

# A Healthy Start for the Los Angeles Healthy Kids Program

Findings from the First Evaluation Case Study

*Prepared for:*



*Prepared by:*

**Ian Hill  
Brigette Courtot  
The Urban Institute**

**Eriko Wada  
The University of Southern California**

**December 2005**



## **Acknowledgments**

We would like to acknowledge the support and cooperation of the numerous individuals who met with our research team to provide the information summarized in this report. These individuals were extraordinarily generous in giving of their time and in sharing their insights about the First 5 LA Healthy Kids initiative. (A complete list of key informants appears in Appendix A.) In addition, we would like to acknowledge the program staff at First 5 LA and at the Los Angeles Department of Health Services for their invaluable assistance with the planning and coordination of our site visit. The authors are indebted to Patricia Barreto of the UCLA Center for Healthier Children, Families, and Communities for her critical input regarding the design and execution of our case study. Finally, we are grateful for the careful direction and support provided by our project officers at First 5 LA and The California Endowment—Will Nicholas and Astrid Hendricks-Smith.

For more information about First 5 LA and its initiatives, go to [www.first5.org](http://www.first5.org)

## Table of Contents

Executive Summary .....	i
I. Program Overview.....	1
II. Background .....	2
III. Outreach, Enrollment and Retention.....	7
IV. Benefits .....	24
V. Service Delivery and Payment Systems.....	27
VI. Cost-Sharing .....	36
VII. Crowd-Out .....	42
VIII. Financing.....	44
IX. Conclusions .....	46
Appendix A: Key Informants	
Appendix B: Healthy Kids Advisory Group Members	
Appendix C: Outreach & Enrollment Contractors	

## Table of Figures

Figure 1: DHS Outreach Contacts by Location, July 2004-June 2005 .....	20
Figure 2: Distribution of Applications Submitted with Assistance by DHS, by Program .....	20
Figure 3: Cumulative Healthy Kids Enrollment, by Month and Age, July 2003-July 2005 .....	21
Figure 4: Status of Healthy Kids Retention Objective for Members Ages 0-5, June 2005 .....	22
Figure 5: Healthy Kids Member Benefits.....	26
Figure 6. Healthy Kids Enrollees by Type of Primary Care Provider Selected, June 2005 .....	32
Figure 7: Healthy Kids Cost-Sharing Policies .....	38
Figure 8. Percent Distribution of Healthy Kids Enrollees by Premium Status.....	41

## Executive Summary

The Los Angeles Healthy Kids program was implemented in July 2003 and extended health coverage to uninsured children from birth through age five, in families with income below 300 percent of the federal poverty level (FPL), who are ineligible for Medi-Cal or Healthy Families. Supported initially by an allocation of \$100 million from First 5 LA, the program was expanded in May 2004 to cover all uninsured children through age 18 with additional funds raised by the Children's Health Initiative (CHI) Coalition of Greater Los Angeles.

Results from this first case study report on Healthy Kids implementation, completed by the Urban Institute and partners under contract with First 5 LA, indicate that the program is off to a very positive start. Researchers found that the program, carefully designed to meet the needs of vulnerable children and families in the County, was implemented smoothly, with few notable problems. Furthermore, it has been nurtured during its early development through the ongoing oversight of the CHI and, in particular, leadership of First 5 LA, L.A. Care Health Plan (hereafter referred to as L.A. Care), The California Endowment, and the County Department of Health Services.

Based on in-depth interviews conducted with over 50 stakeholders, including policymakers, public and private providers, county health and social services administrators, health and dental plan officials, child advocates, health policy researchers, and community-based organizations involved with outreach, and supplemented by process measures, the case study reports the following highlights:

- The Healthy Kids Advisory Committee, selected to include a multi-disciplinary group of 40 experts, conducted a thorough and systematic review of policy options for Healthy Kids during the fall of 2002 and spring of 2003, and ultimately designed a program much like Healthy Families (California's State Children's Health Insurance Program) and those

of other county Children's Health Initiatives. It includes, however, key components uniquely tailored to better meet the needs of the target population in Los Angeles, such as no premium payments for families in the lowest income band (those at or below 133 percent of the federal poverty level), a "premium assistance" program for families that cannot afford to pay Healthy Kids cost sharing, and a "quality enhancement" component to improve the quality of behavioral health and developmental services in Los Angeles County.

- Outreach and application assistance are provided through a broad and diverse network of community-based agencies. Building on models developed in the early 2000s under expansions of Healthy Families and Medi-Cal for Children, the system relies on trusted, community-based, multi-lingual staff to find families with uninsured children, inform them of the availability of coverage, assist parents with completing applications for any available coverage programs that might serve them or their children's needs, and follow-up with families to ensure that needs are being met. Reports from key informants suggested that these outreach workers are extremely effective. Indeed, process measures indicate that they are succeeding in contacting a large number of families in a wide variety of settings, including clinics and doctors offices, WIC centers, Head Start agencies and child care settings, schools, and a variety of community and religious organizations.
- Outreach contractors are also succeeding in assisting families with applications to a variety of coverage programs, not just Healthy Kids. Specifically, over 50 percent of all applications completed by outreach entities are submitted on behalf of children eligible for Medi-Cal; nearly one-quarter for children eligible for Healthy Families; and just 20 percent of applications are for Healthy Kids eligibles.
- Enrollment in Healthy Kids has grown steadily, especially after older children (ages 6 through 18) were included. Over 40,000 children were covered under the program by the summer of 2005. Of these, nearly 8,000 were children ages zero through five, comprising 56 percent of the estimated eligible population and surpassing the objective set by First 5 LA (of enrolling 50 percent of eligible children by June 2005).
- The Healthy Kids benefit package is modeled after that of the Healthy Families program, and includes a comprehensive array of preventive, primary, acute, and specialty care services. Key informants interviewed for this study, including physicians and other health professionals, were generally quite satisfied with the breadth and scope of program benefits and were not aware of instances where children have needed services that were not covered by the program.
- Services are delivered through a network of primary, acute and specialty care providers managed by L.A. Care, a not-for-profit community health plan with extensive experience serving publicly insured families under Medi-Cal and Healthy Families. Dental services are delivered through Safeguard Dental and vision services through VSP Health Plan; both are subcontractors to L.A. Care. Children with qualifying chronic illnesses and disabilities receive specialty care from the California Children Services (CCS) program

under a “carve out” arrangement. All services are financed on a prepaid, capitated basis (with the exception of carved out specialty care, which is financed by CCS).

- Program designers set out to structure the Healthy Kids delivery system around existing “safety net” providers in the county (including community clinics, public hospitals, and health department facilities, among others), because they believed that these entities had more experience serving the target population and would do a particularly good job extending health, developmental and support services to disadvantaged families. Key informants, including child advocates and providers, reported that families seem satisfied with the access that the network is affording their children, and stakeholders are pleased with the finding that 30 percent of children receive primary care from physicians in safety-net settings, a rate that is three-fold higher than for children enrolled in Medi-Cal and Healthy Families.
- Cost sharing was included in Healthy Kids to promote personal responsibility and because designers wanted to create a program that was modeled after private insurance. However, great care was taken to structure cost sharing so that it would not create barriers to enrollment or service use. For example, no premiums are charged to families at the lowest income level (earning below 133 percent of the federal poverty level), and nominal premiums are charged to higher-income families (either \$4 or \$6 per child per month, depending on income). Also, “premium assistance” is offered to families that cannot afford premiums. All families, however, are required to pay \$5 copayments for certain physician visits, emergency room visits, and prescription drugs.
- Key informants interviewed for the study had somewhat mixed impressions of the effects of cost sharing. On one hand, nearly everyone agreed that premiums were not keeping families from enrolling. (Indeed, nearly 90 percent of applicants reside in families with income under 133 percent of poverty and therefore do not pay premiums.) On the other hand, several advocates and some physicians indicated that copayments were creating hardships for families, especially those with disabled or chronically-ill children who need and use higher levels of care.
- Program designers were worried about the potential for “crowd out” under Healthy Kids (that is, that new public coverage might substitute for existing employer-sponsored health insurance). Thus, a three-month “waiting period” for any families that possess insurance for their children at the time of application was included. Two years later, however, there is little evidence that crowd out is occurring. Key informants that we interviewed, including front-line outreach workers who directly assist families, report that it is extremely rare to encounter a parent that has any job-based health insurance, much less dependent coverage for their children. This was not surprising to most stakeholders, given the income and employment profile of families with children in the program.
- Healthy Kids has, to date, been supported by an allocation of \$100 million from First 5 LA and private and philanthropic donations. While ample funds remain from First 5 LA’s commitment to continue serving children under age five, monies to support 6 to 18-year-olds have fallen short, given strong rates of enrollment. In June 2005, a temporary “cap”

was placed on enrollment for these older children as fundraising efforts of the CHI continue.

- Anticipating that longer term funding would eventually be needed, leadership in the CHI, working with counterparts across the state, developed a successful advocacy strategy that resulted in the passage of legislation to create a statewide California Healthy Kids program, supported by a combination of federal, state, local, and private funds. The legislation was vetoed by Governor Schwarzenegger, however.

With a strong start behind it, Healthy Kids moves forward to face certain key issues and challenges. These include:

- *The goal of universal coverage.* Healthy Kids has experienced remarkable enrollment during its first two years, reaching over 50 percent of the estimated target population. Yet, in a classic “is the glass half full, or half empty?” scenario, the program needs to strive to reach the other half of children in Los Angeles County who still lack coverage. Reaching this goal will be challenging, as the population of uninsured children appears to be growing, and some stakeholders speculate that Healthy Kids has thus far only reached the “low-hanging fruit” during its early stage and that harder-to-reach children remain uninsured.
- *Achieving optimal access and utilization.* Insufficient data were available at the time of this writing to understand, accurately, the extent to which Healthy Kids enrollees were using the services to which they are entitled. Yet many stakeholders we interviewed had the impression that service use might be lower than ideal. Whether this is due to the “newness” of the program and parents’ lack of familiarity with using the system, or an indicator that the network might not be sufficient to meet enrollees’ needs, or reflective of some other factor, is impossible to know at this time. Indeed, it may be that parents’ reported continued use of Emergency Medi-Cal and CHDP services means that children are receiving care, but that it is not showing up in Healthy Kids data records. As the program matures, more data will come available to shed light on this issue. But in the meantime, program officials will need to continue to identify strategies that promote access to care.
- *Building “seamlessness” between Healthy Kids, Healthy Families, and Medi-Cal.* Health coverage programs in Los Angeles, as across the state and nation, are often described as a “patchwork” of systems, built upon one another like layers of a cake. As such, it is extremely challenging for policymakers to align rules and systems across programs so that they can work smoothly together and, more importantly, so that they can provide clear and seamless coverage for families with children in multiple programs. We learned, during the site visit, that integration challenges presented themselves most often with regard to eligibility and enrollment systems, and that outreach workers often struggled to learn that status of applications they sent to Sacramento. This finding was known among members of the CHI and, indeed, its Program Integration Workgroup has been working on strategies to improve seamlessness across programs.

- *Establishing stable financing.* Perhaps Healthy Kids’s greatest challenge, at least in the near term, will be to finance children’s coverage in a stable and reliable way into the future. As successful and gratifying as local fundraising efforts have been, leadership acknowledged during our site visit that philanthropic giving would not provide Healthy Kids with all the support it would need in the long term. Once again, successful statewide advocacy efforts, in which Los Angeles leadership has been an active partner, appear to be making headway in addressing this challenge. Yet the future remains unclear in light of the Governor’s recent veto of legislation to create a statewide California Healthy Kids program.

This report was developed as part of the Healthy Kids Program Evaluation under a four-year contract between First 5 LA and The Urban Institute. The Institute and its partners—the University of Southern California, the University of California at Los Angeles, Mathematica Policy Research, Inc., and Castillo & Associates—will continue to study the implementation and impacts of Healthy Kids through the conduct a broad range of evaluation activities, including additional case studies of implementation, focus groups with parents of Healthy Kid enrollees, ongoing process monitoring of the outreach, enrollment, and service delivery systems, analyses of Healthy Kids effects on rates of uninsurance and enrollment in Medi-Cal and Healthy Families, and a longitudinal household survey of new and established enrollees in Healthy Kids.

## I. Program Overview

The Los Angeles Healthy Kids program was implemented in July 2003 extending health coverage to uninsured children from birth through age five, in families with incomes below 300 percent of the federal poverty level (FPL), who are ineligible for Medi-Cal or Healthy Families. The initiative is supported by an allocation of \$100 million from First 5 LA. Subsequent fundraising efforts by the Children’s Health Initiative (CHI) Coalition of Greater Los Angeles raised an additional \$86 million, permitting Healthy Kids to be expanded to all children through age 18 in May 2004. Since its inception, the program has enrolled over 44,000 children, making it the largest Healthy Kids initiative in California. Key components of the program include:

- ***Outreach and Enrollment.*** A network of community-based organizations, supported by contracts with the Los Angeles County Department of Health Services (DHS) and The California Endowment (TCE), conduct outreach to families with uninsured children and provide assistance with applications for all available health programs, including Healthy Kids, Medi-Cal, and Healthy Families.
- ***Benefits.*** Healthy Kids enrollees are covered by a benefit package modeled after that of the Healthy Families program, which include a comprehensive set of preventive, ambulatory, and acute care services, including dental care.
- ***Service Delivery.*** Healthy Kids contracts with L.A. Care—a not-for-profit health plan—for the delivery of all services to enrolled children through a defined network of primary and specialty care providers on a capitated basis. Dental services are delivered under a subcontract with Safeguard Dental through a network of capitated dentists, and vision services are similarly provided by VSP Health Plan. Children with qualifying chronic conditions or disabilities receive specialty care through the California Children’s Services program (the state’s Title V/Children with Special Health Care Needs program) through a “carve out” arrangement.
- ***Cost Sharing.*** Families with incomes below 133 percent FPL pay no premiums under Healthy Kids. Families earning between 134 and 150 percent of FPL pay \$4 per child (with a monthly maximum of \$8 per family), and families earning between 150 and 300 percent FPL pay \$6 per child per month (with a monthly maximum of \$12 per family). For those unable to pay, a “premium assistance” hardship fund exists. All enrollees are required to pay \$5 copayments for physician office visits, prescriptions, and emergency room visits.

