

Growing Pains for the Los Angeles Healthy Kids Program

Findings from the Second Evaluation Case Study

Prepared for:



Prepared by:

Ian Hill
Patricia Barreto
Brigette Courtot
Eriko Wada

The Urban Institute



The University of
California at Los Angeles



The University of
Southern California



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For more information about First 5 LA and its initiatives, go to www.first5la.org.

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Executive Summary

The Los Angeles Healthy Kids program has achieved a great deal during its first four years of existence. Designed to cover all children, regardless of immigration status, living in families with incomes below 300 percent of the federal poverty level and ineligible for Medi-Cal or Healthy Families, the program has provided hands-on outreach, assistance, and support to families throughout the County, and succeeded in extending comprehensive and affordable health coverage to over 40,000 very poor, very vulnerable children. Furthermore, according to newly released survey results, Healthy Kids has had a demonstrable positive impact on children's access to and use of care, reduced parents' concerns about obtaining care for their children, reduced unmet need for virtually all types of services, and actually improved the health of enrolled children.

Yet, over the past two years, Health Kids has faced serious challenges as well, primarily related to financing. Specifically, while funding for younger enrollees ages 0 to 5 remains stable, resources for older children began to run short as early as the spring of 2005, and Healthy Kids was forced to impose an "enrollment hold" for 6 to 18 year-olds. Aggressive fundraising efforts continued with the goal of maintaining coverage for existing enrollees rather than to enable new enrollment. Indeed, enrollment for children ages 6 to 18 has never reopened and, over time after the hold's implementation, enrollment levels for all children have slipped. Beyond financing, Healthy Kids has also faced challenges related to some of the chronic problems in the systems of care into which the program was introduced.

At this critical juncture, the Healthy Kids Program Evaluation continues to monitor the implementation of Healthy Kids and assess its impacts on the target population and systems of care for children. This second case study report was developed under a four-year contract

between First 5 LA and the Urban Institute and its partners. Based on information gathered in interviews with over 40 key informants during a week-long site visit to Los Angeles, this report analyzes the status of the maturing program and delves into some of the complex challenges it has faced.

Outreach, Enrollment, and Retention

Healthy Kids outreach and application assistance are provided through a broad and diverse network of community-based agencies. Relying on a cadre of trusted, multi-lingual staff, these agencies find families with uninsured children, inform them of the availability of coverage, assist parents with completing applications for any available coverage program (including Medi-Cal, Healthy Families, and Healthy Kids), and follow up with families to ensure that children's needs are being met. While various reports developed under this evaluation have attested to this outreach model's effectiveness, this case study describes how approaches have had to be modified in light of the enrollment hold. Specifically, outreach and health plan workers have had to:

- Continue to find and recruit families with young children (ages 0–5), emphasizing that Healthy Kids is still available to this subset of children while working to overcome public misperceptions that the entire program was closed;
- Maintain waiting lists of parents with eligible children ages 6–18 who were not able to enroll in Healthy Kids, periodically checking in with families to gauge their continued interest in the program;
- Actively refer uninsured children affected by the enrollment hold to other sources of coverage, including the Kaiser Child Health Plan, the Public Private Partnership, the Child Health and Disabilities Prevention (CHDP) program and its “Gateway,” and Emergency Medi-Cal; and
- Shift much of their work to assisting families with children on Healthy Kids with their renewal applications, and emphasizing to parents the critical importance of maintaining coverage in light of the enrollment hold.

Benefits, Service Delivery, and Access

The Healthy Kids benefit package mirrors that offered by Healthy Families—California’s SCHIP program—offering a full range of preventive, primary, acute, and specialty care services, including dental, vision, and behavioral care. Services are delivered through a prepaid managed care network managed by LA Care, a not-for-profit community health plan with extensive experience serving publicly insured families. Healthy Kids also emulates Healthy Families with regard to cost sharing, using a sliding scale premium structure that exempts the poorest families from monthly fees, but imposing \$5.00 copayments on all families, regardless of income, for a range of health services. While various reports developed under this evaluation have found the program’s benefits, service delivery, and cost sharing policies to be well designed and implemented, and generally affording very good access to care, this case study identified a range of challenges that have undermined optimal access. These include:

- Geographic barriers to care for some families who live too far away from their primary care physician, or lack adequate transportation to get to doctor’s offices or clinics;
- Long waits for appointments or in clinics for some families, perhaps due to the network’s heavy reliance on busy “safety net” providers;
- Problems with children being assigned to dentists different from those that parents selected during the enrollment process, leading to confusion and delays in obtaining dental care;
- Delays in obtaining care from pediatric dental specialists, owing to a chronic undersupply of these providers;
- Reports of inappropriate copayment charges being levied by some dentists for services not subject to cost sharing;
- Suboptimal use by physicians of formal “clinical assessments” to detect developmental delays in children; and
- Delayed access to needed specialty and mental health care, again due to chronic systemic shortages of pediatric specialty and behavioral providers.

Financing and Sustainability

The Los Angeles Healthy Kids program was launched in 2003 supported by a \$100 million commitment by First 5 LA to extend coverage to children ages 0–5. Aggressive fundraising by the Children’s Health Initiative of Greater Los Angeles (CHI) garnered an additional \$88 million and allowed the program to add coverage of all 6-18 year-old children in 2004. Within 2 years, nearly 45,000 children were enrolled in the program, exceeding all expectation. Yet this success also meant rapid depletion of funds, and the program was forced to halt enrollment of the older age group of children. To address this sustainability challenge, the program has:

- Continued to raise funds through the CHI, repeatedly succeeding in maintaining coverage for existing enrollees;
- Reduced premium levels on three occasions when health plan administrators determined that caring for children on the program was less expensive than anticipated;
- Pursued financial assistance from the state Medicaid program when it was learned that a sizeable proportion of Healthy Kids enrollees also possess Emergency Medi-Cal coverage and use that coverage when obtaining hospital and emergency care; and
- Advocated for a series of legislative and executive branch proposals that would either establish statewide universal child coverage or create universal coverage for all Californians, including children.

Options for Policy and Program Improvement

Based on the findings from this case study, a series of options for policy and program change are offered for consideration, including:

- Integrating the application forms for Medi-Cal, Healthy Families, and Healthy Kids, to reduce complexity and improve enrollment efficiency;
- Offer “copayment assistance” to families with limited means, to remove potential financial barriers to the use of services;
- Eliminate copayments for dental care, to further ease access to the critically needed services;

- Eliminate the three-month “waiting period” for children with other insurance at the time of application, since research has shown that very small percentages of children on Healthy Kids have any access whatsoever to employer sponsored health insurance;
- Provide incentives for enhanced developmental services, including more comprehensive screening for developmental delays;
- Encourage reorganization of clinic operations, to improve efficiency and reduce waiting times; and
- In case universal statewide child coverage fails to be enacted, consider scaling back Healthy Kids coverage to primary care only, with Emergency Medi-Cal serving as a “wrap around” benefit, to further stretch scarce premium dollars.

Today, the Los Angeles Healthy Kids program sits at a critical juncture. Developments in the coming year will determine whether it will have the opportunity to continue to grow and thrive, with solid state financial support, or whether the program will be forced to undertake drastic measures simply to exist. One can only hope that policymakers understand and will embrace the great good that this and similar programs across the state have achieved for vulnerable children, and stake out a leadership role, nationally, in ensuring that all children have access to comprehensive and affordable health coverage.

I. Introduction

As the Los Angeles Healthy Kids program reached its fourth birthday, it could boast of many early successes. After a year of implementation, the program expanded from its original scope of covering children ages zero to five, to include older children ages 6 to 18. By its second anniversary, aggressive outreach efforts had resulted in the enrollment of nearly 45,000 children into coverage. A case study of program implementation found that Healthy Kids was carefully designed to meet the needs of vulnerable children in Los Angeles County, and that it was nurtured during its early development through the ongoing collaborative efforts of the Children's Health Initiative of Greater Los Angeles (the CHI Coalition) and, in particular, the leadership of First 5 LA, the LA Care Health Plan (LA Care), the Los Angeles County Department of Health Services (DHS), and The California Endowment (Hill, Courtot, and Wada 2005). In a series of focus groups, parents with children enrolled in Healthy Kids expressed strong praise for the program, saying that the benefits covered the services their children needed, that access to care was good, that cost sharing was affordable, and that the coverage gave them a strong sense of security and peace of mind (Hill et al. 2006). Finally, a household survey of a representative sample of parents confirmed that Healthy Kids enrollment was associated with both improved access to usual sources of health and dental care, and improved confidence among parents that they can meet their children's health care needs without financial hardship (Dubay and Howell 2006; Howell et al. 2006).

Yet four years in, the program has also been beset by serious challenges, mostly related to financing. Specifically, while funding for younger children ages 0 to 5 remains stable, resources for older children began to run short as early as the spring of 2005. By June of that year, Healthy Kids was forced to impose an "enrollment hold" for 6 to 18 year-olds and maintained a waiting

list of prospective enrollees until the end of March 2006 (at which point the list was also closed). Meanwhile, even as enrollment leveled off and then dropped for these older children, it also dipped for the 0 to 5 group, as the outreach network struggled to market a program that could only serve a subset of younger children. The last year also witnessed increased public attention on issues of illegal immigration, both nationally and in Los Angeles, and residents of LA County staged one of the largest demonstrations of solidarity for immigrant rights in the nation during the spring of 2006. But stakeholders wondered whether this visibility might adversely affect enrollment in Healthy Kids, by driving the primarily undocumented immigrant families it serves underground.

At this critical juncture, the Los Angeles Healthy Kids Program Evaluation continues to monitor the implementation of Healthy Kids and assess its impacts on the target population and systems of care for children. This second case study report was developed under a four-year contract between First 5 LA and the Urban Institute. The Institute and its partners—the University of Southern California (USC), the University of California at Los Angeles (UCLA), Mathematica Policy Research, Inc., and Castillo & Associates—are conducting a broad range of evaluation activities over the course of the project, including case studies of implementation, focus groups with parents, a longitudinal household survey, and ongoing process monitoring of outreach, enrollment, retention, and utilization measures.

This report is based on information gathered during a week-long site visit to Los Angeles conducted in November 2006. During the site visit, evaluators met with over 40 key informants representing First 5 LA staff, policymakers, public and private providers, county public health officials, health plan administrators, dentists and dental plan officials, child and family advocates, health policy researchers, and community-based outreach workers. (See Appendix A

for a complete list of all site visit informants.) All interviews were conducted using structured protocols by evaluation team members from the Urban Institute, USC, and UCLA.

Whereas the first project case study report described Healthy Kids' design and early implementation phases, this second report analyzes the status of the maturing program and delves into some of the complex challenges it has faced during ongoing implementation. The remainder of this report addresses three key implementation areas:

- Outreach, enrollment and retention;
- Benefits, service delivery and access; and
- Financing.

Within each section, we summarize what the evaluation has learned to date regarding how well these aspects of the program are working, and then draw on the input of our key informants to explore the challenges that have been experienced and why these have been encountered. In the last section of the report, we present a set of options for program improvement for policymakers to consider as Healthy Kids moves forward.

II. Outreach, Enrollment, and Retention

A. Background

The outreach and enrollment efforts adopted as part of the Healthy Kids program have been almost entirely community-based, with a focus on using a holistic, “something for everyone” approach. In other words, outreach workers strive to find and offer some type of health care assistance for every family member, including adults. A diverse group of agencies in the county receive intensive training and are funded to conduct outreach and enrollment activities in a variety of settings, including health clinics and other medical provider offices, WIC clinics, schools and daycare centers, Head Start programs, public health department clinics, churches, and a broad range of community-based family service organizations, among others (Farias, Inkelas, and Courtot 2007).¹ (A detailed summary of the efforts of one Healthy Kids outreach contractor—the Los Angeles Unified School District—is found in Vignette #1.) These groups typically identify uninsured children and families, offer information, assist with completing applications for health coverage, and follow up with families to confirm enrollment and encourage the use of services. Over time, agencies have also increasingly focused on promoting the importance of maintaining health coverage and assisting families with the renewal process. Application assistance is provided for all available programs, not just Healthy Kids.

Previous evaluation findings indicated that the community-based model of outreach and application assistance has been extremely effective in Los Angeles County. Ongoing monitoring of County administrative data shows that outreach contractors are succeeding in contacting a large number of families in a wide variety of settings, with clinics and doctors’ offices leading the way , and that they are assisting families primarily with applications for Medi-Cal and Healthy Families, as well as Healthy Kids and other programs (Wada et al. 2006).

