that specifically address the complex health coverage situations that create particular challenges to accessing health insurance coverage for children and youth; and**

- **Design a truly first-class, consumer-friendly, seamless, and coordinated enrollment system that will effectively serve children and youth and link to other enrollment pathways, including SHOP and the CHDP Gateway.**

We appreciate your ongoing consideration of stakeholder perspectives as you undertake policy decision-making. As the Board, staff, and vendors work to develop the Exchange systems, we would like to offer our organizations, collectively and individually, as a resource on these important issues.

We appreciate the opportunity to provide input and look forward to further engaging the Exchange Board and staff to ensure the best possible health care options for California's children and youth.

Sincerely,

American Academy of Pediatrics - CA District
California Association of Rural Health Clinics
California Children's Hospital Association
California Coverage & Health Initiatives
California Family Resource Association
California Pan-Ethnic Health Network
California Partnership
California School Health Centers Association
Children Now
Children's Defense Fund-California
Children's Specialty Care Coalition
EQUAL Health Network
Family Resource Centers Network of California
First 5 Association of California
Guam Communications Network
Los Angeles Trust for Children's Health
MomsRising
Nana's Wish
National Health Law Program
The Children's Partnership
United Ways of California

cc: Peter Lee, HBEX Executive Director
David Maxwell-Jolly, HBEX Chief Operations Officer
David Panush, HBEX Director of Government Relations
Katie Marcellus, HBEX Director of Program Policy

Recommendations for Serving Children & Youth in the California Health Benefit Exchange

***Policy Recommendation*:**
Expand upon the federal definition of essential community providers to explicitly include specific child- and youth-serving providers.

The California Health Benefit Exchange should ensure that Qualified Health Plans provide not only insurance coverage, but also access to the providers upon which consumers depend. In its final rule on the Establishment of Exchanges and Qualified Health Plans (CMS–9989–F), the U.S. Department of Health and Human Services (HHS) states that a Qualified Health Plan's network must have a "sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals..." Although HHS identifies essential community providers as "health care providers defined in section 340B(a)(4) of the PHS Act; and Providers described in section 1927(c)(1)(D)(i)(IV) of the Act," the Department also clarifies, in its response to comments calling for a broader definition, that this is "not an exhaustive list."

We urge the Exchange Board to expand upon the federal government's broad rule regarding the definition of essential community providers to ensure adequate access to care for underserved children and youth, as required by Section 1311(c)(1)(C) of the Affordable Care Act. Ensuring access for this population requires recognition that children and youth need timely and appropriate preventive care and that this care is critical to successful long term health outcomes. It also requires recognition that children and youth have less capacity to independently seek out health services than do adults and that adolescents are an especially challenging group to reach. Therefore, we request that California's definition of essential community providers *explicitly highlight and include* the provider groups that are critical for pediatric care and that reach medically underserved children and youth. These providers include school-based health centers, children's hospitals, the CCS provider network, and rural health clinics.

These providers uniquely care for children and families in communities throughout California.

- Over 250,000 students have access to the 183 school-based health centers in California, which provide them with preventive, primary and acute care services.
- California's eight private, non-profit children's hospitals are focused on meeting the specific health care needs of children, providing care to over 1.5 million children annually and training more than 650 pediatric professionals each year. Children's hospitals are the principal institutions exclusively invested in pediatric medical training and health care services research.
- The pediatric subspecialists in the California Children's Services (CCS) provider network care for the children with the most severe special health care needs in the Medi-Cal, Healthy Families, and CCS programs. Most patients seen by CCS providers rely on public programs for coverage.
- Each year more than 300 rural health clinics provide millions of health care visits to hundreds of thousands of people living in medically underserved rural communities throughout California, making them vital access points for children and their families.

The vision of the California Health Benefit Exchange is to improve the health of Californians by assuring their access to affordable, high quality care. To successfully realize this vision for children and youth, it is essential that they be able to obtain care in the locations that are most accessible to them. Therefore, we respectfully request that the Exchange Board expand on the federal minimum definition of essential community providers to explicitly include school-based health centers, children's hospitals, CCS providers, and rural health clinics in the regulatory definition.

Note: This recommendation was created in consultation with and is supported by the California State Rural Health Association.

***Policy Recommendation*:**
Include pediatric-specific access and quality measures in the selection and evaluation of Qualified Health Plans participating in the Exchange.

Section 2717 of the Affordable Care Act requires the U.S. Department of Health and Human Services (HHS) to develop reporting requirements for individual and group insurers. During annual open enrollment periods, insurers will be required to report to both plan enrollees and HHS on whether plan benefits and payment structures improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and promote health and wellness. Although HHS was required to develop reporting requirements by March 23, 2012, proposed guidance for Section 2717 has not yet been released.