- ***Crowd Out Prevention.*** Children must be uninsured for at least three months prior to enrollment in Healthy Kids; this “waiting period” is intended to discourage parents from dropping existing employer-based coverage in order to sign up for Healthy Kids.

This report was developed as part of the Healthy Kids Program Evaluation under a four-year contract between First 5 LA and the Urban Institute. The Institute and its partners—the University of Southern California, the University of California at Los Angeles, Mathematica Policy Research, Inc., and Castillo & Associates—will conduct a broad range of evaluation activities over the life of the contract, including case studies of implementation, focus groups with parents, a longitudinal household survey, and ongoing process monitoring of the outreach, enrollment, and service delivery systems.

This first case study report is primarily based on information gathered during a week-long site visit to Los Angeles in November 2004, supplemented by information regarding more recent developments and data from the process monitoring component of the evaluation. During the site visit, the evaluation team met with over 50 key informants representing First 5 LA staff and Commissioners, policymakers, public and private providers, county health and social services administrators, health and dental plan officials, child advocates, health policy researchers, and community-based organizations involved with outreach. (See Appendix A for a complete list of all site visit informants.) All interviews were conducted using structured protocols by evaluation staff from the Urban Institute, the University of Southern California, and the University of California at Los Angeles.

## **II. Background**

The roots of the Los Angeles Healthy Kids program lie in Proposition 10—the California Children and Families First Act of 1998. Passed in November of that year, Proposition 10 added a \$0.50 tax on cigarettes and other tobacco products with revenues earmarked for the purposes of

promoting, supporting, and improving early development among children beginning in the prenatal period and through age five. Twenty percent of funds collected by the tax were allocated to a new state Proposition 10 Commission, while 80 percent were proportionately distributed to county-level Commissions based on each county's number of live births. With roughly 160,000 live births per year, Los Angeles County received the largest allocation, comprising about 31 percent of the total tax distributions.

In December 1998, the Los Angeles County Board of Supervisors adopted Ordinance 98-007 creating the Los Angeles County Children and Families First—Proposition 10 Commission (later renamed First 5 LA). First 5 LA differed from many county Proposition 10 Commissions in that it was created as a quasi-governmental entity, chaired by a member of the County Board of Supervisors. During its formative stages, the Commission adopted the following vision statement:

*All expectant parents, children up to age five and their families will thrive in a safe, **healthy** and nurturing environment that optimizes the growth and development of all children, enables them to reach their potential and prepares them to enter school ready to learn and participate in family and community life. (bold added)*

Seizing on the concept that good health status, enabled by appropriate access to health care, is a key component of early childhood development, Commission members voted in July 2002 to devote \$100 million of its budget to support the creation of the Healthy Kids program. By this time, similar initiatives had been started in three counties across California: Santa Clara, San Mateo, and Alameda. Policymakers and professionals concerned with child health across the county had been anxious to form a Healthy Kids initiative in Los Angeles; First 5 LA committed the resources that would allow the foundation of such a program to be laid (covering children through age five only, in keeping with their mandate) with the hope and expectation that other fundraising would permit the subsequent expansion to cover all uninsured children.

To guide the formulation and design of the program, First 5 LA convened a Healthy Kids Advisory Committee in the fall of 2002 composed of a multi-disciplinary group of 40 experts, including university researchers, county health and social services administrators, county commissioners, physicians, managed care administrators, child and family advocates, and directors of community-based service organizations. (See Appendix B for a list of Advisory Committee members.) As discussed in subsequent sections of this report, the Advisory Committee systematically reviewed, discussed, and debated alternative policies and designs in the program areas of eligibility, outreach, enrollment, benefits, service delivery, cost sharing, and crowd out, among others. Prior to approval of funding for Healthy Kids, and spurred by Dr. Neil Kaufman (a pediatrician and director of Cedars-Sinai Medical Center’s Department of Pediatrics and Division of Academic Primary Care Pediatrics), advisors debated whether First 5 LA funds should support the creation of a health insurance product, or instead be directed to the health care delivery system itself in an effort to enhance its breadth, quality, and appropriateness for low income children. However, a strong consensus emerged that Los Angeles’ program should follow the same fundamental structure of other county Healthy Kids programs and offer insurance coverage through a product modeled after Healthy Families, California’s State Children’s Health Insurance Program. A compromise was reached, however, related to quality. Specifically, and in large part due to the program’s sponsorship by First 5 LA and its emphasis on early childhood development, a “quality enhancement” initiative was adopted with the intent of improving the quality of behavioral health and developmental services in Los Angeles County.<sup>1</sup>

---

<sup>1</sup> Funds totaling \$5.5 million were set aside to fund “quality enhancement” efforts and First 5 LA was receiving proposals for these contracts at the time of this writing.

Key informants interviewed for the study typically described the process followed by the Advisory Group as smooth, effective, and relatively uncontroversial. Advisory group members expressed several key priorities for program design. On one hand, it was widely felt that the program should cover a broad and comprehensive set of benefits (given the expected needs of low income, uninsured children), delivered through a system that included the county's existing "safety net" providers (given their experience meeting the diverse needs of this vulnerable group of children). On the other hand, a majority of members were also keen on making the program "like private health insurance," and thus embraced such notions as family cost sharing, a waiting period for families who already possessed insurance for their children, and a delivery system that included a broad network of private, office-based physicians. Paraphrasing several key informants, the oft-stated opinion was that designers "...did not want Healthy Kids to be a 'county government program.'" Modeling the program after Healthy Families achieved the lion's share of these goals. And while there was lively debate over such issues as cost sharing, there were no instances where the group failed to reach compromises with which all could live.

During the course of the Advisory Group's deliberations, two key "strategic partners" with First 5 LA emerged. The first was the County Department of Health Services (DHS), an agency that had extensive experience, in recent years, working with community-based organizations that were conducting outreach and application assistance. It was decided that DHS would be the lead organization for Healthy Kids outreach and would spearhead efforts to identify and help enroll eligible children. The second partnership, with L.A. Care, evolved slowly and informally. Leadership of the plan, a not-for-profit, community-accountable health maintenance organization, were active members of the Healthy Kids Advisory Group. The plan possessed many years of experience serving more than 800,000 low-income county residents under

Medicaid and Healthy Families; indeed, L.A. Care was the designated “local initiative” under Medi-Cal’s managed care system.<sup>2</sup> While the plan made no overt bid to be the network to serve Healthy Kids enrollees, it became clear over time that there was “a natural fit” between the organization’s goals and experience and the needs of the Healthy Kids program. In the end, L.A. Care was selected as the program’s health plan. (Formal relationships between First 5 LA, DHS and L.A. Care are discussed in more detail in subsequent sections of this report.)

As the Healthy Kids Advisory Committee was completing its work in the spring of 2003, a large group of stakeholders, including many of the same persons and organizations on the Committee, formed the Children’s Health Initiative (CHI) Coalition of Greater Los Angeles to advocate, plan and conduct fundraising for the children’s coverage expansions. Co-convened by L.A. Care, The California Endowment, and the Los Angeles County Department of Health Services, the CHI set its long-term goal as achieving 100 percent coverage for children in Los Angeles County through Medi-Cal, Healthy Families, and Healthy Kids. More immediate was its goal to raise \$128 million to fund the expansion of Healthy Kids to children ages 6-18. The Coalition, comprising healthcare providers, private employers, business leaders, advocacy groups, foundations, public health officials, labor unions, and educators, succeeded in raising over \$80 million during its first year, permitting Healthy Kids to expand to older children effective April 2004.<sup>3</sup> A year later, with program enrollment nearing 40,000 and fundraising reaching \$87 million, the program became a victim of its own success—funds were being spent more rapidly than expected. Beginning in May 2005, the CHI was forced to place an indefinite

---

<sup>2</sup> The Department of Health Services (DHS) has implemented a two-plan Medi-Cal managed care model. One plan, called the local initiative, was developed by the county in conjunction with local stakeholders, including physicians, hospitals, clinics, and pharmacists. The second plan, usually called the commercial plan, is a non-governmentally operated HMO.

“cap” on enrollment of 6-18 year-olds, with plans to hold enrollment steady at 35,000 children until additional funds were raised or broader state and federal support for the program could be achieved. (Further discussion of financing and efforts to broaden state fiscal support of Healthy Kids initiatives across California appears in Section VIII of this report.)

### **III. Outreach, Enrollment and Retention**

This section provides a detailed discussion of how Healthy Kids outreach, enrollment, and retention efforts were designed and implemented during the program’s early phases. Key lessons learned to date are also presented.

#### ***A. Policy Development***

From the first meetings of the Healthy Kids Advisory Group, planners envisioned that outreach efforts would be universal in nature. That is, outreach would strive to recruit all uninsured children into any available health coverage program for which they might be eligible, including Medi-Cal, Healthy Families, and Healthy Kids. Indeed, the system embraced a philosophy that there is “something for everyone” in a family (including adults), and that no family member would walk away from an encounter with an outreach worker without receiving help for a health or social service need.

Members of the advisory group also realized that a two-pronged approach to outreach was necessary, combining marketing through mass media and public relations, and grass-roots, community-based, strategies designed to connect with hard-to-reach families on a one-to-one basis. As described by one DHS official, however, “outreach is simply a means to an end: enrollment.” Thus, the hands-on approach to outreach—whereby families are contacted,

---

<sup>3</sup> 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.

informed of available programs, and assisted with applications for those programs—became the primary emphasis of the Healthy Kids system. This was viewed by the Advisory Group as the most promising strategy for achieving high rates of enrollment, especially for the target population of low-income, vulnerable children; community-based organizations would know and be trusted by their communities, and thus would more likely be successful in helping parents understand the importance of children’s health insurance, and dispel any fears they might have of applying for help through a government program.

This model, in fact, was not a new one. Rather, it built upon and emulated efforts with proven success in enrolling hundreds of thousands of children into both Healthy Families and Medi-Cal for Children since the late 1990s. Specifically, the roots of these efforts go back to 1999 when the County Board of Supervisors, following the recommendation of the Los Angeles Children’s Planning Council, charged the County Department of Public Social Services (DPSS) with the goal of enrolling 100,000 children into Medi-Cal. This charge stimulated the agency to restructure its eligibility systems and “outstation” hundreds of eligibility workers from their traditional locations in welfare offices to community-based settings, such as clinics and hospitals. (Outstationing eligibility workers helped DPSS meet its objective, and this model continues to be in place across the county.) Shortly thereafter, as the Healthy Families program was gaining momentum, the state Department of Health Services and the Managed Risk Medical Insurance Board (MRMIB) each funded similar efforts. The first provided “outreach contracts” to community-based agencies and schools to support their provision of outreach and enrollment assistance. The second—the Certified Application Assistance (CAA) program—provided staff of community agencies training in application assistance and created a \$50 incentive fee for every

---

Parsons Foundation, W.M. Keck Foundation, Unihealth Foundation, Kaiser Permanente Health Plan, and Northrop Grumman Corporation.

application submitted that resulted in successful enrollment. These efforts were largely credited with helping California to achieve strong rates of enrollment in the Medi-Cal and Healthy Families programs,<sup>4,5,6</sup> and also to become the largest SCHIP program in the nation. The outreach efforts were de-funded in 2002 and 2003, as the state experienced severe budget pressures.<sup>7</sup>

DHS became the key strategic partner for implementing outreach, application assistance, and redetermination while First 5 LA took primary responsibility for media and public information strategies. In addition, an information clearinghouse function was housed at Nexcare, a First 5 LA contractor that was already operating a toll-free “warm line.” Finally, it was decided that L.A. Care would receive all Healthy Kids applications and conduct the eligibility determination and renewal processes for the program, new functions for the health plan.

## ***B. Program Characteristics***

### *1. Marketing, Mass Media, and Information*

The Communications Department at First 5 LA oversaw all efforts related to marketing the Healthy Kids program during its early implementation. Activities included writing and distributing numerous press releases, working with local ethnic television and radio outlets to raise awareness of the initiative, holding press conferences and interviews with Commissioners and other leaders, and designing and distributing a range of print materials and brochures advertising the program for distribution at community-based organizations or in response to

---

<sup>4</sup> Ian Hill, Corinna Hawkes, and Mary Harrington. *Congressionally Mandated Evaluation of SCHIP: Final Cross-Cutting Report on the Findings from Ten State Site Visits*. Princeton, NJ: Mathematica Policy Research, Inc. December 2003.

<sup>5</sup> Donna Cohen Ross and Ian Hill. Enrolling Eligible Children and Keeping Them Enrolled. *The Future of Children* Volume 13 (Spring 2003). Available at: [http://www.futureofchildren.org/usr\\_doc/tfoc13-1e.pdf](http://www.futureofchildren.org/usr_doc/tfoc13-1e.pdf).

<sup>6</sup> Ian Hill and Corinna Hawkes. *Congressionally Mandated Evaluation of SCHIP: Site Visit Report - The State of California's Healthy Families Program*. Princeton, NJ: Mathematica Policy Research, Inc. November 2002.

<sup>7</sup> CAA fees were reinstated in July 2005 using funds from part of the settlement from the Blue Cross/Anthem merger.

requests for information. With the intent of casting the net as broadly as possible to reach families with uninsured children, the brochures contained the general message, “Your child may be eligible for health coverage!” and featured Healthy Kids as well as the Medi-Cal and Healthy Families programs.