During the evaluation’s first case-study, stakeholders reported on many positive aspects of the Healthy Kids outreach and enrollment system, including: that outreach workers were successful in dispelling immigrant families’ fears of applying for government assistance and clarifying that obtaining health coverage does not constitute a “public charge” that could harm their ability to obtain citizenship; that families had little trouble with the Healthy Kids application process and were typically able to produce income and county residency verification; and that application processing was occurring smoothly and quickly, with most Healthy Kids determinations being made within 10 days (Hill, Courtot, and Wada 2005). These findings were reinforced one year later when, in a series of focus groups, parents of Healthy Kids enrollees described the Healthy Kids application and renewal processes as “easy” and the assistance they received during the processes as “very helpful” (Hill et al. 2006). Finally, the evaluation’s household survey found that parents were very positive about their encounters with the Healthy Kids outreach and enrollment process. Specifically, the survey showed that 93 percent of parents found the application process “very” or “somewhat” easy (Howell et al. 2006).

B. Key Implementation Issues

As the Los Angeles Healthy Kids program matures, stakeholders are facing new challenges related to implementation of outreach and enrollment, primarily due to funding shortfalls that required Healthy Kids to halt enrollment of children ages 6 through 18. In this section, we review the key issues that arose during our second site visit, focusing on the implementation and perceived impacts of the enrollment cap, and exploring the challenges of coordinating care for

¹ Outreach contracts were also established with the Cities of Pasadena and Long Beach.

Vignette #1: The LAUSD Children's Health Access and Medi-Cal Program

The Los Angeles Unified School District (LAUSD) comprises roughly 800 schools, serves more than 750,000 children, and covers 1,115 square miles in Los Angeles County. To improve student achievement by reinforcing health, the District created the Children's Health Access and Medi-Cal Program (CHAMP) in 1997 with the goal of increasing access to health insurance for uninsured children. CHAMP activities include presentations to parents and school staff on the importance of health coverage, addressing public charge issues, offering health and enrollment fairs, and onsite and telephone enrollment assistance. Today, the CHAMP office has 15 bilingual staff, 14 of whom are Certified Application Assistors (CAAs).

Given the vast size of the school district, CHAMP must focus its efforts to maximize its limited resources. This includes ranking schools based on estimates of uninsured students, and targeting schools with clinics and/or immigrant assessment centers. Through its toll-free helpline, CHAMP staff hold "office hours" (including sessions in the evenings, to accommodate working parents) during which parents can call in for information and assistance.

Developing positive relationships with school principals is a critical component of CHAMP's work, as leadership support is necessary precursor to any on-site work that staff provide. The CHAMP team also work closely with school nurses and physicians caring for students through the Children's Health and Disability Prevention (CHDP) program, providing follow-up application assistance to families. (LAUSD is the largest CHDP provider in the state.) CHDP clinics offer a logical and convenient point of contact with parents, and CHAMP staff educate families on the importance of a medical home and opportunities for coverage under Medi-Cal, Healthy Families, and Healthy Kids.

CHAMP uses a Request for Information (RFI) form to help identify uninsured children in the district, attaching it to Free and Reduced School Lunch applications that are sent home at the beginning of each school year. Interested parents can request assistance from CHAMP with obtaining health coverage for their children, and schools forward completed forms to CHAMP so that staff can follow up with parents. In 2003, LAUSD also participated in a pilot project for the Express Lane Eligibility (ELE) program, which aims to better identify and enroll uninsured children through the school lunch program. Through ELE, consenting parents of free lunch-eligible children allow schools to share the information provided on their school lunch application with the local Medi-Cal office for the purpose of pre-screening children for eligibility. Eligible children receive temporary, full-scope Medi-Cal services while their regular Medi-Cal application is being processed.

In addition to outreach and enrollment activities, CHAMP staff spend time "troubleshooting" a range of problems commonly experienced by parents. For example, staff will support families in their interactions with Medi-Cal offices and staff, assist with switching primary care providers, and finding providers who speak their language.

children with coverage under multiple programs, including Healthy Kids, Emergency Medi-Cal, the CHDP Gateway, and others.

The Healthy Kids Enrollment Hold and Waiting List. Less than one year after the Healthy Kids program expanded to cover children through age 18 in Los Angeles County, premium funds for older children (the 6–18 year old population) were exhausted. Total enrollment for children ages 6–18 had reached approximately 35,000—nearly double the figure that the CHI Coalition had projected for this stage of the program—thus funds for these older children were depleted more quickly than program officials had anticipated. The CHI Coalition and its workgroups deliberated how to best address this issue and decided to implement a “hold” on enrollment for children ages 6-18 starting in June 2005 so that the CHI could raise additional funds to maintain coverage for existing enrollees. For the next ten months, L.A. Care maintained a waiting list of children who had applied for and were determined eligible for the program. Families were informed via written notice from L.A. Care about their child’s enrollment status. Children ages 0-5 were exempt from the enrollment hold and those “aging-out” of the 0-5 age group (i.e., children reaching their sixth birthday) were also exempt, allowing their coverage to continue.

Starting in October 2005, L.A. Care staff made outbound calls to families with children that had been on the waiting list for at least four months to confirm their continued interest in the program and verify contact information. As Healthy Kids members disenrolled (typically because they reached their 19th birthday, moved out of Los Angeles County, or failed to renew their coverage), the funds that had been supporting their premiums were redirected to support enrollment of children off of the waiting list, with priority given to children who had been on the list the longest. The first such enrollment of children from the waiting list occurred in December

2005, six months after the enrollment hold was imposed. In the months that followed, fewer than 200 children were moved off the waiting list and enrolled into the program each month.

In March 2006, program officials stopped accepting Healthy Kids applications for children ages 6–18 and closed the waiting list, in anticipation of an indefinite period of limited funding. At this time, there were more than 4,700 children on the list. The decision to freeze enrollment was spurred by CHI officials’ desire to maintain coverage for existing Healthy Kids enrollees for as long as possible; by March of 2006, there were sufficient funds to guarantee at least six months of coverage for children already on the program. Stakeholders also thought that this decision might prove beneficial for the program’s long-term sustainability, by keeping the program running and by stretching limited funds to cover a smaller number of enrollees for a longer period of time. As one key informant put it, “The longer [Healthy Kids] is around, the more it becomes a part of the landscape.” Even after the waiting list was closed, outreach workers kept their own informal lists of families who had tried to apply for coverage. A “Healthy Kids Interest List” field was added to the Children’s Health Outreach Initiatives (CHOI) database so that workers could track interested families and potential program applicants; approximately 150 children were on this list at the time of our site visit.²

The CHI Coalition continued fundraising efforts, both to maintain current coverage and to secure sufficient funding to enroll the thousands of children still on the waiting list. While stakeholders speculated whether the Healthy Kids enrollment hold and waiting list could have been more publicized to raise awareness about the need for funding, they were ultimately reluctant to draw attention to the fact that the program enrolled mostly undocumented children (especially in light of heightened attention paid to immigration issues during 2006 and several large immigrant rights rallies that were held in Los Angeles County). At the time of this writing,

the CHI had raised sufficient funds to enroll all remaining children from the waiting list, and to guarantee coverage to these and all enrolled 6–18 year-old children through January 2008.

Effects of the Enrollment Hold on Outreach and Enrollment Activities. During the ongoing enrollment hold, outreach workers have had to adjust their messages to families about health insurance coverage availability. Obviously, while working with families with uninsured children ages 6–18, they have had to explain that limited funding had forced Healthy Kids’ indefinite closure. But they continued to work with these families to find alternative coverage (discussed below). For those with children ages 0–5, they emphasized that Healthy Kids was still available, and encouraged parents to apply for the program even if older children in the family were not eligible for coverage. For parents of all current enrollees, they redoubled their emphasis on the critical importance of renewing coverage on time, explaining that if parents inadvertently allowed their older children’s coverage to lapse, they would be unable to reapply (discussed in more detail below).

Outreach staff also modified their activities to reflect the new reality. Since funding for younger children ages 0–5 was ample, they made greater efforts to attempt to find and enroll such children in families with higher incomes, who might be eligible for either the 0–5 component of Healthy Kids or the Healthy Families program.

Even with adjusted outreach messages and targeted activities, key informants unanimously agreed that it became more difficult to promote Healthy Kids after implementation of the enrollment hold for 6–18 year olds. Workers reported approaching outreach more cautiously, explaining that they didn’t “want to give families the impression that the program is available to *all* children.” Also, Healthy Kids’ early enrollment successes were attributed, in large part, to the clear and simple “We’ve got you covered” message that outreach workers could relay when the

² By March 2008, this interest list had grown to approximately 2,850 children.

program could accommodate children of all ages. With the enrollment hold in place, the message became more muddled and, according to outreach staff, less appealing to parents. As one worker noted, “The hold has really affected outreach and enrollment; we experienced more success when we could offer something to every child in the family.” Indeed, administrative data clearly show that the hold negatively affected enrollment for both age cohorts; in addition to the expected decline in total enrollment of 6–18 year-old children, enrollment of young children ages 0–5 also leveled off and subsequently declined after imposition of the enrollment hold. (See Vignette 2 for more discussion.)

Referrals to Other Programs and Services. With the enrollment hold in place, outreach workers have been frustrated by not being able to answer parents’ most pressing question: “When would Healthy Kids enrollment reopen?” However, outreach workers have continued to assist parents by sharing information about alternatives for older children’s coverage, thereby preserving their goal of trying to assist entire family units. As one informant noted, “We can’t offer continual coverage, but we can offer coverage for what children need now.”

Finding coverage alternatives for children who could no longer enroll in Healthy Kids required considerable resourcefulness on the parts of outreach staff. They described referring families to four primary alternatives:

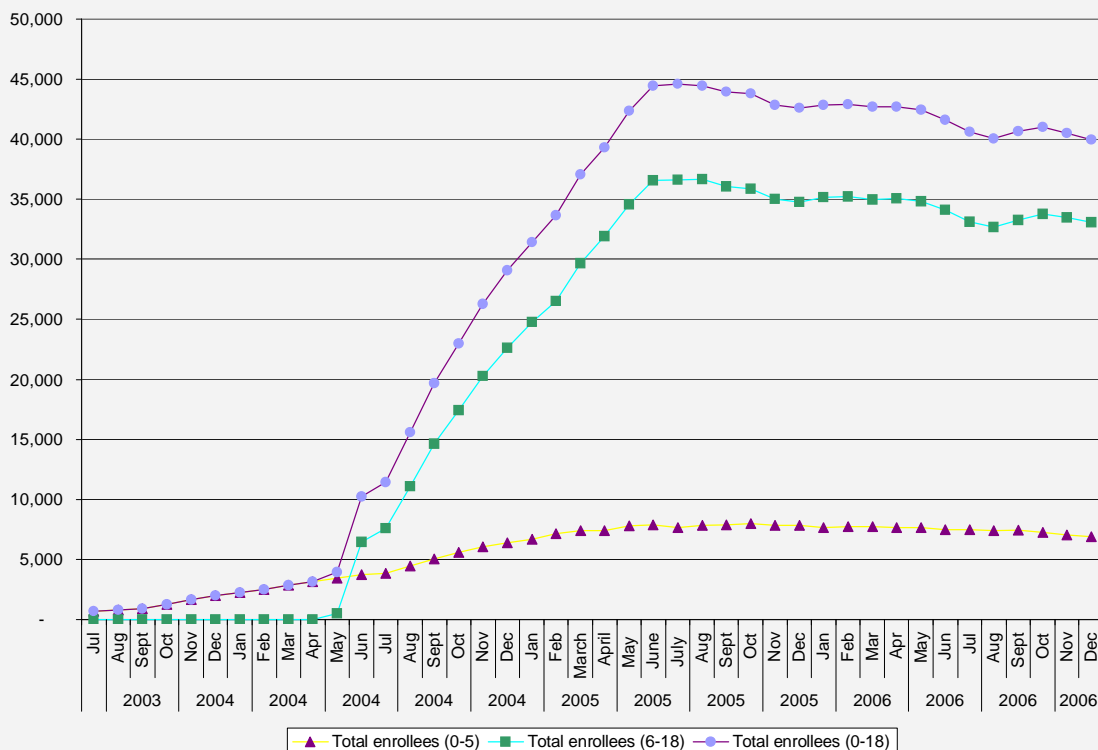
- (1) **Kaiser Child Health Plan**, also known as Kaiser Cares for Kids, is a subsidized program funded by Kaiser Permanente of California that has eligibility guidelines similar to those of Healthy Kids. With the advent of the Healthy Kids enrollment hold, Kaiser (a long-standing member of the CHI) committed to enrolling up to 1,700 children off of the waiting list and from the community. The program quickly became the most common referral option for outreach workers attempting to assist children who could not enroll in Healthy Kids due to the program’s enrollment hold.