In the absence of federal guidance, we urge the Exchange Board to define a comprehensive and rigorous set of pediatric quality measures to monitor and evaluate the performance of Qualified Health Plans and hold them accountable for meeting the needs of California's young people.

The quality measures defined by the Exchange Board should encompass existing and reliable pediatric measures, including those currently used to assess Medi-Cal and Healthy Families Program plans, as well as the 24 Initial CHIPRA Core Measures, which were authorized by Section 401(a) of the Child Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and then expanded and improved upon through the Pediatric Quality Measures Program (PQMP) established by Section 401(b).[1] We urge the Board to adopt measures that span the pediatric developmental spectrum and hold Qualified Health Plans accountable for identifying and addressing the most persistent health problems facing California's children and youth and for focusing on prevention.

In selecting the pediatric Quality Measures, we ask that the Exchange Board include the following categories and, at a minimum, consider the specific measures listed below. We believe that these prioritized measures capture essential indicators of infant, child, and adolescent health care. Of course, to make these pediatric measures effective, the Exchange must have a meaningful enforcement and compliance plan, which includes but is not limited to reporting results to consumers.

Access to Care
- Child and Adolescent Access to Primary Care Practitioners [CHIPRA, HFP, Medi-Cal]
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) [CHIPRA]

Maternal and Prenatal
- Timeliness of Prenatal Care [CHIPRA, Medi-Cal]
- Frequency of Ongoing Prenatal Care [CHIPRA]
- Percentage of Live Births Weighing Less Than 2500 grams [CHIPRA]

Infants and Toddlers
- Developmental Screening in the First Three Years of Life [CHIPRA]
- Well-Child Visits in the First 15 Months of Life [CHIPRA, HFP]

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[1] Medi-Cal measures: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-021.PDF
Healthy Families Program measures: http://www.mrmib.ca.gov/MRMIB/HFP/2010_HFP_HE_DIS.pdf
Initial CHIPRA Core measures: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResouceManual.pdf

School-Aged Children

- Childhood Immunization Status [CHIPRA, HFP, Medi-Cal]
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life [CHIPRA, HFP, Medi-Cal]

Adolescents

- Adolescent Immunization Status [CHIPRA, HFP, Medi-Cal]
- Adolescent Well-Care Visits [CHIPRA, HFP, Medi-Cal]
- Chlamydia Screening [CHIPRA, HFP]

Chronic Disease Management

- Annual Number of Asthma Patients Ages 2-20 Years Old with One or More Asthma-Related Emergency Room Visits [CHIPRA]
- Annual Pediatric Hemoglobin A1C Testing [CHIPRA]
- Weight Assessment and Counseling for Nutrition and Physical Activity [CHIPRA, Medi-Cal]
- Mental Health Utilization, 13-17 Years of Age [HFP]

Dental *(for plans offering dental coverage, including stand alone and supplemental plans)*

- Percentage of Eligibles Who Received Preventive Dental Services [CHIPRA]
- Percentage of Eligibles That Received Dental Treatment Services [CHIPRA]

***Policy Recommendation*:**
Address and incorporate the requirements for child-only plans throughout the planning and development of Exchange-related contracts and systems.

The Affordable Care Act Section 1302(f) requires that health insurance issuers in the Exchange offer child-only plans. Specifically, the law stipulates that, "if a health insurance issuer offers health insurance coverage in any level of coverage specified under section 1302(d)…the issuer shall also offer such coverage in that level as a plan which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21."

This "child-only" plan requirement can positively impact the success and seamlessness of the Exchange if it is thoughtfully and explicitly considered at each step in the planning process – from the selection of Qualified Health Plans, to the development of the eligibility and enrollment system, to the design of marketing and enrollment approaches.

We are unaware of any specific effort underway by the Exchange to address child-only plan requirements, and, accordingly, we recommend that a process be initiated for determining child-only plan benefit design, eligibility, and cost.

Many parents have employer-based coverage for themselves but are unable to enroll children or cannot afford to have their children on the same plan. It is critical that these parents be able to shop for and enroll their children in a quality health plan through the Exchange. In doing so, parents should be able to understand and have access to any premium and/or cost-sharing subsidies for which they are eligible. Determining the correct value of child-only subsidies requires a complex calculation and it is essential that the enrollment process be designed so that families understand their options, are provided accurate information, and are able to make appropriate plan choices for their children.

The Exchange Board must also consider the interaction between individual Exchange coverage, including child-only plans, and the SHOP. It is likely that some parents will enroll themselves in SHOP coverage offered by their small employers, but for financial and/or other reasons may not be able to enroll their children in the same SHOP plan. It is therefore absolutely critical that there be strong linkages and connections between SHOP coverage and individual Exchange coverage, with particular attention to child-only plans. Parents must know about the child-only Exchange coverage options upfront and it should be made as easy as possible for a parent to begin a child-only application with the information already provided as part of a SHOP application (for example, through the pre-population of data on a child-only application).