Starting in January 2002, and pre-dating the launch of Healthy Kids, First 5 LA funded the creation of a toll-free information clearinghouse called *First 5 LA Connect*. With phone lines open 12 hours a day, seven days a week (and a website available 24 hours per day), *Connect* provides broad based information, support, referral and assistance to parents and caregivers of children up to age five. When Healthy Kids was implemented, the potential for the “warm line” to serve as a phone-based application assistance resource for parents seeking health insurance for their children was immediately recognized, and the toll-free number for *First 5 LA Connect* was thus included on all print materials for the program. Shortly thereafter, *Connect* phone assistance was expanded to be available 24 hours per day, and the contractor began providing parents direct application assistance for health coverage (discussed in more detail below).

While no television or radio public service announcements or advertisements were specifically created for Healthy Kids, there were such media strategies for *First 5 LA Connect*, and these often mentioned how the service could help parents obtain health insurance for their children. Television, radio, and print marketing strategies were typically targeted at Spanish-language outlets, and Healthy Kids segments on *Telemundo* resulted in notable enrollment increases.

## *2. Community Based Outreach and Application Assistance*

As mentioned above, the LA County Department of Health Services (more specifically, the DHS Office of Children’s Health Outreach Initiatives, or CHOI) emerged as First 5 LA’s

strategic partner to oversee outreach, enrollment and retention activities for Healthy Kids.<sup>8</sup> The agency received a contract for approximately \$4.7 million for the first year to support this effort, \$3.5 million of which was subcontracted out to community groups to perform outreach, enrollment, and training activities. To distribute these funds, DHS sought bids through a competitive Request for Proposals process. In all, 46 bids were received and awards were made to 14 agencies, including 10 CBOs, two health departments, and two school districts. Additionally, an award was made to an organization to conduct countywide training of outreach and enrollment workers. In making the awards, DHS strove to distribute monies across the county's eight service planning areas (SPAs) roughly proportional to the distribution of uninsured children. And while the agency did not explicitly intend to fund alternative models of outreach, the winning bidders ended up representing a broad range of entities that conduct outreach in a variety of ways. For example, DHS funds outreach workers in clinic settings, a childcare referral agency, a substance abuse treatment center, a legal services agency, a public health department, a family resource agency, and in neighborhoods through a team of volunteer "promotoras" who canvas their community, visiting parents door to door. In addition, DHS contracts with the Los Angeles Unified School District (LAUSD) to support outreach efforts and application assistance throughout the county's schools.

Prior to First 5 LA's commitment of outreach monies, The California Endowment also came forth with funds to support outreach and enrollment assistance. In all, TCE funded 16 diverse CBOs, eight of which were also funded through First 5 LA's contracts with DHS. The scope of work of these agencies is nearly identical to the DHS-funded entities and plans call for them to

---

<sup>8</sup> In addition, the scope of DHS' work includes a focus on families' utilization of services, and outreach workers help families negotiate the health service delivery system and troubleshoot any problems they might be having obtaining needed care.

ultimately enter data into DHS's CHOI database. (See Appendix C for a list of all DHS and TCE outreach and enrollment contractors.)

While outreach is conducted in a variety of settings, the scope of work that each CBO follows is laid out quite specifically in their contracts with DHS, and thus each agency engages in a consistent set of activities. These include, for example:

- **Training.** All workers are required to complete training to provide application and redetermination assistance.
- **Holistic approach to assistance.** Outreach workers strive to assist all members of a given family, with all available health and social services programs.
- **Follow-up and troubleshooting.** Workers follow up with families within 90 days of assistance to inquire about the status of their applications for coverage, to see if the family is having any problems accessing care, to troubleshoot any problems the family might be having, and to assist with application renewals if needed.
- **Data entry.** Outreach workers routinely enter information into DHS's CHOI database, a web-based system that allows for detailed, individual level data entry to document outreach contacts, application submission, follow-up efforts, problems encountered, and renewal activities, among myriad other things.

In addition, most agencies conduct outreach and application assistance in fundamentally the same way. Outreach staff typically work in out in the community, or when employed in a health care setting in the clinics of their agencies (so-called "inreach"). They talk with parents in a group setting or one-on-one, discussing the importance of health insurance, asking about the insurance status of their children, and informing them of the availability of no- or low-cost coverage through Medi-Cal, Healthy Families, and Healthy Kids. They may help families with completing applications right there, on the spot, but typically they make appointments to meet with parents at a later date. This way, they can ask parents to come prepared with the necessary documents for completing the application (typically proof of Los Angeles County residency and verification of income). At these appointments, outreach specialists spend between 30 and 60

minutes with a parent, reviewing each family member's eligibility for various programs and completing the appropriate application(s). They inform the parent that they will follow up from time to time, to check on the status of the applications and help them with any problems they may have encountered. Finally, after the appointment is over, the worker submits the applications to the appropriate administrative agency (Medi-Cal and Healthy Families applications to the "single point of entry" contractor in Sacramento; Healthy Kids to L.A. Care), and enter information related to the encounter into the CHOI database. Again, within 90 days, the worker attempts to contact every family to learn the status of their application. (For detailed examples of alternative outreach models in the county, see the "vignettes" for *GEM*, *MCH Access*, *Crystal Stairs Inc.*, and *NexCare*.)

The Healthy Kids application was modeled after that of the joint Healthy Families/Medi-Cal for Children form. Applications can only be submitted to L.A. Care once they have been certified by an outreach worker. (In other words, parents cannot submit applications directly to the program.) This approach was adopted to ensure that that all families would be screened for Medi-Cal and Healthy Families eligibility before being enrolled in Healthy Kids.

When L.A. Care receives an application, it is forwarded to one of three staff dedicated to Healthy Kids eligibility determination. These staff, using a purpose-designed, Oracle based system, screen each child again for Medi-Cal, Healthy Families, and then Healthy Kids. Applications for children who are found eligible for either of the two larger state programs are forwarded to the "single point of entry" vendor in Sacramento, while applications for Healthy Kids-eligible children are completed in house. According to outreach and enrollment staff, families usually know the outcome of their application within 8 to 10 days of submission.

### *Get Enrollment Moving (GEM)*

GEM (Get Enrollment Moving) is a nonprofit project located in SPA 3 of Los Angeles County, serving the East San Gabriel Valley. With a specific focus on expanding participation in the Medi-Cal, Healthy Families, and Healthy Kids programs, GEM provides education about preventive health care, information about health care options, enrollment assistance into health insurance programs, and support for families navigating the health care system. The project's outreach and enrollment activities are currently funded through grants from the Los Angeles County Department of Health Services, First 5 LA, The California Endowment, and L.A. Care.

GEM has become a well-respected outreach and enrollment entity in a short time - the project was launched just four years ago (2001) by Citrus Valley Health Partners (CVHP) at the Queen of the Valley hospital in West Covina. Among outreach and enrollment organizations within the county, GEM is notable for its community-based model, which utilizes local volunteers called "promotoras de salud" (promoters of health). The promotoras (who refer to themselves as *pueblo que camina*, or "the walking village") conduct outreach door-to-door and distribute information on affordable health insurance and health education services in low-income neighborhoods across the East San Gabriel Valley. Occasionally some of the outreach workers attend events (like health fairs) to familiarize a wider audience with the project, but all informants agreed that individual, targeted outreach to families was a more efficient way to enroll people into health coverage programs. While there is a single paid coordinator of the Promotoras within the project, all others are volunteers. Key informants at the project emphasized that volunteers, of which there are approximately 200, are "the backbone of the project."

Members of the evaluation team accompanied a group of Promotoras one morning as they visited a SPA 3 neighborhood. A group of ten Promotoras met in the parking lot of a local church before splitting into smaller groups and spreading throughout the neighborhood. Promotoras described their goal as working with families to assure that all members have some source for obtaining health care (even if some members are not eligible for enrollment into an insurance program). When they visit a household, workers identify children in the family, and members who are pregnant or disabled that could qualify for enhanced health care benefits. They ask families already enrolled in a health insurance program whether they need any help accessing their benefits. If they find a household with uninsured members, promotoras fill out a preliminary intake form with a contact name and number. Using the information on the form, GEM workers stationed at the program office follow up by calling families to make arrangements for completing a program application.

Key informants at GEM attributed the project's success to the reputation of the Promotoras as trusted members of the communities in which they work. While the barrier that the outreach workers meet most frequently is fear of "public charge", they have been successful in dispelling these fears because of their status as trustworthy and genuine community members. GEM staff described the Healthy Kids program as "heaven-sent" and expressed their happiness at now being able to enroll every child they encounter into an insurance program.

### *Maternal and Child Health Access*

Maternal and Child Health Access (MCHA) is a community-based organization located in downtown Los Angeles that has been serving low-income women and their families for nearly a decade. The agency and its bilingual staff offer outreach and case management assistance as well as weekly educational and support classes to SPAs 4 and 6 in an effort to ensure access to needed health and social services for the community. In addition, MCHA is actively involved in trainings throughout the county on issues related to health access including, among others, training for new public health nurses on when to refer patients to community agencies for enrollment assistance and basic training for new Certified Application Assistors (CAAs). The agency's outreach and enrollment activities are funded by the Los Angeles County Department of Health Services (LACDHS). MCHA has been actively involved in outreach and enrollment with LACDHS since the county began awarding contracts for outreach and enrollment through its 1931(b) funds in 1999.

MCHA's outreach staff participates in a number of strategies: health fairs, presentations at schools and churches, and various forms of street outreach in places such as laundry mats, the Mexican consulate offices, indoor swap meets and the fashion district. While MCHA staff uses these venues to offer enrollment assistance and set up appointments to assist with the application process, the agency finds that most people approached in such settings are already covered. Instead, these families often need help with utilizing services under their current health coverage program and paying medical bills. Therefore, the majority of assistance provided by MCHA is largely focused on what staff refer to as, "troubleshooting". MCHA staff uses their advocacy experience and familiarity with health coverage programs to provide this necessary case management assistance to families.

The agency and its staff also provide comprehensive application assistance. Application assistance is largely provided in person and by appointment, but if needed, MCHA staff also helps families complete applications over the phone and will even mail applications to a family and highlight where they need to sign and indicate what documentation is required. Once an appointment is set up, staff conduct a thorough screening of each family member, assessing their eligibility for the various coverage programs. The screening process begins with Medi-Cal and Healthy Families. MCHA seeks to ensure that "everyone in the family will walk out with something." Once the appropriate applications have been completed, the outreach worker spends additional time with the family to explain utilization and access, health care system basics, and consumer rights and responsibilities. In keeping with its mission to ensure that families utilize and receive services once covered, MCHA staff contact families 3 months, 6 months, and 11 months following application completion to ensure that families obtain approval, utilize services, and maintain coverage over time.

Key informants at MCHA were generous in their praise for the Healthy Kids program. Particularly when compared to Medi-Cal and Healthy Families, Healthy Kids was thought to be the most affordable and the easiest program to apply for and use. In particular, MCHA staff noted that the expansion to cover 6-18 year olds was an important and necessary piece of the local program.

## *NexCare*

The NexCare Collaborative is a non-profit organization created four years ago to serve the health and social services needs of individuals and organizations. Shortly after its launch, the Collaborative contracted with First 5 Los Angeles to develop the First 5 LA *Connect* program. First 5 LA *Connect* is an information and referral center for families and their young children. Caregivers can take advantage of *Connect's* resources by contacting its professional call center (which is free and confidential) or by browsing the program's website for advice about parenting techniques, pregnancy, and childrearing as well as for information about obtaining health care and insurance coverage for their children.

NexCare employs a staff of approximately 40 information specialists to answer calls at its state-of-the-art center. Among the information specialists are nurses, social workers, and other individuals with experience providing care and services to young children and their families. Every specialist is bilingual (the majority speak both English and Spanish) and trained as a Certified Application Assistor (CAA). The specialists assist callers by assessing the need of the entire family and providing links to agencies or services that can meet these needs. The program has an exceptional referral network of more than 17,000 agencies that provide access to childcare, housing, counseling, health insurance, and many other services. Each call is tracked and monitored through a quality assurance system.

Every caregiver that calls in to First 5 LA *Connect* is questioned about health insurance coverage. Uninsured children are screened for Medi-Cal, Healthy Families and Healthy Kids eligibility. Call center specialists fill out an appropriate application electronically (both the screener and the e-application were developed in-house) while caregivers are on the line, after which they mail the nearly complete application to the family for signature and to verify that all information is correct. Families then return applications to NexCare, where they are reviewed thoroughly before being forwarded to L.A. Care or the "single point of entry" vendor in Sacramento. In total, the process takes about 2 weeks and this attention to detail has paid off - the First 5 LA *Connect* program boasts a very low denial rate for the applications they assist clients with; officials indicated that the rate was less than one percent for the first year of Healthy Kids. The center also utilizes a sophisticated retention program where trained specialists call families (enrolled through First 5 LA *Connect*) at renewal time in order to reevaluate family status and assist with renewing coverage.

NexCare officials estimate that about half of the calls they have received were in response to media coverage on local news channels. Remaining calls were generated by the Collaborative's partnerships with organizations that "vouch for [First 5 LA *Connect*] as a safe and confidential place." Informants indicated that media attention and a well-trained staff were key to the program's success; each information specialist must complete two weeks of intensive training.

In the three years that the program was funded, First 5 LA *Connect* served over 100,000 children and their families and assisted in the enrollment of more than 18,000 children into health insurance programs. The largest barrier that NexCare officials reported is inherent to its creation as a call-center, because specialists only have access to parents who make the decision to call in to First 5 LA *Connect*. In this respect, their reach is limited. However, the ability to screen for health insurance eligibility and assist with the completion of applications is a significant draw for the program, and has prompted many parents to make contact with First 5 LA *Connect*.

