

CaliforniaKids Healthcare Foundation

Our History, Our Experience, and Our Future

July 1992 – March 2006

CaliforniaKids

...keeping our children healthy

This report was written by Maureen Finan in collaboration with Michael Koch, Executive Director of the CaliforniaKids Healthcare Foundation and members of the CaliforniaKids Board of Directors both past and present including: Ann Monroe, Brian J. Donnelly, Esq., David Chernoff, M.D., Helen du Plessis, M.D., Lydia C. Bourne, R.N., Sister Michaela Rock, CSJ, and Melissa Thompson.

The CaliforniaKids Healthcare Foundation is a 501(c)(3) nonprofit charitable organization.
On the web at: **www.californiakids.org**



Contents

Introduction

The CaliforniaKids Healthcare Foundation is a 501(c)(3) nonprofit charitable organization whose mission is to provide access to health care for uninsured children in California. Over the past 14 years, CaliforniaKids has provided access to affordable health care to more than 65,000 children in 38 counties (as of October 1, 2006) throughout California.

This paper describes the history and organizational structure of the CaliforniaKids Healthcare Foundation. It is intended to give readers an overview of the background and experience of the Foundation along with an account of the lessons it has learned over its 14 years of service to California's children and families. The CaliforniaKids Board and staff believe that this paper provides an important framework for similar programs currently being considered both by counties and by other organizations committed to reducing the number of uninsured children throughout the state.

This paper is organized into three parts:

PART 1 describes the history and organizational development of the Foundation from its early years to the present.

PART 2 includes lessons learned through experience, innovation, and evaluation, including key findings from several evaluations. Also included are other lessons learned that are not directly linked to evaluations, but come from direct interaction in the community.

PART 3 explores the future of the CaliforniaKids program and reflects on its contributions toward reducing the number of uninsured children in California.

Part 1: Our History

Background

In 1992, it was found that an estimated **2.1 million uninsured children** in California lacked regular access to well-child care such as preventive examinations and essential childhood immunizations.[1] The majority of these children came from families of working parents who lacked employment-based insurance, could not afford private insurance, or did not qualify for Medi-Cal by virtue of immigration status or income eligibility requirements.

During the same time frame, emergency room use was skyrocketing, with an increasing number of children and adults using ERs as their primary source of medical care. Oftentimes, children and adults in such settings became even more ill as a consequence of delayed care, resulting in the need for costlier treatment. In addition, California had virtually no safety net to cover the costs of outpatient services delivered in ERs.

The growing number of uninsured children, coupled with the increasing use of ERs for non-emergency services, prompted staff members at Blue Cross of California (BCC) to explore the possibility of developing a health care program targeted specifically toward uninsured children. The plan was to devise a program that would provide basic preventive and primary health care services to uninsured children in California who did not qualify for Medi-Cal.

By designing such a program, BCC staff members hoped that it could provide cost-effective access to appropriate health services while simultaneously reducing the number of children using ERs for basic medical care. Research in the arena of health care availability has consistently shown that children with access to regular preventive care are far less likely than others to resort to the ER for non-emergency services. The BCC team also believed that such a program could serve as a model for policymakers and others interested in reducing the number of uninsured children while diminishing the costs associated with providing routine medical care via local ERs.

Design and Financing

In order to offer the program, BCC needed to obtain a **material modification**[i] from the **Department of Corporations** (DOC)[ii]. This material modification was necessary because it would allow the program to offer outpatient health care benefits only and to exclude inpatient coverage. The DOC granted BCC a material modification

The growing number of uninsured children, coupled with the increasing use of ERs for non-emergency services, prompted staff members at Blue Cross of California (BCC) to explore the possibility of developing a health care program targeted specifically toward uninsured children.

i A material modification is a request for a substantive change to a previously approved and licensed Knox-Keene health care plan.

ii Today, the Department of Managed Care (DMHC) regulates the health care industry in California.

CalKids was launched on July 30, 1992 as a 501(c)(3) nonprofit organization with a singular mission: to provide access to health care for uninsured children in California.

with the stipulation that the program be administered through a nonprofit organization.

Upon DOC approval, the team began developing the blueprint for what was to become the CaliforniaKids Healthcare Foundation. The Foundation is widely known, and referred to hereafter, simply as CalKids. CalKids was launched on July 30, 1992 as a 501(c)(3) nonprofit organization with a singular mission: to provide access to health care for uninsured children in California.

INSPIRATION

Much of the inspiration for this new health care effort was derived from a model in western Pennsylvania called the *Caring Program for Children*. Developed in the late 1980s, the Caring Program for Children had its origins in the decline of the steel industry. Concerned about children whose parents had lost both their jobs and their health care coverage as a result of massive layoffs, local clergy approached *Blue Cross of Western Pennsylvania* for support and funding with which to launch the children's health program.

Blue Cross of Western Pennsylvania provided the majority of funding to launch the Caring program, and the program later received federal funds to replicate its efforts in other parts of the country. The experience and health benefit design of this effort served as a starting point for CalKids' leadership to begin designing a program of its own.

FUNDING

To help launch the Foundation and the children's health program, BCC provided an initial grant of $40,000 for direct services while also donating technical support as well as all administrative services. CalKids also received a matching grant from the *California Community Foundation* along with additional funding from other businesses.

Cognizant that funding from corporate and philanthropic sources would go only so far, CalKids considered itself a short-term solution to the issues it sought to address. BCC and Foundation leadership knew that philanthropy was not a sustainable long-term solution and hoped that by developing a successful children's program, policymakers and other key stakeholders would learn from the model and make the policy and legislative changes necessary to implement a state-sponsored children's health program, thereby eliminating the need for a philanthropic approach.

BENEFIT DESIGN

CalKids' original benefit package included outpatient preventive and primary medical care only, with no member-paid premiums, no application fee, and minimal copayments at the point of service. The program provided access to health care services for children ages 2 to 18. California's Child Health and Disability Prevention (CHDP) and Access for Infants and Mothers (AIM) programs provided health care services for infants ages 0 to 2 with family household incomes between 100 percent and 200 percent of the federal poverty level (FPL). The Foundation believed that it could finance a premium-free program at a manageable cost. Initial actuarial estimates projected the cost to cover one child for one year at $400.

PROVIDER CONTRACTING

CalKids contracted with the BCC CaliforniaCare HMO provider network in the belief that a capitated-payment approach would minimize financial risk while allowing CalKids to provide health care access to a greater number of uninsured children. During its first year of operation, financial contributions and donated administrative services allowed CalKids to provide health care access to 200 children in Los Angeles County.

Early Challenges

IDENTIFYING AND ENROLLING CHILDREN

Once the tasks of funding, benefit design, and network contracting had been completed, the process of identifying eligible children began. The areas immediately surrounding *Children's Hospital Los Angeles* and neighborhoods in central and south Los Angeles were initially targeted on the basis of need and higher-than-average ER use.

Early enrollment in the program was slow. CalKids staff learned through school nurses that many families with eligible children had not signed up because they perceived CalKids to be a government program. To address this issue, CalKids employed a variety of outreach strategies to ensure that families with eligible children understood that CalKids was an independent, privately run health care foundation. CalKids enlisted the support of several organizations, including the *California School Nurses Organization* (CSNO), to help reach out to families and enroll eligible children in the program. CSNO and individual school nurses were and continue to be a vital link in CalKids' efforts to identify and enroll children.

Early enrollment in the program was slow. CalKids staff learned through school nurses that many families with eligible children had not signed up because they perceived CalKids to be a government program.

Language and cultural barriers also posed a challenge. To meet this challenge, CalKids developed a network of trusted partners in communities to help "spread the word." Understanding that sensitivity

to literacy and language needs was key to the success of this effort, the Foundation prepared all of its materials in both English and Spanish and provided interpreters for other languages whenever necessary.

