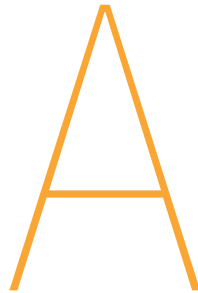


PUBLICLY FUNDED PROGRAMS FOR CHILDREN

OVERVIEW OF MAJOR SYSTEMS AND THEIR COMPONENTS IN THE PUBLIC SECTOR



s discussed above, publicly funded services for CYSHCN in California can be characterized in two ways:

1. **Basic health service programs**, in which individual or family income is the primary eligibility criterion, sometimes in tandem with other criteria such as health status, age, or immigration status. These programs are funded via federal, state, and/or local funds.
2. **Specialized service programs** that serve solely children with special health care needs (and, in some cases, adults as well), in which income may or may not be a criterion for eligibility. These programs typically are organized on the basis of the presence of specific health, mental health, and/or developmental conditions.

BASIC HEALTH SERVICE PROGRAMS

The two major basic health service programs for children that are publicly funded are Medicaid, known as Medi-Cal in California, and the state Children's Health Insurance Program (CHIP), called the Healthy Families program in California. These programs, which are funded through a combination of federal and state funds, are described below. The federal piece is described first, followed by discussion of the state program. Several other health care programs that are funded exclusively by the federal or California state government also are described below.

Federal Medicaid

Medicaid (Title XIX of the Social Security Act) was created in 1965 as the federal program to provide health care coverage for low-income individuals, and is the largest source of funding in the U.S. for medical and health-related services for people with limited income. It is available only to certain low-income individuals and families who meet eligibility criteria that are recognized by federal and state laws.

Medicaid is funded through a combination of federal and state funding and is a state-administered program; each state sets its own guidelines regarding eligibility and services, within guidelines set by the federal government. Federal

guidelines are more prescriptive of the services that must be provided to children than services for adults. For example, federal law requires states to provide Medicaid coverage to all children in families with incomes below poverty. This group of children—the “categorically needy”—is guaranteed Medicaid eligibility and includes children who have poverty-level income, who receive Supplemental Security Income (SSI), or who receive federal foster care or adoption assistance. In addition, states have the option of extending coverage to children at higher income levels through Medicaid and the state Children’s Health Insurance Program. (CHIP is the child health coverage program for low-to-middle income children not eligible for Medicaid; see page 28, for more information.)

Medicaid provides coverage for almost 60 million Americans and finances 16% of national health spending. Medicaid covers over a quarter of all children in the U.S., including nearly one of every five white children and roughly two of every five African American and Latino children. In 2004, 5% of all beneficiaries with the highest health and long term care costs accounted for 57% of total Medicaid spending. For many of those with severely disabling conditions, Medicaid provides access to diverse services and long term care options and assures comprehensive coverage for the complex and extensive health needs of many people with chronic illnesses and severe disabilities. Nearly four in 10 children with special needs are covered by Medicaid (US DHHS, 2005; Kaiser Commission on Medicaid and the Uninsured, 2009; Rowland, 2009).

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program: Vital Comprehensive Benefit for Children

The EPSDT benefit was added to the federal Medicaid program in 1967. It is required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services through a comprehensive set of benefits and services specifically for children. Since one in three U.S. children under age six is eligible for Medicaid, EPSDT offers a very important way to ensure that young children receive appropriate health, mental health, and developmental services.

EPSDT was expanded and better defined by the federal Omnibus Budget Reconciliation Act of 1989 (OBRA ‘89), including rewriting the definition of medical necessity to cover services that can “correct or ameliorate” a condition identified on a screening of any Medicaid beneficiary under 21. Under this definition, EPSDT requires that any medically necessary health care service listed in Section 1905(a) of the Act must be provided to an EPSDT recipient even if the service is not available under the state’s Medicaid plan to the rest of its Medicaid population or if frequency or duration of service is limited under the state’s plan. As a result, under EPSDT, eligible children have access to screening services, vision services, preventive and emergency dental services, hearing services, and any other diagnostic service and health treatment that is covered by Medicaid (The Commonwealth Fund, 2005).

The federal EPSDT benefit, coupled with the comprehensive medical necessity definition, makes Medicaid the gold standard of health care services for all children, and particularly for those with special health care needs.

Federal Medicaid Waivers

Under Sections 1915 and 1115 of the Social Security Act, Medicaid waivers are programs that allow the Secretary of Health and Human Services to permit individual states to receive federal matching funds without complying with certain Medicaid rules. Unlike regular Medicaid services, waiver services can be provided to specific targeted populations or to persons in limited parts of a state. (See Appendix 1 for a table describing the current federal waiver options.)

There are two types of federal Medicaid waivers:

1. Program waivers: Sections 1915(b) and (c) of the Social Security Act allow exemptions for managed care or home and community-based care.

- 1915(b) exempts states from the mandate that recipients have a choice of providers. California is one state that uses the waiver to require recipients to enroll in managed care plans. More than two million of California's Medi-Cal recipients are enrolled in programs under the 1915(b) waiver.
- The 1915(c) waiver, the home and community-based services (HCBS) waiver, is the most frequently used waiver for providing services in the community. These waivers are available to Medicaid-eligible individuals who, without the waiver services, would be institutionalized in a hospital or nursing facility. This type of waiver allows the Secretary to waive certain financial eligibility requirements and the Medicaid requirement that services must be "comparable" among beneficiaries and must be provided statewide.

California has six home and community-based service waivers that serve specified subgroups of the Medi-Cal populations. The enrollment cap for these waivers for 2009-10 is 90,000 clients. California is preparing to implement a new palliative care waiver under 1915(c) that will provide an enhanced package of services to children with serious and life-threatening medical conditions.

(Families USA; CA.gov, Department of Health Care Services [a])

2. Research and demonstration waivers: Section 1115 allows for a broader scope of Medicaid law for the purpose of experimentation and testing programs.