“Kaiser” (as it is commonly referred to) predated the launch of Healthy Kids, though the program has had limited funding and, as a result, opens and closes on an intermittent basis. Outreach workers observed that when both programs were “open,” families tended to prefer Healthy Kids since Kaiser requires all families, regardless of income level, to

Vignette #2: Enrollment Hold's Impact on Children's Enrollment

Since implementation of the Healthy Kids enrollment hold for children ages 6-18 in June 2005, enrollment of these older children has slipped, due to attrition, from 36,574 to 30,647 (in June 2007), or 16 percent. During the same period, even though enrollment for children ages 0-5 has remained open (supported by a \$100 million commitment from First 5 LA), enrollment of these younger children has also dipped, from 7,898 to 6,610 (in June 2007), also a 16 percent decrease (Farias, Inkelas, and Courtot 2007).

Monthly Enrollment in Healthy Kids by Age Group, Children Ages 0–18



Source: Farias, Inkelas, and Courtot, calculations with L.A. Care Health Plan data, March 2007

There has been considerable speculation as to why the enrollment hold would also constrain enrollment among 0–5 year-old children. Key informants interviewed for this study expressed concern that families were confused and perceived that the program was closed to *all* new enrollment; thus fewer parents of young children are seeking out Healthy Kids coverage. Many others reasoned that a program that offered coverage for some, but not all, children in a family is simply not as appealing to parents. This would help explain why Kaiser became such a popular choice for many families with both younger and older children, when confronted by the hold. Finally, some stakeholders said that the slow-down in 0–5 enrollment might not be due to the enrollment hold at all, but rather a result of the fact that early on in the program's implementation, outreach agencies were successful in enrolling the easy-to-reach children (often referred to as the "low-hanging" fruit). Now, several years into program implementation, they are challenged to enroll harder-to-reach children, such as those possessing higher incomes who might not consider themselves eligible for a program like Healthy Kids.

pay monthly premiums ranging from \$8 to \$15 per child. In addition, Kaiser members are required to obtain services at Kaiser health clinics, which can be problematic for families who do not live close to a Kaiser facility.

After just a few months of active referral to the plan from LA Care and outreach agencies in the community, Kaiser reached its capacity for new enrollees in Los Angeles County. Plan officials reported receiving nearly three times as many applications in 2006 as in the previous year. Kaiser halted new enrollment in November 2006. Even after halting its new enrollment in late 2006, Kaiser remained committed to enrolling waitlisted children. At the time of this writing, however, fewer than 300 children on the waitlist have requested the necessary paperwork for Kaiser enrollment.

- (2) **The Public Private Partnership (PPP)**, a County “safety net” funding stream, became another important referral alternative for outreach agencies. PPP, a partnership between Los Angeles County’s Department of Health Services and contracted physicians and clinics across the county, provides outpatient primary care services for uninsured individuals of all ages living at or below 133 percent of poverty. PPP funds are limited and participating clinics and physicians typically exhaust these monies fairly quickly each fiscal year as a result of their efforts to care for the uninsured. Therefore the program is not always a viable alternative.
- (3) **The Children’s Health and Disability Prevention (CHDP)** program and its “**Gateway**” were also heavily used methods for covering health services for children not able to enroll in Healthy Kids. CHDP is California’s Medicaid Early, Periodic Screening, Diagnosis and Treatment (EPSDT) program, providing preventive, primary, and treatment services for children from families with incomes at or below 200% of poverty. The state has always maintained a state-funded version of CHDP to cover children who are not eligible for Medi-Cal. The Gateway was implemented in 2002 as a presumptive eligibility-like mechanism to provide federally-matched short-term coverage for full-scope Medi-Cal to children who appear to be eligible for the program. Gateway applications are completed online during a child’s regularly scheduled CHDP visit and, once enrolled, families receive a temporary Medi-Cal insurance card for their child. During the two-month eligibility period, parents must complete an application for continued Medi-Cal or Healthy Families coverage if they want their child to maintain coverage. Unfortunately, administrative data reveal that many families do not complete those applications. However, there is no limit to the number of times that a child can be enrolled in the Gateway, so lack of follow-through on Medi-Cal and Healthy Families applications is not necessarily a barrier to preventive care, at least. Outreach workers report that the two-month CHDP coverage period is roughly the same amount of time it takes to become enrolled in Healthy Kids, though it is possible for a child to possess both CHDP Gateway-generated Medi-Cal coverage and Healthy Kids coverage at the same time.
- (4) **Emergency Medi-Cal** has always been a critical source of coverage for uninsured individuals and undocumented persons ineligible for the federally-matched Medi-Cal and

Healthy Families programs. Emergency Medi-Cal is also aptly called “limited scope Medi-Cal” as it only covers services needed in an emergency, or services for pregnant women. In an effort to maximize coverage opportunities, outreach workers interviewed for this study told us that when they first began assisting parents with Healthy Kids applications, they continued to also routinely complete an Emergency Medi-Cal application for each child. Over time, this practice diminished, at least for those workers assisting parents of undocumented children with Healthy Kids applications. However, with implementation of the enrollment hold, outreach workers likely increased their reliance on Emergency Medi-Cal as a coverage source for children ages 6-18. (For more information on Emergency Medi-Cal and its relationship with Healthy Kids, see Vignette #3.)

Emphasis on Renewal. As mentioned above, completing eligibility renewal while the enrollment hold is in place is especially important, as children whose coverage has lapsed (and who are thus disenrolled) are not permitted to re-enroll under any circumstance. To help families avoid this consequence, outreach contractors interviewed for this case study told us of their efforts to stress the importance of renewal with parents at the point of initial application and during all follow-up contacts in the post-application period. Outreach workers reported emphasizing retention with all parents, regardless of the program in which their children were enrolled. Health plan staff also stepped up their efforts to support timely renewal for Healthy Kids enrollees. We were told by LA Care officials that enrollment staff were making a minimum of three outbound calls to every family with a child at risk of disenrollment. These included families who failed to return their completed renewal forms (but had successfully received the forms in the mail) as well as those whose forms were sent back to LA Care as undeliverable due to an address change.

Effects of the Enrollment Hold on Families. Program officials, outreach workers, and providers alike reported that many parents were confused about how the Healthy Kids enrollment hold might affect their children. According to the majority of case study informants, once parents understood the implications of the enrollment hold, they responded with

“disappointment and sadness” rather than anger or suspicion. One outreach worker explained, “The families are just so grateful that Healthy Kids exists at all, and no one has responded with anger upon learning about the enrollment hold.”

Some parents were frustrated, however, according to outreach workers we interviewed. These parents were typically either: those with *both* young children under age six who were still eligible for Healthy Kids and older children who were not, and who faced the difficult situation of being able to enroll only some of their children in the program; or those whose children were disenrolled from Healthy Kids for failure to renew coverage and were thus locked out of the program. In the case of the former group, some parents explicitly chose to enroll their children in Kaiser because it offered coverage for all their children within the same program (even though their younger children could have enrolled in the less expensive Healthy Kids program). In the case of the latter group, outreach workers described heart-wrenching circumstances where parents failed to grasp the consequence of not renewing their child’s coverage only to subsequently realize how easy it would have been to keep their child fully insured.

Key informants interviewed for this case study reported that families’ continued trust and support of Healthy Kids—even after implementation of the enrollment hold—could be attributed (at least in part) to the well-trained outreach contractors who worked hard to provide families with clear information about why the enrollment hold was in place and how it worked. While outreach contractors funded by Healthy Kids received regular trainings and updates about policies surrounding the hold, other Certified Application Assistors across the county not affiliated with those contractors did not; there was concern among program officials that these “nonaffiliated” CAAs might share inaccurate information with parents.³ One key informant

³ For more information about this issue, see L.A. Health Action, *Lessons Learned from the February 28, 2006, Los Angeles County Certified Application Assistor Forum* (April 2006).

noted that, since there are so many people certified to provide application assistance, "...it is difficult to get a uniform message out regarding the status of the programs." Indeed, during one site visit interview, two assistors not affiliated with DPH or TCE told us that they believed there was "a cap on everything for [Healthy Kids]" saying that they "...don't even talk about Healthy Kids anymore because we don't want to give [families] false hope."

Key informants shared several theories on why Healthy Kids enrollees so frequently possess dual Healthy Kids and Emergency Medi-Cal coverage, which are described below.

Vignette #3: The High Incidence of Emergency Medi-Cal Coverage among Healthy Kids Enrollees.

For the past two decades, low-income Los Angeles residents who are not U.S. citizens have been able to access emergency care, pregnancy-related care, and nursing home care through an aid category commonly referred to as Emergency Medi-Cal (also called Restricted or Limited-Scope Medi-Cal). Beginning in 1986, with the passage of the Omnibus Budget Reconciliation Act (OBRA), states were permitted to expand Medicaid coverage to undocumented aliens; federal matching funds were made available for state expenditures on immigrants not categorically eligible for Medicaid or who do not meet residency requirements for that program but do meet income requirements and have an emergency medical condition. A key finding from the first wave of the Healthy Kids evaluation survey found that Emergency Medi-Cal plays an important role in providing access to health services for uninsured young children in Los Angeles County (Howell et al. 2006). Over half of surveyed parents reported that their children had Emergency Medi-Cal coverage before enrolling in Healthy Kids, and a large number of Healthy Kids enrollees retain Emergency Medi-Cal coverage after enrolling. Emergency Medi-Cal was also the single largest category of coverage reported by parents when they were surveyed about their own health insurance status; 13.1 percent of Healthy Kids enrollees had at least one parent who was enrolled in Emergency Medi-Cal. Findings from the evaluation's focus groups echo those of the survey, as many parents reported that their child possessed Emergency Medi-Cal even after enrollment in Healthy Kids. In addition, while most parents in the focus groups reported that they were uninsured themselves, those who reported coverage most often cited Emergency Medi-Cal as the source.

Vignette #3: The High Incidence of Emergency Medi-Cal Coverage among Healthy Kids Enrollees. (continued)

- The “Apply For Everything” Approach. Outreach contractors for the Healthy Kids program embrace a “something for everyone” approach to application assistance. During our site visit, it was not uncommon to hear outreach staff say that, once they’ve connected with a family, they strive to “sign everybody up for anything they might be eligible for,” covering all the potential bases. Several outreach workers told us that, although they tend to think of Emergency Medi-Cal as a “last resort,” they still often suggest that parents apply for the program in case their children are not eligible for anything else, and because it offers retroactive coverage for emergent services that the family may have recently obtained.
- Accessing Pregnancy-Related Services. Emergency Medi-Cal also covers some pregnancy related services that the Healthy Kids program does not, and informants suggested that this could result in some adolescents (of childbearing age) being enrolled in both programs.
- Links to Parental Emergency Medi-Cal Coverage. When uninsured parents qualify for Emergency Medi-Cal (often the only source of coverage available to such adults), dependent children named on their application are also automatically enrolled in the limited-scope program. Informants described how this automated process could explain much of children’s dual coverage under both Healthy Kids and Emergency Medi-Cal. Indeed, when outreach workers explained their efforts to educate families about how to appropriately use Healthy Kids and Emergency Medi-Cal, they “...tell parents that they don’t have to cancel Emergency Medi-Cal and can keep it for themselves, but that their child should use the Healthy Kids card for all care, including emergency care.”
- The Mechanics of CHDP Gateway. The CHDP Gateway itself may be another mechanism that contributes to overlapping coverage among children in Healthy Kids and Emergency Medi-Cal. A child who completes a Gateway application receives two months of full-scope Medi-Cal coverage immediately. The Gateway then automatically generates a Medi-Cal application for that child and this is sent to parents with a letter informing them that they must complete the application to maintain their child’s coverage. If parents complete and return the application but their child is not found eligible for full-scope Medi-Cal (because they are not citizens, for example), that child is automatically enrolled in Emergency Medi-Cal.
- Collaborative Outreach Efforts. Program officials also described a joint outreach effort, spearheaded by the CHI Coalition’s Program Integration Workgroup, which may have boosted the number of children carrying both types of coverage. The effort linked the Los Angeles County Department of Public Social Services (DPSS, the agency that determines Medi-Cal eligibility) and LA Care in an effort to identify potential Healthy Kids enrollees. In 2003, the program offices collaborated to produce a mailing to families with children ages 0-5 who were enrolled in Emergency Medi-Cal, and who might be eligible for Healthy Kids. The mailing included information about Healthy Kids and how to obtain assistance in applying for it. A replication of that early undertaking was in progress at the time of this writing.

