

## County Buy-In Program Design Issues Options and Public Comments

Design Issue	Options	Initial Recommendation	Public Feedback Meeting Comments and Written Comments on Design Issues	Recommendation and Reasoning
<p>#1</p> <p>With Whom Should MRMIB Contract?</p>	<p>1. Individual counties, 2. Consortia of counties, 3. First 5 commissions, that are county agencies 4. Or county agencies.</p> <p>Contracting with any other types of entities would require statutory change.</p>	<p>Individual counties or consortia of counties, if counties are required to do eligibility determinations (see issue #3).</p> <p>Counties would have to submit subcontracts/MOUs outlining the roles and responsibilities of those participating (such as Department of Social Services, Health Services, CHIs, non-profits)</p>	<p style="text-align: center;"><u>Public Meeting Comments</u></p> <ul style="list-style-type: none"> <li>• Keep things local. Would like county to do eligibility determination.—<b>Steve Barrow, Kern County</b></li> <li>• Could contract with quasi-county organization, such as a health plan.—<b>Dr. Beed, Orange County HCA</b></li> <li>• County would be best. Politics could affect planning. Might be hard to get them to set-up. Maybe good to have other option. Could contract with other organization such as a large foundation (like hospitals) —<b>Steve Barrow, Kern County</b></li> </ul> <p style="text-align: center;"><u>Written Comments</u></p> <ul style="list-style-type: none"> <li>• Form a workgroup comprised of State, interested counties, counties with current HK programs, health plans, community stakeholders, and advocates to workout the details of each of the design issues.—<b>100% Campaign</b></li> </ul>	<p style="text-align: center;"><u>Recommendation</u></p> <p>Contract with individual counties, First 5 commission that are county agencies and other county agencies.</p> <p style="text-align: center;"><u>Reasoning</u></p> <p>Contract with statutorily approved entities. MRMIB is open to expanding entity definition of other types of entities via statutory change as long as the federal government approves for federal fund participation (FFP)</p>

Design Issue	Options	Initial Recommendation	Public Feedback Meeting Comments and Written Comments on Design Issues	Recommendation and Reasoning
#2 HK Funding Management	<p>Given that a county has multiple parties interested in funding the HK program (which can be accompanied by specific conditions such as only children from a certain city, or only children of a certain age), who should be responsible for accounting for expenditures from the different county funding sources?</p> <ol style="list-style-type: none"> <li>1. County</li> <li>2. MRMIB's Administrative Vendor (AV)</li> </ol>	<p>County should administer.</p>		<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p>County shall administer their funding streams.</p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <p>County shall administer their multiple funding streams and based on the PMPM cost indicate to the AV the number of enrollment slots they can fund.</p>
#3 Eligibility Determination	<p>Given the need to keep strict accounting and control of the amount of enrollment a county can fund (and the circumstances under which children would be funded), who should make determination of eligibility?</p> <ol style="list-style-type: none"> <li>1. County</li> <li>2. MRMIB's Administrative Vendor (AV)</li> </ol>	<p>County conducts eligibility determination then forwards application to AV for MC/HFP coverage screening and HK enrollment.</p>	<p style="text-align: center;"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Keep things local. Would like county to do eligibility determination.—<b>Steve Barrow, Kern County</b></li> <li>• Strongly believe eligibility determination should be at local level. Already in community and have established a sense of trust. Public perception could make it harder to fundraise if perceived as a State program. Would like MRMIB to set up with HIPAA compliant files to better handle plan notifications.—<b>Kena Burke, San Luis Obispo CHI (CHISLO)</b></li> <li>• AER Process is missing.—<b>Dorothy Seleski, LA Care Health Plan</b></li> </ul> <p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Counties will need to be involved in eligibility determination. Counties using Health-e-App, One-e-App, and/or the MC 210 make eligibility determinations. The AV makes eligibility determinations for applications that come in</li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p><b>MRMIB's Administrative Vendor shall conduct eligibility determination and AER determinations.</b></p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Reduces administrative modifications to the SPE/HFP business process; increasing economy of scale and administrative cost savings</li> <li>◆ Provides centralized and streamlined process for processing applications and conducting eligibility determinations.</li> <li>◆ Allows for immediate drawing down of FFP for SCHIP eligible children</li> <li>◆ Eliminates duplication of certain administrative services such as application processing and data entry.</li> <li>◆ AV will be able to respond to incoming inquiries related to the processed applications.</li> </ul>