- Most states have used 1115 waivers to implement Medicaid managed care. These waivers can be used to waive a broader set of federal Medicaid provisions than 1915 waivers as long as the costs are budget neutral. California has used 1115 waivers for community care for individuals who are eligible for both Medicaid and Medicare (often called dual-eligibles or "Medi-Medis") who otherwise would be institutionalized, and in other special circumstances.
- The In-Home Supportive Services (IHSS) Plus waiver provides an array of self-directed personal care assistance and delivery options that are not available under typical IHSS personal care services to persons who are aged or blind or who have disabilities. This waiver allows recipients to remain in their own home. There is no enrollment cap for this waiver.

The Jones family received inadequate care under the constraints of an HMO for their young son, Max, who has mitochondrial disease. His mother often had to act as the primary care coordinator, spending countless, frustrating hours ensuring that referrals were in place so that his care would not be interrupted. With the help of a Medi-Cal waiver, they were able to change to a PPO that covers the difference in out-of-pocket expenses for Max. Now he is able to receive the care he requires in the facilities that can best meet his needs. For the first time in 14 years, Max is more medically stable than ever, thanks to the physicians that he now has access to. His parents can take him where the experts are, not where the HMO dictated that he go.

More specific information on the federal Medicaid program is displayed in Appendix 2.

California's Medicaid Program: Medi-Cal

The Medi-Cal program was established in California in 1965 as the state version of Medicaid. The program originally was designed for people on welfare, but numerous other aid categories have been added over time. Medi-Cal is the primary funder of health care and related services for low-income families, with specific attention to serving children, mothers, and pregnant women. Federal law requires the program to provide a core of basic services including outpatient care, inpatient hospitalizations, physician services, skilled nursing care, laboratory and X-rays, and family planning. Private and public providers may elect to participate in the program. Mandatory Medicaid services, including EPSDT, are covered by federal funds with a state match. (The federal-state match breakdown for the federal Medicaid and CHIP programs is outlined in a table in Appendix 2.)

California's Federal Medical Assistance Percentage, or FMAP, the rate at which the federal government matches state investment in Medicaid, is 50:50, the lowest match rate in the nation (shared with 13 other states). The American Recovery and Reinvestment Act of 2009 (ARRA) will provide \$87 billion for a temporary increase in the federal share of Medicaid costs through 2010. To be eligible for the enhanced federal financing, states must not make changes to restrict eligibility levels or make it more difficult for people to apply for or renew coverage unless they have explicit federal permission to do so. ARRA has increased California's federal FMAP to 61.6% from October 1, 2008, through December 31, 2010, bringing in an estimated \$11.23 billion in new Medicaid dollars during this period.

As of 2007, the number of Californians enrolled in Medi-Cal was 6,510,009, 17% of the total California population. Medi-Cal enrollment is far higher for children, with 3,607,189 of the state's children ages 0-21 or one third of all children, enrolled in the program (California Department of Health Care Services).

The major Medi-Cal program designed specifically for vulnerable children is EPSDT, the comprehensive federal benefit specifically for children discussed above in the section on federal Medicaid. California has several major categories of eligibility for Medi-Cal available to children, including children with special health care needs:

- 1) Categorically needy:** This category includes children and adults who meet a combination of age and income criteria. Criteria of particular importance to children include:
 - Families meeting state Temporary Aid to Needy Families (TANF) eligibility requirements (in California, TANF is called CalWORKS);
 - Pregnant woman and children under age 6 whose family income is at or below 133% of federal poverty level (FPL);
 - Children ages 6 to 19 with family income up to 100% of FPL;

Mary is two years old. She has cerebral palsy. She was hospitalized and required a tracheotomy. She is ready to go home and needs a suction machine for her care at home. There is a backlog at Medi-Cal for authorizing respiratory supplies. Mary must remain in the hospital for an extra two weeks until the authorization comes through.

- Children receiving federal foster care or adoption assistance; or
- Federal Supplemental Security Income (SSI) recipients (see the discussion of SSI beginning on page 32).

2) Medically Needy: This category includes children and adults who have medical conditions but whose income is too high to be eligible as categorically needy. California’s medically needy program includes pregnant women through a 60-day postpartum period and children under age 18 with such conditions as blindness and other disabilities, and medical conditions that qualify them for the SSI program.

Share-of-Cost Medi-Cal: Share-of-cost (SOC) is a term that refers to the amount of health care expenses that must be paid each month before Medi-Cal eligibility begins and applies to those Medi-Cal recipients whose income exceeds the federal poverty level. The majority of share-of-cost beneficiaries are in two Medi-Cal eligibility categories: the medically needy and the medically indigent. (“Medically indigent” is a state-optional Medicaid aid category that covers pregnant women and children who do not meet financial eligibility criteria for Medicaid as “medically needy”; California has elected to offer this option.)

Once beneficiary health care expenses reach an individual’s determined amount, Medi-Cal will pay for any additional covered benefits for the month. The SOC payment is paid directly to the provider of services, as a deductible is satisfied under private insurance, and not to the state. The amount is determined by the county social services agency and is calculated using a formula based on family size and income and determined by state law under federal guidelines. The higher one’s income, the higher the SOC; SOC is calculated monthly and is adjusted as an individual’s financial situation changes. Beneficiaries on Medi-Cal who receive cash assistance through programs like CalWORKS or SSI (the “categorically needy”) are not required to pay SOC, as it applies to Medi-Cal recipients who choose not to receive cash assistance or whose income and resources are too high to qualify under these programs.

SOC Medi-Cal poses many problems for children and adults who fall in this category. An individual who does not pay or is unable to pay the SOC amount simply is not eligible for Medi-Cal benefits for any month in which the SOC has not been paid, regardless of need for medical care. Individual share-of-cost amounts can be prohibitively high for families, thus preventing them from meeting the payment. The Maintenance Need Level has not been updated since 1989 and is approximately \$600 for an individual; anything earned over \$600 a month becomes part of the beneficiary’s SOC for the month.

In addition, SOC may be based on inaccurate calculations of out-of-pocket costs; as recipient income decreases, SOC payments are not always decreased in a timely manner, forcing the beneficiaries to pay a large part of their income toward health services. As a result, Medi-Cal may function only as catastrophic coverage for recipients with high SOC, impeding their access to routine services when families cannot afford to pay the monthly

share. In 2005, there was an average of 403,984 SOC Medi-Cal beneficiaries each month; of this number, only 20% (73,718) were able to pay their SOC (CalOptima, 2005; CA.gov, Department of Health Care Services [b]; Health Consumer Alliance, 2007).