III. Benefits, Service Delivery, and Access

A. Background

The Healthy Kids benefit package mirrors that offered by Healthy Families—California’s State Children’s Health Insurance Program (SCHIP). The program covers a full range of preventive, primary, acute, and specialty care services; dental and vision care; physical, occupational, and speech therapies; inpatient and outpatient hospital services; inpatient and outpatient behavioral health services; emergency care; prescription drugs; durable medical equipment; diagnostic X-ray and laboratory services; and family planning services, among others.

These services are provided through a network organized by one of Healthy Kids’ “strategic partners”—LA Care, a not-for-profit, community-accountable health maintenance organization with years of experience serving over 800,000 low-income county residents under Medi-Cal and Healthy Families. LA Care designed a new network to serve the Healthy Kids population, built largely around the County’s “safety net” of Federally Qualified Health Centers (FQHCs), community clinics, County health department clinics, and public hospitals. Over 300 of its roughly 1,400 primary care physicians practice in safety-net settings; the network also includes nearly 2,500 specialists and 45 hospitals. Dental and vision services, provided under subcontract by Safeguard Dental and VSP Health Plan, respectively, serve Healthy Kids enrollees on a capitated basis. The Healthy Kids network includes one important “carve out” arrangement with the California Children’s Services (CCS) program, the state’s Title V/Children with Special Health Care Needs program. Mimicking the arrangements used by both Medi-Cal and Healthy Families, Healthy Kids refers all enrollees who possess qualifying chronic conditions or disabilities to receive the specialty care related to their condition from the CCS network. A

similar arrangement was made with the County Department of Mental Health for serving children with serious emotional disturbances and other complex mental health needs.

Healthy Kids also emulates Healthy Families with regard to cost sharing policies, and uses a sliding scale premium structure whereby families with incomes below 133 percent of the federal poverty level (FPL) pay no premiums, families with incomes between 134 percent and 150 percent FPL pay \$4 per child per month (to a maximum of \$8 per family), and those with incomes between 150 and 300 percent FPL pay \$6 per child per month (to a maximum of \$12 per family). Unlike Healthy Families, Healthy Kids has a “premium assistance” component whereby any family that cannot afford to pay their premiums can have those premiums waived. All families, regardless of their level of income, are required to pay \$5 copayments when making an outpatient physician or clinic visit, an emergency room visit, or when obtaining a prescription drug. Copayments are due at the time services are delivered and providers are responsible for collecting them from families. A maximum out-of-pocket cost cap is set at \$250 per family per year.

B. Key Implementation Issues

During our interviews with key informants, we reviewed findings from the various components of the evaluation; namely the initial case study, focus groups, and household survey. We then asked informants for their opinions and interpretations of these findings. Highlights of these discussions are presented below.

Primary Care Selection. When applying for Healthy Kids, families are asked to select a primary care physician (PCP) for their children. This can occur when a parent is receiving application assistance from an outreach worker, or LA Care staff can assist parents with PCP

selection after an application is submitted. PCP selection is not formally a condition of completing the eligibility process, but outreach and LA Care staff work closely with parents until a choice of PCP is finalized. Importantly, however, no “auto assignment” default system is in place for families that do not choose a PCP (Hill, Courtot, and Wada 2005).

During our focus groups with parents of Healthy Kids enrollees, most reported that finding a PCP was easy and that they were comfortable with the information that LA Care provided to help with the selection process (typically a list of participating physicians). More than three-quarters of the parents we spoke with had selected a new PCP who was different from the provider they saw before their children were insured, and parents’ choices were usually influenced by providers’ proximity, spoken language, and perceived quality (Hill, et al. 2006).

Interestingly, one-half of parents participating in the first wave of our survey thought that their children’s doctors were chosen for them, by health plan or other assisting staff. Still, 90 percent of these parents said that they were satisfied with the provider that was chosen on their behalf (Howell et al. 2006). Since this is not the way the process is supposed to work, we asked key site visit informants why they thought parents might answer the survey question in this way. Some outreach workers speculated that parents, after receiving advice and guidance from staff that refer to a list of participating physicians, might walk away with the perception that doctors were “chosen for them.” Others speculated that application assistors employed by clinics might subtly steer parents to choose that clinic for their continuing care. Staff at one outreach agency confessed that they do occasionally choose providers on behalf of families, but only when parents can’t make up their minds. When this happens, however, they emphasize that parents are always free to change their child’s PCP if they are unsatisfied. Finally, LA Care officials noted that if an application is received without a selected PCP, and if health plan staff are unable to

contact parents after several attempts, they will assign a primary care provider so that processing is not held up (and coverage is not delayed). Thus it appears that some combination of parents' perceptions and actual enrollment practices explain why so many parents believe that their primary care provider is chosen for them.

Geographic Access. In response to another question on the survey, 70 percent of parents said that their PCP was conveniently located within 30 minutes of their home. However, about 22 percent lived 30 minutes to an hour from their PCP, and another 7 percent said they lived more than an hour away. We asked key informants about their impressions of this finding. In short, while most praised the scope of the network that was assembled for Healthy Kids and believed that access to primary care was particularly strong, they also acknowledged that geographic barriers to care are a chronic problem in a county as large as Los Angeles. In the remote Antelope Valley, for example, there simply are not enough providers practicing. In other, more densely populated areas, chronic traffic congestion and insufficient public transportation networks were cited as geographic barriers to care.

Long Waits for Appointments. Although parents were generally pleased with PCP availability and selection, participants in our focus groups often expressed frustration with long waits to obtain appointments with providers as well as long waits in clinic waiting rooms. Parents reported waiting weeks to months to obtain an appointment and stated that they would often wait "hours" (up to five or six) to be seen by a provider (Hill, et al. 2006). Similarly, according to the 2005 survey of Healthy Kids enrollees, among those reporting unmet need for preventive care, 18 percent cited not being able to schedule an appointment soon enough or not getting approval from the plan as reasons for their unmet need for primary care. The same survey

found that 75 percent of parents reported obtaining their care from a clinic setting, while 25 percent reported seeking care at a doctor's office (Howell et al. 2006).^{4,5}

For this case study report, we met with providers from a variety of settings including hospital-based outpatient clinic providers, safety net/community clinic providers, and private practitioners. We asked providers and staff about their impressions of the focus group and survey findings related to waiting times. Although some providers thought that long waits are common and to be expected in safety net clinics, others offered insight into the factors contributing to the problem as well as successful efforts to reduce wait times.

Factors contributing to long wait times in the provider's office can be grouped into three broad categories:

1. Systems issues, including burdensome paperwork, lack of a medical home/continuity with providers for families, and general "chaos in the system;"
2. Individual clinic capacity (skills and staffing) to run clinic systems efficiently and treat a high volume of patients; and
3. Issues relating to treating a high-risk patient population with complex social factors that impact health (poverty, lack of adequate housing, violence exposure, lack of education/health literacy).

Burdensome paperwork is evident from a healthcare provider's front desk to the back office. For example, the front desk must obtain information from patients, verify insurance status, or complete enrollment in the CHDP Gateway. The back office must obtain authorization and follow up on billing.

⁴ Receipt of primary care at a "doctor's office" is most likely a private provider's office, while receiving care at a "clinic" could refer to a safety net provider or general care clinic.

⁵ According to one of this evaluation's process monitoring reports, approximately 30 percent of children in the Healthy Kids program receive their primary care in a safety-net setting, while fewer than 10 percent of families in Healthy Families or Medi-Cal have a PCP in a safety net setting (Wada et al. 2007). (A safety net provider is defined as one with at least 15 percent of his annual patient workload composed of Medi-Cal patients for each of the preceding two years; thus these are typically Federally Qualified Health Center (FQHC) and other community clinic providers.) It is not clear why there is such a discrepancy between the administrative and survey data on this point.

In addition, many families may not be adequately linked to a medical home and may not have adequate continuity with a primary care provider. Thus, providers may not have access to a complete medical record at the time of the visit. The Healthy Kids survey demonstrated that among those with a usual source of care, two-thirds of parents reported that their child had a personal doctor or nurse who knew their child and was familiar with the child's history (Howell et al. 2006). Thus, those without a usual source of care (9 percent) and approximately 1/3 of those with a usual source do not report continuity with their provider. In contrast, among SCHIP enrollees nationally (who likely have higher socio-economic status), approximately 75 percent report having a personal doctor or nurse who knew their child and was familiar with the child's history (Wooldridge et al. 2005). For families with poor continuity of care, each visit may then become a new-patient visit, typically requiring extra time to obtain and clarify patient histories, establish rapport, and create a treatment plan that is appropriate for the child and his family.

Some key informants reported that the volume of demand for their services overwhelmed their clinics. Others acknowledged that their clinic's systems are outdated or unable to handle a high volume of patients in general. On the other hand, one clinic underwent a clinicwide re-organization process that resulted in dramatic improvements, cutting wait times from two to four hours to less than 45 minutes.

Finally, many key informants commented on the challenges of treating a high-risk patient population with complex psychosocial needs. Families may face poverty, domestic violence, mental illness, lack of education, lack of access to affordable housing and other factors that likely affect their overall health. Providers acknowledged that high quality primary care should address these issues, but also indicated that traditional medical clinic systems often do not have the resources, systems, or experience to "look beyond the sore throat." Some providers have

hired social work staff to assist in addressing the psychosocial needs of the families they treat. Others suggested that the safety net is more accustomed to addressing these issues and therefore may have a greater capacity to address these social determinants of health. The emphasis that the Healthy Kids program places on the safety net may direct families to providers that are better equipped to address complex psychosocial needs. However, in taking the time to address families' needs, these same clinics may sacrifice efficiency, resulting in comprehensive—but not timely—care.

Dental Care. During the evaluation's first site visit in 2004, no service utilization data were yet available for analysis. However, key informants interviewed at the time, including those from LA Care, had the general impression that use rates among children enrolled in the new program were low. The main exception to this observation was for dental care. Administrators from Safeguard described utilization rates that were higher than average among new entrants to Healthy Kids, and on par with children in Healthy Families. This suggested that Healthy Kids enrollees had pent-up demand and high need for dental services (Hill, Courtot, and Wada 2005). Parents participating in our first round of focus groups reinforced these impressions; the majority reported seeking dental care, and most were satisfied with the care their children received (Hill, et al. 2006). A small number of parents, more often those with children with special health care needs, reported difficulties finding a dentist to serve their children, as well as long waits for appointments.

Yet our household survey found that only two-thirds of children ages 0-5 had a usual source of dental care, and more than half of those without a usual source said that they needed more information and education about the availability of dental services (Howell et al. 2006). Furthermore, slightly more than 20 percent of children ages 2 to 5 needed dental care and either

did not receive it or delayed care, a higher rate of unmet need than for any of the medical services studied. Access barriers for these families included lack of information about where to go for care, transportation problems, inability to schedule a timely appointment, or missed appointments. In addition, it is generally true that many dentists do not treat very young children (parents of whom were the target of this survey).

During our second case study site visit to Los Angeles, we learned a great deal more about how dental coverage works under Healthy Kids. We queried outreach workers, child advocates, pediatricians, general dentists, dental specialists, and dental plan administrators about the dental program and its operations, and were able to clarify some of the seemingly discrepant information previously gathered, as described below.

From both dentists and dental plan administrators, we learned that southern California is quite unique, both in the state and nationally, in that it possesses a very large supply of *general* dentists (some even termed this an oversupply).⁶ Informants identified a number of factors as contributing to this situation, including favorable geography and climate, a large number of dental schools producing large numbers of new dentists, a long history of managed dental care in the region, a very large population offering the potential for good business, and relatively lenient licensure rules (that allow, for example, foreign medical graduates to obtain their licenses to practice by simply living in the state for two years and passing the State Board examination).⁷

This large supply of dentists permitted Safeguard to grow its network to over 2,300 general dentists, up from 1,500 in 2003, for Healthy Kids. Plan administrators indicated that the Healthy

⁶ In 2004 California was among the states with the highest dentist to population ratio - 74.36 dentists per 100,000 population versus the U.S. average of 59.4 dentists per 100,000 population. Notably, the state experienced a 20.9 % increase in the number of dentists per 100,000 population between 1991 and 2004 (New York Center for Health Workforce Studies 2006)."