			<p>through SPE. The AV should handle AER. County Buy-In population should be able to take advantage of the same simplified enrollment and renewal “gateways” afforded to HFP/MC children: <b>CHDP Gateway</b>, as with children applying for HFP/MC so coverage could be extended until eligibility determination is made; <b>Express enrollment</b> so applications not eligible for MC but appear eligible for Buy-In should be forwarded to the HFP; <b>Bridge</b> so child can be seamlessly bridged County Buy-In. If Buy-In child becomes eligible for MC, child should be seamlessly bridged to MC; <b>Transition to HFP</b> should family income increase or decrease at AER, child should be transitioned without lapse of coverage. —</p> <p><b>100% Campaign</b></p> <p style="text-align: center;"><b><u>County Partners Feedback</u></b></p> <ul style="list-style-type: none"> <li>• MRMIB staff spoke with county representatives that submitted letters of intent to solicit their opinions on specific design issues.</li> <li>• We had further discussions regarding who should conduct eligibility determinations based on recent Maximus feedback in which they expressed the ability to administer the eligibility determination if they had clear business rules regarding the available county funding streams. The administrative services that are provided by Maximus include mailroom functions; imaging of received documents; SPE screening for program eligibility (MC, HFP, HK); electronic plan enrollment transactions; premium billing, collection and reconciliation; staffing toll-free line; handling appeals; administering AER process; plan capitation administration: and administering and reconciling county HK funding streams.</li> <li>• All counties agreed that this is not a deal breaking issue which ever way the Board decides to design the Buy-In Program.</li> <li>• Four of eleven counties indicated that they might</li> </ul>	
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			<p>prefer to do eligibility determination locally but the final decision would not keep them from participating in the Buy-In Program.</p> <ul style="list-style-type: none"> <li>• Most of the counties believe centralized administration of eligibility for HK and HFP will be less confusing for families and be useful for the AER process. Transition of program eligibility will be seamless for children moving between programs.</li> </ul>	
<p>#4 Eligibility Determination</p>	<p>If MRMIB's Administrative Vendor (AV) conducts eligibility determination, by what means would the Administrative Vendor make eligibility determinations based on the nuances of each county's funding mix?</p>		<p>**#3 and #4 comments were discussed as the same issue at the same time as #2 comments. See #2 above for comments on this design issue.</p>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p><b>As previously indicated in #3 &amp; #4, AV shall conduct eligibility determinations based on the number of enrollment slots allotted by each county based on their available funding.</b></p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ The process allows the counties to administer and be responsible for their multiple funding streams.</li> <li>◆ MRMIB's AV shall conduct eligibility determinations and HK enrollments based on the number of enrollment slots allocated by each county.</li> <li>◆ AV shall provide necessary reports to counties to reconcile enrollment monthly and keep available enrollment slots current.</li> </ul>

<p>#5</p> <p>Appeals</p>	<p>Who handles eligibility appeals?</p> <ol style="list-style-type: none"> <li>1. County</li> <li>2. MRMIB's Administrative Vendor (AV)</li> </ol>	<p>Must be in synch with the answer to issue #3</p>	<p><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• MRMIB should handle 2<sup>nd</sup> level appeals: more objective. Give cost breakdown of State level so county can choose options with regards to cost. Could the cost of the program be too much?—<b>Dr. Beed, Orange County HCA</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p>1<sup>st</sup> level appeals by Administrative Vendor. 2<sup>nd</sup> level appeals by MRMIB staff.</p> <p><b><u>Reasoning</u></b></p> <p>Based on the recommendation to #3, since the AV shall do the eligibility determination the AV shall appropriately handle eligibility 1<sup>st</sup> level appeals from the determination and 2<sup>nd</sup> level appeals by MRMIB staff.</p>