To further encourage enrollment, CalKids developed a simple one-page application. The outreach community embraced this simplified application process, as it reduced the labor and time required for completion. In addition to completing the one-page application, parents had to verify their income by submitting pay stubs or Form 1040 tax documents. The application did not require parents to provide birth certificates, thereby enabling CalKids to reach out to all children.

MARKETING AND FUNDRAISING

From its inception, CalKids faced marketing and fundraising challenges as well. Although BCC had initially established and partially funded the program, it was important for CalKids to distinguish itself from that entity. Thus, its first challenge lay in developing its own brand and identity, marketed under the CaliforniaKids name. Complicating this process was the fact that CalKids had contracted with the BCC provider network and was headquartered at a BCC facility. Although an extensive marketing campaign was ultimately launched, many potential donors continued to believe that CalKids was a BCC program and were therefore reluctant to contribute. To further address this issue, the Foundation moved its offices to a separate location and subsequently partnered with other (non-BCC) health plans.

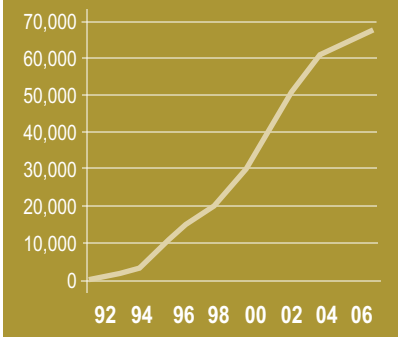
Enrollment Growth

Yet another challenge lay in a lack of public awareness regarding the extent of the problem CalKids sought to address. To overcome this challenge, CalKids leadership targeted prospective funders with data indicating that between 1.8 and 2.1 million children in California were uninsured. Within the same timeframe, the Clinton administration began highlighting the issue on a national scale.

By April 1993, corporate support for the program had begun to grow in lockstep with public awareness. Large corporate sponsors and foundations, including *Procter & Gamble*, *Merck Pharmaceuticals*, and the *California Community Foundation*, were among the program's early supporters.

CalKids partnered with Procter & Gamble in a cause-related marketing campaign to raise funds for the Foundation and to heighten awareness about uninsured children. This partnership attracted the attention of *Major League Baseball*, with teams in Los Angeles, Anaheim, San Francisco, Oakland, and San Diego joining the effort. The campaign significantly increased visibility and funding for the program, enabling CalKids to expand its efforts into the aforementioned communities.

CaliforniaKids Cumulative Enrollment 1992 – 2006



BENEFIT ENHANCEMENTS

In June 1993, after completing its first year of operation, CalKids experienced a funding surplus. This surplus was the product of several factors, including lower-than-anticipated utilization, lower-than-expected program costs, and generous donations from both corporate and philanthropic sources. (It is important to note that first-year enrollment in the program was limited to 200 children, and that this enrollment goal was reached.) CalKids' surplus was not entirely unexpected, as the paucity of data on California's Medi-Cal population had made actuarial estimates difficult to determine at the outset of the program.

Given this funding surplus, the CalKids Board was faced with a critical decision: either to lower its costs and cover more children or to enhance its benefit package. Although CalKids had learned from its outreach partners that dental care access was a much-needed benefit, the Board was reluctant to add dental care at such an early stage given that there was almost no way to project utilization. The decision was thus made to postpone the addition of a dental benefit until more could be learned about the nature of children's dental health and about the potential costs associated with such a benefit.

Recognizing that the objective of the program was to develop a comprehensive outpatient health care model, CalKids added a **vision benefit** in 1994 and contracted with Vision Service Plan (VSP) to administer coverage. Through the VSP provider network, members received one eye exam per year along with eyeglasses or contact lenses if necessary.

Prior to adding a **dental benefit** in 1995, CalKids worked with local dental professionals and Delta Dental staff to help the Foundation better understand which oral health services were essential for children at various stages of their development. Ultimately it was determined that the dental benefit design should include preventive, diagnostic, and restorative services. It was also learned that the aforementioned dental services could be added without increasing member premiums. CalKids added the benefit to its model, and Delta Dental[iii] provided administrative and provider network support.

CalKids also added a **24-hour nurse hotline benefit** in 1996 when it learned that ER use on the part of its members was increasing. One of the factors underlying this increase was the fact that some children became ill at night or over the weekend, when their primary care physicians were not accessible to them. To address this issue, the CalKids Board contracted with Access Health to administer a 24-hour hotline that would allow parents to speak directly to a nurse regarding their children's conditions. Implementing this benefit significantly decreased ER use by redirecting care either to the home or to the member's primary care provider.

BENEFIT ENHANCEMENT TIMELINE

1993 Medical
1994 Vision
1995 Dental
1996 24-Hour Nurse
1998 Behavioral Health

[iii] SafeGuard Dental & Vision is the current provider.

A **behavioral health service** was the last benefit added to the package in 1998. Through its outreach partners in schools and community organizations, CalKids found that learning disabilities and behavioral problems in children were increasing dramatically. Outreach partners were instrumental in defining the issues children were experiencing and urged the program to expand its benefit package to include a behavioral health component. To address the concerns of outreach partners, CalKids contracted with Human Affairs International (HAI)[iv] to provide a Family Assistance Program. HAI developed a model consisting of an eight-session program similar to the employee assistance programs offered by many large employers.

PROGRAM EXPANSION

Enrollment growth continued throughout 1994, with most financial support coming from the business community and from individuals. At the end of 1994, however, BCC made a number of significant philanthropic contributions, and CalKids became the recipient of a generous $22 million donation.

The CalKids Board knew that the demand for health care access for uninsured children was significant and that the BCC donation could provide access for a significant number of children. Before deciding how to use these funds, however, the Board conducted a comprehensive financial analysis that explored several models, including spending down the $22 million to cover the largest number of uninsured children or, alternatively, establishing an endowment and spending only five percent per year on enrolling additional children. Ultimately, the decision was made to go "pedal to the metal" and to enroll more children. The BCC contribution allowed CalKids to expand its program into 33 counties.

CalKids' program expansion proved to be a complement to existing state-run children's health programs. From the start, CalKids' goal was to enroll only those children with no other option for access to health care. An unexpected benefit of program expansion lay in CalKids' ability to identify and enroll children who were qualified for existing programs.

PUBLIC RECOGNITION AND POLICY CHANGES

Over the next three years, the program continued to expand at a rapid pace. As CalKids reached into more counties, publicity surrounding the program focused attention on the staggering number of uninsured children both in California and in the nation as a whole. By 1997, CalKids had been in operation for five years and had enrolled 17,000 children. That same year, the Foundation's executive director was asked to testify before the U.S. Senate Finance Committee along with representatives from several other children's health programs from around the country.

CalKids' program expansion proved to be a complement to existing state-run children's health programs. From the start, CalKids' goal was to enroll only those children with no other option for access to health care.

[iv] The Holman Group administers the behavioral health benefit today.

In his testimony before the Finance Committee, CalKids Executive Director Michael Koch described the program in detail but added, "CaliforniaKids is not the [only] answer, and we can only go so far with private contributions and philanthropic support." Mr. Koch urged the committee to consider appropriating additional funding to develop sustainable programs that would further reduce the number of uninsured children.

Later that year, Congress passed the *State Children's Health Insurance Program* (SCHIP) initiative, a measure that enabled states to access federal funding in order to implement children's health programs. In 1998, the SCHIP initiative led to the implementation of the *Healthy Families* program in California. Healthy Families initially offered health care services to uninsured children of families at 200 percent of FPL, a figure that was later expanded to 250 percent. CalKids subsequently transitioned more than 8,000 of its members to the Healthy Families program while also working with state and local agencies to identify and enroll other eligible children into existing state-run programs. By transitioning its eligible children into this newly established effort, CalKids was able to enroll more children who were not eligible for Healthy Families into its own program.