Kids network is nearly identical to that for the Healthy Families program, and that there is a near 70 percent overlap with Safeguard’s commercial networks. This large supply also permits the plan to exert considerable leverage over its dentists. For example, the plan does not allow dentists to “cherry pick” among the products the plan offers; in many cases, if a dentist wants to sign up for a commercial product, he or she must also agree to see patients enrolled in government programs. Furthermore, the plan is able to pay Healthy Kids-participating dentists rates that it admits amount to only 5 to 10 percent of Usual and Customary Rates (UCR). Specifically, general dentists receive \$5.00 per child per month, plus supplemental payments (of varying amounts) for each encounter, and for crowns, sealants, pulpotomies, prophylaxis, fluoride, etc.⁸ Yet, according to both providers and plan administrators, dentists are willing to work within these constraints because they need the business (or, as one provider put it, “we need to fill chairs”).

The circumstance for pediatric dental specialists⁹ is distinctly different. As is the case across the rest of California (and the nation), there is a serious undersupply of pediatric specialty dentists. Safeguard’s network includes roughly 300 of the 500 specialists in the County. With these providers, Safeguard has little leverage and, according to the specialists we interviewed, the plan must negotiate arrangements with each and every specialist in order to persuade them to participate. Typically, therefore, specialists receive fee-for-service payments for all procedures at levels that are comparable to commercial fee schedules.

⁷ Additionally, if dentists practice a certain number of years in another state, they are not even required to pass the State Boards upon moving to California.

⁸ Thus, for example, a Healthy Kids dentist may receive \$15 for a routine preventive exam (\$5 monthly fee plus \$10 encounter fee), whereas the same visit would pay the dentist approximately \$200 under typical commercial coverage.

⁹ “Pediatric Dentists” (or pedodontists) are considered specialists by virtue of their specialization serving young children. General dentists, in contrast, are trained to serve children ages five and up.

Children gaining access to these dental providers—both general and specialty—has not gone entirely smoothly during the early years of Healthy Kids. Outreach workers from several CBOs told us that their clients occasionally spoke of having to wait long periods of time for appointments with dentists—sometimes two to three months—especially for specialists. These workers also told us that some clients had not received their dental cards in a timely manner, and that they were not signed up with the primary dentist that they chose during the application process. In fact, we learned from Safeguard officials that the primary dentist selection process has not worked as planned; at the time of our visit, LA Care and Safeguard had not worked out a means for transferring, electronically, the information on clients’ selection of primary dentists. Thus, Safeguard was auto-assigning children to dentists using an algorithm that took into account the child’s location (zip code), distance from the provider, primary language, and that also rotated assignment among area dentists so that no single dentists received a disproportionate share of Healthy Kids enrollees. This auto-assignment helps to explain why some parents may have been confused about the status of their child’s dental coverage, and where they were to go to receive dental care. Safeguard officials admitted that many parents likely chose a dentist during the application process, only to find out at a later time that their child was assigned to a different dentist. But they also noted that they had not received many complaints about this, and emphasized to parents that Safeguard staff are available to help families if they wish to switch primary dentists. By the end of 2006, health and dental plan officials were close to working out a solution so that parents’ primary dentist selection information would be systematically passed on to Safeguard.

In further discussions with Safeguard about the dental plan enrollment process, officials described how each new enrollee receives a “welcome packet” from the plan that describes the

benefit package, procedures for obtaining care, and patients' rights and responsibilities. Unlike LA Care, though, Safeguard does not place "welcome calls" to new enrollees. Thus, it is left up to parents to read and digest the large amount of information in the packets and call Safeguard if they have any questions. All materials are printed in Spanish, so that helps reduce the potential for confusion. But Safeguard officials suggested that welcome calls might be a good way of easing parents into coverage and answering any questions about their child's dental provider and coverage. (However, they also believed that their per capita payment from LA Care—amounting to \$11.00 per child—would not cover the costs of welcome calls.)

Still, rates of utilization for dental services (about 40 percent) were described as comparable between Healthy Kids and other government programs. This utilization is between five and 10 percent higher than utilization among commercially insured children.

One final challenge surrounding dental coverage involves cost sharing. According to Healthy Kids rules, parents are not subject to copayments for the vast majority of dental services; \$5.00 copays are only required when a child needs a crown or root canal. Yet several of the dentists we spoke with described how they commonly charge and collect \$5.00 for every Healthy Kids encounter. Worse, advocates and outreach workers indicated that some clients were being charged much higher amounts—sometimes as high as \$100 for resin composite fillings.¹⁰ Dentists admitted that keeping track of the various public programs covering dental care for children, and their rules regarding copayments, was very confusing. (For example, the California Kids program imposes \$20 copayments for all visits.) The improper charging of copayments, while erroneous, may have been due more to confusion than malfeasance.

¹⁰ This issue is explored in greater depth in the evaluation's second round of focus group report, which is forthcoming.

Overall, most key informants agreed that the dental coverage being offered by Healthy Kids was strong and well-used. Specialists were very pleased with how the program treated them, while general dentists were less so. But both groups acknowledged the great need for dental care among the target population and accepted the terms of their participation. Plan administrators from both LA Care and Safeguard also acknowledged that the various implementation challenges they had encountered (identified above) needed to be resolved. There was particular agreement that outreach and information about dental coverage needed to be bolstered so that more children would gain access to this critical benefit.

Developmental Services. This evaluation's first case study report highlighted initial concern among key informants regarding the adequacy of behavioral and developmental systems of care within the Healthy Kids network and the lack of "an explicitly defined developmental screening benefit" (Hill, Courtot, and Wada 2005). Because of First 5 LA's interest in developmental services, the household survey explored parents' experiences with these under Healthy Kids. Specifically, parents were asked a series of questions about whether they had concerns about their child's learning, development, or behavior; whether their provider asked if they had any such concerns; and whether their provider gave them specific information to address their concerns.¹¹ The survey found that 55 percent of parents had at least one concern regarding their child's development (most commonly related to the child's emotions, behaviors, and communication) but that only 28 percent of health care providers had asked about their concerns within the past 6 months. Furthermore, only 25 percent of parents reported receiving specific information addressing those concerns. These rates of developmental screening are lower than national reports for all children—41 percent of parents were asked about their concerns

according to the National Survey of Children’s Health in 2003—but similar to rates reported for low-income, Latino families nationally—29 percent (Howell et al. 2006).

Overall, approximately 60 percent of parents of Healthy Kids enrollees recall having a developmental assessment performed for their child, a rate higher than the national average; the National Survey of Early Childhood Health in 2000 found that, among parents of children ages 19 to 35 months, only 52 percent recalled a developmental assessment within the past 12 months. This evaluation’s first case study report suggested that this higher rate of developmental screening might be related to the fact that a large proportion of enrollees receive primary care in the safety-net setting. Our household survey bolstered this supposition—we found that a higher percentage of parents of children who usually use safety-net clinics reported that their child had a developmental assessment (67 percent), compared to other parents (47 percent) (Howell et al. 2006).

Developmental screening and surveillance practices reported by providers during our second site visit also reflected national trends. According to the 2002 American Academy of Pediatrics survey of fellows (pediatricians), 70 percent of practitioners report always identifying developmental problems through “clinical assessment” while 50 percent report always or sometimes conducting formal developmental screening using published screening tools (American Academy of Pediatrics, 2003). Similarly, some key informants practicing in safety-net clinics reported using standardized developmental screening tools, while others practice a less formal “clinical assessment.” Although “clinical assessment” to detect developmental delay is most commonly practiced, use of standardized developmental screening tests is reported to be

¹¹ These questions were adapted from the Promoting Healthy Development Survey (PHDS) developed by the national Child and Adolescent Health Measurement Initiative (Bethell et al. 2001), and the Parents Evaluation of Developmental Status (PEDS) developmental screening tool (Glascoe 2006).

a more effective means of early identification of developmental problems.¹² Key informants acknowledged such deficits in routine screening for developmental delays, and applauded the efforts of programs such as the Early Developmental Screening and Intervention Initiative (EDSI), a First 5 LA-funded clinic-based quality improvement initiative to improve developmental screening practices among primary care providers.

Healthy Kids' providers often said that they refer children with developmental delays or who are at-risk for developmental delays to schools and "the regional center" for further assessment and treatment. (Regional centers are private, nonprofit corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities.) Some clinics were linked to teaching institutions that provide developmental screening by a pediatric developmental specialist-led team. Key informants did not specify whether this service was covered by Healthy Kids or simply provided as a service of the teaching institution.

Specialty Care Physician Shortages. Early evaluation findings suggested that access to sub-specialists for publicly-insured children was generally poor in Los Angeles County, and in our first case study report key informants warned of potentially poor access to sub-specialty care for Healthy Kids members. The evaluation's first survey report found that 6 percent of parents reported an unmet need for specialist care and another 5 percent reported delayed access to sub-specialty care (Howell et al. 2006). Among children with health problems, 10 percent did not get needed specialist care and 11 percent delayed such care. The survey also found low utilization of specialty care relative to national estimates for SCHIP enrollees, with 11 percent of families

¹² An American Academy of Pediatrics policy statement recommends the use of standardized developmental screening tests to assess development at the 9, 18, and 30 month well-child visits (American Academy of Pediatrics 2006).

reporting any specialist visit, compared to 17 percent for SCHIP enrollees (Wooldridge et al. 2005). The combination of high rates of unmet need and low utilization suggests barriers to sub-specialty care among Healthy Kids enrollees.

Key informants during our second site visit confirmed and expanded upon these findings, universally expressing frustration with access to subspecialty care under all public programs, including Healthy Kids. In general, we learned that while obtaining authorization to see a pediatric sub-specialist is not difficult, scheduling a timely appointment with the sub-specialist is. One pediatrician noted, “Everything is covered, it is just not available.” Providers mentioned 6 to 7 month waiting periods to see a pediatric pulmonologist or neurologist, limited access to less acute services through otolaryngologists, and virtually no access to orthopedic surgeons. Children with orthopedic problems are routinely sent to the Orthopaedic Hospital, near downtown Los Angeles, for their care. Providers relied on colleagues and the emergency room to obtain urgent access to sub-specialty care. For example, a primary care provider needing urgent assessment from a sub-specialist might call his or her training institution and ask a sub-specialist colleague to “work the patient in” to their sub-specialty clinic. In some cases, a family might need to go to an Emergency room to access needed care. Even once in the emergency room, access to pediatric sub-specialists may be limited and may require transfer to a tertiary care center. Some providers worried that children with a need for sub-specialty care were “falling through the cracks” and were not obtaining critical specialty services.

On the other hand, children with CCS-eligible conditions were reported to have better access to this type of care. Often this subset of children with special health care needs is seen in tertiary settings where sub-specialists on staff routinely provide services to CCS enrollees. Similarly, optometry services were reported as accessible and well utilized.

Mental Health Referrals. Key informants also noted that families faced particular difficulties obtaining mental health services for their children. Some reported difficulty with obtaining authorization for mental health services; another simply stated, “I don’t know where to send (patients in need of mental health services).” Emergency room and inpatient mental health services were reported as “difficult to impossible” to obtain. Other key informants explained that situational therapy (or treatment for “non-serious emotional disturbances”) is difficult to access.

As with developmental and subspecialty care, providers used a variety of resources to obtain mental health services for families. For example, they mentioned sending families in need of mental health services to county facilities, schools, and community-based organizations. Some clinics have chosen to hire their own mental health providers. As with sub-specialty care, key informants highlighted the fact that poor access to mental health services is not unique to the Healthy Kids population, but reflects systemic barriers, some particular to low-income families. In response to these shortages, LA Care officials reported that they were, at the time of our visit, developing a new subcontract with Pacific Care Behavioral Health, a network that would expand Healthy Kids’ capacity from 60 to roughly 2,000 providers.

Copayments and Premiums. During our first round of site visits in 2004, key informants generally did not report that the Healthy Kids program’s monthly premiums created a barrier to enrollment for families. Outreach staff noted that the program’s premiums are lower than those required for Healthy Families, and policymakers commented that the vast majority of families with enrolled children earned incomes below 133 percent of poverty, and thus were premium exempt. There was somewhat more concern surrounding copayments, however, as advocates (in particular) worried that even \$5 fees for doctor visits and prescription drugs might discourage service use. Informants expressed particular concern on behalf of children with special health

care needs (CSHCN), whose higher levels of need and service use would lead to more frequent need to make copayments (Hill, Courtot, and Wada 2005).

This evaluation's first round of focus groups, however, dispelled most concerns surrounding cost sharing. Very few parents participating in the groups reported paying premiums at all, and those that did universally said they were affordable. The vast majority of parents also said that copayments were "cheap" and that overall out-of-pocket costs were "much lower" under Healthy Kids than they had been when children were uninsured. However, consistent with the concerns expressed by advocates during our site visit, the majority of parents of CSHCN *did* say that copayments were sometimes a burden, and that they struggled to afford these fees due to the high volume of services and prescriptions needed by their children (Hill et al. 2006).