Other important Medi-Cal-related programs include:

- **Gateway:** In 2003 California created the Gateway as an automated application initiated by Child Health and Disability Prevention (CHDP) program providers that offers up to two months of immediate full-scope Medi-Cal coverage for children while a family completes the full application for continued coverage under either Medi-Cal or Healthy Families. (CHDP is described below in the section beginning on page 33.)
- **Emergency Medi-Cal:** This limited form of Medi-Cal is available to undocumented and recent immigrants who are not otherwise eligible for Medi-Cal. (For details, see the section on health services for immigrants.)

In California, services through Medi-Cal are available through several different delivery mechanisms:

- 1) **Fee-for-Service:** Fee-for-service Medi-Cal is the traditional delivery and payment arrangement for program beneficiaries, under which providers are paid a specified amount for each service rendered. As of January, 2009, there were 1,180,193 children ages 0-21 (32% of Medi-Cal's 0-21 population) enrolled in fee-for-service Medi-Cal (Department of Health Care Services, 2009).

Under fee-for-service Medi-Cal, recipients are free to seek health care from any physicians and other health care providers who participate in the Medi-Cal program. Many children and adults with special health care needs are able to use fee-for-service Medi-Cal and its freedom to choose providers to construct individualized service provider networks that fit their medical and other needs. At the same time, low reimbursement rates and barriers posed by complicated Medi-Cal billing and other requirements have steadily shrunk the Medi-Cal fee-for-service provider network available to children with special health care needs. Medicaid rates are significantly lower than those paid under Medicare, disproportionately affecting children and youth; in addition, adult-oriented procedure codes may be paid at higher rates than pediatric services.

- 2) **Managed Care:** In 1993, the state Department of Health Services (now Department of Health Care Services) began implementation of a plan to transform much of the Medi-Cal program from traditional fee-for-service to managed care. As of January, 2009, there are 2,426,996 children ages 0-21 (68% of Medi-Cal's ages 0-21 population) enrolled in managed care (Department of Health Care Services, 2009). Managed care plans are prospectively paid a capitated payment for each enrollee, for which they are expected to furnish all specified services. The state began managed care implementation in the most populous counties in the state, using three distinct managed care models:

- **Two Plan Model:** In this model, Medi-Cal recipients choose between two plans for their health care services, including perinatal and pediatric care. The two plans include a “local initiative” plan, developed and implemented by a county’s board of supervisors, and a “mainstream” plan, a single HMO selected by the state through a competitive bidding process.

Under the two-plan model, consumers must be offered a choice of primary care providers participating in the plan’s network and must be permitted to change providers if dissatisfied. The local initiative also must ensure a role for “traditional safety net providers” such as public hospitals and clinics.

The 12 counties participating in the two-plan model are Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Each county offers a local initiative plan and a commercial plan, except Fresno, which offers two commercial plans. Recipients with full-scope Medi-Cal (typically CalWORKS recipients) are required to join one of the plans; certain groups of recipients such as those on SSI or in foster care are not required to join but may voluntarily enroll in one of the plans.

- **County-Organized Health Systems:** There are five Medi-Cal county-organized managed care plans in the state. Under this model, the plan is created by the county’s board of supervisors to contract with Medi-Cal to administer a countywide capitated health care system that all full-scope Medi-Cal recipients in the county, including SSI recipients and children in foster care, are required to join. Eleven counties currently have or are in the process of joining county-organized health systems: Orange (CalOPTIMA); Merced, Monterey, and Santa Cruz (Central Coast Alliance for Health); San Mateo (Health Plan of San Mateo); Napa, Solano, Sonoma, and Yolo (Partnership HealthPlan of California); and San Luis Obispo and Santa Barbara (CenCal Health).
- **Geographic Managed Care:** Under this model, available in two counties (Sacramento and San Diego), Medi-Cal CalWORKS recipients are required to join one of a group of Medi-Cal managed care plans in the county. As with the two-plan model, full-scope Medi-Cal recipients in CalWORKS are the major target population for mandatory enrollment, although other full-scope populations, such as people on SSI, may join voluntarily.

Medi-Cal plans are contractually obligated to have certain specialists in their networks and have timelines for scheduling visits. The higher reimbursement rates often offered by managed care plans may attract more providers, including pediatricians and pediatric subspecialists. Yet some children with special health care needs and their families report difficulties in finding appropriate providers within managed care plans’ limited networks, and additionally face obstacles to getting to providers outside the plan networks.

More specific information on Medi-Cal is displayed in Appendix 3.

Health Services for Immigrants Under Medicaid

Citizen/Immigration Status	Definition
Naturalized Citizen	A person who was born a noncitizen and was granted U.S. citizenship through the naturalization process.
Lawful Permanent Resident	A noncitizen residing in the U.S. with permission to permanently live and work in the country. May apply for naturalization after five years.
Refugee or Asylee	A noncitizen granted permission to reside in the U.S. due to a well-founded fear of persecution in his or her country of origin. Persons granted such permission while outside of the U.S. are refugees; those granted permission after they enter the U.S. are asylees. Refugees and asylees may apply to adjust their status to Lawful Permanent Resident after one year.
Nonimmigrant	A person granted permission to enter the U.S. for a specific purpose and a limited period of time. This category includes persons granted temporary permission to live and work in the U.S.
Undocumented immigrants	A person who entered the country illegally or who entered through legal channels but then violated the terms of entry by staying past his or her visa expiration date.
Permanent Residence Under Color of Law (PRUCOL)	PRUCOL is not recognized as an immigration status by the U.S. Citizenship and Immigration Services; this category was created by the courts and is a public benefits eligibility category. For a person to be residing under the color of law, the USCIS must know of the person's presence in the U.S. and must provide the person with written assurance that enforcement of deportation is not planned. A person residing under PRUCOL cannot directly apply for U.S. citizenship.