The passage of the SCHIP legislation and the subsequent implementation of the Healthy Families program proved highly beneficial for CalKids in the policy arena. Having garnered the attention of legislators, CalKids was now able to raise awareness about other "at-risk" populations, including California's foster youth. CalKids knew that once youth were emancipated from the foster care system their Medi-Cal benefits were discontinued at age 18. To ensure that such adolescents experienced no lapse in their health care coverage, CalKids partnered with local foster care agencies to enroll eligible youth into its program. Shortly thereafter, CalKids joined with the *California Partnership for Children* in a successful effort to get legislation passed to extend Medi-Cal benefits to emancipated foster youth ranging from 18 to 21 years of age.

"CaliforniaKids is not the [only] answer, and we can only go so far with private contributions and philanthropic support."

Mike Koch, Executive Director, CaliforniaKids

COLLABORATION WITH THE STATE

By the time Healthy Families was implemented, CalKids had forged a well-established relationship with the state. Since 1995, CalKids has been working closely with *Access for Infants and Mothers* (AIM), another state-sponsored program. AIM provides expectant mothers with prenatal care and gives health care coverage to newborn children up to age two. Once children reach the age of two, they are no longer eligible for services under AIM. CalKids recognized that many of these children would subsequently lose all their heath care coverage as a result of income guidelines or residency restrictions.

CalKids thus partnered with the state to identify AIM children who were nearing their second birthday and enrolled eligible children in the CalKids program. CalKids also developed a provider network that included many AIM providers, thereby enabling continuity of care for many children.

CaliforniaKids Today

Throughout the past 14 years, CalKids has filled a critical gap by providing access to health care services for California's most vulnerable children. In its early years, the majority of CalKids members were the children of the working poor — children whose families did not have employment-based insurance, did not qualify for existing government or state-sponsored programs, or simply could not afford private health insurance. Today, most of these children qualify for state-sponsored programs such as Medi-Cal and Healthy Families.

As its members migrated into expanded state-sponsored programs, however, CalKids continued to fill the gap for uninsured children. Currently, virtually all of CalKids' members are undocumented children. To ensure that CalKids can continue providing access to health care services for the state's undocumented children, program changes have been implemented, including a "share of cost" paid by parents.

SHARE OF COST

For more than 10 years, CalKids successfully raised enough funding, through corporate donations and philanthropic support, to subsidize the cost of each child it enrolled. By 2002, however, the cost of covering one child had increased from $400 to $460 per child per year, making it increasingly difficult to sustain a premium-free program. By way of contrast, the Healthy Families and Healthy Kids programs average over $1,000 per child per year.

With fewer philanthropic dollars available and corporate support on the wane, the Board approved a decision to implement a shared-premium program. In considering its decision, the Board reviewed the results of a 1999 survey conducted for CalKids by the *Social and Behavioral Research Institute at California State University, San Marcos*, which found that "parents were willing to share in the cost of the health care services their children receive by paying a monthly dollar amount."[2]

In January 2003, CalKids implemented its shared-premium program and anticipated that a decline in enrollment would result. Interestingly, however, an overwhelming number of parents chose to re-enroll their children, and hundreds more enrolled for the first time, thereby validating the study findings. Today, parents pay a monthly share of cost amounting to $10 to $20 per child enrolled up to a maximum of

three children. All children enrolled in the CalKids program receive primary and preventive health care benefits, including medical, dental, vision, prescription drug, and behavioral health services, as well as access to 24-hour nurse services. Each child also receives a standard identification card, and care is made available to children from hundreds of health care providers throughout the state.

UTILIZATION

Providing access to a "**medical home**[v]" is a basic tenet of the CalKids program. A medical home not only provides children with access to regular preventive care but also gives parents the assurance that their children have access to the health care services they need. Nonetheless, CalKids found that parents were slow to begin using the services being made available to their children.

This lag in utilization prompted CalKids to explore the issue more intensively. Initially, CalKids' low utilization rates were attributed to the fact that its patient population was largely a healthy one. In fact, although CalKids does not provide inpatient medical coverage, claims data have shown that the number of hospitalizations per year for CalKids members is minimal. (If a member does require hospitalization, CalKids works with Medi-Cal to ensure that the child receives the necessary care.)

Further analysis revealed, however, that other factors were influencing the program's lower-than-expected utilization rates, including limited understanding of insurance concepts, confusion over how to access the health care system, and transportation barriers. It thus became evident that education would be key not only to encouraging appropriate utilization, but also to ensuring that children were receiving the level of care they needed to achieve and maintain good health.

EDUCATING MEMBERS

For many members, the CalKids program represented their first encounter with insurance; parents were receiving ID cards for their children but still had no idea how to navigate the system. CalKids thus enlisted the help of its outreach network to educate families both about insurance concepts and about appropriate ways to access and use the health care system. CalKids found that investing time and effort on educating its members had a direct bearing on utilization. Educating parents about insurance concepts and on the appropriate use of benefits has had a positive effect on the use of all program benefits.

Utilization data show that CalKids members average 1.7 to 2.3 medical visits per year. Utilization of dental services has been and continues to be high, suggesting that access to dental benefits is a highly valued and much-needed benefit. Prescription drug use among the

[v] A "medical home" is defined as both the physical location of a child's medical history and the comfort and familiarity of an ongoing relationship between a child and a medical provider.

CalKids population is consistent with findings among children in the general population, with the drugs most commonly prescribed including antibiotics, antihistamines, and asthma medications. For CalKids members, use of generic drugs is at 70 percent, and additional efforts are under way to encourage appropriate use of generic medications whenever possible.

PROGRAM ADMINISTRATION

Through its cost-effective financing model and the generous support of foundations, corporations, hospitals, and health systems, CalKids has been able to provide affordable access to health care services to more than 65,000 children. CalKids has kept its costs low by providing a limited, outpatient-only benefit package. Although there has been some pressure from children's advocacy groups and funders to add an inpatient component, CalKids maintains its position that the inpatient benefit is unnecessary and would only add to program expense — the argument being that a safety net exists through emergency Medi-Cal, California Children's Services, and other Title V programs in the event that a child requires hospitalization. Estimates suggest that if CalKids were to add a hospitalization benefit to its current benefit package, the cost per child per year would approach $1,000 or more depending on geographic region.

BCC continues to donate administrative services to CalKids, including membership and eligibility processing, issuing program ID cards, conducting member mailings such as summary-of-benefits and benefit updates, distributing eligibility reports for other service vendors, and disseminating capitation reports. BCC also processes monthly provider and vendor capitation payments and adjudicates claims for specialty medical, ER, outpatient, and pharmacy services. CalKids' other health plan partners include SafeGuard Dental & Vision, WellPoint Pharmacy, McKesson HBOC, and the Holman Group, all of which donate a significant portion of their administrative services. Collectively, the savings from these donated services allow CalKids to keep its program costs to a minimum. These savings are estimated at $90 per child per year.

CalKids also keeps its administrative expense low by maintaining a very small paid staff. Over the past 14 years, the CalKids staff expanded from 2 to 12 to meet the operating needs of the program and today averages 9 full-time paid staff. CalKids also leverages technology in ways that allow it to reduce expenses. For example, CalKids evaluated several software systems to meet the technological demands of the share-of-cost program and decided to implement the Solomon accounting program from Microsoft Business Solutions. The system was customized to enable CalKids to execute two main functions: (1) to automatically update membership database through information

transfer from its insurance provider and; (2) to automate the billing process for all its members. This allowed CalKids to reduce operational costs while maintaining a high level of productivity, and saved CalKids more than $130,000 per year. CalKids recouped its capital investment of under $40,000 in the Solomon system through cost savings in the first year.

The CalKids program has been proven to be significantly more cost-effective than similar programs, and it continues to develop and implement strategies aimed at keeping administrative costs low while simultaneously increasing access and improving health outcomes for uninsured children throughout California.