### *Crystal Stairs, Inc.*

Crystal Stairs, Inc. (CSI) is a non-profit organization with twenty-five years of experience in child care, advocacy, and research to serve Los Angeles residents. CSI's mission is to blend services in the fields of child care, child development and family functioning to promote and enrich the lives of its clients. In keeping with this purpose, CSI has been actively involved in health insurance outreach and enrollment efforts throughout Los Angeles County. While the agency and its bilingual staff (a total of 9 outreach specialists) conduct outreach and provide enrollment and case management assistance primarily for SPAs 6, 7, and 8, the organization aims to provide assistance to all those who seek it. CSI's outreach and enrollment efforts are currently being funded by the Los Angeles County Department of Health Services and The California Endowment.

In its outreach efforts, CSI uses a number of strategies, including handing out flyers, sending mass mailings, and informing families about health coverage. In particular, CSI focuses on outreach to WIC sites, churches, schools, and at health fairs and clinics. At these sites, CSI makes presentations, offers health education, and provides enrollment assistance. However, CSI also meets with priests and other key community members to establish new relationships and outreach sites. Typically, outreach workers set up regularly scheduled times at the sites to ensure that families know where and when CSI will be available for assistance. Each outreach worker is responsible for a designated geographic area. When onsite, CSI outreach workers provide health care information and application assistance as needed often by setting up appointments with clients.

The application process is a lengthy one that entails a series of questions about income, family size and other relevant information to determine the eligibility of each family member for the available programs. CSI outreach staff work to ensure that each member is provided assistance with health coverage and will also give safety net options and other health related referrals if needed. Once applications are completed, CSI outreach staff conduct several follow-up telephone calls to ensure that clients are approved for coverage, enrolled, utilize services, and retain coverage over time.

As part of its child care services, CSI sends out a regular newsletter to all families and clients. CSI uses this newsletter to highlight information about health coverage programs, as well as provide basic information on the importance of health care and other health-related topics. CSI has also expanded their outreach efforts by connecting parents seeking child care referrals and services to outreach staff dedicated to enrolling eligible children into available health coverage programs. CSI's participation in outreach and enrollment has enabled the agency to utilize all available resources to reach and enroll families who would otherwise remain uninsured. An educational component of the organization's outreach and enrollment efforts includes addressing health coverage utilization and retention.

Interviews with key staff at CSI indicated that the addition of the Healthy Kids program in Los Angeles County has greatly improved health coverage for children, particularly those ages 6-18. Parents have been positive in their responses to Healthy Kids and sometimes request the program for their child even when he/she is eligible for Medi-Cal. In comparison to other programs, parents view the Healthy Kids program as the easiest and most affordable way to receive comprehensive health coverage for their children.

### *3. Eligibility Renewal*

Children enrolled in Healthy Kids receive 12 months of “continuous eligibility.” That is, regardless of changes in family income or circumstance, children remain eligible for a full year. Given that children were first enrolled in the program in July 2003, it follows that these enrollees would go through their first eligibility redetermination in July 2004. However, officials at L.A. Care and members of the CHI’s Program Integration Workgroup knew at the time that the Healthy Kids renewal procedures were not developed, or simple enough to ensure that eligible children would remain enrolled. Specifically, the renewal form was essentially a blank duplicate of the initial application and would require re-completion by families, as well as resubmission of income and residency verification.

Studying the policies of other counties and selected SCHIP programs, Program Integration Workgroup members set out to design as passive an approach to renewal as possible. What resulted was the creation of a new, “semi-passive” renewal form that is “pre-populated” with family information already in the system. This pre-printed form is sent to families for review and verification. Families are required to respond to L.A. Care, either to confirm that all information is still current and accurate, or to inform the plan of necessary changes. Once returned by mail, the application is then be reviewed by plan staff for ongoing eligibility. Of note, families are sent their renewal packets 45 to 60 days in advance of their renewal date, and L.A. Care places at least three follow-up calls to families to ensure that renewals are completed. For those families that do not respond, 30 days notice is given before any child is disenrolled.

It took several months for this system to be designed and implemented, but the first children to go through the revised Healthy Kids renewal process did so in the fall of 2004.

### *C. Lesson Learned*

By all indications, the Healthy Kids outreach, enrollment, and renewal systems are working very well. Key informants, including numerous front-line application assistors, reported that:

- The CBOs that had received outreach contracts were strong organizations, trusted and well known in their communities, and possessing skilled multi-lingual staff that “connected” with the target population of low-income Latino families;
- Community-based outreach was succeeding in finding families with uninsured children and helping them to complete applications for Medi-Cal, Healthy Families, and Healthy Kids;
- Outreach workers, operating in a variety of settings, were quite successful in dispelling immigrant families’ fears of applying for government assistance and clarifying that obtaining health coverage does not constitute a “public charge” that can harm their ability to obtain citizenship;
- The Healthy Kids application was easy to complete and families typically had little trouble producing income and residency verification, but appreciated the option of self-reporting these requirements if it was deemed necessary;
- Application processing was occurring smoothly and quickly, with most Healthy Kids applications being submitted complete (by CBOs) and most determinations being made within 10 days; and
- The DHS CHOI data system, while taking some getting used to, was easy to use and provided a useful tool to both CBOs and DHS in documenting outreach activities and helping to identify and trouble-shoot problems in the systems.

Process measures collected routinely by the evaluation team strongly support the impressions of key informants. As illustrated in Figure 1, DHS contractors are making a high volume of contacts with families—nearly 130,000 during the calendar year ending June 2005—in a broad range of settings. Nearly one-third of contacts are made in providers’ offices or clinics, while roughly 15 percent occur in WIC clinics or “outdoors” in the community. Remaining contacts are spread relatively evenly across religious and cultural centers, schools and Healthy Start sites, Head Starts and child care centers, and other community settings.

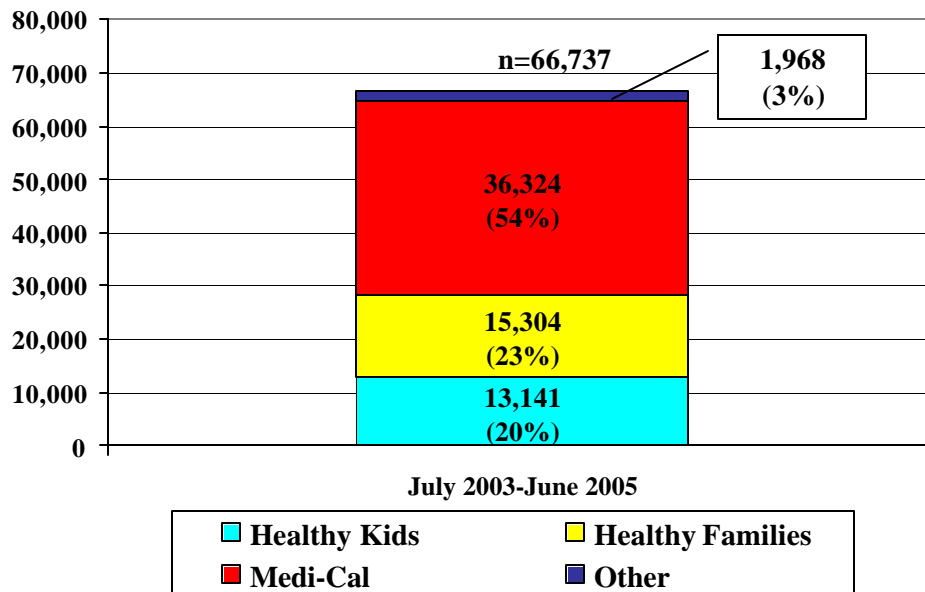
**Figure 1: DHS Outreach Contacts by Location, July 2004-June 2005**

Outreach Locations	July 2004-June 2005	
	# of Contacts	% of Contacts
Providers and Clinics	34,847	27%
WICs	20,601	16%
Outdoor Outreach	19,914	15%
Religious & Cultural Centers	12,052	9%
Schools and Healthy Starts	10,340	8%
Head Starts and Other Child Care Centers	9,444	7%
Community Centers	9,319	7%
Other	13,064	10%
<b>Total</b>	<b>129,581</b>	<b>99%</b>

Source: Estimates using the CHOI Database produced by LAC DHS MCAH staff.  
 \*Estimate does not sum to 100 due to rounding.

Figure 2 provides clear evidence that outreach workers are fulfilling their goal of assisting families with applications for *all* available coverage programs, not just Healthy Kids. Indeed, over 50 percent of all children’s applications are submitted to Medi-Cal, with another 23 percent sent to Healthy Families, and just 20 percent to Healthy Kids. In addition, nearly 2000

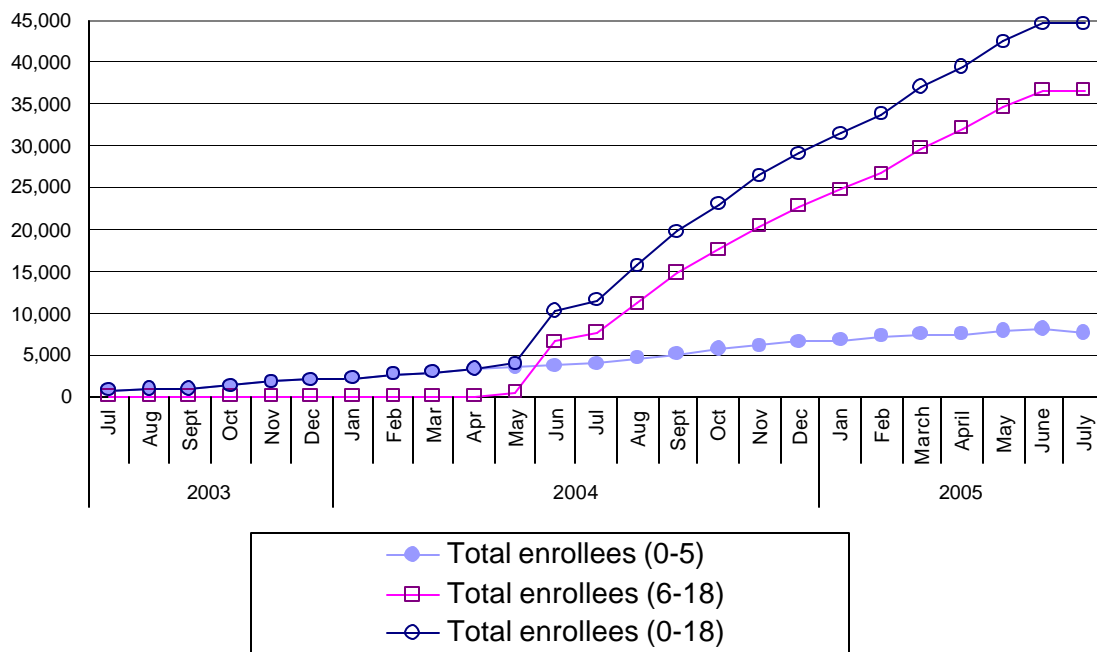
**Figure 2: Distribution of Applications Submitted with Assistance by DHS, by Program**



applications were submitted to “other” programs, most often on behalf of adults.

Effective outreach and application assistance has fueled strong and steady rates of enrollment. Figure 3 illustrates that Healthy Kids has insured over 44,000 children in just over two years; with the most dramatic rate of enrollment growth occurring after May 2004 when children ages 6-18 were added to the program. As of July 2005, 7,870 (17 percent) of the program’s 44,624 enrollees were children ages 0-5. After just two years of implementation, Healthy Kids has already surpassed the enrollment objective set by First 5 LA of enrolling 50 percent of the 14,000 estimated eligible children under age five. Across children of all ages, Healthy Kids has enrolled 51 percent of estimated eligibles.

**Figure 3: Cumulative Healthy Kids Enrollment, by Month and Age, July 2003-July 2005**



With regard to renewals and rates of retention, early data also reveal that the system is working well. As shown in Figure 4, of the first 1,147 children to complete eligibility

redetermination by June 2005, 56 percent retained eligibility. Of the 421 children (36 percent) who were disenrolled, the vast majority were found ineligible upon redetermination because they had moved out of the county, a reason that bears no reflection on the quality of, or parents' satisfaction with, Healthy Kids. This retention rate also surpasses the objective set by First 5 LA of retaining 60 percent of all children enrolled in health coverage programs by June 2005.<sup>9</sup>

**Figure 4: Status of Healthy Kids Retention Objective for Members Ages 0-5, June 2005**

<b>Healthy Kids Enrollment</b>	<b>First 5 LA Objective (By June '05)</b>	<b>Number of Children Enrolled</b>	<b>Percent of Eligible Children*</b>
Children Ages 0-5	50%	7,870	56%
Children Ages 6-18	--	36,552	51%
<b>Total Children</b>	<b>--</b>	<b>44,624</b>	<b>51%</b>

\* Based on 2003 CHIS estimates of total number of uninsured children 0-18 who are ineligible for Medi-Cal or Healthy Families Enrollment as of June 1, 2005

This is not to say that everything is working ideally, however. Key informants did discuss a range of challenges they observed with regard to outreach, enrollment, and retention. Primary among these was the challenge outreach workers faced when attempting to learn the status of applications submitted to Medi-Cal and Healthy Families. Both front-line workers and child advocates often described the submission of applications to the “single point of entry” (SPE) as akin to dropping into a “black hole.” (Slow and inconsistent processing was attributed to the awarding of the SPE contract to a new vendor in 2003; however most informants thought the situation would improve over time.) Unfortunately, most workers (those not working in provider/clinic settings) do not have access to automated verification systems that can tell them

<sup>9</sup> The First 5 LA retention objective is actually 60 percent across *all* coverage programs—Medi-Cal, Healthy Families, and Healthy Kids. Available data, however, only pertain to Healthy Kids retention.

the status of applications, and thus had to rely on self-reports by family members when determining whether children had received, or not received, coverage. Some outreach workers reported that, to avoid problems with the SPE, they would refer families with Medi-Cal eligible children directly to the LA County DPSS for enrollment, to avoid the possibility of their application getting lost or delayed in Sacramento.