(Source: Usafis.org; IRS.gov)

As shown above, the U.S. noncitizen population falls into several basic groupings for the determination of public assistance entitlements. Prior to 1996, legal immigrants were eligible for Medicaid on the same basis as U.S. citizens. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act terminates federal eligibility for regular Medicaid coverage for most legal immigrants during their first five years in the country, regardless of how poor they are or how serious their medical needs. These provisions also apply to CHIP, which was enacted in 1997. Most of the states that traditionally have high concentrations of immigrants continue to provide substantial coverage for legal immigrant children and pregnant women who otherwise would be disqualified by the five-year bar. Research on immigrant coverage, cost, and utilization indicates that immigrants are not huge and costly users of public services:

- Private insurers pay for more than half of health care expenditures for immigrants; only about one-fourth of health care expenditures for immigrants are reimbursed by government programs (National Immigration Law Center, 2006).
- Two thirds of all immigrants in the U.S. have health insurance coverage and about 78% of these insured immigrants are covered by private plans, whether through employers or as individuals, with the remainder covered by Medicaid or Medicare (Migration Policy Institute, 2004).
- Health cost data demonstrate that immigrants have not been responsible for the overall recent increase in the number of uninsured despite significant declines in their own coverage in the past decade (Kaiser Family Foundation, 2004).

- The claim that immigrants are responsible for high rates of emergency room (ER) usage is contradicted by research; in fact, communities with high rates of emergency room usage tend to have relatively small percentages of noncitizen residents (National Immigration Law Center, 2006).
- Low-income citizen children with citizen parents are more than twice as likely to receive Medicaid or state Children’s Health Insurance Program (CHIP) coverage as are low-income children who are not citizens (Kaiser Family Foundation, 2004).
- Only one in four low-income children who are not citizens have Medicaid coverage, compared to almost two out of every four low-income children who are citizens. Similarly, low-income parents who were born in the U.S. are much more likely to receive Medicaid or CHIP coverage than parents who are noncitizens (National Immigration Law Center, 2006).

Many states view these restrictions based on immigration status as unfair and detrimental to the health and well being of the public. Over half have used their own funds to ensure that immigrant families who were rendered ineligible for federal benefits can secure critical services (Ku, L., 2007; U.S. Senate, Committee on Finance, 2009).

California’s Health Care Services for Immigrants Under Medi-Cal

Half of California’s children—about 4.8 million children ages 0-17—have at least one immigrant parent. Eighty-five percent of children in immigrant families in California were born in the U.S. and 54% of children in immigrant families are low-income (Children Now, 2007).

California has an estimated 180,000 undocumented immigrant children; they are predominantly Latino and live in very-low-income working families, lack access to employer-sponsored health coverage, and typically face the highest barriers to access to health care (Brown, 2002).

As detailed above, after 1996 most legal immigrants become ineligible for federally matched Medicaid coverage during their first five years in the U.S. However, California residents do not need to be U.S. citizens to obtain certain types of Medi-Cal. Most immigrants, including children, are eligible only for emergency Medi-Cal, which covers services that meet the federal definition of emergency care. Full-scope Medi-Cal is available to immigrants with “satisfactory immigration status,” a category that includes lawful permanent residents, people who have Permanent Residence Under Color of Law (PRUCOL), and refugee children, who are eligible for full-scope Medi-Cal for a minimum of eight months.

As of 2008, California covered around 16,000 legal immigrant children in the Healthy Families program (described below), almost 2% of total Healthy Families program enrollment (Harbage Consulting, 2009). Medi-Cal also covers prenatal care, family planning, and some other specific services for immigrants, regardless of immigration status.

The federal Deficit Reduction Act of 2005 requires that all applicants for state Medicaid programs provide documentation of their citizenship status for

federally financed Medicaid services, but states are free to provide services to non-federally eligible populations with state funds (CA.gov. Department of Health Care Services [c]). In addition, it should be noted that the status of California state coverage of health care is fluid now, given the state budget situation, and changes may be made in Medi-Cal coverage of immigrants over the coming year.

More specific information on publicly funded services for documented and undocumented immigrants is displayed in Appendix 4.

State Children's Health Insurance Program (CHIP)

CHIP was established by the federal government to provide matching funds to states for health insurance to families with children. The program is designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. The statutory authority for CHIP is under Title XXI of the Social Security Act and it is administered by the federal Centers for Medicare and Medicaid Services within the US DHHS.

States are given flexibility in designing their CHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use CHIP funds to cover the parents of children receiving benefits from both CHIP and Medicaid, pregnant women, and other adults. In some states CHIP is part of the state's Medicaid program, in some states it is separate, and in some states it is a combination of both types of programs. Most states offer this insurance coverage to children in families whose income is at or below 200% of FPL. Children began receiving insurance through CHIP in 1997 and the program helped states expand health care coverage to over five million of the nation's uninsured children. In February, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA or Public Law 111-3) was signed into law and formally reauthorized the program.

CHIPRA provides \$33 billion in additional federal funds to extend and expand CHIP for 4.5 years. A cigarette and tobacco tax increase will fund the program's expansion. Under CHIPRA, states will no longer receive full CHIP matching rates for covering children in families with incomes greater than three times the FPL; they can cover these children with federal approval but will receive a lower Medicaid matching rate.

As of January 1, 2010, states will need to apply the Medicaid citizenship documentation requirement to children who apply for CHIP coverage. Under a new provision, states now have the option to use CHIP funding to subsidize health coverage under certain employer-sponsored health plans for low-income children (and, in some cases, their parents) who are eligible for the CHIP program. If the low-income child decides to receive the subsidy, health coverage for the child is provided through the employer-sponsored health plan instead of being provided through the state's CHIP program.

CHIPRA allows states to cover pregnant women through state plan amendments and also eliminates the five year waiting period for legal immigrant

children and pregnant women who are eligible for Medicaid or CHIP. Each state and U.S. territory as well as the District of Columbia has a CHIP program coordinator who is responsible for the administration of the approved CHIP state plan. CHIP is funded through a partnership of the federal and state governments and has a substantial federal match of 65% federal to 35% state, making it a very attractive program for many states, including California (US DHHS, 2005; Kaiser Family Foundation [b]; Families USA, 2009).