CONCLUSION

Although expanded state-sponsored programs such as Medi-Cal and Healthy Families have greatly reduced the number of uninsured children in California over the past few years, recent studies indicate that nearly one million California children remain without health care coverage. CalKids is proud to be the first children's health care program of its kind in California and is currently providing access to comprehensive outpatient preventive and primary health care benefits to more than 10,000 children statewide.

CalKids has lent its expertise and experience to the development of county-based Healthy Kids initiatives as well as to other privately funded children's health programs, such as *Kaiser Permanente's KP Cares for Kids*. Although these programs reach out to the same population of undocumented children and provide full-scope benefits, they are limited both in financial support and in geographic reach.

CalKids will continue to work with counties and other organizations to help develop long-term solutions to ensure that every child has access to health care coverage. What began as a grassroots effort in 1992 remains a modest foundation committed to providing access to health care services to California's most vulnerable children.

The balance of this paper describes the organizational experience of the Foundation and shares its lessons learned through example and innovation. Additionally, excerpts from program evaluations are included to underscore how necessary program improvements were identified and implemented.

PART 2: OUR EXPERIENCE

Lessons Learned

The elements described below — all essential components of successful health care programs targeting low-income working families — were derived directly from the Foundation's experience in the community. Many of these factors were also supported by the results of program evaluations.

1) **Trust.** Although many families learn of health care programs through flyers, doctors' offices, or the media, most families reported hearing of the CalKids program through word of mouth. Word-of-mouth communication was a significant factor influencing CalKids' ability to promote a positive image of the program while eliminating perceived concerns regarding "public charge[vi]." CalKids staff also invested significant time and energy in building relationships with families by providing bilingual, culturally sensitive staff to answer parents' questions in a timely and professional manner while demonstrating sensitivity to families' needs.

   Experience from the LA CalKids Program. In 1999, Mayor Richard Riordan partnered with CalKids to challenge local businesses, political leaders, foundations, and individuals to address the issue of uninsured children in the city of Los Angeles. Funding for the *LA CalKids Program* came from the *Community Health Improvement initiative of the LA Care Health Plan*. This initiative targeted undocumented, uninsured children living in households with incomes less than 250 percent of the FPL. Within two years, the LA CalKids Program had enrolled 6,000 children, exceeding its initial target of 4,000. Nine out of ten children enrolled had no previous private health coverage.

   The success of this initiative was due in large part to a variety of outreach methods — including word of mouth, which proved to be the most effective means of reaching out to families with eligible children. The experience of the LA CalKids Program helped reinforce the lesson learned that building trust with families and communities is essential to program success — and that word-of-mouth communication contributes significantly to program success.

2) **Partnerships.** CalKids owes a great deal of its success to the trusted partnerships it has built with outreach networks. Early on, CalKids began building relationships with individuals and community-

Lessons Learned:

- Trust
- Partnerships
- Flexibility
- Local Presence
- Member Education
- One-Page Applications
- Demographics
- Share of Cost
- Case Management
- Standard ID Cards
- Benefit Design & Network Flexibility

[vi] The term "public charge" is used by the U.S. Citizenship and Immigration Service to describe some types of public benefits that may affect the eligibility of an alien applying to become a Lawful Permanent Resident (LPR).

based organizations in efforts to help spread the word about the program and to identify and enroll eligible children. Outreach workers continue to be a critical link to the community and have helped CalKids gain a deeper appreciation and understanding of family needs and dynamics. CalKids staff has provided outreach representatives with extensive technical training to ensure that members fully understand the application process, comprehend the range of program benefits, and are familiar with the various materials they receive upon enrollment in the program. The CalKids outreach network includes school nurses, migrant health education advisers, childcare providers, CHDP, AIM, and other community-based organizations. When California implemented the Healthy Families program and trained certified application assistors (CAAs) from local communities to help enroll eligible children, CAAs also became important members of the CalKids outreach network. In addition to helping enroll eligible children, CalKids outreach partners assisted in provider recruitment and helped educate parents on the appropriate utilization of health services and the importance of health insurance.

CalKids and the Solano Kids Insurance Program. Building trusted partnerships with school administrators, school nurses, local clinics, and families was critical to the success of the *Solano Kids Insurance Program (SKIP)*, an effort of the Solano Coalition for Better Health. The goal of the SKIP program was to provide access to health care coverage to all children in 60 elementary schools in Solano County, California. SKIP staff knew that a significant percentage of children in its targeted schools would not be eligible for Medi-Cal or Healthy Families owing to their immigration status. To assist SKIP in reaching its goal, CalKids served as a partner in providing health care benefits to children who were ineligible for state-sponsored programs. To date, more than 33 schools have provided 100 percent of targeted students with access to health care coverage. More than 700 children gained access to care through the CalKids program, and another 13,000 have been enrolled in other health care programs.

3) **Flexibility.** California is home to many families with children whose citizenship is undetermined. In 1998, when Healthy Families was first implemented, CalKids learned that many families had attended enrollment appointments and had started the application process but had abruptly ended their sessions when asked to provide proof of birth for all their children. It was subsequently found that a number of these families had some children who qualified for Medi-Cal or Healthy Families but others, many of them older children, who did not. When these

"blended" families tried to enroll their younger, eligible children, they often found that their older children did not meet the eligibility requirements owing to immigration status. For CalKids, the important lesson learned was that parents were reluctant to enroll their children in a health care program unless all of their children were able to receive access to health care services.

To ensure that all eligible children could be enrolled in Medi-Cal or Healthy Families, CalKids adopted a flexible approach toward enrollment, working with CAAs to provide parents with the option of enrolling their ineligible children in CalKids. In this manner, CalKids was able to enroll children in its own program while allowing parents to enroll their eligible children in Medi-Cal or Healthy Families. Working together in this way, CalKids, Medi-Cal, and Healthy Families were able to reduce the overall number of uninsured children in the state. Had the CalKids program not been available as an option for undocumented children, many more children who were eligible for government-sponsored health care coverage would have remained uninsured.

Note: When "blended families" enroll their children in CalKids, Medi-Cal, or Healthy Families, the children access care through the same provider network. This practice ensures continuity of care and eliminates any concern on the part of parents that their children will receive care from different providers or at different locations.

4) Local presence. The Foundation has seen the most success in enrollment, utilization, and retention in counties where dedicated individuals act as liaisons between the enrollment entity and the CalKids program.

CalKids and the Vaughn Street School project. The Vaughn Street Elementary School is located in Pacoima, California, a largely Latino community. This pilot project involved establishing a small clinic at the school to give students access to basic health care services. At Vaughn, a local physician group provided a nurse practitioner to administer basic preventive and primary care, and parents volunteered to assist children who needed follow-up care at the local physician group. CalKids worked with school leaders, community health care providers, and parents to ensure that children were enrolled in the appropriate publicly funded program for which they qualified. Children who were ineligible for public programs were enrolled in CalKids.

Establishing a local presence at the Vaughn Street School helped CalKids build trusted partnerships with the community while also helping parents gain trust in the health care system and learn the importance of basic health care for their children.

5) **Member education.** After an evaluation of the Los Angeles CalKids Program conducted by the *Center for Health Financing, Policy, and Management, School of Policy, Planning, and Development, University of Southern California,* (December 2001)[3], it was found that most children left the LA CalKids program because their parents either did not know how to access providers or were unfamiliar with benefits. The high rate of disenrollment in the program was disappointing to both the Board and staff of CalKids and prompted several program changes including more personalized member orientation sessions.

CalKids expanded its member orientation process to include structured 7- to 10-minute phone calls. When parents received their new-member packets in the mail, they were asked to activate their ID cards by calling CalKids. If a parent did not call within two weeks, CalKids followed up with a phone call. These calls were designed to educate parents about insurance concepts and health benefits, to confirm who and where their medical providers were, and to walk parents through the information given on their ID cards. By providing an orientation, CalKids was able not only to answer parents' questions but to ensure that parents had all the information they needed to begin using their children's health benefits.