In addition, child-only plans should be thoughtfully integrated into relevant marketing and outreach campaigns. The Exchange should develop strong, coordinated partnerships with Medi-Cal, Healthy Families, local coverage programs and providers, Navigators/Assisters, and others to collectively develop and capitalize on compelling messages around "health care for all children" or "all children eligible for free preventive care."

Finally, children's coverage, including child-only plans, must be a specific and comprehensive component of training on Exchange coverage for all Navigators/Assisters, including brokers/agents

***Policy Recommendation*:**
Maximize the role of schools, and school-based partners, in outreach and enrollment.

It is a stated goal of the California Health Benefit Exchange to maximize enrollment on “Day One” or January 1, 2014, when the Exchange is officially open for business. This ambitious but necessary objective will require a coordinated effort to educate the public about new insurance options and enroll eligible individuals into coverage.

Schools, with their existing networks and relationships, are a proven location for effective outreach and enrollment. In fact, many schools and districts have long been very active in this important work. Schools touch millions of families across the state, making them obvious partners in reaching not only uninsured students but also the one-third of uninsured adults who, according to the 2009 California Health Interview Survey, have children.

Schools are also trusted messengers, and coverage information delivered by staff, administrators, and superintendents will therefore be viewed as important, reliable, and official. With some planning, this information can be included in registration materials for the 2013-14 school year. In addition, many schools have pre-existing partnerships with community organizations, including health centers and Children’s and Community Health Initiatives, which can successfully link students and families to additional information and resources. For all of these reasons, a successful outreach and enrollment effort must engage the state Department of Education in mobilizing school stakeholders, including teacher groups, administrators, school boards, school nurses, school-based health centers, and PTAs.

We were very pleased to see educational partnerships highlighted at several points in the “Statewide Marketing, Outreach & Education and Assisters Program Workplan” discussion draft, presented by Ogilvy Public Relations on May 16, 2012. The draft workplan identifies partnerships with educational entities as one of the top six partnership categories (p. 55), and we strongly support including educational entities as eligible applicants in the proposed education and outreach grant program (p. 55). In addition, the draft identifies a specific role for school districts in reaching Latino communities and Ogilvy correctly states that “having information and Assisters at Enrollment days, Back-to-School events, PTA and other school-based organizational meetings, school health and wellness fairs and other school-based festivals will provide important face-to-face outreach opportunities” (p. 72). While we agree that school districts can be key messengers in Latino communities, we also urge the Exchange to recognize that schools can play a similarly effective role with other hard to reach populations, including adolescents and young adults.

Further, in finalizing the education and outreach grant program and making decisions on eligibility and compensation within the Navigator program, we urge the Exchange Board to consider how best to enable schools and school-based providers to be active participants in outreach and enrollment. Partnerships with schools should build on the successes and lessons learned from existing school-based enrollment efforts, such as Teachers for Healthy Kids, Express Lane Eligibility demonstration sites and Children’s Health Initiatives coordinated school-based enrollment campaigns. We urge the Exchange to recognize that, while schools and school-based providers can leverage existing resources and relationships, they are facing severe budget constraints and will need additional funding to incentivize and support their participation in upcoming outreach and enrollment initiatives.

Policy Recommendation:
Implement marketing, outreach and Navigator/Assister programs that specifically address the complex health coverage situations that create particular challenges to accessing health insurance coverage for children and youth.

The diverse communities and complex households that some California youth live in can create challenges in connecting children with health coverage. Despite the many reforms of the ACA, there will continue to be existing barriers to health coverage for millions of California children. Recent research by the Urban Institute estimates that at least 4.8 million California children and youth live in "complex coverage situations" or family configurations that can inhibit access to health coverage. This includes children who are eligible for Healthy Families or Medi-Cal but whose parents are potentially eligible for coverage through the Exchange or whose parents are undocumented and thus not eligible for coverage. In addition, 3 million California children have at least one absent parent, and their coverage scenarios can be further complicated by kinship care situations and child support orders requiring non-custodial parents to provide health insurance.