More specific information on CHIP is displayed in Appendix 2.

California's CHIP: Healthy Families

The Healthy Families program was established in 1998 as the state version of the federal CHIP. The program, which is administered by the Managed Risk Medical Insurance Board (MRMIB), provides subsidized health coverage, including health, dental, vision, and basic mental health services, to children from birth to age 19 in low-income families who are not eligible for full-scope Medi-Cal and are uninsured. In order to be eligible for Healthy Families, children must meet the following criteria:

- Be citizens
- Live in families with annual incomes between 100% and 250% of the federal poverty level
- Not be eligible for no-cost full-scope Medi-Cal (but children with share-of-cost Medi-Cal are eligible to apply)
- Not have had employer-sponsored health insurance in the last three months

Families of enrolled children pay monthly premiums as well as co-payments for certain services. Healthy Families services are provided through managed care plans. Treatment of complex medical conditions that are eligible for the state's California Children's Services (CCS) program for children with special health care needs are not provided by Healthy Families plans and subscribers are not charged co-payments for the CCS authorized services. (The CCS program is discussed below, beginning on page 35). As of July, 2009, MRMIB reports that about 940,000 children in California were enrolled in Healthy Families.

(Note: The state's budget crisis resulted in a period of frozen enrollment in the Healthy Families program and nearly caused massive disenrollment of currently enrolled children from the program. Program funding has been restored for the current fiscal year by a combination of state First 5 Commission funds (drawn from a tax on tobacco products and dedicated to children ages 0-5), a temporary provider tax on Medi-Cal managed care plans that can draw down federal matching funds, and increased premiums and co-pays for families. This funding solution will sunset in 2010, leaving the program vulnerable again to budget deficits.)

More specific information on Healthy Families is displayed in Appendix 3.

OTHER FEDERALLY FUNDED HEALTH CARE PROGRAMS

The following programs are funded by the federal government (and, in some cases, by other sources, e.g., the payroll taxes that help to support Medicare) without state-required investment.

Medicare

The Centers for Medicare and Medicaid Services administers Medicare, the nation's largest health insurance program, which covers nearly 40 million Americans, most of them seniors and adults with disabilities. Medicare was established in 1965 as the health insurance program for people age 65 or older, some people with disabilities under age 65, and people of all ages with end stage renal disease. Information on the number of children with special health care needs in California who are enrolled in Medicare is not readily available, although it is believed that there are very few and that they are limited to those with end-stage renal disease. (US DHHS, 2009; Kaiser Commission on Medicaid and the Uninsured, 2003)

More specific information on Medicare is displayed in Appendix 2.

TRICARE

TRICARE is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors, and certain former spouses worldwide. As a major component of the Military Health System, TRICARE brings together the health care resources of the uniformed services and supplements them with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide access to high-quality health care services while maintaining the capability to support military operations.

TRICARE provides health services to nearly two million children under the age of 18; 23% of these are children who have special health care needs (US DHHS, 2007). Little information is available on the provision of services specifically for CYSHCN under TRICARE (TRICARE, <http://www.tricare.mil/>).

More specific information on TRICARE is displayed in Appendix 2.

Indian Health Service

The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people and its goal is to raise their health status to the highest possible level.

The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally-recognized tribes in 35 states. Health services are provided directly by the IHS, through tribally contracted and operated health programs and through services purchased from private providers. Because of high rates of poverty among Native Americans, Medicaid is an important publicly funded health program and Native Americans who meet Medicaid eligibility standards are entitled to this coverage. Medicaid also assists low-income elderly and disabled Indians who are eligible for Medicare in meeting their premium and cost-sharing obligations. Finally, Medicaid offers coverage for nursing home care and other long-term care services needed by frail elderly and disabled Native Americans.

Although Medicaid is administered and financed in part by the states, Native Americans who meet the Medicaid eligibility requirements of the state in which they reside are, as a matter of law, entitled to Medicaid coverage. Information is not readily available on the number of children with special health care needs in California who are served through the IHS (Kaiser Commission on Medicaid and the Uninsured; Indian Health Service).

More specific information on Indian Health Service is displayed in Appendix 2.

Federally Qualified/Migrant and Rural Health Centers (FQHC)

The FQHC benefit under Medicare and Medicaid statutes was added in 1991 and includes safety net providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of the program is to enhance the provision of primary care services in underserved urban and rural communities.

FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors of which 50% or more are actual users of clinic services. Section 330 of the Public Health Service Act defines federal grant funding opportunities for organizations to provide care to underserved populations. The types of organizations that may receive Section 330 grants include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, and Public Housing Primary Care Programs. In 2007 there were 110 federally funded Federally Qualified Health Centers in California with 796 service delivery sites that collectively served 2,314,271 patients (California Health Care Foundation, 2009).

Federally Qualified Health Center look-alikes are health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of “health center” under Section 330 of the PHS Act, although they do not receive grant funding under Section 330 (Health Resources and Services Administration; Rural Assistance Center).

More specific information on Federally Qualified/Migrant and Rural Health Centers is displayed in Appendix 2.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help people who are aged or blind or who have disabilities and who have little or no income. The program provides cash to meet their basic needs for food, clothing, and shelter. SSI makes monthly payments to people with low income and limited resources who are age 65 or older or who are blind or have disabilities. Children under age 18 can qualify if they meet Social Security's definition of disability for children, and if their income and resources fall within the eligibility limits. The amount of the SSI payment varies from one state to another because some states add to the SSI payment.

More than 97,775 children in California receive financial assistance from SSI (Social Security Administration, 2007). Many have birth defects and/or a combination of disabilities. Payment rates include both federal and state funds. Payments may be lower depending on the income of the child or the total family income. The SSI law considers the income of the parents as well as the child in determining eligibility and payment amounts. A child under age 18 who lives in his/her parents' household also shares in the family's income and resources.

To receive SSI, the child must have resources (defined as assets such as cash, bank accounts, and land) that do not exceed certain value limits (Social Security Administration, 2009). If a child with a disability resides in an institution, the income and resources of the parents are not usually considered in determining the child's eligibility or payment amount. The SSI payment depends on the type of institution and whether Medi-Cal pays for the cost.