In our survey, most parents (68 percent) reported that meeting their child's health care needs created little or no financial difficulty for them. This is a positive finding overall, but it also indicates that as many as one-third of parents perceive that obtaining care for their children did cause some financial burden, perhaps due to lost wages when parents take their children to the doctor, multiple copayments for children with high rates of service use, or general anxiety among parents about the potential costs should their child become very ill (Howell et al. 2006). Indeed, many participants in our focus groups expressed confusion over what benefits were covered by Healthy Kids, and some expressed the sentiment that the program was almost "too good to be true," and thus worried that they might one day receive a bill for all the care their children were receiving (Hill et al. 2006).

During our second site visit, key informants reinforced many of the lessons regarding cost sharing that had already been learned under prior components of the evaluation. Outreach workers reported that parents almost never express negative opinions of cost sharing; in fact,

some parents even offer to pay premiums so that their citizen children can enroll in Healthy Families after they are told these children are eligible for Medi-Cal (where no premiums are charged). Copayments are viewed as very affordable by parents, and the fact that they make these payments only as they use services reportedly makes intuitive sense to parents. Child advocates echoed that copayments did not seem to present a barrier to the families they worked with, but speculated that that might be due to public clinics waiving copayments for their clients. However, interviews with clinic providers and administrators contradicted this; informants said that clinics routinely collect copayments from patients at check-in and that most parents of Healthy Kids enrollees were “happy to pay” and “happy to have coverage.” These individuals added that the \$5.00 Healthy Kids copay is the lowest amount charged under any of the programs they participate in, and noted that even uninsured patients are asked to pay a \$20.00 fee on the sliding scale used by FQHCs. As mentioned in the Dental Care section of this report, one alarming finding from community-based outreach workers was that parents often said that they were charged copayments for dental care visits, even though dental visits under Healthy Kids are *not* subject to copayments. Worse, these parents said that dental providers often demanded payments well above the \$5.00 amount charged for other types of visits under the program.

IV. Financing and Sustainability

A. Background

The Los Angeles Healthy Kids program was launched in the spring of 2003, supported by a \$100 million commitment from First 5 LA to extend coverage to children from birth through age five, living in families with incomes under 300 percent of poverty, who were ineligible for coverage under Medi-Cal and Healthy Families. Over the next twelve months, aggressive fundraising by the Children’s Health Initiative of Greater Los Angeles (CHI) garnered an additional \$88 million, which was sufficient to expand the program to children ages 6 through 18 in these families.¹³ As has been discussed in earlier sections of this report, this financing permitted the program to experience a very successful second year, during which enrollment of older children exploded, spurring much more rapid enrollment of younger children along the way. By the summer of 2005, nearly 45,000 children were enrolled into coverage under Healthy Kids. It was at this point that sustainability challenges beset the program.

B. Key Implementation Issues

The very success that Healthy Kids achieved with enrollment meant the program was using its fiscal resources faster than anticipated and began experiencing shortfalls. Section II of this report detailed the enrollment “hold” that was imposed beginning June 2005, the waiting list of eligible 6-to-18 year olds that was maintained for ten months, and how the program faced the ongoing threat of closure (for older children), even as fundraising efforts by the CHI continued. On several occasions, new monies were committed by The California Endowment, LA Care, the Blue Shield of California Foundation, and other returning donors. But these funds were sufficient

¹³ Major funders include L.A. Care, The California Endowment, Blue Shield of California Foundation, Queenscare Foundation, California Community Foundation, Weingart Foundation, California Healthcare Foundation, Ralph M. Parsons Foundation, W.M. Keck Foundation, Unihealth Foundation, Kaiser Permanente Health Plan, and Northrop Grumman Corporation.

only to allow continued coverage for existing enrollees, rather than for reopening the program to new enrollees.

Over time, various actions have been taken to address the financing challenges faced by Healthy Kids. Some have been of a stop-gap nature, while others are legislative and executive branch proposals to solve the sustainability problems once and for all. These efforts are described below.

Ongoing fundraising by the CHI. The CHI Coalition of Greater Los Angeles has continued its fundraising efforts at various strategic points and, at the time of this writing, had sufficient funds to provide coverage for all existing enrollees in Healthy Kids through April 2008. Further, in July 2007, the Coalition announced that it had secured sufficient funds to enroll all remaining children from the waiting list. Children ages 0-5 continue to be enrolled in Healthy Kids, since there are sufficient First5 funds for premium subsidies.¹⁴

Premium reductions. Section III of this report described how key informants had the impression, early on in Healthy Kids implementation, that children were using services at what seemed to be relatively low rates (Hill, Courtot, and Wada, 2005). As administrators gained more experience with the program, it became apparent that this was due, at least in part, to the fact that enrollees often possessed coverage under *both* Healthy Kids and Emergency Medi-Cal (discussed in Section II). This evaluation confirmed this dual coverage phenomenon and also revealed that many parents of Healthy Kids enrollees were under the impression that they were supposed to use their Emergency Medi-Cal card when obtaining hospital and/or emergency services for their children, and use their Healthy Kids card for doctor visits (Hill, et al. 2006; Sommers et al. 2007). What's more, it also became clearer that potentially large numbers of new

¹⁴ First 5 LA's funding commitment for children ages 0-5 were due to "sunset" in June 2008. However, in November 2008, the First 5 LA Commission voted to extend available remaining funds for an additional year.

enrollees' first preventive care visits were being rendered through, and financed by, the CHDP "Gateway" rather than Healthy Kids. Since large proportions of children are enrolled into the program by application assistors housed in clinical settings, these same outreach workers likely also sign up their clients into the "Gateway" so that short-term Medi-Cal coverage can cover the cost of their visit. Thus, considering both of these circumstances, utilization rates (as assessed with LA Care data) appear to be artificially low since some portion of the preventive and acute care being consumed by Healthy Kids enrollees is being paid for through other programs (Sommers et al. 2007).

A key side effect of this phenomenon was that LA Care was, essentially being "overpaid" by First 5 LA and the CHI for children enrolled in the program. In other words, the per capita monthly premiums that had been negotiated between LA Care and the funders were based on estimates of the full actuarial equivalent of the program's comprehensive benefit package. But since a portion of some enrollees' care (and associated costs) were being picked up elsewhere, LA Care was being paid premiums that overstated the actual costs they were incurring.

To their credit, and as a not-for-profit entity, LA Care fully acknowledged this situation as it emerged and, on two occasions, the health plan renegotiated its rates with First 5 LA and the CHI. The initial monthly premium of \$86 per child was reduced in 2004 to \$82 per child per month. Then, in 2006, the premium was reduced to \$74 to reflect the lower cost of covering Healthy Kids enrollees. Since 2007, payments have been based on actual costs.

These premium reductions represent an important, if temporary, step for dealing with funding shortfalls. In essence, they allowed LA Care to "stretch" its premium dollars and extend coverage to children for longer periods.

Pursuit of Emergency Medi-Cal Funding. During 2006 and 2007, members of the Policy Change Workgroup of the CHI Coalition worked hard to reach an agreement with state officials to coordinate funds between Emergency Medi-Cal and Healthy Kids, as a means of addressing the inefficiency that results when children are dually covered under both Healthy Kids and Emergency Medi-Cal. The CHI's proposal included developing a joint Healthy Kids/Emergency Medi-Cal application that, if approved, would allow families to choose between full-scope Healthy Kids coverage in combination with restricted-scope Medi-Cal, or stand-alone restricted-scope Medi-Cal coverage that would pay for emergencies and pregnancies. For families that chose to enroll in full scope Healthy Kids in combination with Emergency Medi-Cal, the CHI would be paid an actuarial amount reflecting the value of restricted scope Medi-Cal and then would take responsibility for all coverage. (For families that choose restricted scope Medi-Cal, Healthy Kids would offer no coverage.) Families choosing Healthy Kids would receive one card covering both Emergency Medi-Cal and Healthy Kids, and systems would be enhanced to allow recognition of enrollment and a computer match between L.A. Care and DPSS would be instituted to assure that there is no double-billing. In October 2007, however, negotiations between the CHI and state officials were terminated. State officials cited the obstacles thrown up by the federal Centers for Medicare and Medicaid Services as barriers to continued discussions.

Legislative proposals. Policymakers in the County have known since the founding of Healthy Kids in 2003 that philanthropic donations would never provide a permanent funding base for the program. Thus members of the CHI have continuously advocated for a long-term sustainable solution that would provide health insurance for all California's children. For example, in 2005, the CHI supported AB 772 (Chan), which passed both the State Senate and Assembly and would have provided health insurance to all children living in families earning

less than 300 percent of poverty, regardless of citizenship status. It was vetoed by Governor Schwarzenegger, who defended his action with a statement that there were no funds available for the health insurance expansion.

Later that year, children’s advocates joined forces with a number of health groups to draft Proposition 86, which called for a \$2.60 per pack increase in the state’s tobacco tax to fund a variety of health initiatives, including health insurance for all California’s children. The campaign against the measure was well-financed by tobacco companies and others, however, and the ballot initiative failed by a narrow margin in November 2006. (The failure of Proposition 86 is discussed in more detail in Vignette #4).

Vignette #4: Lessons from the Proposition 86 Defeat

Key informants interviewed for this study provided insight into the reasons why Proposition 86 was defeated at the ballot box. They suggested that, since children’s health advocates were only one of several organizations supporting the proposition (including the American Cancer Society, the American Hospital Association, the American Lung Association, and the California Hospital Association), it was difficult to project a clear message about the Proposition’s relationship to children’s coverage. Furthermore, it was unclear whether a campaign message about providing health insurance for low-income children, some of whom are undocumented, would create opposition to, rather than support for, Proposition 86. Thus the strongest pro-Proposition 86 message was selected by proponents: anti-tobacco. Post-election polls revealed that, indeed, many voters did not even realize that the bill would have provided health insurance coverage for children. Although voters were clearly anti-tobacco, the tobacco industry spent \$70 million on “Vote No on Proposition 86” advertisements, claiming that less than 10 percent of the tobacco tax revenue would go to promote tobacco control, cessation, and disease research, and suggesting that there would be no accountability for the tax’s revenues. Editorials in a number of the state’s newspapers opposed the ballot measure, claiming it was a “money-grab” by the hospital associations. In the end, Proposition 86 proponents were outspent by a factor of 3 to 1 by tobacco companies and the measure failed by a 52 to 48 percent margin (Tobacco Related Disease Research Program 2007).

Children’s advocates were not daunted, however. In January 2007, the state legislature introduced separate, identical bills—AB 1 (Laird and Dymally) and SB 32 (Steinberg)—

designed to “provide access to affordable, comprehensive health insurance to all of California’s children” (The 100% Campaign 2007). These bills would cover children in families earning up to 300 percent of poverty, and provide funds for transitioning children currently covered through county-level CHIs to a newly-created statewide program. At the time of this writing, both bills were still pending and debates over them were taking a secondary level of prominence in the context of the Governor’s larger universal health care reform proposal (discussed below).

Governor’s health care reform proposal. In January 2007, Governor Schwarzenegger also released his sweeping health care reform proposal, which called for health care coverage for all Californians (regardless of immigration status), highlighted the need for health promotion, and proposed strategies to contain health care costs. Under the plan, health insurance would have been obtained through employers, publicly-financed health insurance plans, or the individual market. The plan included requirements: for all employers to either provide health insurance to their employees or pay an “in lieu” fee; for all individuals to obtain at least a basic health insurance plan (an individual mandate); and for insurers to guarantee issue to all applicants with limits on what they could charge for coverage. The Governor proposed to finance his plan through the individual and employer mandates, hospital and provider fees, and expansions of existing public programs (Medi-Cal and Healthy Families) up to 300 percent of the FPL for children and 250 percent of the FPL for adults.

As proposed, the Governor’s plan would have funded the Healthy Kids population beginning in 2010, but made no provision for interim or “bridge” funding. Children’s advocates and CHIs applauded the plan’s intent to cover all children under 300 percent of the FPL and encouraged comprehensive medical coverage for all children regardless of immigration status, inclusion of affordable options for families of children with incomes above 300 percent of the FPL,

continuation of simplified enrollment, retention and eligibility procedures, and continued coverage for children currently enrolled in Healthy Kids.