This problem is just one example of the kinds of challenges that occur when eligibility systems for multiple programs work alongside one another, according to key informants. California's (and the nation's) "patchwork" of coverage programs, layered upon one another, actually have program rules that are fairly well aligned. However, the multitude of pathways through which families can learn of, apply for, and gain coverage can create confusion and barriers to enrollment. Such confusion has only been exacerbated, say outreach workers, with the implementation of the enrollment "cap" and parents' uncertainty over when, or even whether, their older children can gain coverage under Healthy Kids.

Another related challenge was coordinating Healthy Kids eligibility with eligibility under Emergency Medi-Cal and CHDP—the California Health and Disabilities Program. Both Emergency Medi-Cal and CHDP coverage (for preventive health examinations) are available to non-citizen, undocumented children and families. Our interviews with key informants revealed that the vast majority of families had experience with coverage under these two programs and, indeed, often possessed such coverage even after obtaining Healthy Kids. Thus, outreach workers acknowledged that it is often confusing for families to understand which "card" they should use when obtaining services. (This challenge is discussed in further detail in Section V of this report.)

Other challenges identified by key informants interviewed for this study included:

- As well as outreach systems appeared to be working, some key informants observed that the vast majority of enrollees were children of the lowest income families, and speculated that new strategies might eventually be needed to reach higher income families (though these individuals also acknowledged that the pool of eligible higher income children is likely quite small).
- Several outreach workers acknowledged that the program was slow to produce Spanish-language versions of application materials, forcing them to use and translate applications printed in English until the spring of 2004.
- Conducting outreach in school settings was described as consistently challenging. While obviously a setting “where the children are,” outreach workers said that they had to negotiate outreach efforts on a “school-by-school basis,” since support for health coverage outreach varied from principal to principal, and school nurse to school nurse. Generally, informants acknowledged that schools were often overwhelmed in simply meeting their education responsibilities, and the ability to take on additional roles related to health coverage outreach were limited. When resources did permit it, however, the model was described as a very effective one.

## **IV. Benefits**

### ***A. Policy Development***

The Healthy Kids benefit package was designed with special consideration to Healthy Kids initiatives in other counties, as well as Medi-Cal and, in particular, Healthy Families.

Policymakers wished to design a benefits package to address the concern that some families in the county have children enrolled in multiple public insurance programs, or children who move from one program to another over time. Coordination of the three programs could reduce confusion for these so-called “split” families and ensure that benefit levels among Medi-Cal, Healthy Families, and Healthy Kids are equitable.

During the program design phase, members of the Healthy Kids advisory committee weighed the advantages of developing a benefit package like that of Medi-Cal, with its comprehensive benefits and provisions for developmental screenings, versus a package like that of Healthy

Families, which offers broad but somewhat less comprehensive coverage based on private insurance products. Because Healthy Kids provides coverage to children in families with incomes of up to 300 percent of FPL—higher than the limits of the Healthy Families program—policymakers did not want to create a benefit package for Healthy Kids enrollees that was richer and more comprehensive than the package that Healthy Families enrollees would receive. Child health advocates, however, preferred the adoption of a package that mirrored Medi-Cal—considered the “gold standard” because it is so comprehensive—while more fiscally conservatives members of the committee supported the idea of modeling benefits after Healthy Families rather than adopting a package associated with Medi-Cal and the receipt of public welfare. Perhaps most importantly, policymakers were interested in aligning the LA Healthy Kids program with those created by other counties—San Mateo, Santa Clara, Alameda—each of which adopted packages very similar to the state’s Healthy Families benefit package.

### ***B. Program Characteristics***

Ultimately, policymakers designed the Healthy Kids benefit package to mirror that of the Healthy Families program, with only a few differences. Specifically, each of the health plans that participate in Healthy Families have the option of providing chiropractic and orthodontic services; the Healthy Kids plan does not include these services. (Figure 5 lists benefits covered through the Healthy Kids program.)

There are a greater number of distinctions between the Healthy Kids and Medi-Cal benefit packages, however. Medi-Cal child enrollees are covered for both orthodontia and chiropractic care while Healthy Kids enrollees are not. Some prescription drugs are covered by the Medi-Cal program, but not under Healthy Kids. And, most notably, the Early and Periodic Screening, Diagnostic, and Treatment (called Child Health and Disability Program, or CHDP, in California)

**Figure 5: Healthy Kids Member Benefits**

- Well child and preventive services	- Durable medical equipment
- Dental and vision services	- Hearing aids and services
- Physician, outpatient, and surgical services	- Medically necessary skilled nursing facility care
- Physical, occupational, and speech therapies	- Diagnostic X-ray and laboratory services
- Inpatient hospital services	- Health education services
- Inpatient and outpatient mental health services	- Family planning services
- Inpatient and outpatient substance abuse services	- Home health services
- Emergency care	- Skilled nursing care
- Prescription drugs	- Hospice
	- Medical transportation
	- Organ transplants

benefit that is available to all children enrolled in Medi-Cal is absent from the Healthy Kids package. Since Healthy Kids does cover well child exams according to the same periodicity schedule as CHDP, the key difference is Healthy Kids' lack of CHDP's federally-mandated coverage of any and all conditions identified during a CHDP screen, regardless of whether the services are covered under the state's Medi-Cal plan.

### ***C. Lessons Learned***

In general, key informants interviewed for this case study believed that the Healthy Kids benefit package was quite comprehensive and voiced few concerns about its adequacy. Providers reported that preventive and dental care were the most widely-used benefit among program members. Several of the child health advocates that we spoke with indicated that they would have preferred that the package more closely resemble Medi-Cal, with "CHDP-type" protections,

and noted that some benefits that are often needed by older children—such as substance abuse services, family planning, and orthodontia—were not part of the Healthy Kids package at the time of our site visit. Advocates explained that these exclusions reflected the fact that the original Healthy Kids population was children under age five (and thus not in need of these benefits), but pointed out that the benefit package was not initially expanded when the program began enrolling 6-18 year-olds. At the time of this writing, however, member benefits had been enhanced to include substance abuse coverage of both inpatient/detoxification and outpatient services, as well as family planning.

An advisory committee member who is also a pediatrician observed the absence of an explicitly-defined developmental screening benefit under Healthy Kids and suggested that this was a potential weakness, given that the program was created with a key goal of promoting the healthy development of young children. Still, several respondents indicated that developmental assessments were being administered, mostly by safety net providers.<sup>10</sup>

## **V. Service Delivery and Payment Systems**

### ***A. Policy Development***

Children enrolled in Healthy Kids receive care through the L.A. Care Health Plan network. As discussed in Section 1 of this report, there were many reasons why L.A. Care emerged as a natural choice for the program's service delivery system. Primary among these, it is a private, not-for-profit health maintenance organization designed to serve enrollees in public coverage programs. As such, it had a long history and great experience serving families under Medi-Cal and Healthy Families, and had grown to become the largest public health plan in the nation

serving over 750,000 Los Angeles County residents. L.A. Care is the “local initiative” plan for Los Angeles County<sup>11</sup> and the largest Medi-Cal provider in the county, and also an active participant in Healthy Families. Thus, it offered Healthy Kids the promise of relatively seamless coverage for families with children enrolled in multiple programs. The plan also is accountable to the greater Los Angeles community through its governing board, made up of 13 members representing medical and health care professionals, as well as consumers. The other plan that might have offered a viable alternative for the Healthy Kids Advisory Board—the county’s *Community Health Plan*—was removed from consideration early in the Board’s deliberations when First 5 LA Commission Chairman, County Supervisor Zev Yaroslavsky, expressed his preference that Healthy Kids not have the aura of a “county government program.” This view was seconded by the Commission’s representative from the County Department of Health Services, Jonathan Fielding. So, following the lead of Child Health Initiatives in Santa Clara and San Mateo Counties, First 5 LA formed its strategic partnership with the “local initiative” in the county, L.A. Care.

### ***B. Program Characteristics***

L.A. Care designs distinct networks for its various lines of business, thus there is close, but not perfect, overlap between the networks offered for Medi-Cal, Healthy Families, and Healthy Kids. According to L.A. Care officials, the Healthy Kids network is the smallest among the three programs, yet still offers enrollees a choice of over 1,400 primary care providers (PCPs), and includes 2,343 specialist and 45 hospitals. Designers set out to build the Healthy Kids network

---

<sup>10</sup> Another key informant told us that, according to the American Academy of Pediatrics, fewer than 50 percent of pediatricians use validated tools for developmental screening. Most instead ask parents a few questions about how their child is developing and “eyeball” the child.

<sup>11</sup> Under California’s Medicaid managed care system, numerous counties operate under a two-plan model, whereby one plan, called the “local initiative,” is developed by the county in conjunction with local stakeholders including physicians, hospitals, clinics, and pharmacists. The second plan, usually called the commercial plan, is a non-governmentally operated HMO.

around the county's "safety net" of Federally Qualified Health Centers, community clinics, county health departments, and public hospitals. As such, over 300 of its PCPs practice in safety net settings.

Upon enrollment into Healthy Kids, families are contacted by L.A. Care and asked to select a PCP. PCP selection is a condition of completing the eligibility process. No "auto assignment" process exists for Healthy Kids. Thus, staff work with parents until a choice of PCP is made.

L.A. Care's network includes two important subcontractors. First, Safeguard Dental is responsible for delivering children's dental care. Safeguard, a private dental managed care organization formed in 1974 but relatively new to government contracting, began serving Medi-Cal and Healthy Families enrollees in Los Angeles and a handful of other counties across the state in 2003 when it purchased HealthNet. In Los Angeles County, Safeguard has recruited approximately 1,500 dentists for Healthy Families and Healthy Kids (i.e., the two programs' networks are nearly identical), 267 of which are pediatric specialists. For Medi-Cal, Safeguard has experienced more difficulty recruiting participants and the network stands at just under 500 dentists. According to plan administrators, the distribution of dentists across the county is quite even, with more choices available to Healthy Families and Healthy Kids enrollees. L.A. Care's second subcontract is with VSP Health Plan, a private vision managed care organization that is responsible for all vision services for Healthy Kids enrollees.

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). As is the arrangement under Medi-Cal and Healthy Families, children enrolled in Healthy Kids who possess chronic conditions or disabilities that qualify them for coverage under CCS are eligible to receive all specialty care related to their condition through

the CCS network. The CCS network comprises not only an extensive network of pediatric specialty physicians and children's tertiary centers, but also a county-based staff of public health nurses who provide CCS-eligible children and their families with case management and other support services.

With regard to payment arrangements, L.A. Care receives a single monthly capitation fee for each Healthy Kids enrollee. As of late 2005, this amount was \$82 dollars per member per month (PMPM). Of this, approximately \$13 (per member per month) supports dental service delivery through Safeguard Dental, and just under \$2 supports vision care services through VSP. L.A. Care, Safeguard, and VSP sub-capitate the primary medical, dental, and vision providers in their networks. (That is, each physician, dentist, and vision provider receives a per-member monthly fee for each child that elects them as their PCP, dental, and vision provider.) Sub-capitation amounts are not publicly available. Safeguard also pays additional fees for selected procedures, and all dental specialists are reimbursed on a fee-for-service basis.

### *C. Lessons Learned*

At this early point in the program's history, it was premature for most key informants to comment on the adequacy of the Healthy Kids network. However, most had the general impression that it was sound and well designed, and that sufficient numbers of providers participated to afford children access to needed care, especially primary care. No individual interviewed for this study, including outreach workers that directly assist families with utilization problems, were aware of specific instances where the system had failed with any serious consequence.

That said, most informants, including L.A. Care officials, believed that utilization rates for many services were somewhat low. The exception was at Safeguard Dental, where officials

described utilization rates that were on par with those under Healthy Families and higher than average among new entrants to the program, suggesting that Healthy Kids enrollees have pent-up demand (and needs) for dental services.<sup>12</sup> While data on actual service use will not be available for some time, some speculated that the utilization picture was being confused by parents' continued use of both CHDP and Emergency Medi-Cal. Reports of outreach workers, child advocates, and physicians and clinic staff suggest that families with children enrolled in Healthy Kids often still possess Emergency Medi-Cal and, in fact, use the cards when obtaining emergency or hospital care. If this is the case, that service use would not be reflected in Healthy Kids encounter or claims data, and thus would tend to understate actual service use. Similarly, given that we know that nearly one-third of children enroll in Healthy Kids with the assistance of outreach workers stationed at clinics or doctors' offices, we might presume that at least some of these children obtained CHDP screens at the same visits during which they enrolled in the program. Thus, again, these critical well-child services would not be paid for by Healthy Kids, nor captured in the Healthy Kids data.

There were also cautionary opinions expressed about whether or not the Healthy Kids network would afford timely access to specialty care. Physicians we interviewed described how difficult it typically was to find pediatric specialists to serve their publicly insured patients, including those on Healthy Kids, and how this resulted in children and families facing delays in obtaining specialty referrals and care. Even though Healthy Kids has established a "carve out" arrangement with CCS, plan officials acknowledged that there is no standardized test or screen that is administered to new enrollees to identify the presence of chronic illnesses or disabilities.