Social Security Disability Insurance (SSDI)

The SSDI program pays benefits to adults who have a disability that began before the age of 22. This SSDI benefit is considered a "child" benefit because it is paid on a parent's Social Security earnings record. For an adult with a disability to become entitled to this "child" benefit, one of his or her parents must be receiving Social Security retirement or disability benefits or have died and worked long enough under Social Security. These benefits also are payable to an adult who received dependent benefits on a parent's Social Security earnings record prior to age 18, if he or she has a disability at age 18. The disability decision is based on disability rules for adults. SSDI disabled adult "child" benefits continue as long as the individual remains disabled (Social Security Online, 2009).

More specific information on SSDI is displayed in Appendix 2.

STATE FUNDED HEALTH CARE PROGRAMS

California has several programs that are state-funded and provide basic health care services for children.

Child Health and Disability Prevention (CHDP) Program

The CHDP program is responsible for early and periodic screening components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth. CHDP is a preventive health program that not only delivers periodic health assessments to Medi-Cal beneficiaries under 21 years of age, but also provides these services to low-income children and youth to age 19 living in families with annual incomes at or below 200% of FPL.

CHDP provides care coordination to assist families whose children have received CHDP health assessments with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referrals for any needed diagnosis and treatment.

CHDP is operated at the local level by counties and the three California cities with their own health departments (Berkeley, Long Beach, and Pasadena). In 2007, 2,016,558 children received screening and health assessments through the CHDP program (Maternal and Child Health Bureau, 2008).

As noted in the Medi-Cal section above, in 2003 the CHDP program began using the “CHDP Gateway,” an automated pre-enrollment process for non-Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or the Healthy Families program. The CHDP Gateway is based on federal law found in Titles XIX and XXI of the Social Security Act that allows states to establish presumptive eligibility programs for children/youth.

A 2007 study of the Gateway program found that, although many children received temporary Medi-Cal coverage through Gateway (approximately 600,000 children in one year), only 11% achieved long-term stable enrollment in either Medi-Cal or Healthy Families. In more than 90% of pre-enrollments, families requested a joint application for Medi-Cal and Healthy Families, but fewer than 20% returned them in time to have their children’s temporary eligibility extended. In addition, denial rates for long-term coverage were high, mostly because of a “failure to cooperate” with follow-up requests for information (Teare, Finocchio, & Martin-Young, 2007).

More specific information on CHDP is displayed in Appendix 3.

Access for Infants and Mothers (AIM)

AIM was created in 1992 to provide services to pregnant and postpartum women and their infants up to two years of age in families with incomes between 200% and 300% of FPL who are uninsured and are not eligible for Medi-Cal, or who have insurance that either does not cover perinatal care or has a high deductible. AIM is a private health insurance model; it is not an entitlement program.

The state contracts with private insurance plans to provide perinatal health services to pregnant women and women up to 60 days post-delivery; pediatric health services for their infants up to age two are provided under the Healthy Families program, for which these infants are automatically eligible, as long as the AIM-enrolled mother applies for that coverage. These infants are eligible for Healthy Families until age two with family incomes up to 300% of FPL, as opposed to the standard Healthy Families eligibility ceiling of 250%. AIM has a share-of-cost, with enrollees charged 1.5% of annual adjusted family income. As of June, 2009, 7,025 women were enrolled in AIM (Access for Infants and Mothers, 2002; Harbage Consulting, 2009).

(Note: The status of California state coverage of health care is fluid, given the state budget situation, and changes may be made in funding for the AIM program that will affect access to it.)

More specific information on AIM is displayed in Appendix 3.

COUNTY FUNDED HEALTH CARE PROGRAMS

Children's Health Initiatives

Many California counties across the state have implemented children's health initiatives (CHI). In 2000, Santa Clara County was the first county to implement a CHI, and over the past five years several other counties have followed suit by establishing Healthy Kids programs modeled after Healthy Families.

These initiatives vary by county, but they generally combine several funding sources including state and county First 5 Commission funds (for children ages 0-5 years), public funds, and philanthropic donations raised by their CHI coalitions, including support from The California Endowment and the David and Lucile Packard Foundation. Their aim is to provide health care coverage to children from low- and moderate-income families who are ineligible for Medi-Cal and Healthy Families, and to aid with enrollment in Medi-Cal and Healthy Families for those children who are eligible (Institute for Health Policy Solutions). In addition, some counties have applied to draw down federal matching dollars through CHIP funding to match local funding to provide Healthy Kids insurance to children living in families with incomes between 251% and 300% of the federal poverty level (CA.gov, Managed Risk Medical Insurance Board).

About 25 counties established age and income eligibility criteria, ranging from 300% FPL (in Los Angeles and several other counties) to 400% FPL (in San Mateo County, for example). While the intent was to cover uninsured children who are ineligible for Medi-Cal or Healthy Families, because Medi-Cal and Healthy Families cover citizen children in families with incomes up to 250% FPL, the largest group of children insured through CHI efforts is undocumented children. Continued support of these county programs is threatened by uncertainty about the future funding of the Healthy Families program.

A number of evaluations conducted over the past five years suggests that CHI efforts produced coverage that expanded access to care (Trenholm, Howell, Hill, & Hughes, 2007). For example, the Los Angeles Healthy Kids program evaluation found that 30% of families enrolling their young children in Healthy Kids perceived financial difficulties associated with obtaining needed care for their children compared to a pre-enrollment period rate of 51% (Hill et al., 2008). Because CYSHCN are a small proportion of newly covered children, relatively few outcomes associated with CYSHCN have been assessed in CHI program evaluations.

SPECIALIZED SERVICE PROGRAMS

California Children's Services (CCS)

California Children's Services (CCS), within Children's Medical Services (CMS), was established in 1927 to cover medical care for low-income children with serious medical conditions. It is now the state's Title V Program for Children with Special Health Care Needs. The goal of the federal Title V program is to "support development and implementation of comprehensive, culturally competent, coordinated systems of care for the estimated 18 million U.S. children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally" (Maternal Child and Health Bureau).