CalKids also learned that yet another factor contributing to disenrollment lay in the transitory living conditions of many families. In efforts to reduce disenrollment and lapses in coverage, CalKids informed parents that the program was "portable" — i.e., that their children could still access their benefits through provider networks in other communities — and asked families to notify CalKids in the event that they moved.

Initially, the goal of these member orientation sessions was to ensure better retention rates. However, an unexpected benefit of the sessions was increased utilization. The success of this program prompted other program partners — including *Children's Hospital of Orange County (CHOC)* and the Solano Schools project — to adopt the orientation session scripts, make several enhancements to them, and begin providing orientation sessions to their families locally. CalKids' current retention rate is 83 percent, as measured from August 2003 through July 2004.

Experience from the LA CalKids program. In the same study[3], it was concluded that CalKids' initial enrollment success demonstrated that low-income immigrant parents would in fact enroll in formal health insurance programs. The study also found, however, that retention in the LA CalKids Program was less than 50 percent. It further revealed that while families had expressed a high degree of satisfaction with the program, many did not re-

enroll. This finding led to several recommendations, including improved communication between CalKids and enrollees. The Foundation now facilitates member orientation sessions to establish relationships and a point of contact with new families.

6) **One-page application.** CalKids' philosophy has always been to "keep it simple." The Foundation learned early on that if a program had the appearance of a government-run effort, enrollment was likely to be adversely affected. As a result, CalKids worked diligently to ensure that no aspect of CalKids resembled a government program. CalKids created a simple, one-page application to capture basic family information. (By contrast, Healthy Families' original application was 24 pages long, although it has since been reduced to four pages.) Experience taught CalKids that the more information a family is asked to provide, the less likely they will be to apply. Simplifying the enrollment process contributed to significant enrollment growth. CalKids also eliminated medical underwriting, so no health questions are asked during the application process. Moreover, CalKids does not deny coverage to any child because of a preexisting medical condition.

   Outreach workers embraced CalKids' one-page application, reporting that it reduced barriers and parental concerns about applying for a health care program. Decreasing the amount of time spent on each application also allowed outreach workers to focus more on educating parents about the health care system and about the benefits of the program.

   Note: During its early years, CalKids did not require birth certificates; instead, eligibility for the program depended only on age and income. Today, CalKids requires birth certificates to ensure that children are enrolled in the appropriate programs for which they qualify.

7) **Demographics.** An evaluation of the CalKids program conducted by CHOC showed that "parents were very conscientious about reading through and readily referring to the printed materials that were supplied to them, especially when such materials were provided in Spanish."[4] The findings of another study for CalKids, conducted by the *Institute for Health Policy Studies at the University of San Francisco* (August 1998), indicated that to ensure understanding and program success, CalKids needed to "consider the cultural and linguistic needs of its beneficiaries."[5]

   The Foundation produces all of its materials in English and Spanish, relying on partner agencies to assist in outreach as well as to help interpret enrollment materials in a variety of other languages. All materials are reviewed for cultural appropriateness and literacy levels.

The San Marcos study[2] confirmed that parents not only were prepared to contribute to the cost of their children's health care but were willing to pay a monthly share of that cost.

8) **Share of cost.** Although CalKids was initially implemented as a premium-free program, parents were making small copayments at the point of service from the program's inception. Over time, however, parents told CalKids that making small copayments did not give them a strong sense of ownership or participation in the program. The San Marcos study[2] confirmed that parents not only were prepared to contribute to the cost of their children's health care but were willing to pay a monthly share of that cost. The study also tested varying amounts to determine the threshold at which parents felt they were contributing substantially to their children's' health care.

As an outcome of the study, CalKids initiated a one-time $25 application fee in addition to the copayments. The underlying assumption was that asking parents to contribute would foster a sense of ownership and participation in their children's health care, which would in turn encourage utilization.

Note: Today, new members do not pay the $25 application fee; however, depending on county of residence, families pay monthly premiums ranging from $10-20 per child per month up to three children enrolled.

CalKids' experience with share of cost. In 2002, the Foundation retained *Milliman & Associates* to research several shared-premium models ($10, $15, and $20 per child per month) in efforts to determine the threshold at which families would find participation affordable. In this context, it was also important to develop a cost structure that would not discourage new enrollment or lead to significant disenrollment. It was further determined that this cost structure would need to be administratively convenient, easy to communicate to parents, and perceived as equitable by both parents and funders. The models showed that with a $10 premium, the program could anticipate the most participation and the highest retention; however, that figure was too low to support program needs. Interestingly, the models also showed that if members were asked to pay $5, it created an operational barrier, whereas charging $20 resulted in lower participation.

Although there was some concern that implementing a shared premium would result in disenrollment through failure to re-enroll and other forms of attrition, CalKids decided to take a risk, and in January 2003 it implemented a $15 shared premium. Initially, the program did experience a modest decrease in enrollment, but most families stayed with the program. Following this initial downturn in enrollment, CalKids opened enrollment for new members. The Foundation then experienced increased enrollment and utilization, with families indicating that they felt a "sense of active participation" in the program because they were contributing a share of the cost.

Note: Families pay between $15-20 per child per month for each child up to three children, depending on county of residence. Families with more than three children do not pay premiums for the additional children, although there are very few eligible families with more than three children.

CalKids' experience. When CalKids announced that it would begin a shared-premium program, many health care advocates were opposed to the action. They believed that charging a premium would create a barrier to care for many families. The success story for CalKids is that it was willing to take a risk to keep its program going; CalKids experienced its highest retention rate (83 percent) and was able to enroll an additional 5,000 children. Interestingly, other publicly funded children's health care programs, such as Healthy Families, are also charging a premium of up to $15 per child per month.

9) **Case management.** An evaluation of the case management component of the CalKids program at CHOC, it was found that case-managed children "completed significantly more visits to their primary care provider" and had "significantly fewer emergency room visits." Case managers were found to be effective in assisting families with scheduling doctors' appointments, ensuring that families receive the correct referrals for specialty care, providing them with additional resources, and tracking the health care needs of all family members[4].

CalKids' experience. The CalKids Case Management Program at CHOC represented an effort to close the final gap between enrollment and utilization. CalKids and CHOC sought to understand the effect of case management on utilization. CHOC personnel included one nurse, one care coordinator, and a CAA. CAA participation was critical in helping parents enroll in the program and gain greater awareness of their role in their children's health care. Parents reported gaining significantly better understanding of the appropriate use of health care services and the best ways to access those services.

The results of the CHOC study on case management informed several program improvements for CalKids. Clearly, case management improves knowledge of the program and utilization of services. The study also found that case management contributed to the lowering of attrition rates as compared to other programs. Other findings helped CalKids understand and improve its member orientation process, in which it uses the assistance of CAAs to help enroll members and explain basic program benefits.

10) **Standard ID cards.** The CalKids program issues standard Blue Cross and SafeGuard ID cards to all of its members, allowing families to show proof of their children's coverage to providers while eliminating the need for embarrassing questions about their ability to pay at the point of service. CalKids believes in treating all families with dignity and respect, and families say they feel a sense of pride in having the ID cards for their children. The cards are identical to those issued for commercial members.

11) **Benefit Design and Provider Network Flexibility.** In an effort to enhance access and increase utilization of benefits, CalKids has met with community stakeholders to better understand the various barriers to access and take the necessary actions to improve the health outcomes of its members.

CalKids' experience. In Marin County, access to dental providers was limited, and member copayments were determined to be a barrier to access as well. In response to these concerns, CalKids changed its dental network to a preferred provider network (PPO), changed its provider reimbursement arrangement to a PPO schedule, and eliminated member copayments. These actions were also adopted in Del Norte, El Dorado, Humboldt, and Mendocino counties.