<p>#6</p> <p>Waiting List</p>	<p>Who should maintain a waiting list or simply close enrollment?</p> <ol style="list-style-type: none"> <li>1. County</li> <li>2. MRMIB's Administrative Vendor (AV)</li> </ol> <p>Should maintenance of a waiting list be a requirement for participation or at the counties option?</p> <ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	<p>Waiting list should be at the option of and administered by the county.</p> <p>Counties should submit to AV what their policy is. AV should advise a family whose child cannot be enrolled due to funding problems to contact county.</p>	<p><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Allow counties to maintain waiting lists. Policies need to address age-out requirements at age 6 and also siblings. MRMIB should suggest waiting list rules to help standardize.—<b>Steve Barrow, Kern County</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p>Waiting lists shall be at county option and shall be administered by the county.</p> <p><b><u>Reasoning</u></b></p> <p>County administers the funding resources and allocates the available number of enrollment slots within their county; the county is the appropriate location for waiting list inquiries. AV will need to establish communication process with county.</p>

<p>#7</p> <p>Subscriber Premium Administration</p>	<p>Who should bill, collect and reconcile subscriber premiums?</p> <ol style="list-style-type: none"> <li>1. County</li> <li>2. MRMIB's Administrative Vendor (AV)</li> </ol>	<p>AV administers subscriber premiums</p>	<p><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Three costs: MRMIB admin, plan coverage costs (capitation), county administration and outreach, which will not be reimbursable by First 5 for 6-18 year olds. MRMIB needs start up funds and initial coverage costs (capitation)—how will the costs be rolled together? How will the counties be charged for all of these?—<b>Perry Rickard, Kings County Public Health</b></li> <li>• How would Sac County pay MRMIB, per child or per a coverage plan? If the financial burden of start up falls on initial counties, how will counties that join later contribute to the start up amount?—<b>Jennifer Sipe, Sacramento County DHS</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p>MRMIB's Administrative Vendor.</p> <p><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ MRMIB's AV is experienced in HFP billing, collection and reconciling of subscriber premiums; they have existing infrastructure to handle the administrative function.</li> <li>◆ Counties do not have the expertise and/or existing infrastructure; they would need to develop and would have associated costs.</li> </ul>
<p>#8</p> <p>Subscriber Premium Administration</p>	<p>Should premium be standardized?</p> <ol style="list-style-type: none"> <li>1. HK Statewide standard</li> <li>2. Vary by county</li> </ol>	<p>If state collects premiums, premiums should be standard across the state for HK.</p>	<p><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Families will have to deal with two agencies back and forth of application between county and admin vendor. Good to have one form to fill out. Seamlessness should be the goal. Could be confusing for families with children eligible for different programs.—<b>Jenny Kattlove, The Children's Partnership/100% Campaign</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p>HK Statewide standard.</p> <p><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Administrative consistency across the state and administrative simplicity; increasing economy of scale and administrative cost savings.</li> <li>◆ Consumer fairness that all Buy-In families will be paying the same premiums levels based on family income.</li> </ul>

<p>#9</p> <p>Subscriber Premium Amount</p>	<p>If premium is standard, what should it be?</p>	<p>Consistent with premium policies of MC and HFP</p>	<p style="text-align: center;"><u>Written Comments</u></p> <ul style="list-style-type: none"> <li>Structure County Buy-In premiums on the current MC and HFP rates.--<b>100% Campaign</b></li> </ul>	<p style="text-align: center;"><u>Recommendation</u></p> <p><b>Consistent with HFP premium policies (premium categories A, B &amp; C)</b></p> <p><b>A-\$4-\$7PCPM; \$14 Max</b>  <b>B-\$6-\$9PCPM; \$27 Max</b>  <b>C-\$12-\$15PCPM; \$45 Max</b></p> <p style="text-align: center;"><u>Reasoning</u></p> <ul style="list-style-type: none"> <li>Monthly communication with the family through the billing statements process increases program integrity.</li> <li>Administrative consistency across the state and administrative simplicity; increasing economy of scale and administrative cost savings.</li> <li>Consistent with premium levels of most existing HK programs.</li> </ul>