California's Title V program is based on medical diagnoses, reflecting its founding in the era of polio epidemics, and is the most important program in the state for health care delivery to children with complex medical conditions. Children are covered from birth to age 21. CCS-eligible diagnoses include:

- Heart conditions
- Neoplasms
- Blood disorders (hemophilia, sickle cell anemia)
- Respiratory system disorders (cystic fibrosis, chronic lung disease)
- Endocrine, nutritional, and metabolic disorders (PKU, thyroid problems, or diabetes)
- Genito-urinary system disorders (serious kidney problems)
- Gastrointestinal system disorders (biliary atresia)

For the first year of her life, my husband and I stayed home and worked with Alison and her professionals full time. In her busiest week, Alison had 22 appointments with various therapists and doctors. After she turned one, I went back to work. I worked nights so that I could attend meetings and appointments during the day when necessary. The regional center providing respite care was a life-saver for us. As she got older we received equipment through CCS that included a helmet, walker, ankle foot orthoses, and an orthopedic stroller.

- Serious birth defects (cleft lip/palate, spina bifida)
- Sense organ disorders (hearing loss, loss of vision due to glaucoma or cataracts)
- Nervous system disorders (cerebral palsy, uncontrolled epilepsy)
- Musculoskeletal and connective tissue disorders (muscular dystrophy, juvenile rheumatoid arthritis)
- Severe disorders of the immune system (HIV)
- Disabling injuries and poisonings requiring intensive care or rehabilitation (severe brain injuries, spinal cord injuries, and burns)
- Complications of premature birth requiring an intensive level of care

The CCS program has developed quality standards for pediatric specialty care and maintains a pediatric provider network through credentialing of individual pediatric providers and approval of facilities and programs. The program's services include case finding and eligibility determination, coverage of diagnostic services, treatment planning and medical case management, authorization of all services related to the CCS-eligible condition, and program monitoring and oversight. A system of CCS-approved special care centers provides quality specialty and subspecialty care at local and regional locations.

The CCS program also includes a direct services component, the Medical Therapy Program, which provides physical and occupational therapy and other services for medically eligible children regardless of their family income. The majority of these children receive special education services, including physical and occupational therapy and other services included in their Individualized Education Plans (IEP).

CCS is primarily a program for low-income children (i.e., children living in families with annual family income under \$40,000), and the vast majority of children in the program are enrolled in Medi-Cal or Healthy Families or are uninsured. There are two exceptions to the \$40,000 income ceiling:

- 1) CCS covers specialty care for medically eligible children in higher-income families when the costs of their child's care reach 20% or more of annual family income.
- 2) Children with CCS-eligible conditions who are enrolled in Healthy Families are deemed financially eligible for CCS even if their family income exceeds \$40,000. This is an artifact of the mismatch between CCS income eligibility, a flat income ceiling, and Healthy Families income eligibility, based on percentage of the federal poverty level which is calibrated by family size.

Administration of the CCS program is shared between the state and California counties:

- The state develops quality standards; provides panels providers, facilities, and programs; sets policy and procedures for and oversees implementation of the program statewide; and conducts quality assurance activities.

My son, Pablo, is 21 years old and because of extreme prematurity (26 weeks), he has cerebral palsy, developmental disability, and autism. He cannot eat solid foods and does not speak, but he enjoys a happy life with an adoring and supporting family. A client of the regional center, Pablo receives respite care, diapers, academic consultation, and adult transition services. Respite allows us some time away from worrying about our son's care, helping us to strengthen our family. For us, diapers would be an ongoing expense that most families do not have. Academic consultation has guided us through the IEP process, which ensured that Pablo was getting the right academic content and support services.

- The 31 more populated counties fully administer their own CCS programs, including eligibility determination and case management.
- The 27 less populated counties share their administrative and case management activities with the state via several regional offices.

Many of the more populated counties also have significant managed care enrollment of Medi-Cal and Healthy Families recipients. In most of these counties, CCS services are “carved out” of Medi-Cal managed care plans. Under this carve-out arrangement, Medi-Cal managed care plans are responsible for primary care and other services not related to CCS-eligible conditions, while all services related to CCS-eligible conditions are authorized and managed by the CCS program.

Five counties predate the legislation establishing the CCS carve-out from Medi-Cal managed care: Napa, Solano, Yolo, Santa Barbara, and San Mateo. In these counties, all with county organized health systems, the managed care plans bear risk for CCS services and the CCS programs remain responsible for eligibility determination, case management, and service authorizations. CCS services are carved out of all Healthy Families managed care plans, and Healthy Families enrollees are not responsible for co-pays for their CCS-authorized services.

The CCS caseload in July, 2009, was about 175,000. Approximately 75% of these children are enrolled in Medi-Cal; 15% are Healthy Families subscribers and 10% are enrolled in state-only CCS (also known as “straight CCS”). Approximately 26,000 children receive services through the CCS Medical Therapy Program (Personal Communication, Marian Dalsey, Children’s Medical Services).

More specific information on CCS is displayed in Appendix 3.

Genetically Handicapped Persons Program (GHPP)

The Genetically Handicapped Persons Program provides health coverage for adults and financially non-CCS-eligible children who have specific genetic diseases (cystic fibrosis, hemophilia, sickle cell, and certain neurological and metabolic conditions). Unlike most public programs, GHPP has no income ceiling; families with incomes over 200% of FPL pay fees based on a sliding scale. In 2008 there were approximately 1,600 enrollees in the program (Maternal and Child Health Services, 2008).

More specific information on GHPP is displayed in Appendix 3.

Regional Centers for Persons with Developmental Disabilities

Under contract with the state Department of Developmental Services, 21 private nonprofit centers located around the state provide services for children and adults with developmental disabilities, including mental retardation, cerebral palsy, epilepsy, and autism, as well as young children ages 0-3 who have developmental delays, under the Early Start program. Services provided include case management; early intervention services for children ages 0-3 who

have developmental delay; family support; respite; crisis intervention; special living arrangements; community integration; interpreter/translator services; advocacy; transportation vouchers; assessment; rehabilitation and training; vocational placements; and speech/language, vision, and audiology services. Services may be provided from birth throughout the full life course.