In addition, it was determined that the behavioral health network in Marin was inadequate and culturally inappropriate to the CalKids population. CalKids and its behavioral health plan, the Holman Group, met with community leaders to address this concern. This resulted in the addition of seven community-based organizations to the network, as well as reimbursement for therapy delivered by licensed providers and supervised interns.

CONCLUSION

CalKids' success can be attributed to 14 years of organizational experience coupled with the combined efforts of individuals who have worked to make substantive changes in the health care system. Throughout the years, CalKids has sought to improve its program and operations through experience, innovation, and evaluation. Although traditional research studies have informed several program improvements and CalKids has developed and implemented several innovative strategies of its own, the Foundation believes that its greatest lessons learned have come directly from the families, children, and communities it serves.

The aforementioned lessons learned can serve as building blocks for other agencies and organizations seeking to implement efforts similar to that of CalKids. CalKids considers these lessons learned to be universal and, that they can be implemented by any organization working with low-income families and communities. *In summary, they are as follows:*

Throughout the years, CalKids has sought to improve its program and operations through experience, innovation, and evaluation.
...the Foundation believes that its greatest lessons learned have come directly from the families, children, and communities it serves.

1) **Trust.** Build trust by involving families; they will spread the word.

2) **Partnerships.** Engage local agencies and organizations in your work; build bridges.

3) **Flexibility.** Demonstrate awareness and understanding of the diverse needs of the communities you serve, and be prepared to offer a variety of solutions to meet family needs.

4) **Local presence.** Ensure that you have local points of contact in the community; members need to sense that they are "connected."

5) **Member education.** Invest in member education; the more informed your members are, the better decision makers they will be.

6) **One-page application.** Keep it simple; complex applications will result in lower enrollment.

7) **Demographics.** Know your members; be respectful of their privacy, and know that culture and values matter.

8) **Share of cost.** Invite participation by parents; they want to contribute.

9) **Case management.** Manage benefit utilization for appropriateness of use and better outcomes.

10) **Standard ID cards.** Issue ID cards that give families a sense of dignity and pride.

11) **Benefit design and provider network flexibility.** Remain flexible to meet the needs of the member and the community; one size does not fit all.

Innovation

As the first and only program of its kind in California, CalKids has been characterized by innovation since its inception. The Board and staff of the program knew early on that they would have to take some risks and remain willing to test new ideas. CalKids gained valuable experience from this approach toward solving organizational challenges. The following section highlights some of the innovations CalKids has implemented.

OUTREACH

CalKids learned the value of partnerships early on, reaching out to a variety of organizations, including schools, health coalitions, and local clinics. Partnering with already well-established programs in communities lent CalKids credibility and visibility. Because many of CalKids' children are from hard-to-reach families, partnering with trusted local organizations helped CalKids identify and enroll eligible children. School nurses were especially important during CalKids' early outreach efforts, as nurses knew the children and had trusted relationships with their parents.

Because many of CalKids' children are from hard-to-reach families, partnering with trusted local organizations helped CalKids identify and enroll eligible children.

The *Pasadena-based Young & Healthy* program was among CalKids' earliest partners. This program provided health care services to children through volunteer physicians on an episodic basis. The concern was that while children received necessary care when needed, the Young & Healthy program did not provide a medical home, nor was it designed to do so. CalKids partnered with Young & Healthy to identify eligible children and enroll them into the CalKids program, thereby providing them with much-needed continuity of care and a medical home.

Another example of an innovative CalKids outreach strategy was the *Vaughn Street Elementary School project* in Pacoima, California. This pilot project involved working with involved parents or promotores to identify all children who were uninsured, help enroll them into either a government-sponsored health program or CalKids, and develop and implement a school-based health clinic to provide children with basic preventive and primary health care services at the school.

These are just two examples of how CalKids was able to establish a local presence for itself through other trusted organizations. Without the aid of its outreach network, CalKids would likely have faced impediments both in locating hard-to-reach children and families and in fostering the trust necessary for families to enroll their children in the program.

An unexpected consequence of CalKids' active outreach efforts was the ability to increase enrollment for other programs. Through its partnerships, CalKids was able to identify families whose children's immigration status varied. Often, younger children were born in the

United States and qualified for government-sponsored health care programs, while other, older children did not have the necessary documentation. CalKids served as an option for undocumented children, thereby ensuring that all children in such families had access to health care services. The result was increased enrollment in Medi-Cal and Healthy Families along with a corresponding decrease in the overall number of uninsured children.

Another unintended consequence of CalKids' strong partnerships was the ability to help educate families about navigating the health care system. Many of CalKids' families had no previous health insurance and did not understand basic insurance concepts. CalKids was able to help families become informed health care consumers and gain a positive experience with the health care system.

CalKids' success at outreach required a significant investment of time to identify, establish, and nurture the relationships needed to build trust in the community. Sustaining these relationships in local communities allowed CalKids to build the infrastructure it needed to support future outreach efforts. Over time, this allowed the Foundation to identify eligible children, enroll them in the appropriate programs, and educate parents about the health care system.

FUNDRAISING

Of the many fundraising strategies CalKids has developed, its partnership with Major League Baseball was likely its most innovative. This partnership evolved when CalKids joined forces with Procter & Gamble in a cause-related marketing campaign that attracted the attention of the Los Angeles Dodgers. The campaign consisted of a baseball player whose batting performance triggered contributions to CalKids; for each hit, sponsors donated to CalKids. In addition, the radio station broadcasting the game donated a 30-second in-game and post-game radio spot recognizing the athlete, the sponsors, and CalKids. CalKids' partnership with Procter & Gamble and Major League Baseball subsequently expanded to include the Angels, Giants, A's, and Padres. The campaign continued for several years and raised more than $600,000 for the program. At the conclusion of its three-year Procter & Gamble commitment, CalKids continued its partnership with the Dodgers and Angels — a partnership that not only generated financial support but further promoted awareness of the CalKids program.

The high visibility of the Major League Baseball promotion subsequently prompted other large corporations to get involved. CalKids then became engaged in other cause-related marketing campaigns as well as in annual employee giving campaigns.

CalKids suggests that counties or other entities planning to launch children's health initiatives have a minimum of three years of funding in place before starting the enrollment process.

Although these fundraising efforts were seen as innovative at the time, CalKids learned early on that they alone would not generate enough income to sustain a program. Philanthropic and corporate contributions were essential funding streams in CalKids' early years; however, over time it became critical to establish more secure, longer-term funding strategies. CalKids suggests that counties or other entities planning to launch children's health initiatives have a minimum of three years of funding in place before starting the enrollment process.

ADVOCACY

CalKids has been a strategic and trusted partner to key stakeholders at both the federal and state level. By sharing the fundamental components and experience of its program, CalKids has played an influential role in inspiring and launching several statewide and local children's health initiatives, including Healthy Families, Healthy Kids, and KP Cares for Kids.

In addition to undocumented children, CalKids learned that another, much smaller at-risk population — that of emancipated foster youth — was also going without the health care they needed. Once they were emancipated from the foster care system, such youth were automatically excluded from Medi-Cal coverage upon reaching their 18th birthday. Successful advocacy by CalKids and the California Partnership for Children resulted in the extension of Medi-Cal coverage for emancipated foster youth up to their 21st birthday.

PARTNERSHIPS

CalKids has relied greatly on the strength of its partnerships to help achieve its mission. The following are some examples of the innovative partnerships CalKids has established over the years.

Hospital systems. In 1998, *St. Joseph Health System, Hoag Memorial Hospital Presbyterian, and CHOC* partnered with CalKids to increase access to health care services for children in Orange County. The goal of this partnership was twofold: to establish a medical home for uninsured children and to improve the overall health and well-being of children in the county. To date, more than 8,000 children have received access to health care services as a consequence of this effort. The success of this collaboration resulted from the combined efforts of local government officials, hospitals, corporations, business owners, and local foundations.