On a similar note, some key informants also pointed out that the network might not possess sufficient links with behavioral and developmental providers and systems of care. This was seen

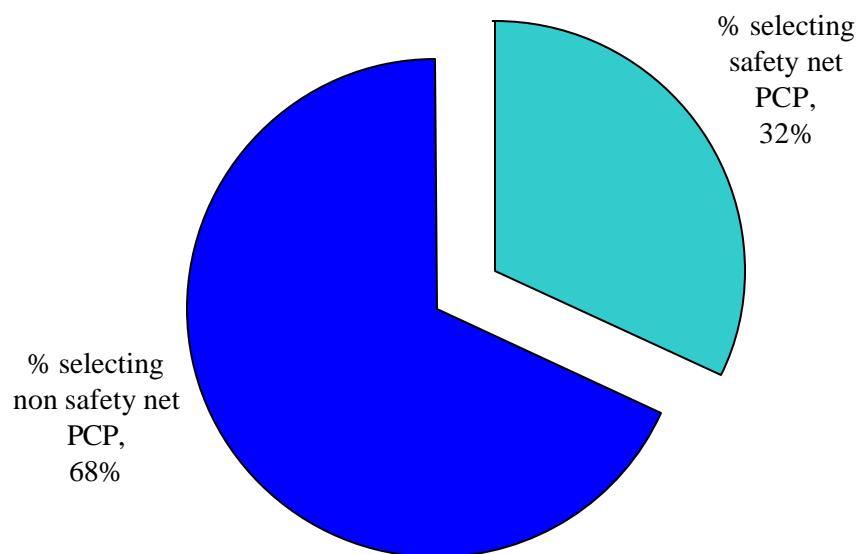
---

<sup>12</sup> Unfortunately, given the newness of the program, utilization data were not available.

as problematic, especially given First 5 LA’s explicit emphasis on supporting programs to promote healthy child development. (For detailed examples of various providers’ experiences with Healthy Kids, see the “vignettes” for *The Venice Family Clinic, A Private Pediatric Provider, and The Long Beach Children’s Clinic, Serving Children and Their Families.*)

Process measures collected by the evaluation, however, suggest that many children may be benefiting from developmental screening and follow-up services by virtue of their choice of primary care providers. As illustrated in Figure 6, fully one-third of Healthy Kids enrollees receive their primary care from PCPs who work in safety net settings. L.A. Care officials and others involved in designing the Healthy Kids program were gratified by this measure, as it was intentional that the network be built around Los Angeles County’s safety net providers for the very reason that they were better equipped and more likely to administer developmental screens and provide follow-up care to those that required it. Importantly, this rate is three-fold higher than that of Medi-Cal and Healthy Families, where only 10 percent of children receive primary care from PCPs who work in safety net settings.

**Figure 6. Healthy Kids Enrollees by Type of Primary Care Provider Selected, June 2005**



Source: L.A. Care Health Plan

### *The Venice Family Clinic*

The Venice Family Clinic (VFC) is the largest free clinic in the nation and provides primary care to low-income, uninsured and homeless individuals on the west side of Los Angeles. Founded in 1970, VFC began as a small volunteer-based clinic providing services in a borrowed office space. Today VFC serves over 21,000 patients annually at seven locations, including two high school clinics and a clinic located in a public housing complex. The patient population served by VFC is 64 percent Latino, 11 percent African American, and 3 percent Asian. Fifty-eight percent of patients are women, 22 percent are children, and 17 percent are homeless. Although the majority of VFC patients are uninsured (77 percent), 55 percent of children at VFC have some form of public health insurance. To serve its patients, VFC relies on a network of over 2000 volunteers, including 462 physicians that provide services on site or in their private offices.

Key informants at the clinic reported that Healthy Kids enrollees comprise approximately 10 percent of the pediatric practice. To date, no differences in health status between children with Medi-Cal, Healthy Families or Healthy Kids have been observed. At VFC, all children receive primary care regardless of their insurance status, either on a free basis or with the support of programs like CHDP and Emergency Medi-Cal. Therefore, most patients have had previous access to health care, even when uninsured.

The most commonly treated conditions include weight problems, asthma, and behavioral/learning problems. To address these issues, the clinic has a developmental pediatrician on staff, a volunteer allergist/immunologist, and health educators and nutritionists. Overall, the benefit package for all three programs is reportedly adequate except in a few key areas. Specifically, key informants noted problems with accessing orthopedic care and ophthalmologists, reporting several occasions in which children were treated by an orthopedic surgeon on an emergent basis, then sent out to find follow-up care with a different provider. Despite this, the clinic is reportedly able to provide an adequate medical home for children.

The Venice Family Clinic routinely accepts donations from patients. Because VFC is an FQHC, its reimbursement for Medi-Cal is cost-based. In contrast, the capitated rates provided through Healthy Families and Healthy Kids are much lower.

VFC has had an active health insurance outreach and enrollment program since 1999. Currently they have five staff and an out-stationed Medi-Cal worker to identify, enroll, and case manage patient issues related to health insurance.

Overall, VFC interviewees see Healthy Kids as an important program for uninsured children. Enhancing access to sub-specialists and reducing the administrative burden through health insurance program integration and simplification would improve health care access for families in the future.

### *A Private Pediatric Provider*

A private pediatric provider serving Healthy Kids enrollees in a community in Service Planning Area 3 reported that the majority of his patients are Latino, but that he also serves residents from a variety of racial/ethnic groups. The provider, a Spanish speaker, joined a group practice in Los Angeles in 1996 and started a solo practice in 2001. The practice sees approximately 70 patients per day. Seventy percent of the patients are low-income and qualify for CHDP, Medi-Cal, Healthy Families, or Healthy Kids. The remaining 30 percent are privately insured and a small number of uninsured patients are also served on a sliding scale basis. Uninsured patients that need care beyond the scope of the practice are referred to University of Southern California, Children's Hospital of Los Angeles, or Queen of the Valley hospital.

Although originally trained in internal medicine in Central America, the provider now practices General Pediatrics and sees children for well-child care and common illnesses such as asthma, gastroenteritis, skin infections, and respiratory illnesses. The health status of low-income patients is worse than that of privately-insured patients, according to this informant. Approximately 5 to 10 percent of children in the practice have special health care needs, including ex-premature infants, children with cerebral palsy and developmental delay. For these patients, the pediatrician relies heavily on services provided through the local Regional Center, and notes that that few sub-specialists take Medi-Cal and the wait to see a neurologist is often three to four months.

Eighty percent of the practice's publicly insured population are capitated through various Independent Practice Association contracts. The other 20 percent are seen under fee-for-service (FFS) contracts, including those with the CHDP program. Office staff only collect copayments from families with private health insurance, and the provider was not aware that his practice was supposed to collect copays from Healthy Kids enrollees.

Overall, moving families from CHDP to a capitated plan represents a financial loss for the practice. However, the pediatrician recognizes that children have better access to services under a publicly funded health insurance program compared to CHDP, and is therefore supportive of their transition to a health plan. In addition, this informant reports frustration regarding vaccine reimbursement through the Healthy Kids program and claims that enrolling children in Healthy Kids is "not good for business."

The practice does not have staff dedicated to outreach and enrollment for health insurance programs. Fear of the U.S. Immigration and Naturalization Service (INS) in the area is strong according to this provider; INS "raids" in the community have resulted in families avoiding use of health services for themselves and their children. The provider believes that families may be fearful of applying for public coverage in this climate.

Overall, this private provider praised Healthy Kids and recognized it as an important program for the families he serves.

### *The Children's Clinic, Serving Children and Their Families*

Since its establishment in 1939, the Children's Clinic (TCC) has provided comprehensive and affordable health care to low-income and medically underserved families throughout the greater Long Beach area. Long Beach is the second largest city in Los Angeles County and is the most ethnically diverse city of its size in the country; 60 different languages are spoken by residents representing over 40 different cultures (including the largest population of Cambodians outside of Cambodia).

A network of six clinics across the city offer a full range of health care services and referrals to community resources. Three satellite clinics are located in elementary or middle schools. With such a diverse target population, TCC is dedicated to providing quality health care in ways that are linguistically appropriate and culturally sensitive. To meet the needs of working families, the clinics hold extended evening and weekend hours as well. Notably, the Children's Clinic has developed many programs that cater to low-income children with special health care needs (CSHCN) and their families. The clinic offers pediatric specialty care (with referrals for any specialist that is not on-site) and chronic disease management of asthma and diabetes.

The Children's Clinic employs ten CAA-trained outreach workers who rotate among the six sites, conducting in-reach to patients already seeking services at the clinics to assess eligibility and assist with applications for the Medi-Cal, Healthy Families, or Healthy Kids programs. Clinic officials estimate that about half of all TCC patients are uninsured. Around 70 percent of their clients are children. Providers indicate that much of the TCC patient population cycles on and off of public health insurance programs.

Key informants emphasized the importance of sustaining TCC activities and services through private fundraising and supplemental federal funding. They noted that, despite low reimbursements from public health insurance programs, providers "can spend the time we need to with patients" because of successful fundraising and TCC's status as a Federally-Qualified Health Center (FQHC).

Providers at The Children's Clinic acknowledged the important role that Healthy Kids plays for low-income families in the Long Beach area but expressed concern over the adequacy of program reimbursement rates and recommended that these be increased to encourage provider participation and endorsement. Currently, there are misaligned incentives for providers, who receive a higher payment for care they give children who are uninsured (through the CHDP Gateway program) than they receive once a child is enrolled in Healthy Kids. Additionally, providers at TCC were worried that copayment requirements for Healthy Kids enrollees may create a disincentive to enroll in the program for some parents, or may cause parents to delay seeking care for a sick child or obtaining needed medication. Concerned that copayments can force decision-making between food and clothing or medical care for patients living in extreme poverty, officials reported that they waive copayments if necessary.

When asked about the baseline health status of the children they were serving, physicians we interviewed reported that kids were generally healthy, and no less so than children insured under Medi-Cal or Healthy Families. Providers attributed this to the quality and effectiveness of the health care safety net for the uninsured, and also Emergency Medi-Cal and CHDP, which likely helped families and their children to access needed care. At the same time, they acknowledged the importance of the new Healthy Kids program, underscoring that it provided these children with more stable coverage and access to a primary care medical home. In terms of day-to-day practices, these physicians tended to think of publicly insured children as a single group, and did not explicitly treat or serve them differently, depending on their source of insurance.

With regard to payment, L.A. Care officials stated that the capitations they received for Healthy Kids enrollees were sufficient to cover their costs. Indeed, given apparent low utilization, they requested that rates for the second year of their contract with First 5 LA be lowered from \$88 PMPM to the current \$82 PMPM. Physicians, on the other hand, were not so favorably disposed. They reported that the payments they received under Healthy Kids were comparable to those of Medi-Cal and Healthy Families, and did not hesitate to say that they believed all three were inadequate.

## **VI. Cost-Sharing**

### ***A. Policy Development***

The design of cost-sharing policies garnered considerable debate within the Healthy Kids advisory committee during the program's planning phase. Committee members were not opposed to cost sharing, per se, (having anticipated that the policies would be included in the program's design), but were quite concerned with how the requirements would be structured.

Mainly, there was divisiveness over whether or not to impose cost sharing for families in the lowest-income band—those earning incomes just over the FPL. The primary arguments against imposing cost sharing on these families were centered on affordability, and the concerns that premiums would act as a barrier to enrollment and copayments a barrier to service use. Also, opponents pointed out that under Medi-Cal, families earning incomes below 133 percent of poverty faced no cost sharing. Finally, a provider on the committee explained that families who have only recently immigrated to the United States may have little or no knowledge of how health insurance works, and thus not be familiar with the concept of a premium. For these families, the notion of paying a premium every month regardless of whether or not they used services might be a “hard sell,” discouraging them from enrolling their children.

Those who supported cost sharing for all Healthy Kids enrollees (regardless of family income) felt that the requirements likened the program to commercial insurance and Healthy Families, pointing out that families with children enrolled in that program often report that they take pride in contributing something toward the cost of their coverage. Additionally, including the cost sharing policies would make Healthy Kids consistent with other county initiatives, all of which have policies which require premiums or enrollment fees and copayments for all enrollees, regardless of family income level.

Ultimately, a compromise was reached: in return for creating a three-tiered premium structure in which the very lowest-income families (those at or below 133 percent of FPL) would not pay premiums, it was decided that all Healthy Kids enrollees, regardless of income level, would pay copayments for certain health services. Also, to help offset concerns that premiums might create a barrier to enrollment for higher income families, policymakers created a “hardship” fund for families who report that they cannot afford the monthly payments. Key

informants interviewed for this study reported general satisfaction with this compromise, and the Los Angeles Healthy Kids program is currently the only county initiative that does not require a premium or enrollment fee for families in the Medi-Cal equivalent income group.

***B. Program Characteristics***

Families with children enrolled in Healthy Kids may or may not contribute a portion of the Healthy Kids monthly premium depending on their income, but all are required to pay copayments when obtaining certain services. Figure 7 displays details regarding the Healthy Kids cost-sharing structure.

**Figure 7: Healthy Kids Cost-Sharing Policies**

<b>Premiums</b>	
<b>Family Income Level</b>	<b>Monthly Payment</b>
0 - 133% FPL	\$0 per child
134 - 150 % FPL	\$4 per child/maximum \$8 per family
151 - 300 % FPL	\$6 per child/maximum \$12 per family
<b>Copayments (Required of All Enrollees)</b>	
<b>Service</b>	<b>Payment</b>
Emergency Care	\$5 per visit (waived if child admitted)
Home Health Services	\$5 per visit
Mental Health - Outpatient Visit	\$5 per visit
Prescription Drugs	\$5 per prescription
Professional Services - Outpatient	\$5 per visit

*1. Premiums*

Families with incomes below 133 percent of poverty face no monthly premium. Families earning between 134 percent and 150 percent of poverty are required to pay \$4 per child per month, but will pay no more than \$8 per family per month even if they have more than two children. Families with incomes between 151 and 300 percent of poverty pay \$6 per child, with a family maximum of \$12 per month.

Families are billed each month by L.A. Care for the premium amounts due once enrollment is complete, and can make a payment by cashier's check, personal check, or money order. They have the option of paying 6 months of the premiums in advance, and receive a 25 percent discount if they do so. L.A. Care is responsible for collecting monthly premiums—the family contribution is considered part of the health plan's reimbursement. L.A. Care, in this role, is also the entity responsible for contacting families who fall behind in paying premiums, and do so whenever three months pass without payment. Site visit respondents reported that L.A. Care staff were very pro-active in this respect, and always offered such families "premium assistance" if they are unable to afford the payments. Importantly, failure to pay premiums is not cause for disenrolling a child from Healthy Kids.