To best serve children and youth with complex coverage situations, the outreach, marking and Navigator/Assister programs should include the follow elements:

- A strong component to the outreach and marketing effort that specifically targets the parents and guardians of children and youth living in complex coverage situations. It is critical to find these families, identify their coverage needs, and connect them to appropriate programs. Thoughtful and specific strategies and messaging are needed to accomplish this.
- A robust Navigator/Assister presence in both the individual and small business sides of the Exchange that can act as an important access point and linkage for children whose parents are eligible for SHOP coverage but who are themselves eligible for other coverage.
- Targeted, sensitive, and culturally and linguistically competent marketing, outreach and navigation efforts to all families, with a focus on reaching undocumented parents whose children may be eligible for Medi-Cal or Healthy Families.
- Targeted outreach and marketing to reach grandparents, kinship, and other guardians. Many of these caregivers and guardians may not be subject to the ACA mandate or may not need to shop for health insurance. Partnerships with kinship groups, senior organizations, schools, child support agencies, and other organizations that reach these populations need to be strongly considered in the outreach plan.
- A strong training component for Navigators/Assisters, including brokers/agents that educates them about complex family coverage situations and children's coverage options, identifies the barriers to enrolling in coverage, and trains them to assist families in making the best coverage choices for their children.

***Policy Recommendation*:**
Design a truly first-class, consumer-friendly, seamless, and coordinated enrollment system that will effectively serve children and youth and link to other enrollment pathways, including SHOP and the CHDP Gateway.

The Affordable Care Act requires that states design enrollment processes that impose the minimum possible consumer burden and that systems handle transitions seamlessly, resulting in consumer-friendly processes and tight coordination across agencies. With millions of children and youth qualifying for one of four insurance affordability programs (i.e., the individual Exchange, Medi-Cal, Healthy Families, and the SHOP Exchange), and with many children expected to transition among the coverage programs, the enrollment system will have to be seamless and well-coordinated to prevent them from falling through the cracks.

Moreover, children will be affected by how well the enrollment system serves families with varying circumstances (e.g., family members eligible for different programs, or family members with varying immigration status). The Urban Institute recently estimated that nearly half (48%) of all California children live in a family in which not all family members are eligible for the same type of coverage, highlighting the importance of ensuring that the eligibility and enrollment system be sufficiently coordinated and sophisticated to handle complex family circumstances. For example, a significant number of California children eligible for Healthy Families will have parents qualifying for Exchange coverage, and an estimated three million California children have at least one parent absent from the household, creating complexity in accurately determining a child's eligibility.

To best serve children and youth, especially those with complex family circumstances, the eligibility and enrollment system should include the following elements:

- **A single shared eligibility IT system should carry out automated tasks for all insurance affordability programs.** The interagency agreement between the programs should provide for a single service that gathers data, compares data matches and consumer attestations to eligibility requirements, and identifies any additional information that is needed from the consumer. Such a system must use a single and coordinated eligibility business rules engine. The underlying enrollment system used by the insurance affordability programs should be capable of making eligibility determinations for Medi-Cal, Healthy Families, and premium subsidies for Exchange coverage. We urge you to resist the federal regulatory option that allows the IT enrollment system to merely screen for MAGI Med-Cal or HFP eligibility and then refer the application to another system for a final determination. This bifurcated approach would most certainly cause delays and inconsistencies in eligibility determinations for children and youth.

- **Linkages and smart connections through multiple enrollment doorways and accessible consumer assistance.** We recommend that the Exchange require the development and implementation of appropriate enrollment linkages between SHOP and other public coverage options. We also support the preservation and promotion of existing pathways to coverage such as the Child Health and Disability Prevention (CHDP) Gateway to temporary and ongoing coverage for children. These programs offer an expedited means of connecting millions of youth with care and coverage. In addition, the Exchange should consider an Express Lane Eligibility strategy using data from families' existing CalFresh case file to expedite enrollment for uninsured children and parents.

- **Easy navigation of coverage, particularly for families with complex and mixed coverage circumstances.** The Exchange should include the following elements for ease of navigation through the enrollment system:

- Coordinate and consolidate how mixed-coverage families choose health plans, make premium payments, and receive correspondence;
- Design the premium payment function in the enrollment system so that consumers receive one monthly bill for the whole family;
- Discount the Healthy Families premium for mixed-coverage families paying other premiums and conform the HFP premium grace period to match the Exchange grace period (three months);
- Establish consumer-friendly procedures and navigation assistance for those facing changing family circumstances, eliminate unnecessary paperwork, and ensure that consumers transferring between programs experience no gaps in coverage;
- For families applying for coverage outside the Exchange open enrollment period, enroll eligible children in Healthy Families but reset their renewal date to coincide with their parents' eventual Exchange enrollment;
- Promote the availability of Medi-Cal, Healthy Families, and child-only plans for children even with parents who are not themselves eligible for insurance affordability programs; and
- Ensure careful coordination with the California Department of Child Support Services and other entities to address the structure of child support orders involving the provision of health insurance and the wide variety of other challenges to attaining health insurance for children with non-custodial parent.