<p>#10</p> <p>Hardship Fund</p>	<p>Should program require a hardship fund?</p> <ol style="list-style-type: none"> <li>Yes</li> <li>No</li> </ol>	<p>Hardship fund should be at the option of the county;</p> <p>However, AV will need to communicate with county and subscribers about its availability, if adopted</p>	<p style="text-align: center;"><u>Public Meeting Comments</u></p> <ul style="list-style-type: none"> <li>Standardize name, rules, and how often. Families should initiate a request for funds. Call it “premium assistance” instead of “hardship fund” for family dignity.—<b>Steve Barrow, Kern County</b></li> <li>Supports keeping it optional for each county.—<b>Dr. Beed, Orange County HCA</b></li> </ul>	<p style="text-align: center;"><u>Recommendation</u></p> <p>Hardship funds shall be at the option of the county and administered by the county.</p> <p style="text-align: center;"><u>Reasoning</u></p> <ul style="list-style-type: none"> <li>Not all counties may desire a premium assistance fund.</li> <li>County should have the option to implement and administer their local process.</li> <li>AV will establish communication process to notify counties of their HK subscribers that are in arrears.</li> </ul>

<p>#11</p> <p>Term of Contract</p>	<p>Should contract require participation in the buy-in for a set period?</p> <p>1. Yes 2. No</p> <p>If yes, what term of contract?</p>	<p>Require 2 year buy-in commitment from county</p>	<p><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Should be opt out clause in contract. Two year commitment okay.—<b>Perry Rickard, Kings County Public Health</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p>County is required to make a 2 year commitment to the Buy-In Program in order to participate</p> <p><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Consistent with the AB 495 participation requirement</li> <li>◆ Provides State assurance that counties will participate for at least 2 years</li> </ul>
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<p>#12</p> <p>Continuity of coverage</p>	<p>Given fiscal unpredictability, how can an enrolled child's continuity of coverage be assured?</p>	<p>Require county to deposit funds for 12 months of coverage for each enrolled child.</p>	<p style="text-align: center;"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Need for upfront funding. 12 months seems prudent. Could funding be for 6 to 8 months at a time? Should have counties involved in rate negotiation agreements for their input. Maybe a county advisory board to keep everybody informed. When in the 12 month period would a county need to come up with the next 12 month in funds? Consider safety net in contracts to allow for funding stream in around 8 months or so. Should not be so rigid to allow for unpredictable funding streams. Someone is going to have to help families choose plans. Need to keep it easy for families to choose.—<b>Steve Barrow, Kern County</b></li> <li>• Guaranty at least 12 months capitation. Should not allow 6-8 months because health coverage is already very fragmented. Let's have some continuity of care for families.—<b>Dr. Beed, Orange County HCA</b></li> <li>• Yes to 12 month commitment with monthly reconciliation so county can sign another kid after a disenrollment. What if child moves within the state? This creates a funding issue. May have to be put on a waiting list in another county.—<b>Kena Burke, CHISLO</b></li> <li>• Asked what MRMIB has to offer to counties wanting to participate in a HK program.—<b>Marian Mulkey, CHCF</b></li> <li>• Asked to clarify eligibility/immigration question. We'd mandate <b>12 month</b> funding, other funders would probably agree.—<b>Peter Long, The California Endowment</b></li> </ul> <p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Supports condition that counties provide (funding) 12 months of coverage at a time.—<b>100% Campaign</b></li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p>Require county to deposit funds for at least 12 months of coverage for each enrolled child.</p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>• Assures sufficient funding to provide HK coverage for 12 months.</li> <li>• Provides for continuity of care for each enrolled subscriber.</li> <li>• 12 months coverage is mandated by many of the private funders.</li> <li>• 12 months coverage is the existing statewide standard for children's coverage in HFP, MC and existing HK programs.</li> </ul>