(Note: Regional center programs have sustained major service reductions in the wake of the state’s financial crisis, including significant changes in Early Start eligibility and services. These changes include elimination of eligibility for certain populations of at-risk children from birth to three years of age and creation of a new non-entitlement “prevention program” with a capped budget. While details are still being finalized, these changes will have major impact on access to services, particularly for children from birth to age three who have or are at risk for developmental delays.)

More specific information on regional centers is displayed in Appendix 3.

Special Education

Special education is a system of specially designed instruction and related services provided by school districts to meet the unique needs of a pupil with a disability. A “pupil with a disability” is defined as a child or youth from birth through 21 years of age (i.e., to age 22) who meets eligibility criteria as defined in the Education Code and as determined by assessments. A child may be found eligible if one or more of these handicapping conditions exist: hearing impairment (including deafness), visual impairment (including blindness), concomitant hearing and visual impairments, language or speech disorder, severe orthopedic impairment, acute health problems, autism, mental retardation, emotional disturbance, specific learning disability, and traumatic brain injury. The presence of one or more of these conditions also must significantly impact a child’s ability to learn. A child with a “solely low incidence” impairment (i.e., deaf, blind, deaf and blind, or severe orthopedic impairment) may begin receiving services from a school district at birth, but eligibility for children meeting other special education criteria begins at age three. Children and youth receiving special education services also may be eligible for regional center and/or public mental health services.

Special education services are based on a student’s unique needs, are provided through school districts, and may include assistive devices/services, audiology services, family training, counseling, home visits (Early Start-eligible children only), some health services, diagnostic services, nursing assessments, occupational and speech therapy, psychological services, respite (Early Start-eligible children only), special instruction, speech/language services, vision services, and transportation. Through a California interagency agreement known as AB3632, both mental health services and California Children’s Services can be offered through the county to address specific areas for children eligible for special education. There are no income requirements for special education services.

More specific information on special education is displayed in Appendix 3.

I stopped working after the birth of my first child, Simon (now 13) because of his medical problems and physical needs. Now with a second child with special needs, I use In-Home Supportive Services to provide them with 24/7 care. I have not been able to work outside the home because I could not put either of my children in a regular daycare with all of their needs. My husband works to provide health insurance. Just recently, due to the economy, my caseworker told me that my husband makes too much money for my kids to receive IHSS, which devastated us. How am I supposed to go back to work and plug them into a daycare? Instead, I have to go through a long application process to keep my IHSS (to replace county dollars with federal dollars), but I will only be able to claim the hours when my husband is at work. My children are non-ambulatory and sometimes need me all through the night. I am frustrated because these programs are not dedicated to helping children with disabilities and their families. We are struggling because my kids are not getting SSI or Medi-Cal because of my husband's income.

In-Home Supportive Services (IHSS)

IHSS is intended to enable recipients to remain in their own homes and to avoid long-term care facilities. IHSS can cover a variety of services, including housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for people with mental impairments. IHSS services are available for income-eligible children or adults who are blind or have other disabilities as well as some seniors who require such assistance.

Eligibility criteria include receipt of or income eligibility for Supplemental Security Income (SSI); there also is a share-of-cost option for people who meet the criteria for SSI but exceed the income level. Individuals eligible for IHSS as a result of disability also are eligible for full-scope Medi-Cal, and personal care services are a Medi-Cal benefit. As of May, 2009, there were 446,849 authorized IHSS cases in California (State of California, 2009).

(Note: The status of California state coverage of health care is fluid, given the state budget situation. Major reductions have been made in funding for IHSS and major changes in eligibility and services are anticipated, although final details are not yet available.)

More specific information on IHSS is displayed in Appendix 3.

High Risk Insurance Pool

The state agency, Major Risk Medical Insurance Program (MRMIP), provides health insurance for those unable to obtain coverage in the individual health insurance market (e.g., due to a pre-existing condition). Children and youth who are not eligible for other publicly funded programs and are unable to obtain insurance in the private market may apply for coverage through MRMIP. The cost of premiums is shared between MRMIP and the enrollee and varies by plan and other factors. The program has a set annual deductible (\$450 per household in 2008), an out-of-pocket maximum of \$2,500 per individual and \$4,000 per household, an annual cap on covered service costs (\$75,000), and a lifetime cap on covered costs (\$750,000). Tobacco tax funds currently subsidize the MRMIP.

Program applicants must be California residents. They cannot be eligible for both Part A and Part B of Medicare unless eligibility is based solely on end-stage renal disease. Nor can they be eligible to purchase any health insurance for continuation of benefits under COBRA or CalCOBRA. Finally, they must be unable to secure adequate coverage in the private market. Because of funding limitations, MRMIP may have a wait list; as of August, 2009, there were approximately 230 applicants on the wait list.

More specific information on MRMIP and its insurance program is displayed in Appendix 3.

Mental Health Services

Publicly funded mental health programs serve children and youth with full scope Medi-Cal (ages 0-21 years); children and youth enrolled in the Healthy Families program (ages 0-18 years); and children and youth ages 0-22 who receive special education referrals from schools. Provision of these services can be complex:

- Mental health services for children on full-scope Medi-Cal are provided through county-based mental health managed care plans, with certain exceptions such as psychotropic and other medications that are provided through the child's health services delivery system, whether Medi-Cal fee-for-service or managed care plan.
- Basic mental health services for children enrolled in Healthy Families are provided through the child's Healthy Families managed care plan, but children needing specialized mental health services for a serious emotional disturbance (SED) condition may receive care from their local county department of mental health as part of a carve-out arrangement.

There are no income limits for children referred for mental health services by the school system.

Data from the 2007 National Survey of Children's Health and analyzed by the Kaiser Family Foundation indicated that 54% of children in California who were identified with emotional, developmental, or behavioral problems received mental health care, as opposed to 60% of children in the nation as a whole (Kaiser Family Foundation [c]).

More specific information on mental health services is displayed in Appendix 3. A graphic display of income eligibility for publicly funded programs for children may be found in the Health Insurance Chart in Appendix 5.