In the fall of 2007, a special session was called by the Governor to continue debates on health care reform. By December, a compromise was reached between the Governor and Speaker Fabian Nunez (D-Los Angeles) that resulted in the Assembly's passage of ABX11. Co-sponsored by Speaker Nunez and Senate President Pro Tempore Don Perata (D-Oakland), ABX11 proposed requiring nearly all Californians to have insurance starting in 2010, providing subsidies and tax credits for those who would have trouble paying their share of premiums. The bill's financing would be secured through a ballot initiative, and funding would have been provided for all CHIs across the state. But the bill faced resistance in the Senate almost immediately, with concerns centering on the estimated \$14.9 billion price tag (coming at a time when California was facing a \$14.5 billion budget deficit) and the bill's "individual mandate," which some Senators feared placed too much burden and risk on low-income persons who might not be able to afford premiums. When the state's Legislative Analysts Office released a report finding that the bill's annual costs might exceed revenues by \$300 million by the program's fifth year, support was further diminished. On January 28, 2008, the Senate Health Committee voted 7 to 1 against the measure, effectively defeating California's ambitious health care reform initiative for the time being.

At the time of this writing, CHI officials and child advocates were reassessing their strategies and considering the possibility of reintroducing a ballot initiative that would provide universal children's coverage, as an incremental step toward the goal of broader universal coverage.

V. Options for Policy and Program Change

Based on the findings from this second evaluation case study and an assessment of Healthy Kids' four years of implementation experience, we offer for consideration the following set of options for policy and program change. Some represent small, but potentially significant adjustments to the policies that govern program operations and could be enacted whether the program is expanded statewide or not. Others offer larger, more fundamental changes to program design and financing that may have to be considered if current financing problems are not resolved.

- ***Option #1: Integrate the Application Forms for Medi-Cal, Healthy Families, and Healthy Kids.*** The designers of Healthy Kids chose to model the program closely after Healthy Families, California's SCHIP program (Hill, Courtot, and Wada 2005). In the areas of benefits, service delivery, cost sharing, crowd out prevention, eligibility, and outreach, Healthy Kids adopted policies that are distinctly similar to those of both Healthy Families and Medi-Cal for children. However, when it came to the program's application form, designers concluded that it would be quicker and easier to create a separate application for Healthy Kids than to attempt to integrate the county program's form with the "joint" application used by the two larger state programs.

There have been significant negative ramifications of this decision. Outreach workers commonly spend time filling out multiple applications for each child they serve in an attempt to establish eligibility for as many programs as possible. And, fortunately or unfortunately, dual coverage is in fact established for many children, leading to confusion and financing inefficiencies that result when a child has coverage under CHDP Gateway, Emergency Medi-Cal, and Healthy Kids.

If state policymakers succeed in establishing a statewide funding mechanism for the currently county-funded Healthy Kids programs, then eligibility rules and application forms will, no doubt, be integrated. However, if such an outcome is not achieved, then Los Angeles health leaders should strongly consider developing an integrated Medi-Cal/Healthy Families/Healthy Kids application. Such exercises are always complex and often require the programs to alter some of their individual rules to bring them into alignment with one another. When alignment is not possible (or resisted by program administrators), the development of joint applications can result in longer, more complex forms (as was the case in 1997 when California developed its first joint Medi-Cal/Healthy Families for Children form). But with concerted effort and flexible negotiation, and given the already very similar policies governing the programs, it seems quite feasible that a three-way application for the programs could be designed and implemented. And if the programs succeeded in doing so, much of the current complexity that surrounds the County's current "layer cake" of coverage programs could be eliminated.

- **Option #2: Offer “Copayment Assistance” to Families with Limited Means.** In designing Healthy Kids to mirror Healthy Families, policymakers built cost sharing into the program. Given the low socio-economic status of the target population, sliding scale monthly premium levels were set lower than those of Healthy Families and, as an added safeguard against creating a potential barrier to enrollment, a “premium assistance” component was adopted (Hill, Courtot, and Wada 2005). Under current rules, any family that can’t afford to make the monthly premium payment may request such assistance and have their premium waived. As it turns out, this benefit has rarely been used in the history of the program. In fact, the vast majority of enrollees are in families that earn less than 133 percent of poverty and are thus exempt from any premium payments (Farias, Inkelas, and Courtot 2007).

In contrast to the sliding scale structure for premiums, *all* Healthy Kids enrollees are subject to copayments, typically \$5.00, when obtaining health services. Focus group and survey results from this evaluation have found that these payments are affordable for the vast majority of families (Hill et al. 2006). However, these same studies revealed that copayments can create hardships for certain families, especially those with children with special health care needs who are more likely to use a large number of services and/or need large numbers of prescription drugs.

To ensure that no policies adopted by Healthy Kids create a potential barrier to the receipt of services, it seems reasonable that Healthy Kids leadership consider the creation of a “Copayment Assistance” benefit for enrollees that could mirror “premium assistance” and be available to any family that requested it. To keep administrative and paperwork burdens to a minimum, self-attestation of hardship should be allowed (as it is for premium assistance), and an exemption from copayments could be granted for a set period of time (for example, one year). To make the point-of-service interaction between parents and providers as easy as possible, a sticker could be affixed to the card of a child that has been granted “copay assistance” that would let the provider know that no copayment should be collected on behalf of the child. And since the lack of copayment would represent a real decrease in the fee that a provider would receive for that visit, providers should be allowed to bill LA Care for a supplemental payment covering that loss. This would require the health plan to develop a new system for requesting such payments but to minimize administrative burdens, providers could be asked to submit a single consolidated bill once a month for the children they served who were receiving copay assistance. Alternative approaches that might offer simpler, more automatic relief might include making children in families with incomes below 133 percent of poverty “copay exempt,” just as they are currently premium exempt, or designating particular populations of children—such as those with chronic illnesses or disabilities—as exempt from copayments. Once again, a system for providers to recoup missed copayments from LA Care would need to be developed.

- **Option #3: Eliminate Copayments for Dental Services.** This case study revealed alarming and widespread misunderstanding of copayment rules as they apply to dental care. As discussed in Section III, \$5.00 copayments are only supposed to be charged on a

limited set of services (crowns and root canals). Yet the dentists we spoke with commonly described how they charge and collect \$5.00 for *every* Healthy Kids encounter (including preventive check-ups), and advocates and outreach workers indicated that many families have been charged much higher amounts (e.g., \$100) for procedures like resin composite fillings. Whether these charges accidental or intentional is less important than the fact that they are likely creating barriers to children's receipt of needed dental care. Therefore, because copayments were only intended to be imposed on less frequent, high-cost procedures, it is suggested that all copayments be eliminated for dental services so that vulnerable children can receive this critically needed care.

- ***Option #4: Eliminate the Three-Month Waiting Period for Children with Other Health Insurance.*** Another way that Healthy Kids was designed to mirror Health Families was in the creation of a “waiting period” for children who already possessed insurance at the time they applied for Healthy Kids. (Waiting periods are a fairly common feature of SCHIP programs, nationally.) The rationale for imposing a waiting period is to discourage families with existing coverage from dropping that coverage to sign up for the new program. In the case of SCHIP, which explicitly targeted working poor families, policymakers wanted to avoid the “crowding out” (or substitution) of private employer-sponsored coverage with typically less expensive public coverage.

While concerns about so-called “crowd out” are not baseless, many states have reduced or eliminated waiting periods under SCHIP because policymakers believe the potential for substitution is relatively small among low-wage workers and/or because they recognize that the shrinking base of employer-sponsored health insurance (ESI) de-facto reduces the likelihood of crowd out (Westpfahl Lutzky and Hill 2001).

In the case of Healthy Kids, there is significant evidence that the risk of crowd out is extremely small. According to findings from this evaluation's first household survey, only 3 percent of children had ESI before enrolling in Healthy Kids; thus, very few parents dropped ESI coverage in order to enroll their children (Howell et al. 2006). Furthermore, the survey found that the vast majority of enrollees have almost no access to ESI whatsoever, let alone access to coverage that is affordable. Specifically, only 9.9 percent of parents of Healthy Kids enrollees reported having an offer of ESI and only 2.9 percent of parents are covered under an employer policy (an indicator that most employer policies are not affordable). Additionally, among those parents with an ESI offer, only half work for employers that subsidize the premium for dependent coverage. Taken together, it is clear that children on Healthy Kids have little or no access to affordable employer-based coverage through their parents.

Given this finding, one could argue that maintaining the three-month waiting period carries no negative consequence—if so few children have ESI, then the waiting period has no effect on the vast majority of children. Yet from another perspective, the low incidence of ESI can also support the claim that the waiting period be eliminated. It is affecting very few children to begin with, and for those it does effect, it may present a barrier to the more comprehensive and affordable coverage that Healthy Kids provides. For example, research on families with children with special health care needs suggests

that parents of such children are more likely to make job choices based on the availability of employment-based health coverage for their children, and that this coverage is often more expensive and more limited in scope than public coverage under Medicaid or SCHIP (Hill, Westpfahl Lutzky, and Schwalberg 2001). However, because their children have special needs, these parents are reluctant to risk even a three-month “bare” period so that their kids can enroll in more affordable and comprehensive care. Thus, the waiting period effectively eliminates the availability of public coverage for these especially vulnerable children. Based on these facts, it is suggested that Healthy Kids policymakers consider elimination of the program’s waiting period.

- **Option #5: Provide Incentives for Enhanced Developmental Services.** Enhancing developmental services has been a challenge for pediatric providers. The American Academy of Pediatrics (AAP) recommends developmental surveillance at every well child visit and formal developmental screening at the 9, 18, and 30 month visits (American Academy of Pediatrics 2006). Although up to 18 percent of children may have a developmental delay, less than half are identified before school entry (Palfrey et al. 1987). However, with formal screening, providers can identify between 70 and 80 percent of children with delays (Rydz et al. 2006).

The 2002 survey of the AAP fellows highlighted the fact that fewer than 50 percent of providers use formal screening tools to assess development in their clinical practice (American Academy of Pediatrics 2003). Barriers to use of screening tools in routine practice include: lack of familiarity with the tools; the need to develop new clinical systems/protocols to administer and score screening tools; lack of referral resources if a developmental delay is identified; time constraints; and, lack of adequate reimbursement (U.S. Department of Health and Human Services, Centers for Disease Control).

Encouraging providers to adopt new systems for adherence to the AAP recommendations will require additional training for providers, support for clinical systems change, and adequate reimbursement for screening activities. First 5 LA’s Early Developmental Screening and Intervention Initiative (EDSI) is an example of a comprehensive approach to support enhanced developmental services in a pediatric provider setting. A goal of EDSI is to build capacity of primary care practices and early care and education settings to provide preventive and developmental services. EDSI staff assist teams in putting best practices into place within their own organizations (Inkelas et al. 2007). Such efforts may improve quality of care for young children in Los Angeles County although a range of barriers beyond health insurance coverage affect the practice of developmental services.

In addition, developmental screening toolkits designed to facilitate practice change, such as *The Practical Guide for Healthy Development* (or “The Guide”), are available online (Center for Children’s Healthcare Improvement and the Vermont Child Health Improvement Program 2006).¹⁵

¹⁵ The Guide was developed as part of the Healthy Development Learning Collaborative, a quality improvement initiative in primary care offices in Vermont and North Carolina. The Guide includes six modules, including Assessing your Practice’s Office Systems; Developmental Screening and Surveillance; Family Psychosocial

Given the growing base of knowledge and tools available to assist pediatric providers with developmental surveillance, Healthy Kids officials should consider adopting incentives that would encourage more providers to adopt state-of-the-art practices into their routine operations.

- **Option #6: Encourage Reorganization of Clinic Operations.** Previous sections of this report have described the many challenges to creating effective and efficient clinic systems to serve vulnerable patient populations with complex needs. Despite these challenges, some clinics have made strides in reducing their wait times and the time it takes to get appointments. One widely-known strategy to improve efficient access to health care services is known as “Open Access,” a form of “on demand” appointment scheduling that allows for same-day appointments to accommodate families’ urgent needs. Implementation of the Open Access system has been associated with decreased wait times for appointments and improved patient satisfaction (O’Hare et al. 2004). LA Care currently offers training for providers in a variety of models designed to improve clinic efficiency. We believe that additional training and incentives could support more widespread efforts to reorganize clinic operations and improve their efficiency and effectiveness.
- **Option #7: Require Safeguard Dental to Make “Welcome Calls” to Parents of New Enrollees.** Beyond problems related to the inappropriate charging of copayments for dental services (discussed above), this case study also shed light on a variety of other relatively small, but potentially significant, problems related to the provision of dental care under Healthy Kids. Specifically, we learned that Safeguard Dental had been auto-assigning parents to general dentists rather than assigning them to the dentist they selected during the enrollment process. Further, we were told that the plan does not make “welcome calls” to parents of new enrollees to introduce them to and discuss the workings of the dental benefit and the procedures for obtaining care. These two circumstances may help explain why just 40 percent of children had a dental visit in the past six months, and why many parents expressed confusion about what dental services were covered and how they were supposed to get their children into care (Howell et al. 2006).