## *2. Copayments*

All enrollees are required to pay \$5 when obtaining a prescription drug, making an emergency room visit, and receiving certain outpatient services. Copayments are due at the time of service delivery or when a prescription is filled. Individual providers and pharmacists are responsible for collecting copayments from families, and this amount is factored into the rate that L.A. Care pays those individuals.

Like the Healthy Families program, Healthy Kids policy maintains that no family should contribute more than 5 percent of their annual income towards cost sharing. In addition, rules state that the annual copayment maximum is \$250, meaning that families are not required to pay more than that amount during one benefit year, regardless of how many services they obtain. Families are responsible for monitoring their own contributions, but L.A. Care officials reported that they attempt to monitor this as well, through the plan's pharmacy and utilization databases.

### *C. Lessons Learned*

Key informants interviewed for this study generally did not believe that the program's monthly premiums created a barrier to enrollment for families. Outreach staff noted that Healthy Kids premiums are lower than those required of many Healthy Families enrollees from the same income group, and that the monthly maximum payments were also lower than those set by the SCHIP program.<sup>13</sup>

These informants felt comfortable making this observation given that enrollment data indicated that the vast majority of families with enrolled children earned income below 133 percent of poverty, and thus faced no premium obligation. Indeed, process measures collected for this evaluation illustrate that fully 87 percent of families are premium exempt, that 3 percent pay premiums at the \$4 per child level, and that just 10 percent of families with enrolled children pay at the higher \$6 per child level. (See Figure 8 – Percent Distribution of Healthy Kids Enrollees by Premium Status.)

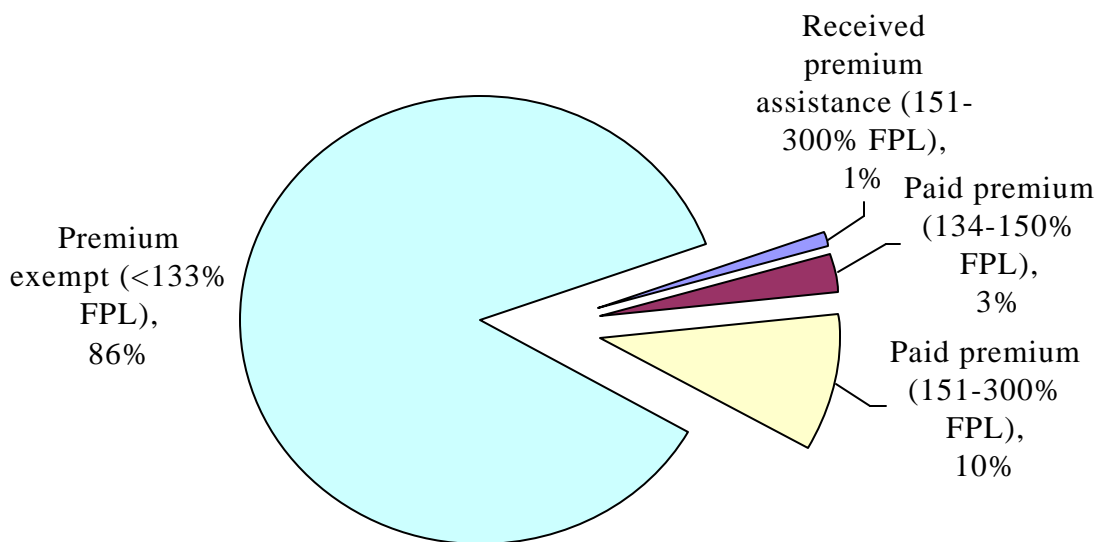
Another indicator that premiums are probably affordable for families is that very few parents accept premium assistance when it is offered. Since the program's inception, less than one-half of one percent of families have claimed hardship and accepted this assistance.

Case study interviews revealed that there was more concern surrounding the affordability of Healthy Kids copayments, however. Some individuals we interviewed had heard anecdotes about financial hardships associated with Healthy Kids copayments, particularly the prescription drug copay. Outreach staff said that some parents with Healthy Kids enrollees, particularly those

---

<sup>13</sup> As of July 2005, Healthy Families requires enrollees to pay the following monthly premiums (first amount given is for enrollees of the Community Health Plan, the second amount given is for enrollees of all other health plans): Children from families with incomes between 100 and 150% of the FPL pay \$4 or \$7 per child/\$8 or \$14 family maximum; incomes between 151 and 200% of the FPL pay \$6 or \$9 per child/\$18 or \$27 family maximum; incomes between 201 and 250% of the FPL pay \$12 or \$15 per child/\$36 or \$45 family maximum.

**Figure 8. Percent Distribution of Healthy Kids Enrollees by Premium Status**



Source: L.A. Care Health Plan, 2005

with children with special health care needs that need and use more services and prescription drugs, expressed concern about the affordability of mounting copayments. These same workers noted that there was no formal mechanism in place to waive copayments for families that cannot afford them, although providers have the option of forgiving copayments at the point of service delivery. We spoke with one provider whose clinic routinely did so, in order to avoid situations where parents might delay seeking care for their children. She asserted that “sometimes any payment can be a barrier to getting care.” Another provider with whom we spoke was not even aware that Healthy Kids enrollees were required to pay copayments (thus he, also, had not collected them).

Problems of affordability are complicated by the fact that other programs that pre-dated Healthy Kids and were often used by immigrant families to access health services—namely Public Private Partnership (PPP) funding or Emergency Medi-Cal—do not require any

copayments. Therefore, certain key informants we interviewed feared that some parents, facing mounting copayments, may be motivated to drop their children's Healthy Kids coverage and seek Emergency Medi-Cal or PPP-funded care instead. Other parents might not apply for Healthy Kids at all, if they perceive that it will be too expensive. To combat this possibility, several officials noted the need for education about the importance of continuous coverage and preventive care, and the differences between Healthy Kids and the alternative programs in these regards.

## **VII. Crowd-Out**

### ***A. Policy Development***

The substitution of publicly funded health insurance for existing private coverage, a phenomenon referred to as “crowd-out,” was a concern for policymakers during the Healthy Kids design phase. Crowd-out can occur in one of two ways—a privately-insured individual can choose to drop their private coverage in order to enroll in a public program for which they are eligible, or employers who offer private insurance to their employees can choose to discontinue that offer once they become aware of a public program for which their employees may be eligible. Many policymakers on the Healthy Kids advisory committee were unwavering in their insistence that the potential for crowd out was real, and on including policies to prevent it. Many others, however, strongly opined that substitution was unlikely to occur among the families eligible for Healthy Kids, arguing that virtually none of them had private health insurance, nor received offers of coverage (or dependent coverage) from their employers.

### ***B. Program Characteristics***

Ultimately, policymakers again chose to replicate the crowd-out policy of the Healthy Families program; a course also taken by other county initiatives in California. Specifically, the

policy states that children are only eligible for Healthy Kids if they have not been covered by an employer-sponsored health insurance plan in the three months preceding application.

### *C. Lessons Learned*

While no one denied the theoretical potential for crowd-out with the creation of Healthy Kids, it was widely agreed by the majority of informants interviewed for this study that virtually no crowd out was occurring under the new program, and that the population most likely to be eligible for Healthy Kids would be unlikely to have offers of employer-based health insurance for themselves or their dependents. Outreach staff noted that most of the clients they assisted with Healthy Kids enrollment were day laborers, with no prospects of health benefits through their jobs. For example, one outreach worker told us that she could remember only one family, out of approximately 2,000 that she had helped since the start of the program, that had employer-sponsored dependent coverage when they tried to apply for Healthy Kids.

Recent data from the 2003 California Health Interview Survey (CHIS), shared with us by another member of the advisory committee, provided further evidence of the unlikelihood of crowd out. The 2003 CHIS found that roughly two-thirds of all children within the income eligibility limits of Healthy Kids were not eligible for or did not receive an offer of employer-based insurance coverage. And since most Healthy Kids enrollees live in families with incomes below the poverty level, it is believed that the availability of private insurance would be even more rare for these families. At the same time, given that the upper income limit for the program is 300 percent of poverty, it is possible that adults in higher income families might possess jobs that offer coverage, and thus the potential for crowd out would grow.

Some respondents described what they consider to be a more probable crowd-out scenario, where area employers might decide to not offer dependent coverage for employees because they

are aware that government-sponsored programs like Healthy Kids exist. Once again, however, given the income profile of current Healthy Kids enrollees, most informants thought that employer-based crowd out was a greater danger for the Healthy Families program, which serves a generally higher income working poor population.

## **VIII. Financing**

As described in Section I, the Healthy Kids initiative began when First 5 LA committed \$100 million of the county's Proposition 10 funds to the creation of a children's health insurance program. State regulations require that these funds only be used to support programs and services for children ages zero through five, and that was the subset of children initially covered under the program. But it was always the hope and intent of policymakers that this investment would act as seed money, and that the program would eventually be expanded to serve all children through 18 years of age. Indeed, with the launch of the first phase of Healthy Kids, stakeholders immediately set out to plan and organize fundraising efforts for the subsequent expansion of the program to cover 6- through 18-year-olds.

The Children's Health Initiative (CHI) Coalition was created for the initial purpose of raising funds for the expansion of Healthy Kids. The CHI Coalition is made up of representatives from roughly 50 organizations, including First 5 LA, healthcare providers, private employers, business leaders, child and family advocacy groups, foundations, public health officials, labor unions, and educators. The three co-conveners of the Coalition are L.A. Care Health Plan, the California Endowment, and the Los Angeles County Department of Health Services. Members of the CHI meet monthly and a Fundraising Workgroup has worked tirelessly to raise sufficient money to provide stable, long-term health coverage for every child in Los Angeles County. By April 2004, the CHI had raised over \$80 million, enough money to begin the second phase of Healthy Kids

and start enrolling 6 through 18 year-old children. At the time of this writing, the CHI had raised just under \$100 million toward its ultimate goal of \$129 million, which would enable Healthy Kids to cover 44,250 children between the ages of 6 and 18 for three years.<sup>14</sup>

As positive as the fundraising has been, CHI Coalition leadership have long acknowledged that philanthropic support alone cannot sustain the Healthy Kids program in the long term. Indeed, the issue of long-term sustainability was brought into bold relief in June 2005 when strong program enrollment, exceeding expectations and projections, forced the CHI to place a “cap” on enrollment. At the time of this writing, enrollment stood at approximately 44,000 children, and just under 4,000 children were on the program waiting list. Attrition is expected to lower program enrollment to 35,000 children by late 2005, at which point plans call for lifting the cap and enrolling children off the waiting list.

As early as the fall of 2004, CHI leadership discussed with us the early development of a legislative strategy for obtaining state, and possibly federal, support for Healthy Kids initiatives across California. Since that time, the effort quickly gained momentum and the new Californians for Healthy Kids organization, organized by the PICO California Project and the 100% Campaign, began building statewide support for the effort and drafting legislative proposals for funding. Two bills were introduced to the California Assembly over the summer of 2005—one that would establish the California Healthy Kids Insurance program under which the existing children's health insurance programs—Healthy Families and Medi-Cal for Children—would operate in a more coordinated and seamless way, and a combination of private, federal, and state funds would be garnered to support health coverage for all uninsured children in the state; and a

---

<sup>14</sup> Major contributors include L.A. Care Health Plan, The California Endowment, Blue Shield of California Foundation, Queenscare Foundation, California Community Foundation, Weingart Foundation, Ralph M. Parsons Foundation, UniHealth Foundation, Kaiser Permanente Health Plan, Northrup Grumman, and the W.M. Keck Foundation.

second companion bill would create a Children's Health Care Trust Fund as a repository for public funds and private contributions to supplement existing state and federal funds already available for the California Healthy Kids program. By early September, both bills had passed through the legislature. In October, however, the bills were vetoed by Governor Arnold Schwarzenegger.

By all accounts, the CHI of Greater Los Angeles is providing the community with a dynamic and effective forum for both overseeing the ongoing operations of the Healthy Kids program, and for advocating universal children's coverage in Los Angeles. Without exception, key informants interviewed for this study commended the CHI coalition members for their commitment and (largely voluntary) investment of time and energy in the children's health initiative, as well as the group's ability to "work together without hierarchy." One respondent praised the CHI for "producing something of high value that is useful" and another reported that philanthropists have been more willing to give to the CHI expansion because the Healthy Kids infrastructure had been established and operating well for children ages zero through five; donors appreciated that all monies they pledged would be put directly towards premiums, rather than the development of a new program. As one policymaker summarized: "The CHI promotes a clear and powerful message—that every child in the county in a family with an income of 300 percent of poverty or less, can be covered through a health insurance program."

## **IX. Conclusions**

The Los Angeles Healthy Kids program is off to a good start. Based on information gathered during in-depth interviews with a broad range of stakeholders, it is clear that the program was carefully conceived and, to date, implementation has proceeded smoothly and with very few problems. Furthermore, it has been constantly nurtured during its early development through the

ongoing oversight of the Children's Health Initiative of Greater Los Angeles and, in particular, leadership of First 5 LA, L.A. Care, The California Endowment, and the County Department of Health Services. Selected highlights from our case study include:

- The Healthy Kids Advisory Committee, selected to include a multi-disciplinary group of experts, conducted a thorough and systematic review of policy options for Healthy Kids and ultimately designed a program much like Healthy Families and those of other county Children's Health Initiatives. It includes, however, key components uniquely tailored to better meet the needs of the target population in Los Angeles, such as no premium payments for families in the lowest income band (those at or below 133 percent of the federal poverty level), a "premium assistance" program for families unable to afford Healthy Kids cost sharing, and a "quality enhancement" component to improve the quality of behavioral health and developmental services in Los Angeles County.
- Outreach and application assistance are provided through a broad and diverse network of community-based agencies. Multi-lingual staff work to find families with uninsured children, inform them of the availability of coverage, assist parents with completing applications for any available coverage programs that might serve them or their children's needs, and follow-up with families to ensure that needs are being met.
- Process measures indicate that the outreach system is succeeding in contacting a large number of families in a wide variety of settings, including clinics and doctors offices, WIC centers, Head Start agencies and child care settings, schools, and a variety of community and religious organizations.
- Enrollment in Healthy Kids has grown steadily; over 40,000 children were covered under the program by the summer 2005, comprising over 50 percent of the estimated eligible population.
- A comprehensive package of benefits is delivered through a network of primary, acute and specialty care providers managed by L.A. Care Health Plan. Key informants, including child advocates, reported that families seem satisfied with the access that the network is affording their children, and stakeholders are pleased with the finding that 30 percent of children receive primary care from physicians in safety-net settings, where it is believed they will receive more comprehensive health and developmental care.