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<p>#13</p> <p>Population to be served</p>	<p>Should income eligibility be standardized?</p> <ol style="list-style-type: none"> <li>1. Statewide income eligibility standard</li> <li>2. Income eligibility varies by county</li> </ol>	<p>Establish a uniform statewide standard of 300% FPL</p>	<p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Counties should have the option to establish income eligibility levels above 300%.—<b>100% Campaign</b></li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p>Statewide standard of 300% FPL.</p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Administrative consistency across the state and administrative simplicity; increasing economy of scale and administrative cost savings.</li> <li>◆ Consumer fairness that all families will have the same access to the Buy-In Program based on family income.</li> </ul>
<p>#14</p> <p>Population to be served</p>	<p>Should counties be allowed to buy in just for children from 0-5 (for whom they are most likely to have funding due to First 5 Commission)?</p> <ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	<p>Consistent with the requirements of the First 5 Commission that require a county to have a plan for covering all children up through age 18. Can begin by funding children 0-5.</p>	<p style="text-align: center;"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• It would be nice to be flexible to let counties serve 0-5 first, but they need to be committed to working towards serving 0-18.—<b>Steve Barrow, Kern County</b></li> <li>• Same as Steve B. Put some requirements in place regarding goal of 0-18.—<b>Peter Long, The California Endowment</b></li> <li>• Waiting lists will be confusing with the 0-5, 0-18 issue.—<b>Kena Burke, CHISLO</b></li> </ul> <p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Discourage counties from providing coverage to only limited subsets for children, such as children under age 5 or children who qualify for FFP. Important to allow counties to phase in their programs by age group.—<b>100% Campaign</b></li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p>County shall be required to have a plan for covering all children through the age 18; they can begin by funding children 0-5 but must have plan for funding the children 6-18.</p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Program commitment to serving all eligible uninsured children in California</li> <li>◆ Understanding the reality of available funds through the First 5 commissions for children 0-5</li> <li>◆ Understanding that many private funders will be targeting grant funding for children 6-18 but it may take time for counties to secure funding commitments.</li> </ul>

<p>#15</p> <p>Population to be served</p>	<p>To the extent counties do have funding for ages above 5, should each county be able to specify the ages that it would cover?</p> <ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	<p>Coverage for all children on first apply first enrolled basis; except for 0-5 group.</p>	<p style="text-align: center;"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• General consensus during the public meeting was that this should be consistent across county lines.</li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p>Coverage for all children on first apply first enrolled basis; except for children 0-5.</p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Program commitment to serving all eligible uninsured children in California</li> <li>◆ Understanding the reality of available funds through the First 5 commissions for children 0-5</li> <li>◆ Understanding that many private funders will be targeting grant funding for children 6-18 but it may take time for counties to secure funding commitments.</li> </ul>