Given the extraordinary need for dental care among low-income immigrant children, and given the expressed desire of dental plan officials to “get more children into chairs,” it seems reasonable to require Safeguard to make “welcome calls” to parents of new enrollees. Such calls could represent an important step to improve access, by providing an opportunity for plan staff to clarify for parents the benefits their children are eligible for, the dentists they are assigned to, the process through which they can arrange care, and the recourse they have if they are having trouble obtaining care.

- ***Option #8: Scaling Back Healthy Kids Coverage to Primary Care Only, with Emergency Medi-Cal Serving as Wrap-Around Coverage.*** If state policymakers are unable to pass universal child coverage, drastic steps may be needed if Healthy Kids programs across the state, and in Los Angeles, are to survive. While clearly not an ideal solution, one option may be for Healthy Kids to scale back its coverage to encompass preventive and primary medical and dental care only. As discussed previously, many Healthy Kids enrollees are also dually covered by Emergency Medi-Cal, which could “wrap around” a scaled back Healthy Kids benefit by covering acute hospital and emergency care. Similarly, the California Children’s Services program exists to cover the specialty care needs of children with certain disabilities and chronic care needs, and could continue to offer such support to Healthy Kids enrollees with special needs. Furthermore, the County’s mental health system might help those children with severe mental and behavioral needs.

The obvious disadvantage to this solution is that it would perpetuate the County’s complex systems of health coverage and burden families with negotiating multiple systems of coverage to obtain the health care their children need. Seamless and integrated service delivery would be sacrificed in order to stretch scarce dollars to the maximum extent possible.

This avenue might not be needed if state and local officials are able to reopen negotiations over mechanisms for Healthy Kids to obtain federal and state Emergency Medi-Cal dollars to cover the costs of services received by children under that program. That solution would be preferable, as it would help maintain a centralized locus for service delivery at LA Care and improve the chances that children receive care in an integrated, efficient, and high quality manner.

VI. Conclusions

The Healthy Kids program has achieved a great deal during its first four years of existence. This evaluation has demonstrated that program has succeeded in extending comprehensive and affordable health coverage to over 40,000 very poor, very vulnerable children, and provided hands-on outreach, assistance, and support to families with undocumented children. Furthermore, according to newly released survey results, Healthy Kids has had a demonstrable positive impact on children's access to and use of care, reduced parents' concerns about obtaining care for their children, reduced unmet need for virtually all types of services, and actually improved the health of enrolled children (Howell et al. 2007).

Yet, over the past two years, the program has faced very serious challenges as well. These are primarily related to financing, but they also involve challenges related to chronic problems in the systems of care into which Healthy Kids was introduced. Included in the latter category are geographic barriers to access, knowledge and educational barriers, and problems associated with shortages of various types of providers. Healthy Kids also explicitly set out to improve the development of young children, yet the program appears to have been less effective in spurring the health system to better identify and address children's developmental and behavioral needs. It is hoped that this case study will provide program administrators, providers, and those concerned with children's coverage with insights into how the program might evolve to better address these challenges.

Today, the Los Angeles Healthy Kids program sits at a critical juncture. Developments in the coming year will determine whether it will have the opportunity to continue to grow and thrive, with solid state financial support, or whether the program will be forced to undertake drastic measures simply to exist. One can only hope that policymakers understand and will embrace the

great good that this and similar programs across the state have achieved for vulnerable children, and stake out a leadership role, nationally, in ensuring that all children have access to comprehensive and affordable health coverage.

References

The 100 % Campaign. *Campaign Update: Children's Coverage Bills Pass Health Committees*. April 2007. Accessed on 11/16/07 at:

<http://www.100percentcampaign.org/resources/updates/2007/update-070426.htm>

American Academy of Pediatrics (Division of Health Policy Research). *Periodic Survey #53: Identification of Children <36 Months at Risk for Developmental Problems and Referral to Early Identification Programs*. April 2003. Accessed on 11/16/07 at:

<http://www.aap.org/research/periodicsurvey/ps53exs.htm>

American Academy of Pediatrics; Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. *Pediatrics* 118(1): 405-420. July 2006.

Bethell, Christina, et al. *Child and Adolescent Health Measurement Initiative (CAHMI). The promoting healthy development survey*. Portland (OR): CAHMI - The Child and Adolescent Health Measurement Initiative. 2001.

The Center for Children's Healthcare Improvement and the Vermont Child Health Improvement Program. *A Practical Guide for Healthy Development*. The Commonwealth Fund. April 2006. Accessed on 11/16/07 at:

http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=462115

The Department of Health and Human Services Centers for Disease Control and Prevention, Child Development, Developmental Screening. *Barriers to Developmental Screening According to Pediatricians*. Accessed August 19, 2007 :

<http://www.cdc.gov/ncbddd/child/documents/DSbarriersrpt.pdf>

Dubay, Lisa, and Embry Howell. *Los Angeles Healthy Kids Improves Access to Care for Young Children: Early Results from the Healthy Kids Evaluation*. The Urban Institute Health Policy Brief No. 18. July 2006.

Farias, Albert, Moira Inkelas, and Brigitte Courtot. *Los Angeles Healthy Kids Evaluation Quarterly Process Monitoring Report: First and Second Quarters 2007*. Prepared for the First 5 LA Commission and The California Endowment. September 2007.

Glascoc, Francis P. *Parents Evaluation of Developmental Status (PEDS)*. Nashville, TN: Ellsworth & Vandermeer Press LLC. 2006. Accessible at: www.pedstest.com.

Hill, Ian, Amy Westpfahl Lutzky, and Renee Schwalberg. *Are We Responding to Their Needs? States' Early Experiences Serving Children with Special Health Care Needs Under SCHIP*. Occasional Paper No. 48. Washington, DC: The Urban Institute, June 2001.

Hill, Ian, Brigitte Courtot, and Eriko Wada. *A Healthy Start for the Los Angeles Healthy Kids Program: Findings from the First Evaluation Site Visit*. Prepared for the First 5 LA Commission. October 2005.

Hill, Ian, Brigitte Courtot, Patricia Barreto, Eriko Wada, and Enrique Castillo. *What Do Parents Say about the Healthy Kids Program?: Findings from Focus Groups with Parents of Healthy Kids Enrollees*. Prepared for the First 5 LA Commission. April 2006.

Howell, Embry, Lisa Dubay, Genevieve Kenney, Louise Palmer, Ian Hill, Moira Inkelas, and Martha Kovac. *A Profile of Young Children in the Los Angeles Healthy Kids Program: Who are They and What Are Their Experiences on the Program?* Prepared for the First 5 LA Commission. September 2006.

Howell, Embry, Lisa Dubay, and Louise Palmer. *The Impact of the Los Angeles Healthy Kids Program on Access to Care, Use of Services, and Health Status*. Prepared for the First 5 LA Commission. July 2007.

Inkelas M, Martinez S, Espinosa L, et al. (2007). Policy Scan: Desired Results and Achieving Improvement in a System of Early Identification and Intervention in Los Angeles County. September. Los Angeles, CA: UCLA Center for Healthier Children, Families and Communities.

New York Center for Health Workforce Studies (2006). United States Health Workforce Profile. Rensselaer, NY.

O'Hare, C. Dennis, MD, MSc, and John Corlett. *The Outcomes of Open-Access Scheduling Family Practice Management*. Volume 11 No. 2 Feb 2004

Palfrey JS, Singer JD, Walker DK, Butler JA. *Early identification of children's special needs: a study in five metropolitan communities*. J Pediatr. 1987;111 :651 –659)

David Rydz, MSc, Myriam Srour, MD, CM, Maryam Oskoui, MD, CM, Nancy Marget, MSc, Mitchell Shiller, MD, CM, Rena Birnbaum, MSc, OT, Annette Majnemer, PhD, OT and Michael I. Shevell, MD, CM *Screening for Developmental Delay in the Setting of a Community Pediatric Clinic: A Prospective Assessment of Parent-Report Questionnaires*. PEDIATRICS Vol. 118 No. 4 October 2006, pp. e1178-e1186

Sommers, Anna, Embry Howell, and Ian Hill. *Utilization in the Los Angeles Healthy Kids Program: A Preliminary Study of Health Plan Administrative Data*. Prepared for the First 5 LA Commission. August 2007.

Tobacco Related Disease Research Program. *Burning Issues: Tobacco's Hottest Topics*. Newsletter Volume 9(1). January 2007. Accessed on 11/16/07 at: <http://www.trdrp.org/publications/newsletters/2007/107nwsltr.pdf>.

Wada, Eriko, Moira Inkelas, Anna Sommers, and Joshua McFeeters. *Los Angeles Healthy Kids Evaluation Quarterly Process Monitoring Report: Third and Fourth Quarters 2005*. Prepared for the First 5 LA Commission and The California Endowment. May 2006.

Westpfahl Lutzky, Amy, and Ian Hill. *Has the Jury Reached a Verdict? States' Early Experiences with Crowd Out under SCHIP*. Occasional Paper No. 47. Washington, DC: The Urban Institute, June 2001.

Wooldridge, Judith, Genevieve Kenney, Christopher Trenholm, Lisa Dubay, Ian Hill, Anna Sommers, Stephen Zuckerman, et al. *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Report to Congress*. Mathematica Policy Research, Inc. June 2005.

Appendix A
List of Site Visit Informants
(in alphabetical order)

Irene Avalar, Clinic Director, AltaMed Health Services (East Los Angeles/Commerce Clinic)
Linda Barconey, Pediatric Dentist, Children's Dentistry
Cathleen Bemis, Contractor Database, Los Angeles County Department of Health Services
Parul Bhatia, Pediatrician, Children's Hospital of Los Angeles
Suzanne Bostwick, Contractor Monitoring, Los Angeles County Department of Health Services
Esteban Coronado, Children's Health Access and Medical Program, Los Angeles Unified School District
Scott Crawford, Product Operations Manager, Managed Care Services, L.A. Care Health Plan
Esperanza Elliot, Children's Health Access and Medical Program, Los Angeles Unified School District
Agripina Estrella, Outreach Worker, Maternal and Child Health Access
Steven Feig, Office-Based Pediatrician
Scott Fishman, Pediatric Dentist, Lakewood Cerritos Dental Center
Gissel Garcia, Children's Health Access and Medical Program, Los Angeles Unified School District
Melissa Gutierrez, AltaMed Health Services (East Los Angeles/Commerce Clinic)
Tyrette Hamilton, Vice President, Government Programs, SafeGuard Dental and Vision
Scott Jacks, Pediatric Dentist, Children's Dental Group
Howard Kahn, Chief Executive Officer, L.A. Care Health Plan
Gregory Kaplan, Cosmetic and Reconstructive Dentist, Wilshire Center Dental Group
Jenny Kattlove, Health Policy Manager, The Children's Partnership
Neal Kaufman, First 5 LA Commissioner
Lynn Kersey, Executive Director, Maternal and Child Health Access
Luis Lopez, Office-Based Pediatrician
Paula Lopez, Director, Government and Special Programs, SafeGuard Dental and Vision
Elisa Nicholas, Executive Director, The Children's Clinic, Serving Children and Their Families
Will Nicholas, Project Officer, First 5 Los Angeles
Laura Ojeda, Outreach Coordinator, First 5 Los Angeles
Naga Parsangi, National Dental Director, SafeGuard Dental and Vision
Liz Ramirez, Director, Education and Training, Maternal and Child Health Access
Courtney Ransom, Vice President, Claims and Quality Management, SafeGuard Dental and Vision
Wendy Schiffer, Director of Children's Health Initiatives, Los Angeles County Department of Health Services
Dorothy Seleski, Chief, Managed Care Operations, L.A. Care Health Plan
Barbara Siegel, Managing Attorney, Health Consumer Center, Neighborhood Legal Services of Los Angeles County
Shawnalynn Smith-Thomas, Manager of the Children's Health Initiative of Greater Los Angeles, L.A. Care Health Plan
Steven Song, Children's Health Access and Medical Program, Los Angeles Unified School District
Alan Stobaugh, Account Management for Government Programs, SafeGuard Dental and Vision
Sharon Swonger, Coordinator, Children's Health Access and Medical Program, Los Angeles Unified School District
Lynn Thompson, Director of Provider Relations, SafeGuard Dental and Vision
Ana Valenzuela, Outreach Worker, Maternal and Child Health Access
Yolanda Vera, Director, LA Health Action
Susan Wu, Pediatrician, Children's Hospital of Los Angeles
Lucien Wulsin, Director, Insure the Uninsured Project
Eleanor Young, Director, Health Outcomes and Analysis, L.A. Care Health Plan