Moving forward after this positive start, the program faces two primary challenges:

ensuring that the promise of health coverage is realized in the forms of good access to care and improved health status for children; and securing stable and ongoing financial support so that critical coverage that has been provided by Healthy Kids can continue indefinitely into

the future. On the first count, while it appears that a strong network has been put in place, certain stakeholders feared that timely access to specialty and developmental care might be problematic. Early data, while imperfect, also suggest that children's utilization of services may be lower than optimal. On the second count, it is promising that effective statewide advocacy produced draft legislation to create a financing infrastructure for children's health initiatives across California. But the Governor's veto of this legislation left the issue unresolved for 2006.

The vulnerable children of Los Angeles, and the parents that care for them, deserve both of these outcomes, and the Los Angeles Healthy Kids Evaluation will continue to monitor and assess the progress and impacts of this important initiative.

## **Appendix A Key Informants**

**Tanya Adija**, Coordinator of Health Education, Tarzana Treatment Center  
**Elmer Alfaro**, Program Specialist, Crystal Stairs Inc.  
**Blanca Alvarado**, Outreach Department, GEM (Get Enrollment Moving)  
**Ana Arevalo**, Outreach Department, GEM (Get Enrollment Moving)  
**Elaine Batchlor**, Chief Medical Officer, L.A. Care Health Plan  
**Frances Bates**, Outreach Department, GEM (Get Enrollment Moving)  
**Cathleen Bemis**, Contractor Database, Los Angeles County Department of Health Services  
**Ishak Bishara**, Family Practitioner, Durfee Family Care Medical Group  
**Suzanne Botswik**, Contractor Monitoring, Los Angeles County Department of Health Services  
**Debra Boudreaux**, Outreach Department, GEM (Get Enrollment Moving)  
**Jessica Bravo**, Community Advocate, Long Beach Department of Health and Human Services  
**E. Richard Brown**, Director, UCLA Center for Health Policy Research  
**Sarah Covarrubias**, Community Advocate, Long Beach Department of Health and Human Services  
**Scott Crawford**, Product Operations Manager, Managed Care Services, L.A. Care Health Plan  
**Armando De Leon**, Outreach Department, GEM (Get Enrollment Moving)  
**Rhea Durr**, Project Coordinator, Community Health Councils, Inc.  
**Maria Espinoza**, Outreach Worker, Venice Family Clinic  
**Jonathan Fielding**, First 5 LA Commissioner; Director of Public Health, Health Officer, Los Angeles County  
**Olga Gallardo**, Outreach Department, GEM (Get Enrollment Moving)  
**Ayda Ghebrezghi**, Contractor Monitoring, Los Angeles County Department of Health Services  
**Maria Gonzalez**, Outreach Department, GEM (Get Enrollment Moving)  
**Gerrie Grant**, Maternal and Child Health Director, Long Beach Department of Health and Human Services  
**Tyrette Hamilton**, Vice President, Government Programs, SafeGuard Dental and Vision  
**Ronald Hansen**, Health Services Deputy to Zev Yaroslavsky, Supervisor, 3rd District of Los Angeles County  
**David Hothkiss**, Provider Relations, SafeGuard Dental and Vision  
**Sergio Infante**, Outreach Department, GEM (Get Enrollment Moving)  
**Jorge Jaramillo**, Office-Based Pediatrician, La Puente  
**Marilyn Jellison**, Director of the Children's Health Initiative of Greater Los Angeles, L.A. Care Health Plan  
**Mandy Johnson**, Chief Executive Officer, Community Clinic Association  
**Howard Kahn**, Chief Executive Officer, L.A. Care Health Plan  
**Neal Kaufman**, First 5 LA Commissioner; Director, Academic Primary Care Pediatrics, Cedars-Sinai Medical Center  
**Lynn Kersey**, Executive Director, Maternal and Child Health Access  
**Lynn Kohoutek**, Medi-Cal Program, Los Angeles County Department of Social Services  
**Amy Kwan**, Outreach Department, GEM (Get Enrollment Moving)  
**Marlene Larsen**, Chief Operating Officer and Vice President of Programs, National Health Foundation  
**Karen Lauterbach**, Health Insurance Program Coordinator, Venice Family Clinic  
**Marilyn Lawrence**, Director, Crystal Stairs Inc.  
**Margaret Lee**, Director, Special Projects, Los Angeles County Department of Health Services  
**Phina Li**, Outreach Department, GEM (Get Enrollment Moving)  
**Linda Lopez**, Outreach Worker, Venice Family Clinic  
**Paula Lopez**, Director, Government and Special Programs, SafeGuard Dental and Vision  
**Theresa Marino**, Bureau Manager, Public Health, Long Beach Department of Health and Human Services

## **Appendix A Key Informants**

**Tom McGuinness**, Senior Vice President, Citrus Valley Health Partners  
**Rafael Montiel**, Outreach Department, GEM (Get Enrollment Moving)  
**D'Ann Morris**, Manager, Crystal Stairs Inc.  
**Colleen Moskal**, Human Services Administrator of the Medi-Cal Program, Los Angeles County Department of Social Services  
**Irma Muniz**, Volunteer Coordinator, GEM (Get Enrollment Moving)  
**Amy Muratalla**, Outreach Department, GEM (Get Enrollment Moving)  
**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  
**Lidia Ortega**, Outreach Department, GEM (Get Enrollment Moving)  
**Hemi Pak**, Service Delivery Coordinator, First 5 Los Angeles  
**Maria Peacock**, Outreach Department, GEM (Get Enrollment Moving)  
**Liz Ramirez**, Director, Education and Training, Maternal and Child Health Access  
**Armida Reyes**, Community Advocate, Long Beach Department of Health and Human Services  
**Sylvia Rodriguez**, Project Director, GEM (Get Enrollment Moving)  
**Pejman Salimpour**, President and CEO, NexCare Collaborative  
**Wendy Schiffer**, Director of Children's Health Initiatives, Los Angeles County Department of Health Services  
**Dorothy Seleski**, Senior Director, Managed Care Services, L.A. Care Health Plan  
**Vouchmeng Sieng**, Community Advocate, Long Beach Department of Health and Human Services  
**Amalia Silva**, Outreach Department, GEM (Get Enrollment Moving)  
**Theresa Smit**, Account Manager, SafeGuard Dental and Vision  
**Shawnalynn Smith-Thomas**, Manager, Children's Health Initiative of Greater Los Angeles, L.A. Care Health Plan  
**Susan Ton**, Program Coordinator, Medi-Cal Outreach, Long Beach Department of Health and Human Services  
**Ernestina Torres**, Outreach Department, GEM (Get Enrollment Moving)  
**Lisa Tran**, Outreach Department, GEM (Get Enrollment Moving)  
**Linda Triplett**, Outreach Department, GEM (Get Enrollment Moving)  
**Celia Valdez**, Project Director, Outreach and Eligibility, Maternal and Child Health Access  
**Ana Valenzuela**, Outreach Worker, Maternal and Child Health Access  
**Gloria Velazquez**, Outreach Department, GEM (Get Enrollment Moving)  
**Irma Wilson**, Contractor Monitoring, Los Angeles County Department of Health Services  
**Eleanor Young**, Manager, Healthcare Outcomes and Analysis, L.A. Care Health Plan

## Appendix B Healthy Kids Advisory Committee Members

**Anthony Abbate**, *Former Vice President, Los Angeles Region, Hospital Association of Southern California (HASC)*

**Carol K. M. Kim / Wendy Aron**, *Assistant Health Services Deputy, Office of Supervisor Yaroslavsky, 3<sup>rd</sup> District*

**E. Richard Brown**, *Professor/Director, UCLA Center for Health Policy Research*

**Michael J. Koch**, *Executive Director, CaliforniaKids Healthcare Foundation*

**Eugene Casagrande**, *Executive Director, Los Angeles Oral Health Foundation*

**Stewart Kwoh / Dennis Kao**, *Executive Director, Asian Pacific American Legal Center (APALC)*

**Rini Chakraborty**, *Policy Analyst, California Immigrant Welfare Collaborative (CIWC)*

**Deena Lahn**, *Director, California Office, Children's Defense Fund*

**Timothy R. Collins / Maritza Cabezas**, *Dental Director, LAC Department of Health Services (DHS)*

**Gladys Lee**, *Chief Professional Officer, Pacific Clinics*

**Michael R. Cousineau**, *Professor/Director, USC Keck School of Medicine, Division of Community Health*

**Margaret Lee**, *Director, Special Projects, LAC Department of Health Services (DHS)*

**John DiCecco / Sharon Swonger**, *Director, LAUSD, Integrated Health Partnerships*

**Barbara Masters**, *Health Policy Advisor, The California Endowment*

**Margaret C. Dunkle**, *National Advisory Committee Member, Robert Wood Johnson Foundation's Covering Kids and Families*

**Patricia Miller / Miriam Simmons**, *Health Deputy, Office of Supervisor Burke, 2<sup>nd</sup> District*

**Richard Espinosa**, *Health Deputy, Office of Supervisor Knabe, 4<sup>th</sup> District*

**Larissa Z. Mohamadi**, *Health Program Coordinator, The Children's Partnership*

**David W. Fleming**, *Attorney, Latham & Watkins LLP*

**Colleen Moskal**, *Human Services Administrator, Medi-Cal Program, LAC Dept Public Social Services (DPSS)*

**Len Finocchio**, *Principal Policy Associate, Children Now*  
**Elisa Nicholas**, *Executive Director, The Children's Clinic, Serving Children and Their Families*

**David Fong**, *President, United Pharmacists Network, Inc.*

**Alba Escobar**, *Clinica Msr. Oscar A. Romero*

**Lark Galloway-Gilliam / Rhea Durr**, *Executive Director, Community Health Councils, Inc.*

**Xavier Reyes**, *Director of Communications & Education, Coalition Humane Immigrant Rights of L.A.*

**J. Eugene Grigsby III / Marlene Checel Larson**, *President/CEO, National Health Foundation*

**Ressie Roman / Raine Ritchey**, *Health Deputy, Office of Supervisor Antonovich, 5<sup>th</sup> District*

**David E. Hayes-Bautista**, *Professor/Director, UCLA General & Internal Medicine/Center for the Study of Latino Health & Culture*

**Wendy Schiffer**, *Director, Children's Health Initiatives, LAC Department of Health Services (DHS)*

**Moira Inkelas**, *Adjunct Assistant Professor, UCLA School of Public Health*

**Richard L. Seidman**, *Chief Medical Officer, Northeast Valley Health Corporation*

**Bobbi Johnson / Louisa Ollague**, *Health Deputy, Office of Supervisor Molina, 1<sup>st</sup> District*

**Haydee Urita**, *Research Coordinator, Office of Assembly Member Jackie Goldberg, 45<sup>th</sup> District*

**Mandy Johnson / Debra Ward**, *Chief Executive Officer, Comm Clinics Assoc of LA Co (CCALAC)*

**Yolanda Vera**, *Senior Health Policy Attorney, San Fernando Valley Neighborhood Legal Services (NLS) of L.A. County*

**Lynn Kersey**, *Executive Director, Maternal & Child Health Access*

**Lucien Wulsin**, *Project Director, Insure the Uninsured Project (ITUP)*

## **Appendix C Outreach & Enrollment Contractors**

### ***Contractors Funded by the Los Angeles County Department of Health Services (DHS)***

AltaMed Health Services Corporation

Asian Pacific Health Care Venture, plus 3 additional subcontractors:

- Chinatown Services Center
- Korean Health, Education and Information Resource Center (KHEIR)
- South Asian Network

California Hospital Medical Center

Citrus Valley Health Partners (G.E.M. Project)

Community Health Councils

Crystal Stairs, Inc.

Glendale Adventist Hospital

Los Angeles County Office of Education

Los Angeles Unified School District

Maternal & Child Health Care Access plus 2 additional subcontractors:

- San Fernando Neighborhood Legal Services (Health Consumer Center)
- Worksite Wellness

Tarzana Treatment Center

Venice Family Clinic

City of Long Beach Department of Health Medi-Cal Outreach Program plus 5 additional subcontractors:

- The Children's Clinic
- Westside Neighborhood Clinic
- Guam Communications Network
- Cambodian Association
- Families in Good Health

Pasadena Public Health Department

National Health Foundation

**Appendix C**  
**Outreach & Enrollment Contractors**

***Contractors Funded by The California Endowment (TCE)***

AltaMed Health Services Corps

Asian Pacific Health Care Venture

California WIC Association

Child and Family Guidance Center

Citrus Valley Health Partners

Crystal Stairs, Inc.

Healthy Kids 4 Healthy Communities

Korean Health, Education, Information and Research Center (KHEIR)

Los Angeles Unified School District

Mission City Community Network

Neighborhood Legal Services of Los Angeles County

New Economics for Women

Northeast Valley Health Corporation

Watts Labor Community Action Committee

QueensCare Family Clinics

Valley Community Clinic