<p>#16</p> <p>Federal Fund Participation (FFP)</p>	<p>Design the program to immediately be able to draw down FFP for children who would be otherwise SCHIP eligible but have income too high for HFP or design without attempting to draw down FFP.</p> <ol style="list-style-type: none"> <li>1. Immediate FFP draw down</li> <li>2. Year 2 FFP draw down</li> </ol>	<p>Consider adding in a later phase such as year 2</p>	<p style="text-align: center;"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Asked what funds are available for FFP.—<b>Kristin Gardner, Health Insurance for All, Mendocino County</b></li> <li>• Asked how MRMIB would separate undocumented for FFP.—<b>Linda Karas, Blue Cross</b></li> </ul> <p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• The State should explore ways in which counties can start drawing FFP as soon as possible.—<b>100% Campaign</b></li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p><b>Based on recommendation for #3, we shall draw down FFP immediately for SCHIP eligible children</b></p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Since MRMIB's AV will do eligibility determinations, AV will have necessary information and documentation to identify SCHIP eligible children that can draw down FFP</li> <li>◆ Provides 2/3 federal matching funds for the SCHIP eligible children</li> <li>◆ Allows county funds to be stretched further and provide services for non-SCHIP eligible children.</li> <li>◆ Implementing FFP in separate phases will increase system and operational modification costs rather than doing it all at one time.</li> </ul>

<p>#17</p> <p>Federal Fund Participation (FFP)</p>	<p>If the program is designed to bring in FFP should participation in this feature be at county option?</p> <p>1. Yes 2. No</p>	<p>FFP Participation should be standardized statewide</p> <p>Only about 10% of a HK population is above 250%. Hopefully, county could manage to find the funds for this small number.</p>	<ul style="list-style-type: none"> <li>• 70% of HK kids are undocumented. Being able to tell State who is undocumented is difficult because population is reluctant to identify status.—<b>Jane Ogle, Santa Clara County</b></li> <li>• Discussed INS/public charge issues. Families are fearful of disclosing info to State or any gov't. Need to let families know that feds won't get any info. Marketing this aspect is important!!!—<b>Barbara Zarate, Marin County.</b></li> </ul> <p><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Concerned about having database that contains the names of undocumented children and who may be able to get access to that information.—<b>Elena Chavez, Consumers Union</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p>FFP participation shall be standardized statewide</p> <p><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Administrative consistency across the state and administrative simplicity; increasing economy of scale and administrative cost savings.</li> <li>◆ Provides 2/3 federal matching funds for the SCHIP eligible children</li> <li>◆ Allows county funds to be stretched further and provide services for non-SCHIP eligible children.</li> </ul>
<p>#18</p> <p>Federal Fund Participation (FFP)</p>	<p>If the program is designed to bring in FFP, should counties operating their own Healthy Kids program be able to opt in solely for children with incomes between 250-300%</p>	<p>Defer decision until program option may be added in later phase such as year 2 (see issue #16)</p>	<p><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Counties with existing CHI's should have the option to participate in the County Buy-In. This could free up resources currently spent on administration. Would be a step toward transitioning to a statewide program.—<b>100% Campaign</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p><b>Based on recommendations #3 and #16, MRMIB will allow existing HK programs to opt in solely for FFP (children 250%-300% FPL) purposes. Counties would be required to comply with the program design model requirements as laid out in this document. We have no requests for the option at this time.</b></p> <p><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Provides 2/3 federal matching funds for the SCHIP eligible children</li> <li>◆ Allows county funds to be stretched further and provide services for non-SCHIP eligible children.</li> </ul>

<p>#19 Application</p>	<p>Should there be one application for MC/HFP and HK?</p> <ol style="list-style-type: none"> <li>1. Yes, one application</li> <li>2. No, allow multiple applications</li> </ol>	<p>Use one application for all programs The application would be the joint HFP/MC application (or the currently accepted MC210).</p>	<p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Recommends use of current joint HFP/MC application or MC 210. —<b>100% Campaign</b></li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p>Use the joint HFP/MC application (or the currently accepted MC210).</p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Administrative consistency across the state and administrative simplicity; increasing economy of scale and administrative cost savings.</li> </ul>