Employers. In 2001, CalKids launched an outreach effort to small employers, enabling them to offer health benefits to dependent children of employees. *American Apparel, Inc.,* in Los Angeles was the first employer to offer CalKids coverage to its employees, with more than 100 children found to be eligible to enroll. This outreach effort also helped identify and enroll eligible children in either Medi-Cal or Healthy Families.

Community organizations. In 2003 the *Orange County Community Housing Corporation (OCCHC)* partnered with CalKids in a unique collaboration aimed at providing access to health insurance to children residing in OCCHC housing facilities. To date, more than 250 children have received access to health care services as a result of this effort.

Community foundations. *The Marin Community Foundatio*n and the local First 5 Commission partnered with CalKids in 2000 to ensure that all children in Marin County have access to health coverage. By subsidizing premiums for eligible CalKids members, this collaboration has provided health coverage to more than 1,100 children.

Schools. *Solano Kids Insurance Program (SKIP)* in Solano County partnered with CalKids in 2003 to cover children who were not eligible for government-sponsored programs. The goal of the SKIP program is to provide access to health care coverage to all children in 60 elementary schools in Solano County. To date, more than 33 schools have provided 100 percent of their students with access to health care coverage as a result of this effort. More than 700 children received access to care through the CalKids program, and another 13,000 children have been enrolled in other health care programs.

These innovative partnerships and programs demonstrate what can be achieved when organizations collaborate. Many of these partnerships began as grassroots efforts and have since grown into highly successful programs serving the health care needs of children throughout the state.

EVALUATION

The Board and staff of CalKids are committed to continuous improvement of the CalKids program. To accomplish this goal, CalKids reaches out to its program partners and to the academic and research community to help assess and evaluate the program. Throughout this paper, references have been made to the evaluations highlighted below. These rigorous reviews of program practices and policies have resulted in program improvements and enhancements that we believe have been of direct benefit to the children, families, and communities CalKids serves. Program evaluation highlights are listed in chronological order.

EVALUATION OF THE CALIFORNIAKIDS HEALTHCARE PROGRAM, AUG 1998

Funded by the David & Lucile Packard Foundation, Center for the Future of Children. Conducted by the Institute for Health Policy Studies, University of California, San Francisco

OBJECTIVES

1) Determine the extent to which the CalKids program met the needs of enrolled children from the perspective of families.
2) Assess the feasibility of expanding or replicating the model to cover additional uninsured children in California on the basis of the utilization and expenditure experiences of children enrolled in CalKids compared to children enrolled in commercial health plans.

KEY FINDINGS

- Eligibility criteria must change to ensure that CalKids continues to target children who are ineligible for other insurance programs. The new Healthy Families program will now enroll children who had previously been within the eligibility criteria of CalKids. Eligibility criteria will thus need to change. One option would be to raise the income eligibility threshold above 200 percent of FPL. Alternatively, the program could target undocumented children who will be ineligible for Healthy Families and Medi-Cal regardless of their family income.
- Improvements could be made to the dental component of the program based on data from survey respondents.
- Satisfaction levels with the program overall were high, but ratings for the dental component were less favorable. Specifically, respondents identified a paucity of available providers and the high cost of services.
- The program needs to consider the cultural and linguistic needs of its beneficiaries. Written materials and verbal messages should be provided in multiple languages.

REPLICABILITY

- The program has great appeal, does not require appropriation of public dollars, and has low administrative costs.
- It is questionable that the program could expand to accommodate those who remain uninsured (approximately 700,000) even after full implementation of Healthy Families and new Medi-Cal reforms.
- Expansion of the program would require additional staff, the raising of administrative costs, and continued pro bono claims processing and other administrative services.
- Current financing has proven workable through donations, grants, and other fundraising support, but the raising of funds for significantly larger numbers of children is less certain.
- Replicability is questionable from the standpoint of a comprehensive health plan. In its current configuration, the program relies on charity and does not cover hospital inpatient care or services such as mental health or learning disabilities.

CONCLUSION

Overall, the study's findings suggest that the CalKids program produced positive results. Taken together, they also suggest that despite conventional wisdom, the children CalKids serves are no more costly than other, higher-income children with respect to medical care costs.

FINAL REPORT, CALKIDS HEALTHCARE STUDY, MAR 1999

Social and Behavioral Research Institute, California State University, San Marcos

OBJECTIVES

1) Evaluate the delivery of service of the program to its clients.
2) Assess the interest in this type of low-cost health care program for children within the service of the San Diego Unified School District (SDUSD).
3) Assess interest in expansion of the program outside the current service district.

KEY FINDINGS

- Program subscribers seemed pleased with the services provided by CalKids. They were also pleased with the overall program, including its information, pricing structure, and current level of program use.

- Most (nonsubscriber households outside SDUSD) respondents (84 percent) who did not have coverage for their children indicated that if affordable health care coverage were available, they would be very likely to purchase the coverage.
- Families are willing to pay a monthly amount for their children's health care.
- Fewer than half (43 percent) of respondents remembered having seen the informational flyer, indicating that most subscribers learned about the program from other sources.
- Of those who saw the flyer, high proportions (99 percent) said it was easy to understand, and 90 percent said they understood the pricing information contained in the flyer.

EVALUATION OF THE LOS ANGELES CALKIDS PROGRAM, DEC 2001

Prepared for California HealthCare Foundation by the Center for Health Financing, Policy, and Management, School of Policy, Planning, and Development, University of Southern California. A copy of the study is available online at: www.chcf.org

OBJECTIVES

1) Enrollment and outreach methods. To what extent was the program able to attract sufficient numbers of children from the eligible population? What outreach methods seemed to work best for this population?
2) Access, utilization, and costs. Did health insurance coverage reduce financial barriers to access and help the target population increase appropriate utilization of health services?
3) Satisfaction with the program. To what extent were families satisfied with the program and its services?

KEY FINDINGS

Enrollment and Outreach:

- The LA CalKids program was very successful in enrolling the uninsured immigrant-eligible population. Enrollment was robust from the beginning, and the program exceeded its target enrollment of 4,000 children, reaching 6,000 within 24 months.
- Various outreach methods were employed, most using trusted local agents to inform and enroll members. No single strategy emerged as superior; however, word of mouth proved to be the strongest enrollment mechanism.
- Parents were concerned that enrollment in LA CalKids and the perception of a public subsidy ("public charge") would jeopardize them or their children in their application for legal immigration and citizenship.

Access:

- Even before enrollment in LA CalKids, most families had a regular source of care. Upon enrollment, families were more likely to use physicians rather than clinics as their regular source of care. Their perceptions and experiences following enrollment suggest that access substantially improved under LA CalKids.
- Enrollee perceptions of access: Many families reported access problems prior to enrolling in LA CalKids. Nearly 30 percent indicated that they had forgone needed medical care for their children at least once in the six months prior to enrollment. More than three-quarters of those unable to obtain care cited cost as the primary barrier; 6 percent said they could not find a provider to see their children, and 5 percent cited inconvenient provider hours.
- Transportation: Travel times showed a slight increase following enrollment (possibly due to members' need to select providers from a designated list) but did not appear to be a significant barrier.

Utilization:

- Dental use surged. The proportion of children using dental services nearly doubled following enrollment, far exceeding that of children in comparison groups, suggesting a significant need among the largely immigrant population covered by the program.
- Physician use was extremely low prior to enrollment. Even though it increased following enrollment, it remained low. Although physician visits increased following enrollment, the rates were still low compared to those of other children.
- Use of emergency rooms decreased following enrollment in LA CalKids. This reduction in ER use, combined with the increase in physician visits, suggests that physician use may have substituted for some ER use, reflecting a more appropriate use of resources.
- Use of vision services among children enrolled in LA CalKids was low.
- A high percentage of LA CalKids members did not use any health care services whatsoever in the 6-month periods immediately preceding and following enrollment.