<p>#20 Application</p>	<p>Should apps for HK coverage be submitted to MC for emergency only coverage.</p> <ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>		<p style="text-align: center;"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• CHISLO immediately enrolls all applications into emergency MC. This provides immediate emergency coverage during HK enrollment process. This also puts/keeps child and parents in the system from the start and makes it easier for renewal.—<b>Kenna Burke, CHISLO</b></li> </ul> <p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Important for DHS not to require all applications be submitted to MC for emergency-only coverage. Emergency only MC is designed to reimburse health facilities for uninsured patients who require care in emergency departments.—<b>Ellen Brown, Health Net</b></li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p><b>Defer recommendation until further research has been completed.</b></p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <p>Pending completion of research.</p>

<p>#21 Outreach</p>	<p>Who should be responsible for outreach?</p> <ol style="list-style-type: none"> <li>1. County</li> <li>2. State</li> </ol>	<p>County responsibility</p>	<p><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Good recommendation.—<b>Peter Long, The California Endowment</b></li> <li>• Good Idea.—<b>Steve Barrow, Kern County</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p>County shall be responsible for outreach.</p> <p><b><u>Reasoning</u></b></p> <p>County has established local expertise and community partners.</p>
<p>#22 Outreach Rules</p>	<p>Should MRMIB establish particular outreach requirements, or alternately, establish recommended approaches?</p> <ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	<p>Require counties to provide an outreach plan that communicates critical message of how it will offer coverage to all children.</p> <p>Plan should include statement from it local partners that agree to the outreach principles.</p>	<p><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• All State supported outreach activities directed at enrolling children into MC/HFP should also target children eligible for County Buy-In. CAA's should be allowed to claim enrollment and renewal fees as with HFP/MC. State's CAA training module should include a component on the County Buy-In.—<b>100% Campaign</b></li> </ul>	<p><b><u>Recommendation</u></b></p> <p>MRMIB shall establish outreach requirements including outreach message of health coverage for all children and require commitment of local partners on the outreach principles.</p> <p><b><u>Reasoning</u></b></p> <ul style="list-style-type: none"> <li>◆ Program commitment to serving all eligible uninsured children in California</li> <li>◆ Outreach message will target all uninsured children and increase enrollment in all appropriate programs (MC, HFP, &amp; HK)</li> </ul>

<p>#23</p> <p>Benefits</p>	<p>Should the benefits package be the same as the HFP including health, dental and vision?</p> <ol style="list-style-type: none"> <li>1. Yes</li> <li>2. No</li> </ol>	<p>HFP benefit package (health, dental and vision), including co-payments</p>	<p style="text-align: center;"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Benefits package is not current and is obsolete with clinical standards. Examples: standard care in dental is no longer amalgam. Standard care in vision is contact lenses for kids.—<b>Charla Parker, Healthy Kids, Healthy Future</b></li> <li>• Against catastrophic care benefit package because it doesn't provide comprehensive coverage.—<b>Steve Barrow, Kern County</b></li> </ul> <p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Important that County Buy-In children are afforded the same health plans and benefits as HFP.--<b>100% Campaign</b></li> <li>• Benefits should mirror the HFP. Any changes to the HFP benefits, including carve-outs and off-sets, should be discussed further with the health plans.—<b>Chad Westover, Blue Cross</b></li> <li>• Blue Shield would like the benefits to mirror those in HFP. Having a different set of benefits could require contract amendments and would increase admin costs for the program.—<b>Donovan Ayers, Blue Shield</b></li> <li>• VSP would be able to provide the same basic plan design and co-pay as we currently offer under the HFP model.—<b>Janet Findley, VSP</b></li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p>HFP benefits package (health, dental and vision including co-payments)</p> <p>Reasoning</p> <ul style="list-style-type: none"> <li>◆ Administrative consistency across the state and administrative simplicity; increasing economy of scale and administrative cost savings.</li> <li>◆ Consistency of health programs benefits (MC, HFP &amp; HK)</li> <li>◆ Comprehensive health coverage model</li> </ul>