Cost:

- Families reduced out-of-pocket costs under LA CalKids.
- Overall satisfaction with the LA CalKids program was very high, and participants were highly likely to recommend it to others.
- Dental benefits were highly valued by enrollees.
- Enrollees identified multilingual and simplified benefit information as areas needing improvement.

- Although enrollee satisfaction was extremely high, the re-enrollment rate was very low.

Policy Implications:

- Low-income immigrant families will enroll in formal health insurance programs.
- Maintaining enrollment requires new approaches by health insurance programs along with additional research to better understand the demand for health insurance among low-income immigrant families.
- Additional outreach and educational efforts may be needed to ensure that enrollees fully understand program benefits and how to access them.
- Discounted fee-for-service payment for physician services may be preferable to capitation given the lower-than-expected utilization of services in this population.

Opportunities for Program Improvements:

- Maintaining greater contact with enrollees in order to encourage re-enrollment.
- Better educating enrollees about program benefits and how to access services.
- Reviewing financial arrangement with plans and providers to ensure that available funds are used to maximum advantage.

CHILDREN'S HOSPITAL OF ORANGE COUNTY: AN EVALUATION OF THE CALIFORNIAKIDS CASE MANAGEMENT PROGRAM, OCT 2004

Prepared by Research Support Services, Olivia de la Rocha, Ph.D., Scientific Staff

OBJECTIVES: The study posed five questions that statistical and qualitative data were used to answer.

1) What is the cost per child to administer the program, and how are costs distributed across various sources of expense?
2) Is case management more effective than no case management in impacting utilization?
3) What is the pattern of specialty care utilization? Are children getting to needed specialists, and where are they being referred?
4) Are parents' knowledge and beliefs changed by the program's educational efforts? And do parents who are case managed gain more information than those without the benefit of case management?
5) What do parents believe they got from the program's case management?

KEY FINDINGS

- Cost per child to administer the program. The findings are based on medical claims data from CHOC Health Alliance, CHOC administrative costs, the cost of a nurse and care coordinator, and CalKids' capitated monthly rate of just over $14 per member per month, covering vision, dental, behavioral health, and prescription drugs. Taken together, the average cost for a case-managed child per month was just under $68. It is likely that this cost could be further reduced, as the program had the capacity to serve more children. The paid claims portion of the costs was further broken down into primary care (65 percent), labs and imaging (20 percent), specialty care (11 percent), hospital and surgery (2 percent), and emergency medicine (2 percent).
- Effectiveness of case management. Case management was unequivocally deemed effective. Over the same 6-month periods in 2002 and 2003, case-managed children completed significantly more visits and had submitted on their behalf significantly more claims for primary care and specialty care. They also had significantly fewer emergency medicine claims than the comparison group.
- Patterns of specialty care. Although the risk assessment component of the program encountered only 57 children who required specialty care referrals directly from the program, 114 referrals were made on their behalf. These referrals were made in four general areas: medical/prevention (50 percent), social services (26 percent), psychological counseling (12 percent), and educational (12 percent).
- Parents' knowledge and beliefs. Case-managed parents made significant and measurable gains in their levels of knowledge from the time they were intercepted initially by the case management team and again six months later. It is presumed that the case management team imparted much of the knowledge. However, focus groups revealed that parents reported they were very conscientious about reading through and readily referring to the printed materials that were supplied to them by CalKids, especially when such materials were provided in Spanish. Parents educated by the case management team also overcame gaps in their knowledge that had existed between them and the comparison group when they first entered the case management group. They did not exceed the comparison group scores on a follow-up questionnaire; however, that is what the evaluation team anticipated.

- What parents believe they got from the case management program. Most parents told us that their reward for being involved with CalKids was a sense of security and peace of mind that they had not previously enjoyed. They also saw the case management team as an important resource in helping them utilize their coverage, although they failed to demonstrate any awareness of the different roles played by the team members. Absent to some degree, also, was a sense that the concept of prevention had really taken hold in the groups of parents that participated in the focus groups.

STUDY RECOMMENDATIONS

- Overall, the case management program has successfully narrowed the gap between outreach, application, and full utilization of health care services.
- Strengthen the parent educational component. Offer a special segment on prevention. Results show that parents still believe they need to take their children to the doctor only when the children are ill.

Part 3: Our Future

CalKids has a long history of success in working with diverse stakeholders. The organization is committed to sharing its experience by working collaboratively with communities to develop and implement solutions that work. Thousands of children are still without access to health care. CalKids is actively working with local, county and state organizations to seek long-term solutions — but in the interim, we have a program that works today. The CalKids program is the bridge to comprehensive health care services for uninsured children.

Our years of experience have contributed to a vast body of knowledge and understanding about the needs of uninsured children and their families. We offer a variety of services designed to help counties and other organizations develop and implement children's health programs. *These include the following:*

Turnkey program with a statewide network of quality health care providers and community-based outreach partners

Affordable, cost-effective benefit package that includes outpatient medical, emergency care, and dental, vision, pharmacy, and behavioral health care services

Annual benefit reviews to ensure that children are receiving necessary, high-quality health care services, and the flexibility to customize the benefit package and provider network as needs arise

Dedicated, experienced staff with bilingual member education, customer service, and enrollment assistance

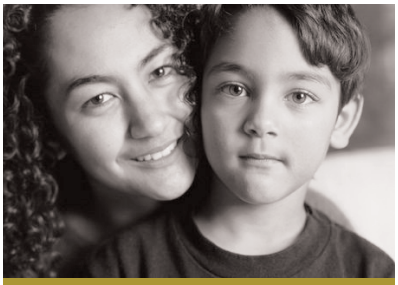
Leading-edge administrative systems that provide real-time membership and enrollment data; streamlined billing and collection functions; and customized report generation

Leveraging of our administrative systems to create an almost paperless process

Knowledge of the health care industry and political forces that influence it

Expertise in fundraising and cause-related marketing with foundations, corporations, businesses, and local First 5 children's health commissions

Trusted partnerships with health care providers and community-based organizations



We are committed to sharing our experience by working collaboratively with communities to develop and implement solutions that work.

CONCLUSION

Fourteen years ago, before CalKids enrolled its first child, the Board and staff took steps to ensure that every CalKids family, regardless of citizenship status, would be treated with dignity and respect. That commitment remains unchanged. Although the immigration debate continues, the Board and staff of CalKids remain focused on their mission to provide access to health care services for uninsured children in California, regardless of immigration status.

CalKids members today are largely undocumented children, and the program will continue to seek out California's most vulnerable children. CalKids is currently providing access to health care services to more than 10,000 children and is expanding its program into Humboldt, Imperial, and Mendocino counties through a generous grant from the California HealthCare Foundation. With matching funds from those counties, CalKids will expand its program by enrolling 1,500 children in the very near future. CalKids is committed to continuing to work with policymakers, counties, and other organizations to develop long-term solutions to ensure that every child in California has access to the health care services they need and deserve. ◢

REFERENCES

Testimony of Michael J. Koch, Executive Director, CaliforniaKids Healthcare Foundation, before the U.S. Senate Committee on Finance, April 20, 1997.

ENDNOTES

1 UCLA Center for Health Policy Studies, 1992.

2 CaliforniaKids Healthcare Survey, Social and Behavioral Research Institute, California State University, San Marcos, 1999.

3 Evaluation of the Los Angeles CaliforniaKids Program, Center for Health Financing, Policy, and Management, School of Policy, Planning, and Development, University of Southern California, December 2001.

4 de la Rocha, Olivia, Children's Hospital of Orange County: An Evaluation of the CaliforniaKids Case Management Program, October 15, 2004.

5 Evaluation of the CaliforniaKids Healthcare Program—Final Report; Institute for Health Policy Studies, University of California, San Francisco, August 1998.

CaliforniaKids Healthcare Foundation
5200 Lankershim Boulevard, Suite 360
North Hollywood, CA 91601

www.californiakids.org

Printed December 2006