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<p>#24</p> <p>Benefits</p>	<p>How to handle CCS coverage for HK?</p>	<p>Work with CCS, BC and other plans</p>	<p style="text-align: center;"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Would not like counties to pay for CCS costs. <b>Dr. Beed, Orange County</b></li> <li>• CHISLO has 17% CCS cases. CHISLO doesn't see this as a risk. It is their responsibility.—<b>Kena Burke, CHISLO</b></li> <li>• 4-6 CCS referrals from Kern HK program since inception.—<b>Ellen Brown, Health Net</b></li> <li>• 1-2% of HFP kids were CCS. BC would like to cover them from a humanitarian view, but they would need sufficient compensation for the company/stockholders. Maybe HK (capitation) rates would have to be higher than HFP rates.—<b>Linda Karas, Blue Cross</b></li> </ul> <p style="text-align: center;"><b><u>Written Comments</u></b></p> <ul style="list-style-type: none"> <li>• Health Net believes that CCS coverage should remain a carve-out for the County Buy-In Program. Recommend waiting 2-3 years to assess the experience of HK plans to get numbers of children referred to CCS, numbers denied because of incomes above CCS eligibility guidelines and health plan expenditures for these cases before making a decision on this issue. Encourage families to complete the entire CCS application packet, including program services agreement. % of children not eligible for County Buy-In, but not CCS will be small. Health Net willing to assume risk until additional data can be evaluated.—<b>Ellen Brown, Health Net</b></li> <li>• Blue Shield agrees with Blue Cross that the benefits would need to have CCS eligibility for the program to be implemented as integrated into HFP. Would there be a different payment rate for individuals who are not CCS eligible, since the provider capitation rates are currently based on the CCS carve out?—<b>Donovan Ayers, Blue Shield</b></li> </ul>	<p style="text-align: center;"><b><u>Recommendation</u></b></p> <p><b>Defer recommendation until further research is completed. This is a major issue and potential barrier to implementation.</b></p> <p style="text-align: center;"><b><u>Reasoning</u></b></p> <p>Pending completion of research.</p>
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#25 Plan	Should subscribers have choice of all HFP plans in their county of residence?  1. Yes 2. No	Yes	<p align="center"><b><u>Public Meeting Comments</u></b></p> <ul style="list-style-type: none"> <li>• Asked if we would blend rate for HK and HFP to come up with one cost for everyone.—<b>Peter Long, The California Endowment</b></li> </ul>	<p align="center"><b><u>Recommendation</u></b></p> <p><b>Allow counties the option of selecting all HFP plans in their county or selecting the lowest cost HFP plan combination (health, dental, &amp; vision)</b></p> <p align="center"><b><u>Reasoning</u></b></p> <p>Provides the counties choice of either offering full choice or most affordable health coverage combination.</p>
#26 Plan	How do counties pay for plan costs without violating MRMIB's rate confidentiality?	Develop method of average cost of plans in given area	**#25 #26 comments were discussed as the same issue at the same time. See #25 above for comments on this design issue.	<p align="center"><b><u>Recommendation</u></b></p> <p>MRMIB shall develop a blended rate in a given area which includes the health coverage and administrative costs (PMPM). Also, county contracts will require confidentiality of rates.</p> <p align="center"><b><u>Reasoning</u></b></p> <p>Blended rates and confidentiality requirement will protect the confidentiality of MRMIB's plan rates.</p>
#27 Funding	Need start-up funds in the year prior to implementation for MRMIB staffing; AV system and operational changes and any special enrollment materials	Joint brainstorming and solicitation efforts by state and county partners in securing needed start-up funds	**Sections #2, #3, and #4, discussed HK Funding management and eligibility determinations. This issue was addressed during that discussion.	This item is a statement of the existing facts under which MRMIB may implement the Buy-in Program.
#28 Funding	Because there is no "float" will have to collect funds from counties in advance of expenditures	Yes, we will have to collect funds in advance from counties.	**Sections #2, #3, and #4, discussed HK Funding management and eligibility determinations. This issue was addressed during that discussion.	This item is a statement of the existing facts under which MRMIB may implement the Buy-in Program.